

# ICD-11

## International Classification of Diseases for Mortality and Morbidity Statistics

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Eleventh Revision

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World Health  
Organization

## CHAPTER 06

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# Mental, behavioural or neurodevelopmental disorders

This chapter has 162 four-character categories.

Code range starts with 6A00

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

**Exclusions:** Acute stress reaction (QE84)  
Uncomplicated bereavement (QE62)

**Coded Elsewhere:** Sleep-wake disorders (7A00-7B2Z)  
Sexual dysfunctions (HA00-HA0Z)  
Gender incongruence (HA60-HA6Z)

This chapter contains the following top level blocks:

- Neurodevelopmental disorders
- Schizophrenia or other primary psychotic disorders
- Catatonia
- Mood disorders
- Anxiety or fear-related disorders
- Obsessive-compulsive or related disorders
- Disorders specifically associated with stress
- Dissociative disorders
- Feeding or eating disorders
- Elimination disorders
- Disorders of bodily distress or bodily experience
- Disorders due to substance use or addictive behaviours
- Impulse control disorders
- Disruptive behaviour or dissocial disorders
- Personality disorders and related traits
- Paraphilic disorders
- Factitious disorders
- Neurocognitive disorders

- Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium
- Secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere

## Neurodevelopmental disorders (6A00-6A0Z)

Neurodevelopmental disorders are behavioural and cognitive disorders that arise during the developmental period that involve significant difficulties in the acquisition and execution of specific intellectual, motor, language, or social functions. Although behavioural and cognitive deficits are present in many mental and behavioural disorders that can arise during the developmental period (e.g., Schizophrenia, Bipolar disorder), only disorders whose core features are neurodevelopmental are included in this grouping. The presumptive etiology for neurodevelopmental disorders is complex, and in many individual cases is unknown.

**Coded Elsewhere:** Primary tics or tic disorders (8A05.0)

Secondary neurodevelopmental syndrome (6E60)

### 6A00

#### Disorders of intellectual development

Disorders of intellectual development are a group of etiologically diverse conditions originating during the developmental period characterised by significantly below average intellectual functioning and adaptive behaviour that are approximately two or more standard deviations below the mean (approximately less than the 2.3rd percentile), based on appropriately normed, individually administered standardized tests. Where appropriately normed and standardized tests are not available, diagnosis of disorders of intellectual development requires greater reliance on clinical judgment based on appropriate assessment of comparable behavioural indicators.

**Coding Note:** Use additional code, if desired, to identify any known aetiology.

**Exclusions:** Dementia (6D80-6D8Z)

#### 6A00.0

##### Disorder of intellectual development, mild

A mild disorder of intellectual development is a condition originating during the developmental period characterised by significantly below average intellectual functioning and adaptive behaviour that are approximately two to three standard deviations below the mean (approximately 0.1 – 2.3 percentile), based on appropriately normed, individually administered standardized tests or by comparable behavioural indicators when standardized testing is unavailable. Affected persons often exhibit difficulties in the acquisition and comprehension of complex language concepts and academic skills. Most master basic self-care, domestic, and practical activities. Persons affected by a mild disorder of intellectual development can generally achieve relatively independent living and employment as adults but may require appropriate support.

**6A00.1****Disorder of intellectual development, moderate**

A moderate disorder of intellectual development is a condition originating during the developmental period characterised by significantly below average intellectual functioning and adaptive behaviour that are approximately three to four standard deviations below the mean (approximately 0.003 – 0.1 percentile), based on appropriately normed, individually administered standardized tests or by comparable behavioural indicators when standardized testing is unavailable. Language and capacity for acquisition of academic skills of persons affected by a moderate disorder of intellectual development vary but are generally limited to basic skills. Some may master basic self-care, domestic, and practical activities. Most affected persons require considerable and consistent support in order to achieve independent living and employment as adults.

**6A00.2****Disorder of intellectual development, severe**

A severe disorder of intellectual development is a condition originating during the developmental period characterised by significantly below average intellectual functioning and adaptive behaviour that are approximately four or more standard deviations below the mean (less than approximately the 0.003rd percentile), based on appropriately normed, individually administered standardized tests or by comparable behavioural indicators when standardized testing is unavailable. Affected persons exhibit very limited language and capacity for acquisition of academic skills. They may also have motor impairments and typically require daily support in a supervised environment for adequate care, but may acquire basic self-care skills with intensive training. Severe and profound disorders of intellectual development are differentiated exclusively on the basis of adaptive behaviour differences because existing standardized tests of intelligence cannot reliably or validly distinguish among individuals with intellectual functioning below the 0.003rd percentile.

**6A00.3****Disorder of intellectual development, profound**

A profound disorder of intellectual development is a condition originating during the developmental period characterised by significantly below average intellectual functioning and adaptive behaviour that are approximately four or more standard deviations below the mean (approximately less than the 0.003rd percentile), based on individually administered appropriately normed, standardized tests or by comparable behavioural indicators when standardized testing is unavailable. Affected persons possess very limited communication abilities and capacity for acquisition of academic skills is restricted to basic concrete skills. They may also have co-occurring motor and sensory impairments and typically require daily support in a supervised environment for adequate care. Severe and profound disorders of intellectual development are differentiated exclusively on the basis of adaptive behaviour differences because existing standardized tests of intelligence cannot reliably or validly distinguish among individuals with intellectual functioning below the 0.003rd percentile.

**6A00.4 Disorder of intellectual development, provisional**

Disorder of intellectual development, provisional is assigned when there is evidence of a disorder of intellectual development but the individual is an infant or child under the age of four or it is not possible to conduct a valid assessment of intellectual functioning and adaptive behaviour because of sensory or physical impairments (e.g., blindness, pre-lingual deafness), motor or communication impairments, severe problem behaviours or co-occurring mental and behavioural disorders.

**6A00.Z Disorders of intellectual development, unspecified**

**Coding Note:** Use additional code, if desired, to identify any known aetiology.

**6A01**

**Developmental speech or language disorders**

Developmental speech or language disorders arise during the developmental period and are characterised by difficulties in understanding or producing speech and language or in using language in context for the purposes of communication that are outside the limits of normal variation expected for age and level of intellectual functioning. The observed speech and language problems are not attributable to regional, social, or cultural/ethnic language variations and are not fully explained by anatomical or neurological abnormalities. The presumptive aetiology for Developmental speech or language disorders is complex, and in many individual cases, is unknown.

**6A01.0 Developmental speech sound disorder**

Developmental speech sound disorder is characterised by difficulties in the acquisition, production and perception of speech that result in errors of pronunciation, either in number or types of speech errors made or the overall quality of speech production, that are outside the limits of normal variation expected for age and level of intellectual functioning and result in reduced intelligibility and significantly affect communication. The errors in pronunciation arise during the early developmental period and cannot be explained by social, cultural, and other environmental variations (e.g., regional dialects). The speech errors are not fully explained by a hearing impairment or a structural or neurological abnormality.

**Inclusions:** Functional speech articulation disorder

**Exclusions:** Deafness not otherwise specified (AB52)

Diseases of the nervous system (Chapter 08)

Dysarthria (MA80.2)

Verbal apraxia (MB4A)

**6A01.1 Developmental speech fluency disorder**

Developmental speech fluency disorder is characterised by frequent or pervasive disruption of the normal rhythmic flow and rate of speech characterised by repetitions and prolongations in sounds, syllables, words, and phrases, as well as blocking and word avoidance or substitutions. The speech dysfluency is persistent over time. The onset of speech dysfluency occurs during the developmental period and speech fluency is markedly below what would be expected for age. Speech dysfluency results in significant impairment in social communication, personal, family, social, educational, occupational or other important areas of functioning. The speech dysfluency is not better accounted for by a Disorder of Intellectual Development, a Disease of the Nervous System, a sensory impairment, or a structural abnormality, or other speech or voice disorder.

**Exclusions:** Tic disorders (8A05)

**6A01.2 Developmental language disorder**

Developmental language disorder is characterised by persistent deficits in the acquisition, understanding, production or use of language (spoken or signed), that arise during the developmental period, typically during early childhood, and cause significant limitations in the individual's ability to communicate. The individual's ability to understand, produce or use language is markedly below what would be expected given the individual's age. The language deficits are not explained by another neurodevelopmental disorder or a sensory impairment or neurological condition, including the effects of brain injury or infection.

**Exclusions:** Autism spectrum disorder (6A02)  
Diseases of the nervous system (Chapter 08)  
Deafness not otherwise specified (AB52)  
Selective mutism (6B06)

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

Developmental language disorder with impairment of receptive and expressive language is characterised by persistent difficulties in the acquisition, understanding, production, and use of language that arise during the developmental period, typically during early childhood, and cause significant limitations in the individual's ability to communicate. The ability to understand spoken or signed language (i.e., receptive language) is markedly below the expected level given the individual's age and level of intellectual functioning, and is accompanied by persistent impairment in the ability to produce and use spoken or signed language (i.e., expressive language).

**Inclusions:** developmental dysphasia or aphasia, receptive type  
**Exclusions:** acquired aphasia with epilepsy [Landau-Kleffner] (8A62.2)  
Autism spectrum disorder (6A02)  
Selective mutism (6B06)  
dysphasia NOS (MA80.1)  
Diseases of the nervous system (Chapter 08)  
Deafness not otherwise specified (AB52)

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

Developmental language disorder with impairment of mainly expressive language is characterised by persistent difficulties in the acquisition, production, and use of language that arise during the developmental period, typically during early childhood, and cause significant limitations in the individual's ability to communicate. The ability to produce and use spoken or signed language (i.e., expressive language) is markedly below the expected level given the individual's age and level of intellectual functioning, but the ability to understand spoken or signed language (i.e., receptive language) is relatively intact.

- Inclusions:** Developmental dysphasia or aphasia, expressive type
- Exclusions:** acquired aphasia with epilepsy [Landau-Kleffner] (8A62.2)  
 Selective mutism (6B06)  
 dysphasia and aphasia: developmental, receptive type (6A01.20)  
 dysphasia NOS (MA80.1)  
 aphasia NOS (MA80.0)  
 Diseases of the nervous system (Chapter 08)  
 Deafness not otherwise specified (AB52)

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

Developmental language disorder with impairment of mainly pragmatic language is characterised by persistent and marked difficulties with the understanding and use of language in social contexts, for example making inferences, understanding verbal humour, and resolving ambiguous meaning. These difficulties arise during the developmental period, typically during early childhood, and cause significant limitations in the individual's ability to communicate. Pragmatic language abilities are markedly below the expected level given the individual's age and level of intellectual functioning, but the other components of receptive and expressive language are relatively intact. This qualifier should not be used if the pragmatic language impairment is better explained by Autism Spectrum Disorder or by impairments in other components of receptive or expressive language.

- Exclusions:** Diseases of the nervous system (Chapter 08)  
 Selective mutism (6B06)

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

Developmental language disorder with other specified language impairment is characterised by persistent difficulties in the acquisition, understanding, production or use of language (spoken or signed), that arise during the developmental period and cause significant limitations in the individual's ability to communicate. The pattern of specific deficits in language abilities is not adequately captured by any of the other developmental language disorder categories.

- Exclusions:** Autism spectrum disorder (6A02)  
 Diseases of the nervous system (Chapter 08)  
 Disorders of intellectual development (6A00)  
 Selective mutism (6B06)

**6A01.Y Other specified developmental speech or language disorders**

**6A01.Z Developmental speech or language disorders, unspecified**

**6A02**

**Autism spectrum disorder**

Autism spectrum disorder is characterised by persistent deficits in the ability to initiate and to sustain reciprocal social interaction and social communication, and by a range of restricted, repetitive, and inflexible patterns of behaviour, interests or activities that are clearly atypical or excessive for the individual's age and sociocultural context. The onset of the disorder occurs during the developmental period, typically in early childhood, but symptoms may not become fully manifest until later, when social demands exceed limited capacities. Deficits are sufficiently severe to cause impairment in personal, family, social, educational, occupational or other important areas of functioning and are usually a pervasive feature of the individual's functioning observable in all settings, although they may vary according to social, educational, or other context. Individuals along the spectrum exhibit a full range of intellectual functioning and language abilities.

**Inclusions:** Autistic disorder

**Exclusions:** Rett syndrome (LD90.4)

**6A02.0 Autism spectrum disorder without disorder of intellectual development and with mild or no impairment of functional language**

All definitional requirements for autism spectrum disorder are met, intellectual functioning and adaptive behaviour are found to be at least within the average range (approximately greater than the 2.3rd percentile), and there is only mild or no impairment in the individual's capacity to use functional language (spoken or signed) for instrumental purposes, such as to express personal needs and desires.

**6A02.1 Autism spectrum disorder with disorder of intellectual development and with mild or no impairment of functional language**

All definitional requirements for both autism spectrum disorder and disorder of intellectual development are met and there is only mild or no impairment in the individual's capacity to use functional language (spoken or signed) for instrumental purposes, such as to express personal needs and desires.

**6A02.2 Autism spectrum disorder without disorder of intellectual development and with impaired functional language**

All definitional requirements for autism spectrum disorder are met, intellectual functioning and adaptive behaviour are found to be at least within the average range (approximately greater than the 2.3rd percentile), and there is marked impairment in functional language (spoken or signed) relative to the individual's age, with the individual not able to use more than single words or simple phrases for instrumental purposes, such as to express personal needs and desires.

**6A02.3 Autism spectrum disorder with disorder of intellectual development and with impaired functional language**

All definitional requirements for both autism spectrum disorder and disorder of intellectual development are met and there is marked impairment in functional language (spoken or signed) relative to the individual's age, with the individual not able to use more than single words or simple phrases for instrumental purposes, such as to express personal needs and desires.



**6A02.5 Autism spectrum disorder with disorder of intellectual development and with absence of functional language**

All definitional requirements for both autism spectrum disorder and disorder of intellectual development are met and there is complete, or almost complete, absence of ability relative to the individual's age to use functional language (spoken or signed) for instrumental purposes, such as to express personal needs and desires

**6A02.Y Other specified autism spectrum disorder**

**6A02.Z Autism spectrum disorder, unspecified**

**6A03 Developmental learning disorder**

Developmental learning disorder is characterised by significant and persistent difficulties in learning academic skills, which may include reading, writing, or arithmetic. The individual's performance in the affected academic skill(s) is markedly below what would be expected for chronological age and general level of intellectual functioning, and results in significant impairment in the individual's academic or occupational functioning. Developmental learning disorder first manifests when academic skills are taught during the early school years. Developmental learning disorder is not due to a disorder of intellectual development, sensory impairment (vision or hearing), neurological or motor disorder, lack of availability of education, lack of proficiency in the language of academic instruction, or psychosocial adversity.

**Exclusions:** Symbolic dysfunctions (MB4B)

**6A03.0 Developmental learning disorder with impairment in reading**

Developmental learning disorder with impairment in reading is characterised by significant and persistent difficulties in learning academic skills related to reading, such as word reading accuracy, reading fluency, and reading comprehension. The individual's performance in reading is markedly below what would be expected for chronological age and level of intellectual functioning and results in significant impairment in the individual's academic or occupational functioning. Developmental learning disorder with impairment in reading is not due to a disorder of intellectual development, sensory impairment (vision or hearing), neurological disorder, lack of availability of education, lack of proficiency in the language of academic instruction, or psychosocial adversity.

**Exclusions:** Disorders of intellectual development (6A00)

- 6A03.1 Developmental learning disorder with impairment in written expression**  
Developmental learning disorder with impairment in written expression is characterised by significant and persistent difficulties in learning academic skills related to writing, such as spelling accuracy, grammar and punctuation accuracy, and organisation and coherence of ideas in writing. The individual's performance in written expression is markedly below what would be expected for chronological age and level of intellectual functioning and results in significant impairment in the individual's academic or occupational functioning. Developmental learning disorder with impairment in written expression is not due to a disorder of intellectual development, sensory impairment (vision or hearing), a neurological or motor disorder, lack of availability of education, lack of proficiency in the language of academic instruction, or psychosocial adversity.  
**Exclusions:** Disorders of intellectual development (6A00)
- 6A03.2 Developmental learning disorder with impairment in mathematics**  
Developmental learning disorder with impairment in mathematics is characterised by significant and persistent difficulties in learning academic skills related to mathematics or arithmetic, such as number sense, memorization of number facts, accurate calculation, fluent calculation, and accurate mathematic reasoning. The individual's performance in mathematics or arithmetic is markedly below what would be expected for chronological or developmental age and level of intellectual functioning and results in significant impairment in the individual's academic or occupational functioning. Developmental learning disorder with impairment in mathematics is not due to a disorder of intellectual development, sensory impairment (vision or hearing), a neurological disorder, lack of availability of education, lack of proficiency in the language of academic instruction, or psychosocial adversity.  
**Exclusions:** Disorders of intellectual development (6A00)
- 6A03.3 Developmental learning disorder with other specified impairment of learning**  
Developmental learning disorder with other specified impairment of learning is characterised by significant and persistent difficulties in learning academic skills other than reading, mathematics, and written expression. The individual's performance in the relevant academic skill is markedly below what would be expected for chronological age and level of intellectual functioning and results in significant impairment in the individual's academic or occupational functioning. Developmental learning disorder with other specified impairment of learning is not due to a disorder of intellectual development, sensory impairment (vision or hearing), neurological disorder, lack of availability of education, lack of proficiency in the language of academic instruction, or psychosocial adversity.  
**Exclusions:** Disorders of intellectual development (6A00)
- 6A03.Z Developmental learning disorder, unspecified**

**6A04****Developmental motor coordination disorder**

Developmental motor coordination disorder is characterised by a significant delay in the acquisition of gross and fine motor skills and impairment in the execution of coordinated motor skills that manifest in clumsiness, slowness, or inaccuracy of motor performance. Coordinated motor skills are markedly below that expected given the individual's chronological age and level of intellectual functioning. Onset of coordinated motor skills difficulties occurs during the developmental period and is typically apparent from early childhood. Coordinated motor skills difficulties cause significant and persistent limitations in functioning (e.g. in activities of daily living, school work, and vocational and leisure activities). Difficulties with coordinated motor skills are not solely attributable to a Disease of the Nervous System, Disease of the Musculoskeletal System or Connective Tissue, sensory impairment, and not better explained by a Disorder of Intellectual Development.

**Exclusions:**

- Abnormalities of gait and mobility (MB44)
- Diseases of the musculoskeletal system or connective tissue (Chapter 15)
- Diseases of the nervous system (Chapter 08)

**6A05****Attention deficit hyperactivity disorder**

Attention deficit hyperactivity disorder is characterised by a persistent pattern (at least 6 months) of inattention and/or hyperactivity-impulsivity that has a direct negative impact on academic, occupational, or social functioning. There is evidence of significant inattention and/or hyperactivity-impulsivity symptoms prior to age 12, typically by early to mid-childhood, though some individuals may first come to clinical attention later. The degree of inattention and hyperactivity-impulsivity is outside the limits of normal variation expected for age and level of intellectual functioning. Inattention refers to significant difficulty in sustaining attention to tasks that do not provide a high level of stimulation or frequent rewards, distractibility and problems with organisation. Hyperactivity refers to excessive motor activity and difficulties with remaining still, most evident in structured situations that require behavioural self-control. Impulsivity is a tendency to act in response to immediate stimuli, without deliberation or consideration of the risks and consequences. The relative balance and the specific manifestations of inattentive and hyperactive-impulsive characteristics varies across individuals and may change over the course of development. In order for a diagnosis to be made, manifestations of inattention and/or hyperactivity-impulsivity must be evident across multiple situations or settings (e.g., home, school, work, with friends or relatives), but are likely to vary according to the structure and demands of the setting. Symptoms are not better accounted for by another mental, behavioural, or neurodevelopmental disorder and are not due to the effect of a substance or medication.

**Inclusions:**

- attention deficit disorder with hyperactivity
- attention deficit syndrome with hyperactivity

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

All definitional requirements for attention deficit hyperactivity disorder are met and inattentive symptoms are predominant in the clinical presentation. Inattention refers to significant difficulty in sustaining attention to tasks that do not provide a high level of stimulation or frequent rewards, distractibility and problems with organisation. Some hyperactive-impulsive symptoms may also be present, but these are not clinically significant in relation to the inattentive symptoms.

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

All definitional requirements for attention deficit hyperactivity disorder are met and hyperactive-impulsive symptoms are predominant in the clinical presentation. Hyperactivity refers to excessive motor activity and difficulties with remaining still, most evident in structured situations that require behavioural self-control. Impulsivity is a tendency to act in response to immediate stimuli, without deliberation or consideration of the risks and consequences. Some inattentive symptoms may also be present, but these are not clinically significant in relation to the hyperactive-impulsive symptoms.

**6A05.2 Attention deficit hyperactivity disorder, combined presentation**

All definitional requirements for attention deficit hyperactivity disorder are met. Both inattentive and hyperactive-impulsive symptoms are clinically significant, with neither predominating in the clinical presentation. Inattention refers to significant difficulty in sustaining attention to tasks that do not provide a high level of stimulation or frequent rewards, distractibility and problems with organisation. Hyperactivity refers to excessive motor activity and difficulties with remaining still, most evident in structured situations that require behavioural self-control. Impulsivity is a tendency to act in response to immediate stimuli, without deliberation or consideration of the risks and consequences.

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

**6A05.Z Attention deficit hyperactivity disorder, presentation unspecified**

**6A06 Stereotyped movement disorder**

Stereotyped movement disorder is characterised by the persistent (e.g., lasting several months) presence of voluntary, repetitive, stereotyped, apparently purposeless (and often rhythmic) movements that arise during the early developmental period, are not caused by the direct physiological effects of a substance or medication (including withdrawal), and markedly interfere with normal activities or result in self-inflicted bodily injury. Stereotyped movements that are non-injurious can include body rocking, head rocking, finger-flicking mannerisms, and hand flapping. Stereotyped self-injurious behaviours can include repetitive head banging, face slapping, eye poking, and biting of the hands, lips, or other body parts.

**Exclusions:** Tic disorders (8A05)  
Trichotillomania (6B25.0)  
Abnormal involuntary movements (MB46)

**6A06.0****Stereotyped movement disorder without self-injury**

This category should be applied to forms of Stereotyped movement disorder in which stereotyped behaviours markedly interfere with normal activities, but do not result in self-inflicted bodily injury. Stereotyped movement disorder without self-injury is characterised by voluntary, repetitive, stereotyped, apparently purposeless (and often rhythmic) movements that arise during the early developmental period, are not caused by the direct physiological effects of a substance or medication (including withdrawal), and markedly interfere with normal activities. Stereotyped movements that are non-injurious can include body rocking, head rocking, finger-flicking mannerisms, and hand flapping.

**6A06.1****Stereotyped movement disorder with self-injury**

This category should be applied to forms of Stereotyped movement disorder in which stereotyped behaviours result in self-inflicted bodily injury that is significant enough to require medical treatment, or would result in such injury if protective measures (e.g., helmet to prevent head injury) were not employed. Stereotyped movement disorder with self-injury is characterised by voluntary, repetitive, stereotyped, apparently purposeless (and often rhythmic) movements that arise during the early developmental period, are not caused by the direct physiological effects of a substance or medication (including withdrawal). Stereotyped movements that are self-injurious can include head banging, face slapping, eye poking, and biting of the hands, lips, or other body parts.

**6A06.Z****Stereotyped movement disorder, unspecified****6A0Y****Other specified neurodevelopmental disorders****6A0Z****Neurodevelopmental disorders, unspecified**

## Schizophrenia or other primary psychotic disorders (6A20-6A2Z)

Schizophrenia and other primary psychotic disorders are characterised by significant impairments in reality testing and alterations in behaviour manifest in positive symptoms such as persistent delusions, persistent hallucinations, disorganised thinking (typically manifest as disorganised speech), grossly disorganised behaviour, and experiences of passivity and control, negative symptoms such as blunted or flat affect and avolition, and psychomotor disturbances. The symptoms occur with sufficient frequency and intensity to deviate from expected cultural or subcultural norms. These symptoms do not arise as a feature of another mental and behavioural disorder (e.g., a mood disorder, delirium, or a disorder due to substance use). The categories in this grouping should not be used to classify the expression of ideas, beliefs, or behaviours that are culturally sanctioned.

**Coded Elsewhere:** Substance-induced psychotic disorders

Secondary psychotic syndrome (6E61)

### 6A20

#### Schizophrenia

Schizophrenia is characterised by disturbances in multiple mental modalities, including thinking (e.g., delusions, disorganisation in the form of thought), perception (e.g., hallucinations), self-experience (e.g., the experience that one's feelings, impulses, thoughts, or behaviour are under the control of an external force), cognition (e.g., impaired attention, verbal memory, and social cognition), volition (e.g., loss of motivation), affect (e.g., blunted emotional expression), and behaviour (e.g., behaviour that appears bizarre or purposeless, unpredictable or inappropriate emotional responses that interfere with the organisation of behaviour). Psychomotor disturbances, including catatonia, may be present. Persistent delusions, persistent hallucinations, thought disorder, and experiences of influence, passivity, or control are considered core symptoms. Symptoms must have persisted for at least one month in order for a diagnosis of schizophrenia to be assigned. The symptoms are not a manifestation of another health condition (e.g., a brain tumour) and are not due to the effect of a substance or medication on the central nervous system (e.g., corticosteroids), including withdrawal (e.g., alcohol withdrawal).

**Exclusions:** Schizotypal disorder (6A22)  
schizophrenic reaction (6A22)  
Acute and transient psychotic disorder (6A23)

#### 6A20.0

##### Schizophrenia, first episode

Schizophrenia, first episode should be used to identify individuals experiencing symptoms that meet the diagnostic requirements for Schizophrenia (including duration) but who have never before experienced an episode during which diagnostic requirements for Schizophrenia were met.

#### 6A20.00

Schizophrenia, first episode, currently symptomatic

All definitional requirements for Schizophrenia, first episode in terms of symptoms and duration are currently met, or have been met within the past one month.

- 6A20.01** Schizophrenia, first episode, in partial remission  
All definitional requirements for Schizophrenia, first episode in terms of symptoms and duration were previously met. Symptoms have ameliorated such that the diagnostic requirements for the disorder have not been met for at least one month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment. The partial remission may have occurred in response to medication or other treatment.
- 6A20.02** Schizophrenia, first episode, in full remission  
All definitional requirements for Schizophrenia, first episode in terms of symptoms and duration were previously met. Symptoms have ameliorated such that no significant symptoms remain. The remission may have occurred in response to medication or other treatment.
- 6A20.0Z** Schizophrenia, first episode, unspecified
- 6A20.1** **Schizophrenia, multiple episodes**  
Schizophrenia, multiple episode should be used to identify individuals experiencing symptoms that meet the diagnostic requirements for Schizophrenia and who have also previously experienced episodes during which diagnostic requirements were met, with substantial remission of symptoms between episodes. Some attenuated symptoms may remain during periods of remission, and remissions may have occurred in response to medication or other treatment.
- 6A20.10** Schizophrenia, multiple episodes, currently symptomatic  
All definitional requirements for Schizophrenia, multiple episodes in terms of symptoms and duration are currently met, or have been met within the past one month.
- 6A20.11** Schizophrenia, multiple episodes, in partial remission  
All definitional requirements for Schizophrenia, multiple episodes in terms of symptoms and duration were previously met. Symptoms have ameliorated such that the diagnostic requirements for the disorder have not been met for at least one month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment. The partial remission may have occurred in response to medication or other treatment.
- 6A20.12** Schizophrenia, multiple episodes, in full remission  
All definitional requirements for Schizophrenia, multiple episodes in terms of symptoms and duration were previously met. Symptoms have ameliorated such that no significant symptoms remain. The remission may have occurred in response to medication or other treatment.
- 6A20.1Z** Schizophrenia, multiple episodes, unspecified
- 6A20.2** **Schizophrenia, continuous**  
Symptoms fulfilling all definitional requirements of Schizophrenia have been present for almost all of the illness course over a period of at least one year, with periods of subthreshold symptoms being very brief relative to the overall course.

- 6A20.20** Schizophrenia, continuous, currently symptomatic  
All definitional requirements for Schizophrenia, continuous in terms of symptoms and duration are currently met, or have been met within the past one month.
- 6A20.21** Schizophrenia, continuous, in partial remission  
All definitional requirements for Schizophrenia, continuous in terms of symptoms and duration were previously met. Symptoms have ameliorated such that the diagnostic requirements for the disorder have not been met for at least one month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment. The partial remission may have occurred in response to medication or other treatment.
- 6A20.22** Schizophrenia, continuous, in full remission  
All definitional requirements for Schizophrenia, continuous in terms of symptoms and duration were previously met. Symptoms have ameliorated such that no significant symptoms remain. The remission may have occurred in response to medication or other treatment.
- 6A20.2Z** Schizophrenia, continuous, unspecified
- 6A20.Y** **Other specified episode of schizophrenia**
- 6A20.Z** **Schizophrenia, episode unspecified**

## **6A21**

### **Schizoaffective disorder**

Schizoaffective disorder is an episodic disorder in which the diagnostic requirements of schizophrenia and a manic, mixed, or moderate or severe depressive episode are met within the same episode of illness, either simultaneously or within a few days of each other. Prominent symptoms of schizophrenia (e.g. delusions, hallucinations, disorganisation in the form of thought, experiences of influence, passivity and control) are accompanied by typical symptoms of a moderate or severe depressive episode (e.g. depressed mood, loss of interest, reduced energy), a manic episode (e.g. an extreme mood state characterised by euphoria, irritability, or expansiveness; increased activity or a subjective experience of increased energy) or a mixed episode. Psychomotor disturbances, including catatonia, may be present. Symptoms must have persisted for at least one month. The symptoms are not a manifestation of another medical condition (e.g. a brain tumor) and are not due to the effect of a substance or medication on the central nervous system (e.g. corticosteroids), including withdrawal (e.g. alcohol withdrawal).

### **6A21.0** **Schizoaffective disorder, first episode**

Schizoaffective disorder, first episode should be used to identify individuals experiencing symptoms that meet the diagnostic requirements for Schizoaffective disorder (including duration) but who have never before experienced an episode during which diagnostic requirements for Schizoaffective disorder or Schizophrenia were met.



- 6A21.00** Schizoaffective disorder, first episode, currently symptomatic  
All definitional requirements for Schizoaffective disorder, first episode in terms of symptoms and duration are currently met, or have been met within the past one month.
- 6A21.01** Schizoaffective disorder, first episode, in partial remission  
All definitional requirements for Schizoaffective disorder, first episode in terms of symptoms and duration were previously met. Symptoms have ameliorated such that the diagnostic requirements for the disorder have not been met for at least one month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment. The partial remission may have occurred in response to medication or other treatment.
- 6A21.02** Schizoaffective disorder, first episode, in full remission  
All definitional requirements for Schizoaffective disorder, first episode in terms of symptoms and duration were previously met. Symptoms have ameliorated such that no significant symptoms remain. The remission may have occurred in response to medication or other treatment.
- 6A21.0Z** Schizoaffective disorder, first episode, unspecified
- 6A21.1** **Schizoaffective disorder, multiple episodes**  
Schizoaffective disorder, multiple episodes should be used to identify individuals experiencing symptoms that meet the diagnostic requirements for Schizoaffective disorder and who have also previously experienced episodes during which diagnostic requirements for Schizoaffective disorder or Schizophrenia were met, with substantial remission of symptoms between episodes. Some attenuated symptoms may remain during period of remission, and remissions may have occurred in response to medication or other treatment.
- 6A21.10** Schizoaffective disorder, multiple episodes, currently symptomatic  
All definitional requirements for Schizoaffective disorder, multiple episodes in terms of symptoms and duration are currently met, or have been met within the past one month.
- 6A21.11** Schizoaffective disorder, multiple episodes, in partial remission  
All definitional requirements for Schizoaffective disorder, multiple episodes in terms of symptoms and duration were previously met. Symptoms have ameliorated such that the diagnostic requirements for the disorder have not been met for at least one month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment. The partial remission may have occurred in response to medication or other treatment.
- 6A21.12** Schizoaffective disorder, multiple episodes, in full remission  
All definitional requirements for Schizoaffective disorder, multiple episodes in terms of symptoms and duration were previously met. Symptoms have ameliorated such that no significant symptoms remain. The remission may have occurred in response to medication or other treatment.
- 6A21.1Z** Schizoaffective disorder, multiple episodes, unspecified

- 6A21.2 Schizoaffective disorder, continuous**  
Symptoms fulfilling all definitional requirements of Schizoaffective disorder have been present for almost all of the illness course over a period of at least one year, with periods of subthreshold symptoms being very brief relative to the overall course.
- 6A21.20** Schizoaffective disorder, continuous, currently symptomatic  
All definitional requirements for Schizoaffective disorder, continuous in terms of symptoms and duration are currently met, or have been met within the past one month.
- 6A21.21** Schizoaffective disorder, continuous, in partial remission  
All definitional requirements for Schizoaffective disorder, continuous in terms of symptoms and duration were previously met. Symptoms have ameliorated such that the diagnostic requirements for the disorder have not been met for at least one month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment. The partial remission may have occurred in response to medication or other treatment.
- 6A21.22** Schizoaffective disorder, continuous, in full remission  
All definitional requirements for Schizoaffective disorder, continuous in terms of symptoms and duration were previously met. Symptoms have ameliorated such that no significant symptoms remain. The remission may have occurred in response to medication or other treatment.
- 6A21.2Z** Schizoaffective disorder, continuous, unspecified
- 6A21.Y Other specified schizoaffective disorder**
- 6A21.Z Schizoaffective disorder, unspecified**

**6A22**

**Schizotypal disorder**

Schizotypal disorder is characterised by an enduring pattern (i.e. characteristic of the person's functioning over a period of at least several years) of eccentricities in behaviour, appearance and speech, accompanied by cognitive and perceptual distortions, unusual beliefs, and discomfort with— and often reduced capacity for— interpersonal relationships. Symptoms may include constricted or inappropriate affect and anhedonia. Paranoid ideas, ideas of reference, or other psychotic symptoms, including hallucinations in any modality, may occur, but are not of sufficient intensity or duration to meet the diagnostic requirements of schizophrenia, schizoaffective disorder, or delusional disorder. The symptoms cause distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Inclusions:** Schizotypal personality disorder

**Exclusions:** Autism spectrum disorder (6A02)  
Personality disorder (6D10)

**6A23****Acute and transient psychotic disorder**

Acute and transient psychotic disorder is characterised by acute onset of psychotic symptoms that emerge without a prodrome and reach their maximal severity within two weeks. Symptoms may include delusions, hallucinations, disorganisation of thought processes, perplexity or confusion, and disturbances of affect and mood. Catatonia-like psychomotor disturbances may be present. Symptoms typically change rapidly, both in nature and intensity, from day to day, or even within a single day. The duration of the episode does not exceed 3 months, and most commonly lasts from a few days to 1 month. The symptoms are not a manifestation of another medical condition (e.g. a brain tumour) and are not due to the effect of a substance or medication on the central nervous system (e.g. corticosteroids), including withdrawal (e.g. alcohol withdrawal).

**6A23.0 Acute and transient psychotic disorder, first episode**

Acute and transient psychotic disorder, first episode should be used to identify individuals experiencing symptoms that meet the diagnostic requirements for acute and transient psychotic disorder but who have never before experienced a similar episode.

**6A23.00 Acute and transient psychotic disorder, first episode, currently symptomatic**

All definitional requirements for Acute and transient psychotic disorder, first episode in terms of symptoms and duration are currently met, or have been met within the past one month.

**6A23.01 Acute and transient psychotic disorder, first episode, in partial remission**

All definitional requirements for Acute and transient psychotic disorder, first episode in terms of symptoms and duration were previously met. Symptoms have ameliorated such that the diagnostic requirements for the disorder have not been met for at least one month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment. The partial remission may have occurred in response to medication or other treatment.

**6A23.02 Acute and transient psychotic disorder, first episode, in full remission**

All definitional requirements for Acute and transient psychotic disorder, first episode in terms of symptoms and duration were previously met. Symptoms have ameliorated such that no significant symptoms remain. The remission may have occurred in response to medication or other treatment.

**6A23.0Z Acute and transient psychotic disorder, first episode, unspecified****6A23.1 Acute and transient psychotic disorder, multiple episodes**

Acute and transient psychotic disorder, multiple episodes should be used to identify individuals experiencing symptoms that meet the diagnostic requirements for acute and transient psychotic disorder and who have experienced similar episodes in the past.

**6A23.10 Acute and transient psychotic disorder, multiple episodes, currently symptomatic**

All definitional requirements for Acute and transient psychotic disorder, multiple episodes in terms of symptoms and duration are currently met, or have been met within the past one month.

**6A23.11** Acute and transient psychotic disorder, multiple episodes, in partial remission  
All definitional requirements for Acute and transient psychotic disorder, multiple episodes in terms of symptoms and duration were previously met. Symptoms have ameliorated such that the diagnostic requirements for the disorder have not been met for at least one month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment. The partial remission may have occurred in response to medication or other treatment.

**6A23.12** Acute and transient psychotic disorder, multiple episodes, in full remission  
All definitional requirements for Acute and transient psychotic disorder, multiple episodes in terms of symptoms and duration were previously met. Symptoms have ameliorated such that no significant symptoms remain. The remission may have occurred in response to medication or other treatment.

**6A23.1Z** Acute and transient psychotic disorder, multiple episodes, unspecified

**6A23.Y** **Other specified acute and transient psychotic disorder**

**6A23.Z** **Acute and transient psychotic disorder, unspecified**

**6A24** **Delusional disorder**

Delusional disorder is characterised by the development of a delusion or set of related delusions, typically persisting for at least 3 months and often much longer, in the absence of a Depressive, Manic, or Mixed mood episode. The delusions are variable in content across individuals, but typically stable within individuals, although they may evolve over time. Other characteristic symptoms of Schizophrenia (i.e. clear and persistent hallucinations, negative symptoms, disorganised thinking, or experiences of influence, passivity, or control) are not present, although various forms of perceptual disturbances (e.g. hallucinations, illusions, misidentifications of persons) thematically related to the delusion are still consistent with the diagnosis. Apart from actions and attitudes directly related to the delusion or delusional system, affect, speech, and behavior are typically unaffected. The symptoms are not a manifestation of another medical condition (e.g., a brain tumour) and are not due to the effect of a substance or medication on the central nervous system (e.g. corticosteroids), including withdrawal effects (e.g. alcohol withdrawal).

**6A24.0** **Delusional disorder, currently symptomatic**  
All definitional requirements for Delusional disorder in terms of symptoms and duration are currently met, or have been met within the past one month.

**6A24.1** **Delusional disorder, in partial remission**  
All definitional requirements for Delusional disorder in terms of symptoms and duration were previously met. Symptoms have ameliorated such that the diagnostic requirements for the disorder have not been met for at least one month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment. The partial remission may have occurred in response to medication or other treatment.

**6A24.2 Delusional disorder, in full remission**

All definitional requirements for Delusional disorder in terms of symptoms and duration were previously met. Symptoms have ameliorated such that no significant symptoms remain. The remission may have occurred in response to medication or other treatment.

**6A24.Z Delusional disorder, unspecified**

**6A25**

**Symptomatic manifestations of primary psychotic disorders**

These categories may be used to characterize the current clinical presentation in individuals diagnosed with Schizophrenia or another primary psychotic disorder, and should not be used in individuals without such a diagnosis. Multiple categories may be applied. Symptoms attributable to the direct pathophysiological consequences of a health condition or injury not classified under Mental, behavioural or neurodevelopmental disorders (e.g., a brain tumour or traumatic brain injury), or to the direct effects of a substance or medication on the central nervous system, including withdrawal effects, should not be considered as examples of the respective types of symptoms.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of these symptoms in primary psychotic disorders.

**6A25.0 Positive symptoms in primary psychotic disorders**

Positive symptoms in primary psychotic disorders include persistent delusions, persistent hallucinations (most commonly verbal auditory hallucinations), disorganised thinking (formal thought disorder such as loose associations, thought derailment, or incoherence), grossly disorganised behaviour (behaviour that appears bizarre, purposeless and not goal-directed) and experiences of passivity and control (the experience that one's feelings, impulses, or thoughts are under the control of an external force). The rating should be made based on the severity of positive symptoms during the past week.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of these symptoms in primary psychotic disorders.

**6A25.1 Negative symptoms in primary psychotic disorders**

Negative symptoms in primary psychotic disorders include constricted, blunted, or flat affect, alogia or paucity of speech, avolition (general lack of drive, or lack of motivation to pursue meaningful goals), asociality (reduced or absent engagement with others and interest in social interaction) and anhedonia (inability to experience pleasure from normally pleasurable activities). To be considered negative psychotic symptoms, relevant symptoms should not be entirely attributable to antipsychotic drug treatment, a depressive disorder, or an under-stimulating environment, and should not be a direct consequence of a positive symptom (e.g., persecutory delusions causing a person to become socially isolated due to fear of harm). The rating should be made based on the severity of negative symptoms during the past week.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of these symptoms in primary psychotic disorders.

**6A25.2 Depressive mood symptoms in primary psychotic disorders**

Depressive mood symptoms in primary psychotic disorders refer to depressed mood as reported by the individual (feeling down, sad) or manifested as a sign (e.g. tearful, defeated appearance). If only non-mood symptoms of a depressive episode are present (e.g., anhedonia, psychomotor slowing), this descriptor should not be used. This descriptor may be used whether or not depressive symptoms meet the diagnostic requirements of a separately diagnosed Depressive disorder. The rating should be made based on the severity of depressive mood symptoms during the past week.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of these symptoms in primary psychotic disorders.

**6A25.3 Manic mood symptoms in primary psychotic disorders**

Manic mood symptoms in primary psychotic disorders refer to elevated, euphoric, irritable, or expansive mood states, including rapid changes among different mood states (i.e., mood lability). It also includes increased subjective experience of energy, which may be accompanied by increased goal-directed activity. The severity of associated non-mood symptoms of a Manic or Hypomanic Episode (e.g., decreased need for sleep, distractibility) should not be considered in making a rating. Increased non-goal-directed psychomotor activity should be considered as part of the rating of the 'psychomotor symptoms in primary psychotic disorders' rather than here. This descriptor may be used whether or not the manic symptoms meet the diagnostic requirements of a separately diagnosed bipolar disorder. The rating should be made based on the severity of manic mood symptoms during the past week.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of these symptoms in primary psychotic disorders.

**6A25.4 Psychomotor symptoms in primary psychotic disorders**

Psychomotor symptoms in primary psychotic disorders include psychomotor agitation or excessive motor activity, usually manifested by purposeless behaviours such as fidgeting, shifting, fiddling, inability to sit or stand still, wringing of the hands, psychomotor retardation, or a visible generalised slowing of movements and speech, and catatonic symptoms such as excitement, posturing, waxy flexibility, negativism, mutism, or stupor. The rating should be made based on the severity of psychomotor symptoms during the past week.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of these symptoms in primary psychotic disorders.

### 6A25.5 Cognitive symptoms in primary psychotic disorders

Cognitive symptoms in primary psychotic disorders refer to cognitive impairment in any of the following domains: speed of processing, attention/concentration, orientation, judgment, abstraction, verbal or visual learning, and working memory. The cognitive impairment is not attributable to a neurodevelopmental disorder, a delirium or other neurocognitive disorder, or the direct effects of a substance or medication on the central nervous system, including withdrawal effects. Ideally, use of this category should be based on the results of locally validated, standardized neuropsychological assessments, although such measures may not be available in all settings. The rating should be made based on the severity of cognitive symptoms during the past week.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of these symptoms in primary psychotic disorders.

**Exclusions:** Neurocognitive disorders (6D70-6E0Z)  
Neurodevelopmental disorders (6A00-6A0Z)

### 6A2Y Other specified primary psychotic disorder

### 6A2Z Schizophrenia or other primary psychotic disorders, unspecified

## Catatonia (6A40-6A4Z)

Catatonia is a syndrome of primarily psychomotor disturbances, characterized by the co-occurrence of several symptoms of decreased, increased, or abnormal psychomotor activity. The assessment of catatonia is complex and requires observation, interview and physical exam. Catatonia can occur in the context of another mental disorder, such as Schizophrenia or Other Primary Psychotic Disorders, Mood Disorders, and Neurodevelopmental Disorders, especially Autism Spectrum Disorder. Catatonia can also develop during or soon after intoxication or withdrawal from certain psychoactive substances, including phencyclidine (PCP), cannabis, hallucinogens such as mescaline or LSD, cocaine and MDMA or related drugs, or during the use of certain psychoactive and non-psychoactive medications (e.g. antipsychotic medications, benzodiazepines, steroids, disulfiram, ciprofloxacin). Finally, Catatonia can occur as a direct pathophysiological consequence of a medical condition not classified under Mental, Behavioural or Neurodevelopmental Disorders. Examples of medical conditions that may be associated with Catatonia include diabetic ketoacidosis, hypercalcemia, hepatic encephalopathy, homocystinuria, neoplasms head trauma, cerebrovascular disease, and encephalitis.

**Exclusions:** Harmful effects of drugs, medicaments or biological substances, not elsewhere classified (NE60)

**Coded Elsewhere:** Secondary catatonia syndrome (6E69)

### 6A40 Catatonia associated with another mental disorder

Catatonia associated with another mental disorder is a syndrome of primarily psychomotor disturbances, characterized by the co-occurrence of several symptoms of decreased, increased, or abnormal psychomotor activity, which occurs in the context of another mental disorder, such as Schizophrenia or Other Primary Psychotic Disorders, Mood Disorders, and Neurodevelopmental Disorders, especially Autism Spectrum Disorder.

**6A41****Catatonia induced by substances or medications**

Catatonia induced by substances or medications is a syndrome of primarily psychomotor disturbances, characterized by the co-occurrence of several symptoms of decreased, increased, or abnormal psychomotor activity, which develops during or soon after intoxication or withdrawal from certain psychoactive substances, including phencyclidine (PCP), cannabis, hallucinogens such as mescaline or LSD, cocaine and MDMA or related drugs, or during the use of certain psychoactive and non-psychoactive medications (e.g. antipsychotic medications, benzodiazepines, steroids, disulfiram, ciprofloxacin).

**Exclusions:** Neuroleptic malignant syndrome (8A00-8A0Z)  
Serotonin syndrome (8D85)

**6A4Z****Catatonia, unspecified**

**Coding Note:** Code also the causing condition



## Mood disorders (6A60-6A8Z)

Mood Disorders refers to a superordinate grouping of Bipolar and Depressive Disorders. Mood disorders are defined according to particular types of mood episodes and their pattern over time. The primary types of mood episodes are Depressive episode, Manic episode, Mixed episode, and Hypomanic episode. Mood episodes are not independently diagnosable entities, and therefore do not have their own diagnostic codes. Rather, mood episodes make up the primary components of most of the Depressive and Bipolar Disorders.

**Coded Elsewhere:** Substance-induced mood disorders  
Secondary mood syndrome (6E62)

### Bipolar or related disorders (6A60-6A6Z)

Bipolar and related disorders are episodic mood disorders defined by the occurrence of Manic, Mixed or Hypomanic episodes or symptoms. These episodes typically alternate over the course of these disorders with Depressive episodes or periods of depressive symptoms.

#### 6A60

#### **Bipolar type I disorder**

Bipolar type I disorder is an episodic mood disorder defined by the occurrence of one or more manic or mixed episodes. A manic episode is an extreme mood state lasting at least one week unless shortened by a treatment intervention characterised by euphoria, irritability, or expansiveness, and by increased activity or a subjective experience of increased energy, accompanied by other characteristic symptoms such as rapid or pressured speech, flight of ideas, increased self-esteem or grandiosity, decreased need for sleep, distractibility, impulsive or reckless behaviour, and rapid changes among different mood states (i.e., mood lability). A mixed episode is characterised by the presence of several prominent manic and several prominent depressive symptoms consistent with those observed in manic episodes and depressive episodes, which either occur simultaneously or alternate very rapidly (from day to day or within the same day). Symptoms must include an altered mood state consistent with a manic and/or depressive episode (i.e., depressed, dysphoric, euphoric or expansive mood), and be present most of the day, nearly every day, during a period of at least 2 weeks, unless shortened by a treatment intervention. Although the diagnosis can be made based on evidence of a single manic or mixed episode, typically manic or mixed episodes alternate with depressive episodes over the course of the disorder.

**Exclusions:** Cyclothymia (6A62)  
Bipolar type II disorder (6A61)

**6A60.0****Bipolar type I disorder, current episode manic, without psychotic symptoms**

Bipolar type I disorder, current episode manic, without psychotic symptoms is diagnosed when the definitional requirements for Bipolar type I disorder are met, the current episode is manic, and there are no delusions or hallucinations present during the episode. A manic episode is an extreme mood state lasting at least one week unless shortened by a treatment intervention characterised by euphoria, irritability, or expansiveness, and by increased activity or a subjective experience of increased energy, accompanied by other characteristic symptoms such as rapid or pressured speech, flight of ideas, increased self-esteem or grandiosity, decreased need for sleep, distractibility, impulsive or reckless behaviour, and rapid changes among different mood states (i.e., mood lability). If the individual has experienced Manic or Mixed Episodes in the past, a duration of one week is not required in order to diagnose a current episode if all other diagnostic requirements are met.

**6A60.1****Bipolar type I disorder, current episode manic, with psychotic symptoms**

Bipolar type I disorder, current episode manic with psychotic symptoms is diagnosed when the definitional requirements for Bipolar type I Disorder have been met, the current episode is Manic and there are delusions or hallucinations present during the episode. A manic episode is an extreme mood state lasting at least one week unless shortened by a treatment intervention characterised by euphoria, irritability, or expansiveness, and by increased activity or a subjective experience of increased energy, accompanied by other characteristic symptoms such as rapid or pressured speech, flight of ideas, increased self-esteem or grandiosity, decreased need for sleep, distractibility, impulsive or reckless behaviour, and rapid changes among different mood states (i.e., mood lability). If the individual has experienced Manic or Mixed Episodes in the past, a duration of one week is not required in order to diagnose a current episode if all other diagnostic requirements are met.

**6A60.2****Bipolar type I disorder, current episode hypomanic**

Bipolar type I disorder, current episode hypomanic is diagnosed when the definitional requirements for Bipolar type I disorder have been met and the current episode is hypomanic. A hypomanic episode is a persistent mood state lasting at least several days characterised by mild elevation of mood or increased irritability and increased activity or a subjective experience of increased energy, accompanied by other characteristic symptoms such as rapid speech, rapid or racing thoughts, increased self-esteem, an increase in sexual drive or sociability, decreased need for sleep, distractibility, or impulsive or reckless behaviour. The symptoms are not severe enough to cause marked impairment in occupational functioning or in usual social activities or relationships with others, does not necessitate hospitalization, and there are no accompanying delusions or hallucinations.

**6A60.3****Bipolar type I disorder, current episode depressive, mild**

Bipolar type I disorder, current episode depressive, mild is diagnosed when the definitional requirements for Bipolar type I disorder have been met and the current episode is depressive at a mild level of severity. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a mild depressive episode, the individual is usually distressed by the symptoms and has some difficulty in continuing to function in one of more domains (personal, family, social, educational, occupational, or other important domains). There are no delusions or hallucinations during the episode.

**6A60.4****Bipolar type I disorder, current episode depressive, moderate without psychotic symptoms**

Bipolar type I disorder, current episode depressive, moderate, without psychotic symptoms is diagnosed when the definitional requirements for Bipolar type I disorder have been met and the current episode is depressive at a moderate level of severity and there are no delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a moderate depressive episode, several symptoms of a depressive episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).

**6A60.5****Bipolar type I disorder, current episode depressive, moderate with psychotic symptoms**

Bipolar type I disorder, current episode depressive, moderate, with psychotic symptoms diagnosed when the definitional requirements for Bipolar type I disorder have been met and the current episode is depressive at a moderate level of severity and there are delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a moderate depressive episode, several symptoms of a depressive episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).

**6A60.6 Bipolar type I disorder, current episode depressive, severe without psychotic symptoms**

Bipolar type I disorder, current episode depressive, severe, without psychotic symptoms is diagnosed when the definitional requirements for Bipolar type I disorder are met and the current episode is severe and there are no delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a severe depressive episode, many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).

**6A60.7 Bipolar type I disorder, current episode depressive, severe with psychotic symptoms**

Bipolar type I disorder, current episode depressive, severe, with psychotic symptoms is diagnosed when the definitional requirements for Bipolar type I disorder are met and the current episode is severe and there are delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a severe depressive episode, many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).

**6A60.8 Bipolar type I disorder, current episode depressive, unspecified severity**

Bipolar type I disorder, current episode depressive, unspecified severity is diagnosed when the definitional requirements for Bipolar type I disorder have been met and the current episode is depressive, but there is insufficient information to determine the severity of the current depressive episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. The symptoms are associated with at least some difficulty in continuing with ordinary work, social, or domestic activities.

**6A60.9 Bipolar type I disorder, current episode mixed, without psychotic symptoms**  
Bipolar type I disorder, current episode mixed, without psychotic symptoms is diagnosed when the definitional requirements for Bipolar type I disorder are met and the current episode is mixed and there are no delusions or hallucinations present during the episode. A mixed episode is characterised by the presence of several prominent manic and several prominent depressive symptoms consistent with those observed in manic episodes and depressive episodes, which either occur simultaneously or alternate very rapidly (from day to day or within the same day). Symptoms must include an altered mood state consistent with a manic and/or depressive episode (i.e., depressed, dysphoric, euphoric or expansive mood), and be present most of the day, nearly every day, during a period of at least 2 weeks, unless shortened by a treatment intervention. If the individual has experienced Manic or Mixed Episodes in the past, a duration of 2 weeks is not required in order to diagnose a current episode if all other diagnostic requirements are met.

**6A60.A Bipolar type I disorder, current episode mixed, with psychotic symptoms**  
Bipolar type I disorder, current episode mixed, with psychotic symptoms is diagnosed when the definitional requirements for Bipolar type I disorder are met and the current episode is mixed and there are delusions or hallucinations present during the episode. A mixed episode is characterised by the presence of several prominent manic and several prominent depressive symptoms consistent with those observed in manic episodes and depressive episodes, which either occur simultaneously or alternate very rapidly (from day to day or within the same day). Symptoms must include an altered mood state consistent with a manic and/or depressive episode (i.e., depressed, dysphoric, euphoric or expansive mood), and be present most of the day, nearly every day, during a period of at least 2 weeks, unless shortened by a treatment intervention. If the individual has experienced Manic or Mixed Episodes in the past, a duration of 2 weeks is not required in order to diagnose a current episode if all other diagnostic requirements are met.

**6A60.B Bipolar type I disorder, currently in partial remission, most recent episode manic or hypomanic**  
Bipolar type I disorder, currently in partial remission, most recent episode manic or hypomanic is diagnosed when the definitional requirements for Bipolar type I disorder have been met and the most recent episode was a manic or hypomanic episode. The full definitional requirements for a manic or hypomanic episode are no longer met but some significant mood symptoms remain. In some cases, residual mood symptoms may be depressive rather than manic or hypomanic, but do not satisfy the definitional requirements for a depressive episode.

**6A60.C Bipolar type I disorder, currently in partial remission, most recent episode depressive**  
Bipolar type I disorder, currently in partial remission, most recent episode depressive is diagnosed when the definitional requirements for Bipolar type I disorder have been met and the most recent episode was a depressive episode. The full definitional requirements for the episode are no longer met but some significant depressive symptoms remain.

- 6A60.D Bipolar type I disorder, currently in partial remission, most recent episode mixed**  
Bipolar type I disorder, currently in partial remission, most recent episode mixed is diagnosed when the definitional requirements for Bipolar type I disorder have been met and the most recent episode was a mixed episode. The full definitional requirements for the episode are no longer met but some significant mood symptoms remain.
- 6A60.E Bipolar type I disorder, currently in partial remission, most recent episode unspecified**  
Bipolar type I disorder, currently in partial remission, most recent episode unspecified is diagnosed when the definitional requirements for Bipolar type I disorder have been met but there is insufficient information to determine the nature of the most recent mood episode. The full definitional requirements for a mood episode are no longer met but some significant mood symptoms remain.
- 6A60.F Bipolar type I disorder, currently in full remission**  
Bipolar type I disorder, currently in full remission is diagnosed when the full definitional requirements for Bipolar I disorder have been met in the past but there are no longer any significant mood symptoms.
- 6A60.Y Other specified bipolar type I disorder**
- 6A60.Z Bipolar type I disorder, unspecified**
- 6A61 Bipolar type II disorder**  
Bipolar type II disorder is an episodic mood disorder defined by the occurrence of one or more hypomanic episodes and at least one depressive episode. A hypomanic episode is a persistent mood state lasting for at least several days characterised by persistent elevation of mood or increased irritability as well as increased activity or a subjective experience of increased energy, accompanied by other characteristic symptoms such as increased talkativeness, rapid or racing thoughts, increased self-esteem, decreased need for sleep, distractability, and impulsive or reckless behavior. The symptoms represent a change from the individual's typical mood, energy level, and behavior but are not severe enough to cause marked impairment in functioning. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as changes in appetite or sleep, psychomotor agitation or retardation, fatigue, feelings of worthless or excessive or inappropriate guilt, feelings or hopelessness, difficulty concentrating, and suicidality. There is no history of manic or mixed episodes.

**6A61.0****Bipolar type II disorder, current episode hypomanic**

Bipolar type II disorder, current episode hypomanic is diagnosed when the definitional requirements for Bipolar type II disorder have been met and the current episode is hypomanic. A hypomanic episode is a persistent mood state lasting at least several days characterised by mild elevation of mood or increased irritability and increased activity or a subjective experience of increased energy, accompanied by other characteristic symptoms such as rapid speech, rapid or racing thoughts, increased self-esteem, an increase in sexual drive or sociability, decreased need for sleep, distractibility, or impulsive or reckless behaviour. The symptoms are not severe enough to cause marked impairment in occupational functioning or in usual social activities or relationships with others, does not necessitate hospitalization, and there are no accompanying delusions or hallucinations.

**6A61.1****Bipolar type II disorder, current episode depressive, mild**

Bipolar type II disorder, current episode depressive, mild is diagnosed when the definitional requirements for Bipolar type II disorder have been met and the current episode is depressive at a mild level of severity. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a mild depressive episode, the individual is usually distressed by the symptoms and has some difficulty in continuing to function in one of more domains (personal, family, social, educational, occupational, or other important domains). There are no delusions or hallucinations during the episode.

**6A61.2****Bipolar type II disorder, current episode depressive, moderate without psychotic symptoms**

Bipolar type II disorder, current episode depressive, moderate, without psychotic symptoms is diagnosed when the definitional requirements for Bipolar type II disorder have been met and the current episode is depressive at a moderate level of severity and there are no delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a moderate depressive episode, several symptoms of a depressive episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).

**6A61.3 Bipolar type II disorder, current episode depressive, moderate with psychotic symptoms**

Bipolar type II disorder, current episode depressive, moderate, with psychotic symptoms diagnosed when the definitional requirements for Bipolar type II disorder have been met and the current episode is depressive at a moderate level of severity and there are delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a moderate depressive episode, several symptoms of a depressive episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).

**6A61.4 Bipolar type II disorder, current episode depressive, severe without psychotic symptoms**

Bipolar type II disorder, current episode depressive, severe, without psychotic symptoms is diagnosed when the definitional requirements for Bipolar type II disorder are met and the current episode is severe and there are no delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a severe depressive episode, many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).

**6A61.5 Bipolar type II disorder, current episode depressive, severe with psychotic symptoms**

Bipolar type II disorder, current episode depressive, severe, with psychotic symptoms is diagnosed when the definitional requirements for Bipolar type II disorder are met and the current episode is severe and there are delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a severe depressive episode, many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).



- 6A61.6 Bipolar type II disorder, current episode depressive, unspecified severity**  
Bipolar type II disorder, current episode depressive, unspecified severity is diagnosed when the definitional requirements for Bipolar type II disorder have been met and the current episode is depressive, but there is insufficient information to determine the severity of the current depressive episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. The symptoms are associated with at least some difficulty in continuing with ordinary work, social, or domestic activities.
- 6A61.7 Bipolar type II disorder, currently in partial remission, most recent episode hypomanic**  
Bipolar type II disorder, currently in partial remission, most recent episode hypomanic is diagnosed when the definitional requirements for Bipolar type II disorder have been met and the most recent episode was a hypomanic episode. The full definitional requirements for a hypomanic episode are no longer met but some significant mood symptoms remain. In some cases, residual mood symptoms may be depressive rather than hypomanic, but do not satisfy the definitional requirements for a depressive episode.
- 6A61.8 Bipolar type II disorder, currently in partial remission, most recent episode depressive**  
Bipolar type II disorder, currently in partial remission, most recent episode depressive is diagnosed when the definitional requirements for Bipolar type II disorder have been met and the most recent episode was a depressive episode. The full definitional requirements for the episode are no longer met but some significant depressive symptoms remain.
- 6A61.9 Bipolar type II disorder, currently in partial remission, most recent episode unspecified**  
Bipolar type II disorder, currently in partial remission, most recent episode unspecified is diagnosed when the definitional requirements for Bipolar type II disorder have been met but there is insufficient information to determine the nature of the most recent mood episode. The full definitional requirements for a mood episode are no longer met but some significant mood symptoms remain.
- 6A61.A Bipolar type II disorder, currently in full remission**  
Bipolar type II disorder, currently in full remission, is diagnosed when the definitional requirements for Bipolar type II disorder have been met but there are no longer any significant mood symptoms.
- 6A61.Y Other specified bipolar type II disorder**
- 6A61.Z Bipolar type II disorder, unspecified**

**6A62****Cyclothymic disorder**

Cyclothymic disorder is characterised by a persistent instability of mood over a period of at least 2 years, involving numerous periods of hypomanic (e.g., euphoria, irritability, or expansiveness, psychomotor activation) and depressive (e.g., feeling down, diminished interest in activities, fatigue) symptoms that are present during more of the time than not. The hypomanic symptomatology may or may not be sufficiently severe or prolonged to meet the full definitional requirements of a hypomanic episode (see Bipolar type II disorder), but there is no history of manic or mixed episodes (see Bipolar type I disorder). The depressive symptomatology has never been sufficiently severe or prolonged to meet the diagnostic requirements for a depressive episode (see Bipolar type II disorder). The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Inclusions:** Cycloid personality  
Cyclothymic personality

**6A6Y****Other specified bipolar or related disorders****6A6Z****Bipolar or related disorders, unspecified**

## Depressive disorders (6A70-6A7Z)

Depressive disorders are characterised by depressive mood (e.g., sad, irritable, empty) or loss of pleasure accompanied by other cognitive, behavioural, or neurovegetative symptoms that significantly affect the individual's ability to function. A depressive disorder should not be diagnosed in individuals who have ever experienced a manic, mixed or hypomanic episode, which would indicate the presence of a bipolar disorder.

**Coded Elsewhere:** Premenstrual dysphoric disorder (GA34.41)

**6A70****Single episode depressive disorder**

Single episode depressive disorder is characterised by the presence or history of one depressive episode when there is no history of prior depressive episodes. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. There have never been any prior manic, hypomanic, or mixed episodes, which would indicate the presence of a bipolar disorder.

**Exclusions:** recurrent depressive disorder (6A71)  
Adjustment disorder (6B43)  
Bipolar or related disorders (6A60-6A6Z)

**6A70.0****Single episode depressive disorder, mild**

Single episode depressive disorder, mild, is diagnosed when the definitional requirements of a Depressive episode are met and the episode is of mild severity. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a mild depressive episode, the individual is usually distressed by the symptoms and has some difficulty in continuing to function in one of more domains (personal, family, social, educational, occupational, or other important domains). There are no delusions or hallucinations during the episode.

**6A70.1****Single episode depressive disorder, moderate, without psychotic symptoms**

Single episode depressive disorder, moderate, without psychotic symptoms is diagnosed when the definitional requirements of a depressive episode have been met, there is no history of prior depressive episodes, the episode is of moderate severity, and there are no delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a moderate depressive episode, several symptoms of a depressive episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).

**6A70.2****Single episode depressive disorder, moderate, with psychotic symptoms**

Single episode depressive disorder, moderate, with psychotic symptoms is diagnosed when the definitional requirements of a depressive episode have been met, there is no history of prior depressive episodes, the episode is of moderate severity, and there are delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a moderate depressive episode, several symptoms of a depressive episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).

**6A70.3****Single episode depressive disorder, severe, without psychotic symptoms**

Single episode depressive disorder, severe, without psychotic symptoms is diagnosed when the definitional requirements for Single episode depressive disorder are met and the current episode is severe and there are no delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a severe depressive episode, many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).

**Inclusions:** Major depression single episode without psychotic symptoms  
Vital depression single episode without psychotic symptoms

**6A70.4****Single episode depressive disorder, severe, with psychotic symptoms**

Single episode depressive disorder, severe, with psychotic symptoms is diagnosed when the definitional requirements for Single episode depressive disorder are met and the current episode is severe and there are delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a severe depressive episode, many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains). In a severe depressive episode, many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).

**6A70.5****Single episode depressive disorder, unspecified severity**

Single episode depressive disorder, unspecified severity is diagnosed when the definitional requirements of a depressive episode have been met, there is no history of prior depressive episodes, and there is insufficient information to determine the severity of the current depressive episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. The symptoms are associated with at least some difficulty in continuing with ordinary work, social, or domestic activities.

**6A70.6 Single episode depressive disorder, currently in partial remission**

Single episode depressive disorder, currently in partial remission, is diagnosed when the full definitional requirements for a depressive episode have been met and there is no history of prior depressive episodes. The full definitional requirements for a depressive episode are no longer met but some significant mood symptoms remain.

**6A70.7 Single episode depressive disorder, currently in full remission**

Single episode depressive disorder, currently in full remission is diagnosed when the full definitional requirements for one depressive episode have been met in the past and there are no longer any significant mood symptoms. There is no history of depressive episodes preceding the episode under consideration.

**6A70.Y Other specified single episode depressive disorder**

**6A70.Z Single episode depressive disorder, unspecified**

**6A71**

**Recurrent depressive disorder**

Recurrent depressive disorder is characterised by a history or at least two depressive episodes separated by at least several months without significant mood disturbance. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. There have never been any prior manic, hypomanic, or mixed episodes, which would indicate the presence of a Bipolar disorder.

**Inclusions:** seasonal depressive disorder

**Exclusions:** Adjustment disorder (6B43)

Bipolar or related disorders (6A60-6A6Z)

Single episode depressive disorder (6A70)

**6A71.0 Recurrent depressive disorder, current episode mild**

Recurrent depressive disorder, current episode mild is diagnosed when the definitional requirements for Recurrent depressive disorder have been met and there is currently a depressive episode of mild severity. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a mild depressive episode, the individual is usually distressed by the symptoms and has some difficulty in continuing to function in one of more domains (personal, family, social, educational, occupational, or other important domains). There are no delusions or hallucinations during the episode.

**6A71.1 Recurrent depressive disorder, current episode moderate, without psychotic symptoms**

Recurrent depressive disorder, current episode moderate, without psychotic symptoms is diagnosed when the definitional requirements for recurrent depressive disorder have been met and there is currently a depressive episode of moderate severity, and there are no delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a moderate depressive episode, several symptoms of a depressive episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).

**6A71.2 Recurrent depressive disorder, current episode moderate, with psychotic symptoms**

Recurrent depressive disorder, current episode moderate, with psychotic symptoms is diagnosed when the definitional requirements for Recurrent depressive disorder have been met and there is currently a depressive episode of moderate severity, and there are delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a moderate depressive episode, several symptoms of a depressive episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall. The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational, or other important domains).

**6A71.3****Recurrent depressive disorder, current episode severe, without psychotic symptoms**

Recurrent depressive disorder, current episode severe, without psychotic symptoms is diagnosed when the definitional requirements for Recurrent depressive disorder are met and the current episode is severe and there are no delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a severe depressive episode, many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).

**Inclusions:**

- Endogenous depression without psychotic symptoms
- Major depression, recurrent without psychotic symptoms
- Manic-depressive psychosis, depressed type without psychotic symptoms
- Vital depression, recurrent without psychotic symptoms

**6A71.4****Recurrent depressive disorder, current episode severe, with psychotic symptoms**

Recurrent depressive disorder, current episode severe, with psychotic symptoms is diagnosed when the definitional requirements for Recurrent depressive disorder are met and the current episode is severe and there are delusions or hallucinations during the episode. A depressive episode is characterised by a period of depressed mood or diminished interest in activities occurring most of the day, nearly every day during a period lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. In a severe depressive episode, many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains). In a severe depressive episode, many or most symptoms of a Depressive Episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree. The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational, or other important domains).

**Inclusions:**

- Endogenous depression with psychotic symptoms
- Manic-depressive psychosis, depressed type with psychotic symptoms

- 6A71.5 Recurrent depressive disorder, current episode, unspecified severity**  
 Recurrent depressive disorder current episode, unspecified severity is diagnosed when the definitional requirements of a depressive episode have been met and there is a history of prior depressive episodes, but there is insufficient information to determine the severity of the current depressive episode. A depressive episode is characterised by a period of almost daily depressed mood or diminished interest in activities lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. The symptoms are associated with at least some difficulty in continuing with ordinary work, social, or domestic activities.
- 6A71.6 Recurrent depressive disorder, currently in partial remission**  
 Recurrent depressive disorder, currently in partial remission, is diagnosed when the definitional requirements for Recurrent depressive disorder have been met; the full definitional requirements for a depressive episode are no longer met but some significant mood symptoms remain.
- 6A71.7 Recurrent depressive disorder, currently in full remission**  
 Recurrent depressive disorder, currently in full remission is diagnosed when the definitional requirements for recurrent depressive disorder have been met but currently there are no significant mood symptoms.
- 6A71.Y Other specified recurrent depressive disorder**
- 6A71.Z Recurrent depressive disorder, unspecified**
- 6A72 Dysthymic disorder**  
 Dysthymic disorder is characterised by a persistent depressive mood (i.e., lasting 2 years or more), for most of the day, for more days than not. In children and adolescents depressed mood can manifest as pervasive irritability. The depressed mood is accompanied by additional symptoms such as markedly diminished interest or pleasure in activities, reduced concentration and attention or indecisiveness, low self-worth or excessive or inappropriate guilt, hopelessness about the future, disturbed sleep or increased sleep, diminished or increased appetite, or low energy or fatigue. During the first 2 years of the disorder, there has never been a 2-week period during which the number and duration of symptoms were sufficient to meet the diagnostic requirements for a Depressive Episode. There is no history of Manic, Mixed, or Hypomanic Episodes.
- Inclusions:** Dysthymia
- Exclusions:** anxiety depression (mild or not persistent) (6A73)



**6A73****Mixed depressive and anxiety disorder**

Mixed depressive and anxiety disorder is characterised by symptoms of both anxiety and depression more days than not for a period of two weeks or more. Depressive symptoms include depressed mood or markedly diminished interest or pleasure in activities. There are multiple anxiety symptoms, which may include feeling nervous, anxious, or on edge, not being able to control worrying thoughts, fear that something awful will happen, having trouble relaxing, muscle tension, or sympathetic autonomic symptoms. Neither set of symptoms, considered separately, is sufficiently severe, numerous, or persistent to justify a diagnosis of another depressive disorder or an anxiety or fear-related disorder. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. There is no history of manic or mixed episodes, which would indicate the presence of a bipolar disorder.

**6A7Y****Other specified depressive disorders****6A7Z****Depressive disorders, unspecified****6A80****Symptomatic and course presentations for mood episodes in mood disorders**

These categories may be applied to describe the presentation and characteristics of mood episodes in the context of single episode depressive disorder, recurrent depressive disorder, bipolar type I disorder, or bipolar type II disorder. These categories indicate the presence of specific, important features of the clinical presentation or of the course, onset, and pattern of mood episodes. These categories are not mutually exclusive, and as many may be added as apply.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify specific clinically important features of mood episodes in mood disorders.

**Coded Elsewhere:** Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms (6E20)

Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms (6E21)

**6A80.0****Prominent anxiety symptoms in mood episodes**

In the context of a current depressive, manic, mixed, or hypomanic episode, prominent and clinically significant anxiety symptoms (e.g., feeling nervous, anxious or on edge, not being able to control worrying thoughts, fear that something awful will happen, having trouble relaxing, motor tension, autonomic symptoms) have been present for most of the time during the episode. If there have been panic attacks during a current depressive or mixed episode, these should be recorded separately.

When the diagnostic requirements for both a mood disorder and an anxiety or fear-related disorder are met, the anxiety or fear-related disorder should also be diagnosed.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify specific clinically important features of mood episodes in mood disorders.

#### **6A80.1 Panic attacks in mood episodes**

In the context of a current mood episode (manic, depressive, mixed, or hypomanic), there have been recurrent panic attacks (i.e., at least two) during the past month that occur specifically in response to anxiety-provoking cognitions that are features of the mood episode. If panic attacks occur exclusively in response to such thoughts, panic attacks should be recorded using this qualifier rather than assigning an additional co-occurring diagnosis of panic disorder.

If some panic attacks over the course of the depressive or mixed episode have been unexpected and not exclusively in response to depressive or anxiety-provoking thoughts, a separate diagnosis of panic disorder should be assigned.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify specific clinically important features of mood episodes in mood disorders.

**Exclusions:** Panic disorder (6B01)

#### **6A80.2 Current depressive episode persistent**

The diagnostic requirements for a depressive episode are currently met and have been met continuously for at least the past 2 years.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify specific clinically important features of mood episodes in mood disorders.

#### **6A80.3 Current depressive episode with melancholia**

In the context of a current Depressive Episode, several of the following symptoms have been present during the worst period of the current episode: loss of interest or pleasure in most activities that are normally enjoyable to the individual (i.e., pervasive anhedonia); lack of emotional reactivity to normally pleasurable stimuli or circumstances (i.e., mood does not lift even transiently with exposure); terminal insomnia (i.e., waking in the morning two hours or more before the usual time); depressive symptoms are worse in the morning; marked psychomotor retardation or agitation; marked loss of appetite or loss of weight.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify specific clinically important features of mood episodes in mood disorders.

#### **6A80.4 Seasonal pattern of mood episode onset**

In the context of recurrent depressive disorder, bipolar type I or bipolar type II disorder, there has been a regular seasonal pattern of onset and remission of at least one type of episode (i.e., depressive, manic, mixed, or hypomanic episodes), with a substantial majority of the relevant mood episodes corresponding to the seasonal pattern. (In bipolar type I and bipolar type II disorder, all types of mood episodes may not follow this pattern.) A seasonal pattern should be differentiated from an episode that is coincidental with a particular season but predominantly related to a psychological stressor that regularly occurs at that time of the year (e.g., seasonal unemployment).

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify specific clinically important features of mood episodes in mood disorders.

**6A80.5****Rapid cycling**

In the context of bipolar type I or bipolar type II disorder, there has been a high frequency of mood episodes (at least four) over the past 12 months. There may be a switch from one polarity of mood to the other, or the mood episodes may be demarcated by a period of remission. In individuals with a high frequency of mood episodes, some may have a shorter duration than those usually observed in bipolar type I or bipolar type II disorder. In particular, depressive periods may only last several days. If depressive and manic symptoms alternate very rapidly (i.e., from day to day or within the same day), a mixed episode should be diagnosed rather than rapid cycling.

**Coding Note:** These categories should never be used in primary coding. The codes are provided for use as supplementary or additional codes when it is desired to identify specific clinically important features of mood episodes in mood disorders.

**6A8Y****Other specified mood disorders****6A8Z****Mood disorders, unspecified****Anxiety or fear-related disorders (6B00-6B0Z)**

Anxiety and fear-related disorders are characterised by excessive fear and anxiety and related behavioural disturbances, with symptoms that are severe enough to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Fear and anxiety are closely related phenomena; fear represents a reaction to perceived imminent threat in the present, whereas anxiety is more future-oriented, referring to perceived anticipated threat. A key differentiating feature among the Anxiety and fear-related disorders are disorder-specific foci of apprehension, that is, the stimulus or situation that triggers the fear or anxiety. The clinical presentation of Anxiety and fear-related disorders typically includes specific associated cognitions that can assist in differentiating among the disorders by clarifying the focus of apprehension.

**Coded Elsewhere:** Substance-induced anxiety disorders

Hypochondriasis (6B23)

Secondary anxiety syndrome (6E63)

**6B00****Generalised anxiety disorder**

Generalised anxiety disorder is characterised by marked symptoms of anxiety that persist for at least several months, for more days than not, manifested by either general apprehension (i.e. 'free-floating anxiety') or excessive worry focused on multiple everyday events, most often concerning family, health, finances, and school or work, together with additional symptoms such as muscular tension or motor restlessness, sympathetic autonomic over-activity, subjective experience of nervousness, difficulty maintaining concentration, irritability, or sleep disturbance. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. The symptoms are not a manifestation of another health condition and are not due to the effects of a substance or medication on the central nervous system.

**6B01****Panic disorder**

Panic disorder is characterised by recurrent unexpected panic attacks that are not restricted to particular stimuli or situations. Panic attacks are discrete episodes of intense fear or apprehension accompanied by the rapid and concurrent onset of several characteristic symptoms (e.g. palpitations or increased heart rate, sweating, trembling, shortness of breath, chest pain, dizziness or lightheadedness, chills, hot flushes, fear of imminent death). In addition, panic disorder is characterised by persistent concern about the recurrence or significance of panic attacks, or behaviours intended to avoid their recurrence, that results in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. The symptoms are not a manifestation of another medical condition and are not due to the effects of a substance or medication on the central nervous system.

**Exclusions:** Panic attack (MB23.H)

**6B02****Agoraphobia**

Agoraphobia is characterised by marked and excessive fear or anxiety that occurs in response to multiple situations where escape might be difficult or help might not be available, such as using public transportation, being in crowds, being outside the home alone (e.g., in shops, theatres, standing in line). The individual is consistently anxious about these situations due to a fear of specific negative outcomes (e.g., panic attacks, other incapacitating or embarrassing physical symptoms). The situations are actively avoided, entered only under specific circumstances such as in the presence of a trusted companion, or endured with intense fear or anxiety. The symptoms persist for least several months, and are sufficiently severe to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

**6B03****Specific phobia**

Specific phobia is characterised by a marked and excessive fear or anxiety that consistently occurs upon exposure or anticipation of exposure to one or more specific objects or situations (e.g., proximity to certain animals, flying, heights, closed spaces, sight of blood or injury) that is out of proportion to actual danger. The phobic objects or situations are avoided or else endured with intense fear or anxiety. Symptoms persist for at least several months and are sufficiently severe to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

**Inclusions:** Simple phobia

**Exclusions:** Body dysmorphic disorder (6B21)

Hypochondriasis (6B23)

**6B04****Social anxiety disorder**

Social anxiety disorder is characterised by marked and excessive fear or anxiety that consistently occurs in one or more social situations such as social interactions (e.g. having a conversation), doing something while feeling observed (e.g. eating or drinking in the presence of others), or performing in front of others (e.g. giving a speech). The individual is concerned that he or she will act in a way, or show anxiety symptoms, that will be negatively evaluated by others. Relevant social situations are consistently avoided or else endured with intense fear or anxiety. The symptoms persist for at least several months and are sufficiently severe to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

**6B05****Separation anxiety disorder**

Separation anxiety disorder is characterised by marked and excessive fear or anxiety about separation from specific attachment figures. In children and adolescents, separation anxiety typically focuses on caregivers, parents or other family members and the fear or anxiety is beyond what would be considered developmentally normative. In adults, the focus is typically a romantic partner or children. Manifestations of separation anxiety may include thoughts of harm or untoward events befalling the attachment figure, reluctance to go to school or work, recurrent excessive distress upon separation, reluctance or refusal to sleep away from the attachment figure, and recurrent nightmares about separation. The symptoms persist for at least several months and are sufficiently severe to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

**Exclusions:** mood [affective] disorders (6A60-6A8Z)  
 Selective mutism (6B06)  
 Social anxiety disorder (6B04)

**6B06****Selective mutism**

Selective mutism is characterised by consistent selectivity in speaking, such that a child demonstrates adequate language competence in specific social situations, typically at home, but consistently fails to speak in others, typically at school. The disturbance lasts for at least one month, is not limited to the first month of school, and is of sufficient severity to interfere with educational achievement or with social communication. Failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation (e.g. a different language spoken at school than at home).

**Exclusions:** Schizophrenia (6A20)  
 transient mutism as part of separation anxiety in young children (6B05)  
 Autism spectrum disorder (6A02)

**6B0Y****Other specified anxiety or fear-related disorders****6B0Z****Anxiety or fear-related disorders, unspecified**

## Obsessive-compulsive or related disorders (6B20-6B2Z)

Obsessive-compulsive and related disorders is a group of disorders characterised by repetitive thoughts and behaviours that are believed to share similarities in aetiology and key diagnostic validators. Cognitive phenomena such as obsessions, intrusive thoughts and preoccupations are central to a subset of these conditions (i.e., obsessive-compulsive disorder, body dysmorphic disorder, hypochondriasis, and olfactory reference disorder) and are accompanied by related repetitive behaviours. Hoarding Disorder is not associated with intrusive unwanted thoughts but rather is characterised by a compulsive need to accumulate possessions and distress related to discarding them. Also included in the grouping are body-focused repetitive behaviour disorders, which are primarily characterised by recurrent and habitual actions directed at the integument (e.g., hair-pulling, skin-picking) and lack a prominent cognitive aspect. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

**Coded Elsewhere:** Substance-induced obsessive-compulsive or related disorders  
Secondary obsessive-compulsive or related syndrome (6E64)  
Tourette syndrome (8A05.00)

### 6B20

#### Obsessive-compulsive disorder

Obsessive-Compulsive Disorder is characterised by the presence of persistent obsessions or compulsions, or most commonly both. Obsessions are repetitive and persistent thoughts, images, or impulses/urges that are intrusive, unwanted, and are commonly associated with anxiety. The individual attempts to ignore or suppress obsessions or to neutralize them by performing compulsions. Compulsions are repetitive behaviours including repetitive mental acts that the individual feels driven to perform in response to an obsession, according to rigid rules, or to achieve a sense of 'completeness'. In order for obsessive-compulsive disorder to be diagnosed, obsessions and compulsions must be time consuming (e.g. taking more than an hour per day) or result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Inclusions:** anankastic neurosis  
obsessive-compulsive neurosis

**Exclusions:** obsessive compulsive behaviour (MB23.4)

#### 6B20.0

##### Obsessive-compulsive disorder with fair to good insight

All definitional requirements of obsessive-compulsive disorder are met. Much of the time, the individual is able to entertain the possibility that his or her disorder-specific beliefs may not be true and is willing to accept an alternative explanation for his or her experience. At circumscribed times (e.g., when highly anxious), the individual may demonstrate no insight.

#### 6B20.1

##### Obsessive-compulsive disorder with poor to absent insight

All definitional requirements of obsessive-compulsive disorder are met. Most or all of the time, the individual is convinced that the disorder-specific beliefs are true and cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

#### 6B20.Z

##### Obsessive-compulsive disorder, unspecified

**6B21****Body dysmorphic disorder**

Body Dysmorphic Disorder is characterised by persistent preoccupation with one or more perceived defects or flaws in appearance that are either unnoticeable or only slightly noticeable to others. Individuals experience excessive self-consciousness, often with ideas of reference (i.e., the conviction that people are taking notice, judging, or talking about the perceived defect or flaw). In response to their preoccupation, individuals engage in repetitive and excessive behaviours that include repeated examination of the appearance or severity of the perceived defect or flaw, excessive attempts to camouflage or alter the perceived defect, or marked avoidance of social situations or triggers that increase distress about the perceived defect or flaw. The symptoms are sufficiently severe to result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Exclusions:**           Anorexia Nervosa (6B80)  
                                  Bodily distress disorder (6C20)  
                                  Concern about body appearance (QD30-QD3Z)

**6B21.0****Body dysmorphic disorder with fair to good insight**

All definitional requirements of body dysmorphic disorder are met. Much of the time, the individual is able to entertain the possibility that his or her disorder-specific beliefs may not be true and is willing to accept an alternative explanation for his or her experience. At circumscribed times (e.g., when highly anxious), the individual may demonstrate no insight.

**6B21.1****Body dysmorphic disorder with poor to absent insight**

All definitional requirements of body dysmorphic disorder are met. Most or all of the time, the individual is convinced that the disorder-specific beliefs are true and cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

**6B21.Z****Body dysmorphic disorder, unspecified****6B22****Olfactory reference disorder**

Olfactory Reference Disorder is characterised by persistent preoccupation with the belief that one is emitting a perceived foul or offensive body odour or breath that is either unnoticeable or only slightly noticeable to others. Individuals experience excessive self-consciousness about the perceived odour, often with ideas of reference (i.e., the conviction that people are taking notice, judging, or talking about the odour). In response to their preoccupation, individuals engage in repetitive and excessive behaviours such as repeatedly checking for body odour or checking the perceived source of the smell, or repeatedly seeking reassurance, excessive attempts to camouflage, alter, or prevent the perceived odour, or marked avoidance of social situations or triggers that increase distress about the perceived foul or offensive odour. The symptoms are sufficiently severe to result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

- 6B22.0 Olfactory reference disorder with fair to good insight**  
 All definitional requirements of olfactory reference disorder are met. Much of the time, the individual is able to entertain the possibility that his or her disorder-specific beliefs may not be true and is willing to accept an alternative explanation for his or her experience. At circumscribed times (e.g., when highly anxious), the individual may demonstrate no insight.
- 6B22.1 Olfactory reference disorder with poor to absent insight**  
 All definitional requirements of olfactory reference disorder are met. Most or all of the time, the individual is convinced that the disorder-specific beliefs are true and cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.
- 6B22.Z Olfactory reference disorder, unspecified**
- 6B23 Hypochondriasis**  
 Hypochondriasis is characterised by persistent preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses. The preoccupation is accompanied by either: 1) repetitive and excessive health-related behaviours, such as repeatedly checking of the body for evidence of illness, spending inordinate amounts of time searching for information about the feared illness, repeatedly seeking reassurance (e.g. arranging multiple medical consultations); or 2) maladaptive avoidance behaviour related to health (e.g. avoids medical appointments). The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
- Inclusions:** Hypochondriacal neurosis  
 Illness anxiety disorder
- Exclusions:** Body dysmorphic disorder (6B21)  
 Bodily distress disorder (6C20)  
 Fear of cancer (MG24.0)
- 6B23.0 Hypochondriasis with fair to good insight**  
 All definitional requirements of hypochondriasis are met. Much of the time, the individual is able to entertain the possibility that his or her disorder-specific beliefs may not be true and is willing to accept an alternative explanation for his or her experience. At circumscribed times (e.g., when highly anxious), the individual may demonstrate no insight.
- 6B23.1 Hypochondriasis with poor to absent insight**  
 All definitional requirements of hypochondriasis are met. Most or all of the time, the individual is convinced that the disorder-specific beliefs are true and cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.
- 6B23.Z Hypochondriasis, unspecified**



**6B24****Hoarding disorder**

Hoarding disorder is characterised by accumulation of possessions that results in living spaces becoming cluttered to the point that their use or safety is compromised. Accumulation occurs due to both repetitive urges or behaviours related to amassing items and difficulty discarding possessions due to a perceived need to save items and distress associated with discarding them. If living areas are uncluttered this is only due to the intervention of third parties (e.g., family members, cleaners, authorities). Amassment may be passive (e.g. accumulation of incoming flyers or mail) or active (e.g. excessive acquisition of free, purchased, or stolen items). The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**6B24.0****Hoarding disorder with fair to good insight**

All definitional requirements of hoarding disorder are met. The individual recognizes that hoarding-related beliefs and behaviours (pertaining to excessive acquisition, difficulty discarding, or clutter) are problematic. This qualifier level may still be applied if, at circumscribed times (e.g., when being forced to discard items), the individual demonstrates no insight.

**6B24.1****Hoarding disorder with poor to absent insight**

All definitional requirements of hoarding disorder are met. Most or all of the time, the individual is convinced that that hoarding-related beliefs and behaviours (pertaining to excessive acquisition, difficulty discarding, or clutter) are not problematic, despite evidence to the contrary. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

**6B24.Z****Hoarding disorder, unspecified****6B25****Body-focused repetitive behaviour disorders**

Body focused repetitive behaviour disorders are characterised by recurrent and habitual actions directed at the integument (e.g. hair-pulling, skin-picking, lip-biting), typically accompanied by unsuccessful attempts to decrease or stop the behaviour involved, and which lead to dermatological sequelae (e.g., hair loss, skin lesions, lip abrasions). The behaviour may occur in brief episodes scattered throughout the day or in less frequent but more sustained periods. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**6B25.0****Trichotillomania**

Trichotillomania is characterised by recurrent pulling of one's own hair leading to significant hair loss, accompanied by unsuccessful attempts to decrease or stop the behaviour. Hair pulling may occur from any region of the body in which hair grows but the most common sites are the scalp, eyebrows, and eyelids. Hair pulling may occur in brief episodes scattered throughout the day or in less frequent but more sustained periods. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Inclusions:** Compulsive hair plucking

**Exclusions:** stereotyped movement disorder with hair-plucking (6A06)

**6B25.1****Excoriation disorder**

Excoriation disorder is characterised by recurrent picking of one's own skin leading to skin lesions, accompanied by unsuccessful attempts to decrease or stop the behaviour. The most commonly picked sites are the face, arms and hands, but many individuals pick from multiple body sites. Skin picking may occur in brief episodes scattered throughout the day or in less frequent but more sustained periods. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Inclusions:** skin picking disorder

**Exclusions:** Stereotyped movement disorder (6A06)

Acute excoriation of skin (ME62.9)

Chronic excoriation of skin (ME63.7)

**6B25.Y****Other specified body-focused repetitive behaviour disorders****6B25.Z****Body-focused repetitive behaviour disorders, unspecified****6B2Y****Other specified obsessive-compulsive or related disorders****6B2Z****Obsessive-compulsive or related disorders, unspecified**

## Disorders specifically associated with stress (6B40-6B4Z)

Disorders specifically associated with stress are directly related to exposure to a stressful or traumatic event, or a series of such events or adverse experiences. For each of the disorders in this grouping, an identifiable stressor is a necessary, though not sufficient, causal factor. Although not all individuals exposed to an identified stressor will develop a disorder, the disorders in this grouping would not have occurred without experiencing the stressor. Stressful events for some disorders in this grouping are within the normal range of life experiences (e.g., divorce, socio-economic problems, bereavement). Other disorders require the experience of a stressor of an extremely threatening or horrific nature (i.e., potentially traumatic events). With all disorders in this grouping, it is the nature, pattern, and duration of the symptoms that arise in response to the stressful events—together with associated functional impairment—that distinguishes the disorders.

**Exclusions:** Burnout (QD85)  
Acute stress reaction (QE84)

### 6B40

#### Post traumatic stress disorder

Post traumatic stress disorder (PTSD) may develop following exposure to an extremely threatening or horrific event or series of events. It is characterised by all of the following: 1) re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. Re-experiencing may occur via one or multiple sensory modalities and is typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations; 2) avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event(s); and 3) persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Inclusions:** Traumatic neurosis

**Exclusions:** Acute stress reaction (QE84)  
Complex post traumatic stress disorder (6B41)

### 6B41

#### Complex post traumatic stress disorder

Complex post traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g. torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met. In addition, Complex PTSD is characterised by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Exclusions:** Post traumatic stress disorder (6B40)

**6B42****Prolonged grief disorder**

Prolonged grief disorder is a disturbance in which, following the death of a partner, parent, child, or other person close to the bereaved, there is persistent and pervasive grief response characterised by longing for the deceased or persistent preoccupation with the deceased accompanied by intense emotional pain (e.g. sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an inability to experience positive mood, emotional numbness, difficulty in engaging with social or other activities). The grief response has persisted for an atypically long period of time following the loss (more than 6 months at a minimum) and clearly exceeds expected social, cultural or religious norms for the individual's culture and context. Grief reactions that have persisted for longer periods that are within a normative period of grieving given the person's cultural and religious context are viewed as normal bereavement responses and are not assigned a diagnosis. The disturbance causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**6B43****Adjustment disorder**

Adjustment disorder is a maladaptive reaction to an identifiable psychosocial stressor or multiple stressors (e.g. divorce, illness or disability, socio-economic problems, conflicts at home or work) that usually emerges within a month of the stressor. The disorder is characterised by preoccupation with the stressor or its consequences, including excessive worry, recurrent and distressing thoughts about the stressor, or constant rumination about its implications, as well as by failure to adapt to the stressor that causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning. The symptoms are not better explained by another mental disorder (e.g., Mood Disorder, another Disorder Specifically Associated with Stress) and typically resolve within 6 months, unless the stressor persists for a longer duration.

**Exclusions:**

- separation anxiety disorder of childhood (6B05)
- Recurrent depressive disorder (6A71)
- Single episode depressive disorder (6A70)
- Prolonged grief disorder (6B42)
- Uncomplicated bereavement (QE62)
- Burnout (QD85)
- Acute stress reaction (QE84)

**6B44****Reactive attachment disorder**

Reactive attachment disorder is characterised by grossly abnormal attachment behaviours in early childhood, occurring in the context of a history of grossly inadequate child care (e.g., severe neglect, maltreatment, institutional deprivation). Even when an adequate primary caregiver is newly available, the child does not turn to the primary caregiver for comfort, support and nurture, rarely displays security-seeking behaviours towards any adult, and does not respond when comfort is offered. Reactive attachment disorder can only be diagnosed in children, and features of the disorder develop within the first 5 years of life. However, the disorder cannot be diagnosed before the age of 1 year (or a developmental age of less than 9 months), when the capacity for selective attachments may not be fully developed, or in the context of Autism spectrum disorder.

**Exclusions:** Asperger syndrome (6A02)  
disinhibited attachment disorder of childhood (6B45)

**6B45****Disinhibited social engagement disorder**

Disinhibited social engagement disorder is characterised by grossly abnormal social behaviour, occurring in the context of a history of grossly inadequate child care (e.g., severe neglect, institutional deprivation). The child approaches adults indiscriminately, lacks reticence to approach, will go away with unfamiliar adults, and exhibits overly familiar behaviour towards strangers. Disinhibited social engagement disorder can only be diagnosed in children, and features of the disorder develop within the first 5 years of life. However, the disorder cannot be diagnosed before the age of 1 year (or a developmental age of less than 9 months), when the capacity for selective attachments may not be fully developed, or in the context of Autism spectrum disorder.

**Exclusions:** Asperger syndrome (6A02)  
Adjustment disorder (6B43)  
Attention deficit hyperactivity disorder (6A05)  
reactive attachment disorder of childhood (6B44)

**6B4Y****Other specified disorders specifically associated with stress****6B4Z****Disorders specifically associated with stress, unspecified**

## Dissociative disorders (6B60-6B6Z)

Dissociative disorders are characterised by involuntary disruption or discontinuity in the normal integration of one or more of the following: identity, sensations, perceptions, affects, thoughts, memories, control over bodily movements, or behaviour. Disruption or discontinuity may be complete, but is more commonly partial, and can vary from day to day or even from hour to hour. The symptoms of dissociative disorders are not due the direct effects of a medication or substance, including withdrawal effects, are not better explained by another Mental, behavioural, or neurodevelopmental disorder, a Sleep-wake disorder, a Disease of the nervous system or other health condition, and are not part of an accepted cultural, religious, or spiritual practice. Dissociative symptoms in dissociative disorders are sufficiently severe to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Coded Elsewhere:** Secondary dissociative syndrome (6E65)

### 6B60

#### **Dissociative neurological symptom disorder**

Dissociative neurological symptom disorder is characterised by the presentation of motor, sensory, or cognitive symptoms that imply an involuntary discontinuity in the normal integration of motor, sensory, or cognitive functions and are not consistent with a recognised disease of the nervous system, other mental or behavioural disorder, or other medical condition. The symptoms do not occur exclusively during another dissociative disorder and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects, or a Sleep-Wake disorder.

**Exclusions:** Factitious disorders (6D50-6D5Z)

#### 6B60.0

##### **Dissociative neurological symptom disorder, with visual disturbance**

Dissociative neurological symptom disorder, with visual disturbance is characterised by visual symptoms such as blindness, tunnel vision, diplopia, visual distortions or hallucinations that are not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur exclusively during another dissociative disorder.

#### 6B60.1

##### **Dissociative neurological symptom disorder, with auditory disturbance**

Dissociative neurological symptom disorder, with auditory disturbance is characterised by auditory symptoms such as loss of hearing or auditory hallucinations that are not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur exclusively during another dissociative disorder.

#### 6B60.2

##### **Dissociative neurological symptom disorder, with vertigo or dizziness**

Dissociative neurological symptom disorder, with vertigo or dizziness is characterised by a sensation of spinning while stationary (vertigo) or dizziness that is not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and does not occur exclusively during another dissociative disorder.

- 6B60.3 Dissociative neurological symptom disorder, with other sensory disturbance**  
Dissociative neurological symptom disorder, with other sensory disturbance is characterised by sensory symptoms not identified in other specific categories in this grouping such as numbness, tightness, tingling, burning, pain, or other symptoms related to touch, smell, taste, balance, proprioception, kinesthesia, or thermoception. The symptoms are not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur exclusively during another dissociative disorder.
- 6B60.4 Dissociative neurological symptom disorder, with non-epileptic seizures**  
Dissociative neurological symptom disorder, with non-epileptic seizures is characterised by a symptomatic presentation of seizures or convulsions that are not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur exclusively during another dissociative disorder.
- 6B60.5 Dissociative neurological symptom disorder, with speech disturbance**  
Dissociative neurological symptom disorder, with speech disturbance is characterised by symptoms such as difficulty with speaking (dysphonia), loss of the ability to speak (aphonia) or difficult or unclear articulation of speech (dysarthria) that are not consistent with a recognised disease of the nervous system, a neurodevelopmental or neurocognitive disorder, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur exclusively during another dissociative disorder.
- 6B60.6 Dissociative neurological symptom disorder, with paresis or weakness**  
Dissociative neurological symptom disorder, with paresis or weakness is characterised by a difficulty or inability to intentionally move parts of the body or to coordinate movements that is not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and does not occur exclusively during another dissociative disorder.
- 6B60.7 Dissociative neurological symptom disorder, with gait disturbance**  
Dissociative neurological symptom disorder, with gait disturbance is characterised by symptoms involving the individual's ability or manner of walking, including ataxia and the inability to stand unaided, that are not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur exclusively during another dissociative disorder.
- 6B60.8 Dissociative neurological symptom disorder, with movement disturbance**  
Dissociative neurological symptom disorder, with movement disturbance is characterised by symptoms such as chorea, myoclonus, tremor, dystonia, facial spasm, parkinsonism, or dyskinesia that are not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur exclusively during another dissociative disorder.

- 6B60.80** Dissociative neurological symptom disorder, with chorea  
Dissociative neurological symptom disorder, with chorea is characterised by irregular, non-repetitive, brief, jerky, flowing movements that move randomly from one part of the body to another that are not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur exclusively during another dissociative disorder.
- 6B60.81** Dissociative neurological symptom disorder, with myoclonus  
Dissociative neurological symptom disorder, with myoclonus is characterised by sudden rapid jerks that may be focal, multifocal or generalised that are not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur exclusively during another dissociative disorder.
- 6B60.82** Dissociative neurological symptom disorder, with tremor  
Dissociative neurological symptom disorder, with tremor is characterised by involuntary oscillation of a body part that is not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and does not occur exclusively during another dissociative disorder.
- 6B60.83** Dissociative neurological symptom disorder, with dystonia  
Dissociative neurological symptom disorder, with dystonia is characterised by sustained muscle contractions that frequently causing twisting and repetitive movements or abnormal postures that are not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and do not occur exclusively during another dissociative disorder.
- 6B60.84** Dissociative neurological symptom disorder, with facial spasm  
Dissociative neurological symptom disorder, with facial spasm is characterised by involuntary muscle contractions or twitching of the face that is not consistent with a recognised disease of the nervous system, other mental, behavioural or neurodevelopmental disorder, or other medical condition and does not occur exclusively during another dissociative disorder.
- 6B60.85** Dissociative neurological symptom disorder, with Parkinsonism  
Dissociative neurological symptom disorder, with Parkinsonism is characterised by a symptomatic presentation of a Parkinson-like syndrome in the absence of confirmed Parkinson disease that does not occur exclusively during another mental, behavioural or neurodevelopmental disorder, other medical condition, or another dissociative disorder. Dissociative neurological symptom disorder, with Parkinsonism can be distinguished from Parkinson disease by features such as abrupt onset, early disability, bilateral shaking and slowness, nondecremental slowness when performing repetitive movements, voluntary resistance against passive movement without cogwheel rigidity, distractibility, 'give-way' weakness, stuttering speech, bizarre gait, and a variety of behavioural symptoms.
- 6B60.8Y** Dissociative neurological symptom disorder, with other specified movement disturbance



- 6B60.8Z** Dissociative neurological symptom disorder, with unspecified movement disturbance
- 6B60.9** **Dissociative neurological symptom disorder, with cognitive symptoms**  
 Dissociative neurological symptom disorder, with cognitive symptoms is characterised by impaired cognitive performance in memory, language or other cognitive domains that is internally inconsistent and not consistent with a recognised disease of the nervous system, a neurodevelopmental or neurocognitive disorder, other mental, behavioural or neurodevelopmental disorder, or another medical condition and does not occur exclusively during another dissociative disorder.
- Exclusions:** Dissociative amnesia (6B61)
- 6B60.Y** **Dissociative neurological symptom disorder, with other specified symptoms**
- 6B60.Z** **Dissociative neurological symptom disorder, with unspecified symptoms**
- 6B61** **Dissociative amnesia**  
 Dissociative amnesia is characterised by an inability to recall important autobiographical memories, typically of recent traumatic or stressful events, that is inconsistent with ordinary forgetting. The amnesia does not occur exclusively during another dissociative disorder and is not better explained by another mental, behavioural or neurodevelopmental disorder. The amnesia is not due to the direct effects of a substance or medication on the central nervous system, including withdrawal effects, and is not due to a disease of the nervous system or to head trauma. The amnesia results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
- Exclusions:** amnesia NOS (MB21.1)  
 Amnestic disorder due to use of alcohol (6D72.10)  
 Anterograde amnesia (MB21.10)  
 Retrograde amnesia (MB21.11)  
 nonalcoholic organic amnesic syndrome (6D72.0)  
 postictal amnesia in epilepsy (8A60-8A6Z)
- 6B61.0** **Dissociative amnesia with dissociative fugue**  
 Dissociative amnesia with dissociative fugue is characterised by all of the features of Dissociative Amnesia, accompanied by dissociative fugue, i.e., a loss of a sense of personal identity and sudden travel away from home, work, or significant others for an extended period of time (days or weeks). A new identity may be assumed.
- Exclusions:** postictal fugue in epilepsy (8A60-8A6Z)
- 6B61.1** **Dissociative amnesia without dissociative fugue**  
 Dissociative amnesia without dissociative fugue is characterised by all of the features of dissociative amnesia occurring in the absence of symptoms of dissociative fugue.
- 6B61.Z** **Dissociative amnesia, unspecified**

**6B62****Trance disorder**

Trance disorder is characterised by trance states in which there is a marked alteration in the individual's state of consciousness or a loss of the individual's customary sense of personal identity in which the individual experiences a narrowing of awareness of immediate surroundings or unusually narrow and selective focusing on environmental stimuli and restriction of movements, postures, and speech to repetition of a small repertoire that is experienced as being outside of one's control. The trance state is not characterised by the experience of being replaced by an alternate identity. Trance episodes are recurrent or, if the diagnosis is based on a single episode, the episode has lasted for at least several days. The trance state is involuntary and unwanted and is not accepted as a part of a collective cultural or religious practice. The symptoms do not occur exclusively during another dissociative disorder and are not better explained by another mental, behavioural or neurodevelopmental disorder. The symptoms are not due to the direct effects of a substance or medication on the central nervous system, including withdrawal effects, exhaustion, or to hypnagogic or hypnopompic states, and are not due to a disease of the nervous system, head trauma, or a sleep-wake disorder. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**6B63****Possession trance disorder**

Possession trance disorder is characterised by trance states in which there is a marked alteration in the individual's state of consciousness and the individual's customary sense of personal identity is replaced by an external 'possessing' identity and in which the individual's behaviours or movements are experienced as being controlled by the possessing agent. Possession trance episodes are recurrent or, if the diagnosis is based on a single episode, the episode has lasted for at least several days. The possession trance state is involuntary and unwanted and is not accepted as a part of a collective cultural or religious practice. The symptoms do not occur exclusively during another dissociative disorder and are not better explained by another mental, behavioural or neurodevelopmental disorder. The symptoms are not due to the direct effects of a substance or medication on the central nervous system, including withdrawal effects, exhaustion, or to hypnagogic or hypnopompic states, and are not due to a disease of the nervous system or a sleep-wake disorder. The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Exclusions:**

- Schizophrenia (6A20)
- Disorders due to use of other specified psychoactive substances, including medications (6C4E)
- Acute and transient psychotic disorder (6A23)
- Secondary personality change (6E68)

**6B64**

### **Dissociative identity disorder**

Dissociative identity disorder is characterised by disruption of identity in which there are two or more distinct personality states (dissociative identities) associated with marked discontinuities in the sense of self and agency. Each personality state includes its own pattern of experiencing, perceiving, conceiving, and relating to self, the body, and the environment. At least two distinct personality states recurrently take executive control of the individual's consciousness and functioning in interacting with others or with the environment, such as in the performance of specific aspects of daily life such as parenting, or work, or in response to specific situations (e.g., those that are perceived as threatening). Changes in personality state are accompanied by related alterations in sensation, perception, affect, cognition, memory, motor control, and behaviour. There are typically episodes of amnesia, which may be severe. The symptoms are not better explained by another mental, behavioural or neurodevelopmental disorder and are not due to the direct effects of a substance or medication on the central nervous system, including withdrawal effects, and are not due to a disease of the nervous system or a sleep-wake disorder. The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**6B65**

### **Partial dissociative identity disorder**

Partial dissociative identity disorder is characterised by disruption of identity in which there are two or more distinct personality states (dissociative identities) associated with marked discontinuities in the sense of self and agency. Each personality state includes its own pattern of experiencing, perceiving, conceiving, and relating to self, the body, and the environment. One personality state is dominant and normally functions in daily life, but is intruded upon by one or more non-dominant personality states (dissociative intrusions). These intrusions may be cognitive, affective, perceptual, motor, or behavioural. They are experienced as interfering with the functioning of the dominant personality state and are typically aversive. The non-dominant personality states do not recurrently take executive control of the individual's consciousness and functioning, but there may be occasional, limited and transient episodes in which a distinct personality state assumes executive control to engage in circumscribed behaviours, such as in response to extreme emotional states or during episodes of self-harm or the reenactment of traumatic memories. The symptoms are not better explained by another mental, behavioural or neurodevelopmental disorder and are not due to the direct effects of a substance or medication on the central nervous system, including withdrawal effects, and are not due to a disease of the nervous system or a sleep-wake disorder. The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**6B66****Depersonalization-derealization disorder**

Depersonalization-derealization disorder is characterised by persistent or recurrent experiences of depersonalization, derealization, or both. Depersonalization is characterised by experiencing the self as strange or unreal, or feeling detached from, or as though one were an outside observer of, one's thoughts, feelings, sensations, body, or actions. Derealization is characterised by experiencing other persons, objects, or the world as strange or unreal (e.g., dreamlike, distant, foggy, lifeless, colourless, or visually distorted) or feeling detached from one's surroundings. During experiences of depersonalization or derealization, reality testing remains intact. The experiences of depersonalization or derealization do not occur exclusively during another dissociative disorder and are not better explained by another mental, behavioural or neurodevelopmental disorder. The experiences of depersonalization or derealization are not due to the direct effects of a substance or medication on the central nervous system, including withdrawal effects, and are not due to a disease of the nervous system or to head trauma. The symptoms result in significant distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

**6B6Y****Other specified dissociative disorders****6B6Z****Dissociative disorders, unspecified****Feeding or eating disorders (6B80-6B8Z)**

Feeding and Eating Disorders involve abnormal eating or feeding behaviours that are not explained by another health condition and are not developmentally appropriate or culturally sanctioned. Feeding disorders involve behavioural disturbances that are not related to body weight and shape concerns, such as eating of non-edible substances or voluntary regurgitation of foods. Eating disorders involve abnormal eating behaviour and preoccupation with food as well as prominent body weight and shape concerns.

**6B80****Anorexia Nervosa**

Anorexia Nervosa is characterised by significantly low body weight for the individual's height, age and developmental stage that is not due to another health condition or to the unavailability of food. A commonly used threshold is body mass index (BMI) less than 18.5 kg/m<sup>2</sup> in adults and BMI-for-age under 5th percentile in children and adolescents. Rapid weight loss (e.g. more than 20% of total body weight within 6 months) may replace the low body weight guideline as long as other diagnostic requirements are met. Children and adolescents may exhibit failure to gain weight as expected based on the individual developmental trajectory rather than weight loss. Low body weight is accompanied by a persistent pattern of behaviours to prevent restoration of normal weight, which may include behaviours aimed at reducing energy intake (restricted eating), purging behaviours (e.g. self-induced vomiting, misuse of laxatives), and behaviours aimed at increasing energy expenditure (e.g. excessive exercise), typically associated with a fear of weight gain. Low body weight or shape is central to the person's self-evaluation or is inaccurately perceived to be normal or even excessive.

- 6B80.0**            **Anorexia Nervosa with significantly low body weight**  
Anorexia Nervosa with significantly low body weight meets all definitional requirements for Anorexia Nervosa, with BMI between 18.5 kg/m<sup>2</sup> and 14.0 kg/m<sup>2</sup> for adults or between the fifth percentile and the 0.3 percentile for BMI-for-age in children and adolescents).
- 6B80.00**            Anorexia Nervosa with significantly low body weight, restricting pattern  
Anorexia Nervosa with significantly low body weight, restricting pattern refers to individuals who meet the definitional requirements of Anorexia Nervosa with significantly low body weight and who induce weight loss and maintain low body weight through restricted food intake or fasting alone or in combination with increased energy expenditure (such as through excessive exercise) but who do not engage in binge eating or purging behaviours.
- 6B80.01**            Anorexia Nervosa with significantly low body weight, binge-purge pattern  
Anorexia Nervosa with significantly low body weight, binge-purge pattern refers to individuals who meet the definitional requirements of Anorexia Nervosa with significantly low body weight and who present with episodes of binge eating or purging behaviours. These individuals induce weight loss and maintain low body weight through restricted food intake, commonly accompanied by significant purging behaviours aimed at getting rid of ingested food (e.g. self-induced vomiting, laxative abuse or enemas). This pattern also includes individuals who exhibit binge eating episodes but do not purge.
- 6B80.0Z**            Anorexia Nervosa with significantly low body weight, unspecified
- 6B80.1**            **Anorexia Nervosa with dangerously low body weight**  
Anorexia Nervosa with dangerously low body weight meets all definitional requirements for Anorexia Nervosa, with BMI under 14.0 kg/m<sup>2</sup> in adults or under the 0.3rd percentile for BMI-for-age in children and adolescents. In the context of Anorexia Nervosa, severe underweight status is an important prognostic factor that is associated with high risk of physical complications and substantially increased mortality.
- 6B80.10**            Anorexia Nervosa with dangerously low body weight, restricting pattern  
Anorexia Nervosa with dangerously low body weight, restricting pattern refers to individuals who meet the definitional requirements of Anorexia Nervosa with dangerously low body weight and who induce weight loss and maintain low body weight through restricted food intake or fasting alone or in combination with increased energy expenditure (such as through excessive exercise) but who do not engage in binge eating or purging behaviours.
- 6B80.11**            Anorexia Nervosa with dangerously low body weight, binge-purge pattern  
Anorexia Nervosa with dangerously low body weight, binge-purge pattern refers to individuals who meet the definitional requirements of Anorexia Nervosa with dangerously low body weight and who present with episodes of binge eating or purging behaviours. These individuals induce weight loss and maintain low body weight through restricted food intake, commonly accompanied by significant purging behaviours aimed at getting rid of ingested food (e.g. self-induced vomiting, laxative abuse or enemas). This pattern also includes individuals who exhibit binge eating episodes but do not purge.

**6B80.1Z** Anorexia Nervosa with dangerously low body weight, unspecified

**6B80.2** **Anorexia Nervosa in recovery with normal body weight**

Among individuals who are recovering from Anorexia Nervosa and whose body weight is more than 18.5 kg/m<sup>2</sup> for adults or over the fifth percentile for BMI-for-age for children and adolescents, the diagnosis should be retained until a full and lasting recovery is achieved, as indicated by the maintenance of a healthy weight and the cessation of behaviours aimed at reducing body weight independent of the provision of treatment (e.g., for at least 1 year after intensive treatment is withdrawn).

**6B80.Y** **Other specified anorexia Nervosa**

**6B80.Z** **Anorexia Nervosa, unspecified**

**6B81** **Bulimia Nervosa**

Bulimia Nervosa is characterised by frequent, recurrent episodes of binge eating (e.g. once a week or more over a period of at least one month). A binge eating episode is a distinct period of time during which the individual experiences a subjective loss of control over eating, eating notably more or differently than usual, and feels unable to stop eating or limit the type or amount of food eaten. Binge eating is accompanied by repeated inappropriate compensatory behaviours aimed at preventing weight gain (e.g. self-induced vomiting, misuse of laxatives or enemas, strenuous exercise). The individual is preoccupied with body shape or weight, which strongly influences self-evaluation. There is marked distress about the pattern of binge eating and inappropriate compensatory behaviour or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. The individual does not meet the diagnostic requirements of Anorexia Nervosa.

**Exclusions:** Binge eating disorder (6B82)

**6B82** **Binge eating disorder**

Binge eating disorder is characterised by frequent, recurrent episodes of binge eating (e.g. once a week or more over a period of several months). A binge eating episode is a distinct period of time during which the individual experiences a subjective loss of control over eating, eating notably more or differently than usual, and feels unable to stop eating or limit the type or amount of food eaten. Binge eating is experienced as very distressing, and is often accompanied by negative emotions such as guilt or disgust. However, unlike in Bulimia Nervosa, binge eating episodes are not regularly followed by inappropriate compensatory behaviours aimed at preventing weight gain (e.g. self-induced vomiting, misuse of laxatives or enemas, strenuous exercise). There is marked distress about the pattern of binge eating or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Exclusions:** Bulimia Nervosa (6B81)

**6B83****Avoidant-restrictive food intake disorder**

Avoidant-restrictive food intake disorder (ARFID) is characterised by avoidance or restriction of food intake that results in: 1) the intake of an insufficient quantity or variety of food to meet adequate energy or nutritional requirements that has resulted in significant weight loss, clinically significant nutritional deficiencies, dependence on oral nutritional supplements or tube feeding, or has otherwise negatively affected the physical health of the individual; or 2) significant impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g. due to avoidance or distress related to participating in social experiences involving eating). The pattern of eating behaviour is not motivated by preoccupation with body weight or shape. Restricted food intake and its effects on weight, other aspects of health, or functioning is not due to unavailability of food, not a manifestation of another medical condition (e.g. food allergies, hyperthyroidism) or mental disorder, and are not due to the effect of a substance or medication on the central nervous system including withdrawal effects.

**Exclusions:**           Anorexia Nervosa (6B80)  
                                   Feeding problem of infant (MG43.30)  
                                   Feeding problems of newborn (KD32)

**6B84****Pica**

Pica is characterised by the regular consumption of non-nutritive substances, such as non-food objects and materials (e.g., clay, soil, chalk, plaster, plastic, metal and paper) or raw food ingredients (e.g., large quantities of salt or corn flour) that is persistent or severe enough to require clinical attention in an individual who has reached a developmental age at which they would be expected to distinguish between edible and non-edible substances (approximately 2 years). That is, the behaviour causes damage to health, impairment in functioning, or significant risk due to the frequency, amount or nature of the substances or objects ingested.

**6B85****Rumination-regurgitation disorder**

Rumination-regurgitation disorder is characterised by the intentional and repeated bringing up of previously swallowed food back to the mouth (i.e., regurgitation), which may be re-chewed and re-swallowed (i.e. rumination), or may be deliberately spat out (but not as in vomiting). The regurgitation behaviour is frequent (at least several times per week) and sustained over a period of at least several weeks. The regurgitation behaviour is not fully accounted for by another medical condition that directly causes regurgitation (e.g., oesophageal strictures or neuromuscular disorders affecting oesophageal functioning) or causes nausea or vomiting (e.g. pyloric stenosis). Rumination-regurgitation disorder should only be diagnosed in individuals who have reached a developmental age of at least 2 years.

**Exclusions:**           Adult rumination syndrome (DD90.6)  
                                   Nausea or vomiting (MD90)

**6B8Y****Other specified feeding or eating disorders****6B8Z****Feeding or eating disorders, unspecified**

## Elimination disorders (6C00-6C0Z)

Elimination disorders include the repeated voiding of urine into clothes or bed (enuresis) and the repeated passage of faeces in inappropriate places (encopresis). Elimination disorders should only be diagnosed after the individual has reached a developmental age when continence is ordinarily expected (5 years for enuresis and 4 years for encopresis). The urinary or faecal incontinence may have been present from birth (i.e., an atypical extension of normal infantile incontinence), or may have arisen following a period of acquired bladder or bowel control. An Elimination disorder should not be diagnosed if the behaviour is fully attributable to another health condition that causes incontinence, congenital or acquired abnormalities of the urinary tract or bowel, or excessive use of laxatives or diuretics.

### 6C00

#### Enuresis

Enuresis is the repeated voiding of urine into clothes or bed, which may occur during the day or at night, in an individual who has reached a developmental age when urinary continence is ordinarily expected (5 years). The urinary incontinence may have been present from birth (i.e., an atypical extension of normal infantile incontinence), or may have arisen following a period of acquired bladder control. In most cases, the behaviour is involuntary but in some cases it appears intentional. Enuresis should not be diagnosed if unintentional voiding of urine is due to a health condition that interferes with continence (e.g., diseases of the nervous system or musculoskeletal disorders) or by congenital or acquired abnormalities of the urinary tract.

**Inclusions:**

- Functional enuresis
- Psychogenic enuresis
- Urinary incontinence of nonorganic origin

**Exclusions:**

- Stress incontinence (MF50.20)
- Urge Incontinence (MF50.21)
- Functional urinary incontinence (MF50.23)
- Overflow Incontinence (MF50.2)
- Reflex incontinence (MF50.24)
- Extraurethral urinary incontinence (MF50.2)

### 6C00.0

#### Nocturnal enuresis

Nocturnal enuresis refers to repeated voiding of urine into clothes or bed that occurs only during sleep (i.e., during the night) in an individual who has reached a developmental age when urinary continence is ordinarily expected (5 years). The urinary incontinence may have been present from birth (i.e., an atypical extension of normal infantile incontinence), or may have arisen following a period of acquired bladder control. In most cases, the behaviour is involuntary but in some cases it appears intentional.

### 6C00.1

#### Diurnal enuresis

Diurnal enuresis refers to repeated voiding of urine into clothes that occurs only during waking hours in an individual who has reached a developmental age when urinary continence is ordinarily expected (5 years). The urinary incontinence may have been present from birth (i.e., an atypical extension of normal infantile incontinence), or may have arisen following a period of acquired bladder control. In most cases, the behaviour is involuntary but in some cases it appears intentional.



- 6C00.2**      **Nocturnal and diurnal enuresis**
- Nocturnal and diurnal enuresis refers to repeated voiding of urine into clothes or bed that occurs both during sleep (i.e., during the night) and during waking hours in an individual who has reached a developmental age when urinary continence is ordinarily expected (5 years). The urinary incontinence may have been present from birth (i.e., an atypical extension of normal infantile incontinence), or may have arisen following a period of acquired bladder control. In most cases, the behaviour is involuntary but in some cases it appears intentional.
- 6C00.Z**      **Enuresis, unspecified**
- 6C01**      **Encopresis**
- Encopresis is the repeated passage of faeces in inappropriate places. Encopresis should be diagnosed if inappropriate passage of faeces occurs repeatedly (e.g., at least once per month over a period of several months) in an individual who has reached the developmental age when faecal continence is ordinarily expected (4 years). The faecal incontinence may have been present from birth (i.e., an atypical extension of normal infantile incontinence), or may have arisen following a period of acquired bowel control. Encopresis should not be diagnosed if faecal soiling is fully attributable to another health condition (e.g., aganglionic megacolon, spina bifida, dementia), congenital or acquired abnormalities of the bowel, gastrointestinal infection, or excessive use of laxatives.
- 6C01.0**      **Encopresis with constipation or overflow incontinence**
- Encopresis is the repeated passage of faeces in inappropriate places occurring repeatedly (e.g., at least once per month over a period of several months) in an individual who has reached the developmental age when faecal continence is ordinarily expected (4 years). The faecal incontinence may have been present from birth (i.e., an atypical extension of normal infantile incontinence), or may have arisen following a period of acquired bowel control. Encopresis with constipation and overflow incontinence is the most common form of faecal soiling, and involves retention and impaction of faeces. Stools are typically— but not always— poorly formed (loose or liquid) and leakage may range from occasional to continuous. There is often a history of toilet avoidance leading to constipation.
- 6C01.1**      **Encopresis without constipation or overflow incontinence**
- Encopresis is the repeated passage of faeces in inappropriate places occurring repeatedly (e.g., at least once per month over a period of several months) in an individual who has reached the developmental age when faecal continence is ordinarily expected (4 years). The faecal incontinence may have been present from birth (i.e., an atypical extension of normal infantile incontinence), or may have arisen following a period of acquired bowel control. Encopresis without constipation and overflow is not associated with retention and impaction of faeces, but rather reflects reluctance, resistance or failure to conform to social norms in defecating in acceptable places in the context of normal physiological control over defecation. Stools are typically of normal consistency and inappropriate defecation is likely to be intermittent.
- 6C01.Z**      **Encopresis, unspecified**
- 6C0Z**      **Elimination disorders, unspecified**

## Disorders of bodily distress or bodily experience (6C20-6C2Z)

Disorders of bodily distress and bodily experience are characterised by disturbances in the person's experience of his or her body. Bodily distress disorder involves bodily symptoms that the individual finds distressing and to which excessive attention is directed. Body integrity dysphoria involves a disturbance in the person's experience of the body manifested by the persistent desire to have a specific physical disability accompanied by persistent discomfort, or intense feelings of inappropriateness concerning current non-disabled body configuration.

**Exclusions:** Dissociative neurological symptom disorder (6B60)  
Concern about body appearance (QD30-QD3Z)

### 6C20

#### **Bodily distress disorder**

Bodily distress disorder is characterised by the presence of bodily symptoms that are distressing to the individual and excessive attention directed toward the symptoms, which may be manifest by repeated contact with health care providers. If another health condition is causing or contributing to the symptoms, the degree of attention is clearly excessive in relation to its nature and progression. Excessive attention is not alleviated by appropriate clinical examination and investigations and appropriate reassurance. Bodily symptoms are persistent, being present on most days for at least several months. Typically, bodily distress disorder involves multiple bodily symptoms that may vary over time. Occasionally there is a single symptom—usually pain or fatigue—that is associated with the other features of the disorder. The symptoms and associated distress and preoccupation have at least some impact on the individual's functioning (e.g. strain in relationships, less effective academic or occupational functioning, abandonment of specific leisure activities).

**Exclusions:** Tourette syndrome (8A05.00)  
Hair pulling disorder (6B25.0)  
Dissociative disorders (6B60-6B6Z)  
hair-plucking (6B25.0)  
Hypochondriasis (6B23)  
Body dysmorphic disorder (6B21)  
Excoriation disorder (6B25.1)  
Gender incongruence (HA60-HA6Z)  
Sexual dysfunctions (HA00-HA0Z)  
Tic disorders (8A05)  
Sexual pain-penetration disorder (HA20)  
Postviral fatigue syndrome (8E49)  
Chronic fatigue syndrome (8E49)  
Myalgic encephalomyelitis (8E49)

**6C20.0****Mild bodily distress disorder**

All definitional requirements of bodily distress disorder are present. There is excessive attention to distressing symptoms and their consequences, which may result in frequent medical visits, but the person is not preoccupied with the symptoms (e.g., the individual spends less than an hour per day focusing on them). Although the individual expresses distress about the symptoms and they may have some impact on his or her life (e.g., strain in relationships, less effective academic or occupational functioning, abandonment of specific leisure activities), there is no substantial impairment in the person's personal, family, social, educational, occupational, or other important areas of functioning.

**6C20.1****Moderate bodily distress disorder**

All definitional requirements of bodily distress disorder are present. There is persistent preoccupation with the distressing symptoms and their consequences (e.g., the individual spends more than an hour a day thinking about them), typically associated with frequent medical visits. The person devotes much of his or her energy to focusing on the symptoms and their consequences. The symptoms and associated distress and preoccupation cause moderate impairment in personal, family, social, educational, occupational, or other important areas of functioning (e.g., relationship conflict, performance problems at work, abandonment of a range of social and leisure activities).

**6C20.2****Severe bodily distress disorder**

All definitional requirements of Bodily distress disorder are present. There is pervasive and persistent preoccupation with the symptoms and their consequences to the extent that these may become the focal point of the person's life, typically resulting in extensive interactions with the health care system. The symptoms and associated distress and preoccupation cause serious impairment in personal, family, social, educational, occupational, or other important areas of functioning (e.g., unable to work, alienation of friends and family, abandonment of nearly all social and leisure activities). The person's interests may become so narrow so as to focus almost exclusively on his or her bodily symptoms and their negative consequences.

**6C20.Z****Bodily distress disorder, unspecified****6C21****Body integrity dysphoria**

Body integrity dysphoria is characterised by an intense and persistent desire to become physically disabled in a significant way (e.g. major limb amputee, paraplegic, blind), with onset by early adolescence accompanied by persistent discomfort, or intense feelings of inappropriateness concerning current non-disabled body configuration. The desire to become physically disabled results in harmful consequences, as manifested by either the preoccupation with the desire (including time spent pretending to be disabled) significantly interfering with productivity, with leisure activities, or with social functioning (e.g. person is unwilling to have a close relationships because it would make it difficult to pretend) or by attempts to actually become disabled have resulted in the person putting his or her health or life in significant jeopardy. The disturbance is not better accounted for by another mental, behavioural or neurodevelopmental disorder, by a Disease of the Nervous System or by another medical condition, or by Malingering.

**Exclusions:** Gender incongruence of adolescence or adulthood (HA60)

**6C2Y****Other specified disorders of bodily distress or bodily experience****6C2Z****Disorders of bodily distress or bodily experience, unspecified****Disorders due to substance use or addictive behaviours (6C40-6C5Z)**

Disorders due to substance use and addictive behaviours are mental and behavioural disorders that develop as a result of the use of predominantly psychoactive substances, including medications, or specific repetitive rewarding and reinforcing behaviours.

**Disorders due to substance use (6C40-6C4Z)**

Disorders due to substance use include disorders that result from a single occasion or repeated use of substances that have psychoactive properties, including certain medications. Disorders related to fourteen classes or groups of psychoactive substances are included. Typically, initial use of these substances produces pleasant or appealing psychoactive effects that are rewarding and reinforcing with repeated use. With continued use, many of the included substances have the capacity to produce dependence. They also have the potential to cause numerous forms of harm, both to mental and physical health. Disorders due to harmful non-medical use of non-psychoactive substances are also included in this grouping.

**Coded Elsewhere:** Catatonia induced by substances or medications (6A41)

**6C40****Disorders due to use of alcohol**

Disorders due to use of alcohol are characterised by the pattern and consequences of alcohol use. Alcohol—more specifically termed ethyl alcohol or ethanol—is an intoxicating compound produced by fermentation of sugars usually in agricultural products such as fruits, cereals, and vegetables with or without subsequent distillation. There are a wide variety of alcoholic drinks, with alcohol concentrations typically ranging from 1.5% to 60%. Alcohol is predominantly a central nervous system depressant. In addition to ability to produce Alcohol Intoxication, alcohol has dependence-producing properties, resulting in Alcohol Dependence in some people and Alcohol Withdrawal when alcohol use is reduced or discontinued. Unlike most other substances, elimination of alcohol from the body occurs at a constant rate, such that its clearance follows a linear rather than a logarithmic course. Alcohol is implicated in a wide range of harms affecting most organs and systems of the body (e.g., cirrhosis of the liver, gastrointestinal cancers, pancreatitis). Harm to others resulting from behaviour during Alcohol Intoxication is well recognized and is included in the definitions of harmful use of alcohol (i.e., Episode of Harmful Use of Alcohol and Harmful Pattern of Use of Alcohol). Several alcohol-induced mental disorders (e.g., Alcohol-Induced Psychotic Disorder) and alcohol-related forms of neurocognitive impairment (e.g., Dementia Due to Use of Alcohol) are recognized.

**Exclusions:** Hazardous alcohol use (QE10)

**6C40.0 Episode of harmful use of alcohol**

An episode of use of alcohol that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to alcohol intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of alcohol use.

**Exclusions:** Harmful pattern of use of alcohol (6C40.1)  
Alcohol dependence (6C40.2)

**6C40.1 Harmful pattern of use of alcohol**

A pattern of alcohol use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of alcohol use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to alcohol intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of alcohol applies.

**Exclusions:** Alcohol dependence (6C40.2)  
Episode of harmful use of alcohol (6C40.0)

**6C40.10 Harmful pattern of use of alcohol, episodic**

A pattern of episodic or intermittent alcohol use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic alcohol use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to alcohol intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of alcohol applies.

**Exclusions:** Episode of harmful use of alcohol (6C40.0)  
Alcohol dependence (6C40.2)

- 6C40.11** Harmful pattern of use of alcohol, continuous  
 A pattern of continuous (daily or almost daily) alcohol use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous alcohol use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to alcohol intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of alcohol applies.
- Exclusions:** Episode of harmful use of alcohol (6C40.0)  
 Alcohol dependence (6C40.2)
- 6C40.1Z** Harmful pattern of use of alcohol, unspecified
- 6C40.2** **Alcohol dependence**  
 Alcohol dependence is a disorder of regulation of alcohol use arising from repeated or continuous use of alcohol. The characteristic feature is a strong internal drive to use alcohol, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use alcohol. Physiological features of dependence may also be present, including tolerance to the effects of alcohol, withdrawal symptoms following cessation or reduction in use of alcohol, or repeated use of alcohol or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if alcohol use is continuous (daily or almost daily) for at least 3 months.
- Inclusions:** Chronic alcoholism  
 Dipsomania
- Exclusions:** Episode of harmful use of alcohol (6C40.0)  
 Harmful pattern of use of alcohol (6C40.1)
- 6C40.20** Alcohol dependence, current use, continuous  
 Alcohol dependence with continuous consumption of alcohol (daily or almost daily) over a period of at least 1 month.
- Exclusions:** Episode of harmful use of alcohol (6C40.0)  
 Harmful pattern of use of alcohol (6C40.1)
- 6C40.21** Alcohol dependence, current use, episodic  
 During the past 12 months, there has been alcohol dependence with intermittent heavy drinking, with periods of abstinence from alcohol. If current use is continuous (daily or almost daily over at least the past 1 month), the diagnosis of Alcohol dependence, current use, continuous should be made instead.
- Exclusions:** Episode of harmful use of alcohol (6C40.0)  
 Harmful pattern of use of alcohol (6C40.1)

- 6C40.22** Alcohol dependence, early full remission  
 After a diagnosis of alcohol dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from alcohol during a period lasting from between 1 and 12 months.  
**Exclusions:** Episode of harmful use of alcohol (6C40.0)  
 Harmful pattern of use of alcohol (6C40.1)
- 6C40.23** Alcohol dependence, sustained partial remission  
 After a diagnosis of alcohol dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in alcohol consumption for more than 12 months, such that even though intermittent or continuing drinking has occurred during this period, the definitional requirements for dependence have not been met.  
**Exclusions:** Episode of harmful use of alcohol (6C40.0)  
 Harmful pattern of use of alcohol (6C40.1)
- 6C40.24** Alcohol dependence, sustained full remission  
 After a diagnosis of alcohol dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from alcohol for 12 months or longer.  
**Exclusions:** Episode of harmful use of alcohol (6C40.0)  
 Harmful pattern of use of alcohol (6C40.1)
- 6C40.2Z** Alcohol dependence, unspecified
- 6C40.3** **Alcohol intoxication**  
 Alcohol intoxication is a clinically significant transient condition that develops during or shortly after the consumption of alcohol that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of alcohol and their intensity is closely related to the amount of alcohol consumed. They are time-limited and abate as alcohol is cleared from the body. Presenting features may include impaired attention, inappropriate or aggressive behaviour, lability of mood and emotions, impaired judgment, poor coordination, unsteady gait, fine nystagmus and slurred speech. At more severe levels of intoxication, stupor or coma may occur. Alcohol intoxication may facilitate suicidal ideation or behaviour.
- Coding Note:** Code also the causing condition  
**Exclusions:** alcohol poisoning (NE61)  
 Possession trance disorder (6B63)

**6C40.4 Alcohol withdrawal**

Alcohol withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of alcohol in individuals who have developed Alcohol dependence or have used alcohol for a prolonged period or in large amounts. Presenting features of Alcohol withdrawal may include autonomic hyperactivity (e.g. tachycardia, hypertension, perspiration), increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psychomotor agitation, depressed or dysphoric mood, transient visual, tactile or auditory illusions or hallucinations, and distractability. Less commonly, the withdrawal state is complicated by generalised tonic-clonic seizures. The withdrawal state may progress to a very severe form of delirium characterised by confusion and disorientation, delusions, and prolonged visual, tactile or auditory hallucinations. In such cases, a separate diagnosis of Alcohol-induced delirium should also be assigned.

**Coding Note:** Code also the causing condition

**6C40.40 Alcohol withdrawal, uncomplicated**

All diagnostic requirements for Alcohol Withdrawal are met and the withdrawal state is not accompanied by perceptual disturbances or seizures.

**Coding Note:** Code also the causing condition

**6C40.41 Alcohol withdrawal with perceptual disturbances**

All diagnostic requirements for Alcohol withdrawal are met and the withdrawal state is accompanied by perceptual disturbances (e.g., visual or tactile hallucinations or illusions) with intact reality testing. There is no evidence of confusion and other diagnostic requirements for Delirium are not met. The withdrawal state is not accompanied by seizures.

**Coding Note:** Code also the causing condition

**6C40.42 Alcohol withdrawal with seizures**

All diagnostic requirements for Alcohol withdrawal are met and the withdrawal state is accompanied by seizures (i.e., generalised tonic-clonic seizures) but not by perceptual disturbances.

**Coding Note:** Code also the causing condition

**6C40.43 Alcohol withdrawal with perceptual disturbances and seizures**

All diagnostic requirements for Alcohol withdrawal are met and the withdrawal state is accompanied by both seizures (i.e., generalised tonic-clonic seizures) and perceptual disturbances (e.g., visual or tactile hallucinations or illusions) with intact reality testing. Diagnostic requirements for Delirium are not met.

**Coding Note:** Code also the causing condition

**6C40.4Z Alcohol withdrawal, unspecified**

**Coding Note:** Code also the causing condition



**6C40.5 Alcohol-induced delirium**

Alcohol-induced delirium is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of alcohol. The amount and duration of alcohol use must be capable of producing delirium. Specific features of alcohol-induced delirium may include impaired consciousness with disorientation, vivid hallucinations and illusions, insomnia, delusions, agitation, disturbances of attention, and accompanying tremor and physiological symptoms of alcohol withdrawal. In some cases of alcohol withdrawal, the withdrawal state may progress to a very severe form of Alcohol-induced delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

**Inclusions:** Delirium tremens (alcohol-induced)  
Delirium induced by alcohol withdrawal

**6C40.6 Alcohol-induced psychotic disorder**

Alcohol-induced psychotic disorder is characterised by psychotic symptoms (e.g. delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with or withdrawal from alcohol. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Alcohol intoxication or Alcohol withdrawal. The amount and duration of alcohol use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g. Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the alcohol use, if the symptoms persist for a substantial period of time after cessation of the alcohol use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g. a history of prior episodes not associated with alcohol use).

**Coding Note:** Code also the causing condition

**6C40.60 Alcohol-induced psychotic disorder with hallucinations**

Alcohol-induced psychotic disorder with hallucinations is characterised by the presence of hallucinations that are judged to be the direct consequence of alcohol use. Neither delusions nor other psychotic symptoms are present. The symptoms do not occur exclusively during hypnagogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).

**Coding Note:** Code also the causing condition

- 6C40.61** Alcohol-induced psychotic disorder with delusions  
Alcohol-induced psychotic disorder with delusions is characterised by the presence of delusions that are judged to be the direct consequence of alcohol use. Neither hallucinations nor other psychotic symptoms are present. The symptoms do not occur exclusively during hypnogogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).
- Coding Note:** Code also the causing condition
- 6C40.62** Alcohol-induced psychotic disorder with mixed psychotic symptoms  
Alcohol-induced psychotic disorder with mixed psychotic symptoms is characterised by the presence of multiple psychotic symptoms, primarily hallucinations and delusions, when these are judged to be the direct consequence of alcohol use. The symptoms do not occur exclusively during hypnogogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).
- Coding Note:** Code also the causing condition
- 6C40.6Z** Alcohol-induced psychotic disorder, unspecified  
**Coding Note:** Code also the causing condition
- 6C40.7** **Certain specified alcohol-induced mental or behavioural disorders**  
**Coding Note:** Code also the causing condition  
**Coded Elsewhere:** Amnestic disorder due to use of alcohol (6D72.10)  
Dementia due to use of alcohol (6D84.0)
- 6C40.70** Alcohol-induced mood disorder  
Alcohol-induced mood disorder is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from alcohol. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of Alcohol intoxication or Alcohol withdrawal. The amount and duration of alcohol use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the alcohol use, if the symptoms persist for a substantial period of time after cessation of the alcohol use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with alcohol use).
- Coding Note:** Code also the causing condition

**6C40.71****Alcohol-induced anxiety disorder**

Alcohol-induced anxiety disorder is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from alcohol. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of Alcohol intoxication or Alcohol withdrawal. The amount and duration of alcohol use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and Fear-Related Disorder, a Depressive Disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the alcohol use, if the symptoms persist for a substantial period of time after cessation of the alcohol use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with alcohol use).

**Coding Note:** Code also the causing condition

**6C40.Y****Other specified disorders due to use of alcohol****6C40.Z****Disorders due to use of alcohol, unspecified****6C41****Disorders due to use of cannabis**

Disorders due to use of cannabis are characterised by the pattern and consequences of cannabis use. Cannabis is the collective term for a range of psychoactive preparations of the cannabis plant, *Cannabis sativa*, and related species and hybrids. Cannabis contains cannabinoids, a class of diverse chemical compounds that act on endogenous cannabinoid receptors that modulate neurotransmitter release in the brain. The principal psychoactive cannabinoid is  $\delta$ -9-tetrahydrocannabinol (THC). Cannabis is typically smoked in the form of the flowering heads or leaves of the marijuana plant; tobacco is often mixed with cannabis when smoked. There are also cannabis oils that are prepared from these same sources. These preparations vary considerably in their THC potency. Cannabis has predominantly central nervous system depressant effects and produces a characteristic euphoria that may be part of the presenting features of Cannabis Intoxication, which may also include impairment in cognitive and psychomotor functioning. Cannabis has dependence-producing properties resulting in Cannabis Dependence in some people and Cannabis Withdrawal when use is reduced or discontinued. Cannabis is associated with a range of Cannabis-Induced Mental Disorders.

**Exclusions:** Disorders due to use of synthetic cannabinoids (6C42)  
Hazardous use of cannabis (QE11.1)

**6C41.0 Episode of harmful use of cannabis**

An episode of use of cannabis that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to cannabis intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of cannabis use.

**Exclusions:** Cannabis dependence (6C41.2)  
Harmful pattern of use of cannabis (6C41.1)

**6C41.1 Harmful pattern of use of cannabis**

A pattern of cannabis use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of cannabis use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to cannabis intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of cannabis applies.

**Exclusions:** Cannabis dependence (6C41.2)  
Episode of harmful use of cannabis (6C41.0)

**6C41.10 Harmful pattern of use of cannabis, episodic**

A pattern of episodic or intermittent cannabis use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic cannabis use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to cannabis intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of cannabis applies.

**Exclusions:** Episode of harmful use of cannabis (6C41.0)  
Cannabis dependence (6C41.2)

**6C41.11**

## Harmful pattern of use of cannabis, continuous

A pattern of continuous (daily or almost daily) cannabis use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous cannabis use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to cannabis intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of cannabis applies.

**Exclusions:** Episode of harmful use of cannabis (6C41.0)  
Cannabis dependence (6C41.2)

**6C41.1Z**

## Harmful pattern of use of cannabis, unspecified

**6C41.2****Cannabis dependence**

Cannabis dependence is a disorder of regulation of cannabis use arising from repeated or continuous use of cannabis. The characteristic feature is a strong internal drive to use cannabis, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use cannabis. Physiological features of dependence may also be present, including tolerance to the effects of cannabis, withdrawal symptoms following cessation or reduction in use of cannabis, or repeated use of cannabis or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if cannabis use is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of cannabis (6C41.0)  
Harmful pattern of use of cannabis (6C41.1)

**6C41.20**

## Cannabis dependence, current use

Current cannabis dependence with use of cannabis within the past month.

**Exclusions:** Episode of harmful use of cannabis (6C41.0)  
Harmful pattern of use of cannabis (6C41.1)

**6C41.21**

## Cannabis dependence, early full remission

After a diagnosis of cannabis dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from cannabis during a period lasting from between 1 and 12 months.

**Exclusions:** Episode of harmful use of cannabis (6C41.0)  
Harmful pattern of use of cannabis (6C41.1)

- 6C41.22** Cannabis dependence, sustained partial remission  
 After a diagnosis of cannabis dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in cannabis consumption for more than 12 months, such that even though cannabis use has occurred during this period, the definitional requirements for dependence have not been met.
- Exclusions:** Episode of harmful use of cannabis (6C41.0)  
 Harmful pattern of use of cannabis (6C41.1)
- 6C41.23** Cannabis dependence, sustained full remission  
 After a diagnosis of cannabis dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from cannabis for 12 months or longer.
- Exclusions:** Episode of harmful use of cannabis (6C41.0)  
 Harmful pattern of use of cannabis (6C41.1)
- 6C41.2Z** Cannabis dependence, unspecified
- 6C41.3 Cannabis intoxication**  
 Cannabis intoxication is a clinically significant transient condition that develops during or shortly after the consumption of cannabis that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of cannabis and their intensity is closely related to the amount of cannabis consumed. They are time-limited and abate as cannabis is cleared from the body. Presenting features may include inappropriate euphoria, impaired attention, impaired judgment, perceptual alterations (such as the sensation of floating, altered perception of time), changes in sociability, increased appetite, anxiety, intensification of ordinary experiences, impaired short-term memory, and sluggishness. Physical signs include conjunctival injection (red or bloodshot eyes) and tachycardia.
- Coding Note:** Code also the causing condition
- Inclusions:** "Bad trips" due to cannabinoids
- Exclusions:** cannabinoid poisoning (NE60)  
 Possession trance disorder (6B63)
- 6C41.4 Cannabis withdrawal**  
 Cannabis withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of cannabis in individuals who have developed Cannabis dependence or have used cannabis for a prolonged period or in large amounts. Presenting features of Cannabis withdrawal may include irritability, anger or aggressive behaviour, shakiness, insomnia, restlessness, anxiety, depressed or dysphoric mood, decreased appetite and weight loss, headache, sweating or chills, abdominal cramps and muscle aches.
- Coding Note:** Code also the causing condition

**6C41.5 Cannabis-induced delirium**

Cannabis-induced delirium is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of cannabis. The amount and duration of cannabis use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

**6C41.6 Cannabis-induced psychotic disorder**

Cannabis-induced psychotic disorder is characterised by psychotic symptoms (e.g. delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with or withdrawal from cannabis. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Cannabis intoxication or Cannabis withdrawal. The amount and duration of cannabis use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g. Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the cannabis use, if the symptoms persist for a substantial period of time after cessation of the cannabis use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g. a history of prior episodes not associated with cannabis use).

**Coding Note:** Code also the causing condition

**6C41.7 Certain specified cannabis-induced mental or behavioural disorders**

**Coding Note:** Code also the causing condition

**6C41.70 Cannabis-induced mood disorder**

Cannabis-induced mood disorder is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from cannabis. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of Cannabis intoxication or Cannabis withdrawal. The amount and duration of cannabis use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the cannabis use, if the symptoms persist for a substantial period of time after cessation of the cannabis use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with cannabis use).

**Coding Note:** Code also the causing condition

**6C41.71****Cannabis-induced anxiety disorder**

Cannabis-induced anxiety disorder is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from cannabis. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of Cannabis intoxication or Cannabis withdrawal. The amount and duration of cannabis use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and Fear-Related Disorder, a Depressive Disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the cannabis use, if the symptoms persist for a substantial period of time after cessation of the cannabis use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with cannabis use).

**Coding Note:** Code also the causing condition

**6C41.Y****Other specified disorders due to use of cannabis****6C41.Z****Disorders due to use of cannabis, unspecified****6C42****Disorders due to use of synthetic cannabinoids**

Disorders due to use of synthetic cannabinoids are characterised by the pattern and consequences of synthetic cannabinoid use. Synthetic cannabinoids are synthesized diverse chemical compounds that are potent agonists for endogenous cannabinoid receptors. There are several hundred such compounds. The synthetic compound is typically sprayed onto a vehicle such as cannabis or tea leaves and then smoked. The effect of these compounds is distinctly different from smoking naturally cultivated cannabis in that the euphoric effects are typically accompanied or dominated by psychotic-like symptoms (e.g., paranoia, hallucinations, and disorganized behavior). Synthetic Cannabinoid Intoxication may therefore present more frequently with psychotic symptoms in addition to the more typical effects of cannabis. Synthetic cannabinoids are also dependence-producing and Synthetic Cannabinoid Dependence and Synthetic Cannabinoid Withdrawal are recognized. Synthetic Cannabinoid-Induced Mental Disorders also occur; in particular Synthetic Cannabinoid-Induced Psychotic Disorder is recognized.

**Exclusions:** Disorders due to use of cannabis (6C41)

**6C42.0****Episode of harmful use of synthetic cannabinoids**

An episode of use of a synthetic cannabinoid that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to synthetic cannabinoid intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of synthetic cannabinoid use.

**Exclusions:** Harmful pattern of use of synthetic cannabinoids (6C42.1)  
Synthetic cannabinoid dependence (6C42.2)



**6C42.1 Harmful pattern of use of synthetic cannabinoids**

A pattern of use of synthetic cannabinoids that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of synthetic cannabinoid use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to synthetic cannabinoid intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of synthetic cannabinoids applies.

**Exclusions:** Episode of harmful use of synthetic cannabinoids (6C42.0)  
Synthetic cannabinoid dependence (6C42.2)

**6C42.10 Harmful pattern of use of synthetic cannabinoids, episodic**

A pattern of episodic or intermittent use of synthetic cannabinoids that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic synthetic cannabinoid use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to synthetic cannabinoid intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of synthetic cannabinoids applies.

**Exclusions:** Episode of harmful use of synthetic cannabinoids (6C42.0)  
Synthetic cannabinoid dependence (6C42.2)

**6C42.11 Harmful pattern of use of synthetic cannabinoids, continuous**

A pattern of continuous (daily or almost daily) use of synthetic cannabinoids that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous synthetic cannabinoid use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to synthetic cannabinoid intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of synthetic cannabinoids applies.

**Exclusions:** Episode of harmful use of synthetic cannabinoids (6C42.0)  
Synthetic cannabinoid dependence (6C42.2)

**6C42.1Y Other specified harmful pattern of use of synthetic cannabinoids**

**6C42.1Z Harmful pattern of use of synthetic cannabinoids, unspecified**

**6C42.2 Synthetic cannabinoid dependence**

Synthetic cannabinoid dependence is a disorder of regulation of synthetic cannabinoid use arising from repeated or continuous use of synthetic cannabinoids. The characteristic feature is a strong internal drive to use synthetic cannabinoids, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use synthetic cannabinoids. Physiological features of dependence may also be present, including tolerance to the effects of synthetic cannabinoids, withdrawal symptoms following cessation or reduction in use of synthetic cannabinoids, or repeated use of synthetic cannabinoids or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if synthetic cannabinoid use is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of synthetic cannabinoids (6C42.0)  
Harmful pattern of use of synthetic cannabinoids (6C42.1)

**6C42.20 Synthetic cannabinoid dependence, current use**

Current synthetic cannabinoid dependence with use of synthetic cannabinoids within the past month.

**Exclusions:** Episode of harmful use of synthetic cannabinoids (6C42.0)  
Harmful pattern of use of synthetic cannabinoids (6C42.1)

**6C42.21 Synthetic cannabinoid dependence, early full remission**

After a diagnosis of synthetic cannabinoid dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from synthetic cannabinoid use during a period lasting from between 1 and 12 months.

**Exclusions:** Episode of harmful use of synthetic cannabinoids (6C42.0)  
Harmful pattern of use of synthetic cannabinoids (6C42.1)

**6C42.22 Synthetic cannabinoid dependence, sustained partial remission**

After a diagnosis of synthetic cannabinoid dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in synthetic cannabinoid consumption for more than 12 months, such that even though synthetic cannabinoid use has occurred during this period, the definitional requirements for dependence have not been met.

**Exclusions:** Episode of harmful use of synthetic cannabinoids (6C42.0)  
Harmful pattern of use of synthetic cannabinoids (6C42.1)

**6C42.23 Synthetic cannabinoid dependence, sustained full remission**

After a diagnosis of synthetic cannabinoid dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from synthetic cannabinoid use for 12 months or longer.

**Exclusions:** Episode of harmful use of synthetic cannabinoids (6C42.0)  
Harmful pattern of use of synthetic cannabinoids (6C42.1)

**6C42.2Y** Other specified synthetic cannabinoid dependence

**6C42.2Z** Synthetic cannabinoid dependence, unspecified

**6C42.3 Synthetic cannabinoid intoxication**

Synthetic cannabinoid intoxication is a clinically significant transient condition that develops during or shortly after the consumption of synthetic cannabinoids that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of synthetic cannabinoids and their intensity is closely related to the amount of synthetic cannabinoid consumed. They are time-limited and abate as synthetic cannabinoid is cleared from the body. Presenting features may include inappropriate euphoria, impaired attention, impaired judgment, perceptual alterations (such as the sensation of floating, altered perception of time), changes in sociability, increased appetite, anxiety, intensification of ordinary experiences, impaired short-term memory, and sluggishness. Physical signs include conjunctival injection (red or bloodshot eyes) and tachycardia. Intoxication with synthetic cannabinoids may also cause delirium or acute psychosis.

**Coding Note:** Code also the causing condition

**6C42.4 Synthetic cannabinoid withdrawal**

Synthetic cannabinoid withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of synthetic cannabinoids in individuals who have developed Synthetic cannabinoid dependence or have used synthetic cannabinoids for a prolonged period or in large amounts. Presenting features of Synthetic cannabinoid withdrawal may include irritability, anger, aggression, shakiness, insomnia and disturbing dreams, restlessness, anxiety, depressed mood and appetite disturbance. In the early phase, Synthetic cannabinoid withdrawal may be accompanied by residual features of intoxication from the drug, such as paranoid ideation and auditory and visual hallucinations.

**Coding Note:** Code also the causing condition

**6C42.5 Synthetic cannabinoid-induced delirium**

Synthetic cannabinoid-induced delirium is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of synthetic cannabinoids. The amount and duration of synthetic cannabinoid use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

**6C42.6 Synthetic cannabinoid-induced psychotic disorder**

Synthetic cannabinoid-induced psychotic disorder is characterised by psychotic symptoms (e.g., delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with or withdrawal from synthetic cannabinoids. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Synthetic cannabinoid intoxication or Synthetic cannabinoid withdrawal. The amount and duration of synthetic cannabinoid use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g., Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the synthetic cannabinoid use, if the symptoms persist for a substantial period of time after cessation of the synthetic cannabinoid use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g., a history of prior episodes not associated with synthetic cannabinoid use).

**Coding Note:** Code also the causing condition

**6C42.7 Certain specified synthetic cannabinoids-induced mental or behavioural disorders**

**Coding Note:** Code also the causing condition

**6C42.70 Synthetic cannabinoid-induced mood disorder**

Synthetic cannabinoid-induced mood disorder is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from synthetic cannabinoids. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of Synthetic cannabinoid intoxication or Synthetic cannabinoid withdrawal. The amount and duration of synthetic cannabinoid use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the synthetic cannabinoid use, if the symptoms persist for a substantial period of time after cessation of the synthetic cannabinoid use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with synthetic cannabinoid use).

**Coding Note:** Code also the causing condition

**6C42.71****Synthetic cannabinoid-induced anxiety disorder**

Synthetic cannabinoid-induced anxiety disorder is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from synthetic cannabinoids. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of Synthetic cannabinoid intoxication or Synthetic cannabinoid withdrawal. The amount and duration of synthetic cannabinoid use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and Fear-Related Disorder, a Depressive Disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the synthetic cannabinoid use, if the symptoms persist for a substantial period of time after cessation of the synthetic cannabinoid use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with synthetic cannabinoid use).

**Coding Note:** Code also the causing condition

**6C42.Y****Other specified disorders due to use of synthetic cannabinoids****6C42.Z****Disorders due to use of synthetic cannabinoids, unspecified****6C43****Disorders due to use of opioids**

Disorders due to use of opioids are characterised by the pattern and consequences of opioid use. Opioids is a generic term that encompasses the constituents or derivatives of the opium poppy *Papaver somniferum* as well as a range of synthetic and semisynthetic compounds, some related to morphine and others chemically distinct but all having their primary actions on the  $\mu$  opioid receptor. Examples of opioids include morphine, diacetylmorphine (heroin), fentanyl, pethidine, oxycodone, hydromorphone, methadone, buprenorphine, codeine and d-propoxyphene. The opioids all have analgesic properties of different potencies and are primarily central nervous system depressants. They suppress respiration as well as other vital functions and are a common cause of overdose and related deaths. Certain opioids are used or administered parenterally, including heroin, a common and potent opioid that is primarily used non-medically. Therapeutic opioids are prescribed for a range of indications worldwide, and are essential for pain management in cancer pain and palliative care, although they are also used for non-therapeutic reasons. In some countries morbidity and mortality related to therapeutic opioids is greater than that related to heroin. All opioids may result in Opioid Intoxication, Opioid Dependence and Opioid Withdrawal. A range of Opioid-Induced Disorders occur, some of which occur following Opioid Withdrawal.

**Exclusions:** Hazardous use of opioids (QE11.0)

**6C43.0 Episode of harmful use of opioids**

An episode of opioid use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to opioid intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of opioid use.

**Exclusions:** Harmful pattern of use of opioids (6C43.1)  
Opioid dependence (6C43.2)

**6C43.1 Harmful pattern of use of opioids**

A pattern of use of opioids that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of opioid use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to opioid intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of opioids applies.

**Exclusions:** Episode of harmful use of opioids (6C43.0)  
Opioid dependence (6C43.2)

**6C43.10 Harmful pattern of use of opioids, episodic**

A pattern of episodic or intermittent use of opioids that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic opioid use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to opioid intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of opioids applies.

**Exclusions:** Episode of harmful use of opioids (6C43.0)  
Opioid dependence (6C43.2)

- 6C43.11** Harmful pattern of use of opioids, continuous  
 A pattern of continuous (daily or almost daily) use of opioids that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous opioid use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to opioid intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of opioids applies.
- Exclusions:** Episode of harmful use of opioids (6C43.0)  
 Opioid dependence (6C43.2)
- 6C43.1Z** Harmful pattern of use of opioids, unspecified
- 6C43.2** **Opioid dependence**  
 Opioid dependence is a disorder of regulation of opioid use arising from repeated or continuous use of opioids. The characteristic feature is a strong internal drive to use opioids, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use opioids. Physiological features of dependence may also be present, including tolerance to the effects of opioids, withdrawal symptoms following cessation or reduction in use of opioids, or repeated use of opioids or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if opioid use is continuous (daily or almost daily) for at least 3 months.
- Exclusions:** Episode of harmful use of opioids (6C43.0)  
 Harmful pattern of use of opioids (6C43.1)
- 6C43.20** Opioid dependence, current use  
 Opioid dependence, with use of an opioid within the past month.
- Exclusions:** Episode of harmful use of opioids (6C43.0)  
 Harmful pattern of use of opioids (6C43.1)
- 6C43.21** Opioid dependence, early full remission  
 After a diagnosis of opioid dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from opioid use during a period lasting from between 1 and 12 months.
- Exclusions:** Episode of harmful use of opioids (6C43.0)  
 Harmful pattern of use of opioids (6C43.1)

**6C43.22** Opioid dependence, sustained partial remission  
After a diagnosis of Opioid dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in opioid consumption for more than 12 months, such that even though opioid use has occurred during this period, the definitional requirements for dependence have not been met.

**Exclusions:** Episode of harmful use of opioids (6C43.0)  
Harmful pattern of use of opioids (6C43.1)

**6C43.23** Opioid dependence, sustained full remission  
After a diagnosis of Opioid dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from opioids for 12 months or longer.

**Exclusions:** Episode of harmful use of opioids (6C43.0)  
Harmful pattern of use of opioids (6C43.1)

**6C43.2Z** Opioid dependence, unspecified

**6C43.3 Opioid intoxication**

Opioid intoxication is a clinically significant transient condition that develops during or shortly after the consumption of opioids that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of opioids and their intensity is closely related to the amount of opioids consumed. They are time-limited and abate as opioids are cleared from the body. Presenting features may include somnolence, stupor, mood changes (e.g. euphoria followed by apathy and dysphoria), psychomotor retardation, impaired judgment, respiratory depression, slurred speech, and impairment of memory and attention. In severe intoxication coma may ensue. A characteristic physical sign is pupillary constriction but this sign may be absent when intoxication is due to synthetic opioids. Severe opioid intoxication can lead to death due to respiratory depression.

**Coding Note:** Code also the causing condition

**Exclusions:** opioid poisoning (NE60)  
Possession trance disorder (6B63)  
fentanyl poisoning (NE60)  
oxycodone poisoning (NE60)



**6C43.4 Opioid withdrawal**

Opioid withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of opioids in individuals who have developed Opioid dependence or have used opioids for a prolonged period or in large amounts. Opioid withdrawal can also occur when prescribed opioids have been used in standard therapeutic doses. Presenting features of Opioid withdrawal may include dysphoric mood, craving for an opioid, anxiety, nausea or vomiting, abdominal cramps, muscle aches, yawning, perspiration, hot and cold flushes, lacrimation, rhinorrhea, hypersomnia (typically in the initial phase) or insomnia, diarrhea, piloerection, and pupillary dilatation.

**Coding Note:** Code also the causing condition

**6C43.5 Opioid-induced delirium**

Opioid-induced delirium is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of opioids. The amount and duration of opioid use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, Behavioural, and Neurodevelopmental Disorders.

**Coding Note:** Code also the causing condition

**Inclusions:** Delirium induced by opioid withdrawal

**6C43.6 Opioid-induced psychotic disorder**

Opioid-induced psychotic disorder is characterised by psychotic symptoms (e.g. delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with or withdrawal from opioids. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Opioid intoxication or Opioid withdrawal. The amount and duration of opioid use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g. Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the opioid use, if the symptoms persist for a substantial period of time after cessation of the opioid use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g. a history of prior episodes not associated with opioid use).

**Coding Note:** Code also the causing condition

**6C43.7 Certain specified opioid-induced mental or behavioural disorders**

**Coding Note:** Code also the causing condition

**6C43.70****Opioid-induced mood disorder**

Opioid-induced mood disorder is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from opioids. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of Opioid intoxication or Opioid withdrawal. The amount and duration of opioid use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the opioid use, if the symptoms persist for a substantial period of time after cessation of the opioid use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with opioid use).

**Coding Note:** Code also the causing condition

**6C43.71****Opioid-induced anxiety disorder**

Opioid-induced anxiety disorder is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from opioids. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of Opioid intoxication or Opioid withdrawal. The amount and duration of opioid use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and Fear-Related Disorder, a Depressive Disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the opioid use, if the symptoms persist for a substantial period of time after cessation of the opioid use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with opioid use).

**Coding Note:** Code also the causing condition

**6C43.Y****Other specified disorders due to use of opioids****6C43.Z****Disorders due to use of opioids, unspecified****6C44****Disorders due to use of sedatives, hypnotics or anxiolytics**

Disorders due to use of sedatives, hypnotics or anxiolytics are characterised by the pattern and consequences of use of these substances. Sedatives, hypnotics, and anxiolytics are typically prescribed for the short-term treatment of anxiety or insomnia and are also employed to provide sedation for medical procedures. They include the benzodiazepines and the non-benzodiazepine positive allosteric modulators of GABA receptors (i.e., 'Z-drugs') as well as many other compounds. Sedatives, hypnotics, and anxiolytics include barbiturates, which are available much less commonly now than in previous decades. Sedatives, hypnotics, and anxiolytics have dependence-inducing properties that are related to the dose and duration of their use. They may cause intoxication, dependence and withdrawal. Several other mental disorders induced by sedatives, hypnotics, or anxiolytics are recognized.

**Exclusions:** Hazardous use of sedatives, hypnotics or anxiolytics (QE11.2)

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

An episode of use of a sedative, hypnotic or anxiolytic that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to sedative, hypnotic or anxiolytic intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of sedative, hypnotic or anxiolytic use.

**Exclusions:** Sedative, hypnotic or anxiolytic dependence (6C44.2)  
Harmful pattern of use of sedatives, hypnotics or anxiolytics (6C44.1)

**6C44.1****Harmful pattern of use of sedatives, hypnotics or anxiolytics**

A pattern of sedative, hypnotic, or anxiolytic use that has caused clinically significant harm to a person's physical or mental health or in which behaviour induced by sedatives, hypnotics or anxiolytics has caused clinically significant harm to the health of other people. The pattern of sedative, hypnotic, or anxiolytic use is evident over a period of at least 12 months if use is episodic and at least one month if use is continuous (i.e., daily or almost daily). Harm may be caused by the intoxicating effects of sedatives, hypnotics or anxiolytics, the direct or secondary toxic effects on body organs and systems, or a harmful route of administration.

**Exclusions:** Sedative, hypnotic or anxiolytic dependence (6C44.2)  
Episode of harmful use of sedatives, hypnotics or anxiolytics (6C44.0)

**6C44.10****Harmful pattern of use of sedatives, hypnotics or anxiolytics, episodic**

A pattern of episodic or intermittent use of sedatives, hypnotics or anxiolytics that has caused clinically significant harm to a person's physical or mental health or in which behaviour induced by sedatives, hypnotics or anxiolytics has caused clinically significant harm to the health of other people. The pattern of episodic or intermittent use of sedatives, hypnotics or anxiolytics is evident over a period of at least 12 months. Harm may be caused by the intoxicating effects of sedatives, hypnotics or anxiolytics, the direct or secondary toxic effects on body organs and systems, or a harmful route of administration.

**Exclusions:** Episode of harmful use of sedatives, hypnotics or anxiolytics (6C44.0)  
Sedative, hypnotic or anxiolytic dependence (6C44.2)

**6C44.11** Harmful pattern of use of sedatives, hypnotics or anxiolytics, continuous  
A pattern of continuous use of sedatives, hypnotics or anxiolytics (daily or almost daily) that has caused clinically significant harm to a person's physical or mental health or in which behaviour induced by sedatives, hypnotics or anxiolytics has caused clinically significant harm to the health of other people. The pattern of continuous use of sedatives, hypnotics or anxiolytics is evident over a period of at least one month. Harm may be caused by the intoxicating effects of sedatives, hypnotics or anxiolytics, the direct or secondary toxic effects on body organs and systems, or a harmful route of administration.

**Exclusions:** Episode of harmful use of sedatives, hypnotics or anxiolytics (6C44.0)

Sedative, hypnotic or anxiolytic dependence (6C44.2)

**6C44.1Z** Harmful pattern of use of sedatives, hypnotics or anxiolytics, unspecified

**6C44.2 Sedative, hypnotic or anxiolytic dependence**

Sedative, hypnotic or anxiolytic dependence is a disorder of regulation of sedative use arising from repeated or continuous use of these substances. The characteristic feature is a strong internal drive to use sedatives, hypnotics, or anxiolytics, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use these substances. Physiological features of dependence may also be present, including tolerance to the effects of sedatives, hypnotics or anxiolytics, withdrawal symptoms following cessation or reduction in use, or repeated use of sedatives or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if sedative use is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of sedatives, hypnotics or anxiolytics (6C44.0)

Harmful pattern of use of sedatives, hypnotics or anxiolytics (6C44.1)

**6C44.20** Sedative, hypnotic or anxiolytic dependence, current use

Current Sedative, hypnotic or anxiolytic dependence with use of a sedative, hypnotic or anxiolytic drug within the past month.

**Exclusions:** Episode of harmful use of sedatives, hypnotics or anxiolytics (6C44.0)

Harmful pattern of use of sedatives, hypnotics or anxiolytics (6C44.1)

- 6C44.21** Sedative, hypnotic or anxiolytic dependence, early full remission  
After a diagnosis of Sedative, hypnotic or anxiolytic dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from sedatives, hypnotics or anxiolytics during a period lasting from between 1 and 12 months.
- Exclusions:** Episode of harmful use of sedatives, hypnotics or anxiolytics (6C44.0)  
Harmful pattern of use of sedatives, hypnotics or anxiolytics (6C44.1)
- 6C44.22** Sedative, hypnotic or anxiolytic dependence, sustained partial remission  
After a diagnosis of Sedative, hypnotic or anxiolytic dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in sedative, hypnotic or anxiolytic consumption for more than 12 months, such that even though sedative, hypnotic or anxiolytic use has occurred during this period, the definitional requirements for dependence have not been met.
- Exclusions:** Episode of harmful use of sedatives, hypnotics or anxiolytics (6C44.0)  
Harmful pattern of use of sedatives, hypnotics or anxiolytics (6C44.1)
- 6C44.23** Sedative, hypnotic or anxiolytic dependence, sustained full remission  
After a diagnosis of sedative, hypnotic or anxiolytic dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from sedative, hypnotic or anxiolytic for 12 months or longer.
- Exclusions:** Episode of harmful use of sedatives, hypnotics or anxiolytics (6C44.0)  
Harmful pattern of use of sedatives, hypnotics or anxiolytics (6C44.1)
- 6C44.2Z** Sedative, hypnotic or anxiolytic dependence, unspecified

### 6C44.3 **Sedative, hypnotic or anxiolytic intoxication**

Sedative, hypnotic or anxiolytic intoxication is a clinically significant transient condition that develops during or shortly after the consumption of sedatives, hypnotics or anxiolytics that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of sedatives, hypnotics or anxiolytics and their intensity is closely related to the amount of sedatives, hypnotics or anxiolytics consumed. They are time-limited and abate as sedatives, hypnotics or anxiolytics are cleared from the body. Presenting features may include somnolence, impaired judgment, inappropriate behavior (including sexual behavior or aggression), slurred speech, impaired motor coordination, unsteady gait, mood changes, as well as impaired memory, attention and concentration. Nystagmus (repetitive, uncontrolled eye movements) is a common physical sign. In severe cases stupor or coma may occur.

**Coding Note:** Code also the causing condition

**Inclusions:** "Bad trips" due to sedatives, hypnotics or anxiolytics

**Exclusions:** sedative, hypnotic drugs and other CNS depressants poisoning (NE60)

Possession trance disorder (6B63)

### 6C44.4 **Sedative, hypnotic or anxiolytic withdrawal**

Sedative, hypnotic or anxiolytic withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of sedatives, hypnotics or anxiolytics in individuals who have developed dependence or have used sedatives, hypnotics or anxiolytics for a prolonged period or in large amounts. Sedative, hypnotic or anxiolytic withdrawal can also occur when prescribed sedatives, hypnotics or anxiolytics have been used in standard therapeutic doses. Presenting features of Sedative, hypnotic or anxiolytic withdrawal may include anxiety, psychomotor agitation, insomnia, increased hand tremor, nausea or vomiting, and transient visual, tactile or auditory illusions or hallucinations. There may be signs of autonomic hyperactivity (e.g., tachycardia, hypertension, sweating), or postural hypotension. The withdrawal state may be complicated by seizures. Less commonly, there may be progression to a more severe withdrawal state characterised by confusion and disorientation, delusions, and more prolonged visual, tactile or auditory hallucinations. In such cases, a separate diagnosis of Sedative, hypnotic, or anxiolytic-induced delirium should be assigned.

**Coding Note:** Code also the causing condition

### 6C44.40 Sedative, hypnotic or anxiolytic withdrawal, uncomplicated

All diagnostic requirements for Sedative, hypnotic or anxiolytic Withdrawal are met and the withdrawal state is not accompanied by perceptual disturbances or seizures.

**Coding Note:** Code also the causing condition

**6C44.41** Sedative, hypnotic or anxiolytic withdrawal, with perceptual disturbances  
All diagnostic requirements for Sedative, hypnotic or anxiolytic withdrawal are met and the withdrawal state is accompanied by perceptual disturbances (e.g., visual or tactile hallucinations or illusions) with intact reality testing. There is no evidence of confusion and other diagnostic requirements for Delirium are not met. The withdrawal state is not accompanied by seizures.

**Coding Note:** Code also the causing condition

**6C44.42** Sedative, hypnotic or anxiolytic withdrawal, with seizures  
All diagnostic requirements for Sedative, hypnotic or anxiolytic withdrawal are met and the withdrawal state is accompanied by seizures (i.e., generalised tonic-clonic seizures) but not by perceptual disturbances.

**Coding Note:** Code also the causing condition

**6C44.43** Sedative, hypnotic or anxiolytic withdrawal, with perceptual disturbances and seizures  
All diagnostic requirements for Sedative, hypnotic or anxiolytic withdrawal are met and the withdrawal state is accompanied by both seizures (i.e., generalised tonic-clonic seizures) and perceptual disturbances (e.g., visual or tactile hallucinations or illusions) with intact reality testing. Diagnostic requirements for Delirium are not met.

**Coding Note:** Code also the causing condition

**6C44.4Z** Sedative, hypnotic or anxiolytic withdrawal, unspecified

**Coding Note:** Code also the causing condition

**6C44.5** **Sedative, hypnotic or anxiolytic-induced delirium**  
Sedative, hypnotic or anxiolytic-induced delirium is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of sedatives, hypnotics, or anxiolytics. Specific features of Sedative, hypnotic or anxiolytic-induced delirium may include confusion and disorientation, paranoid delusions, and recurrent visual, tactile or auditory hallucinations. The amount and duration of sedative, hypnotic, or anxiolytic use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

**Inclusions:** Delirium induced by sedative, hypnotic or anxiolytic withdrawal

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

Sedative, hypnotic or anxiolytic-induced psychotic disorder is characterised by psychotic symptoms (e.g. delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with or withdrawal from sedatives, hypnotics or anxiolytics. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of intoxication or withdrawal due to sedatives, hypnotics or anxiolytics. The amount and duration of sedative, hypnotic or anxiolytic use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g. Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the sedative, hypnotic or anxiolytic use, if the symptoms persist for a substantial period of time after cessation of the sedative, hypnotic or anxiolytic use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g. a history of prior episodes not associated with sedative, hypnotic or anxiolytic use).

**Coding Note:** Code also the causing condition

**6C44.7 Certain specified sedatives, hypnotics or anxiolytic-induced mental or behavioural disorders**

**Coding Note:** Code also the causing condition

**Coded Elsewhere:** Amnestic disorder due to use of sedatives, hypnotics or anxiolytics (6D72.11)

Dementia due to use of sedatives, hypnotics or anxiolytics (6D84.1)

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

Sedative, hypnotic or anxiolytic-induced mood disorder is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from sedatives, hypnotics or anxiolytics. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of intoxication or withdrawal due to sedatives, hypnotics or anxiolytics. The amount and duration of sedative, hypnotic or anxiolytic use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the sedative, hypnotic or anxiolytic use, if the symptoms persist for a substantial period of time after cessation of the sedative, hypnotic or anxiolytic use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with sedative, hypnotic or anxiolytic use).

**Coding Note:** Code also the causing condition



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

Sedative, hypnotic or anxiolytic-induced anxiety disorder is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from sedatives, hypnotics or anxiolytics. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of intoxication or withdrawal due to sedatives, hypnotics or anxiolytics. The amount and duration of sedative, hypnotic or anxiolytic use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and Fear-Related Disorder, a Depressive Disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the sedative, hypnotic or anxiolytic use, if the symptoms persist for a substantial period of time after cessation of the sedative, hypnotic or anxiolytic use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with sedative, hypnotic or anxiolytic use).

**Coding Note:** Code also the causing condition

**6C44.Y****Other specified disorders due to use of sedatives, hypnotics or anxiolytics****6C44.Z****Disorders due to use of sedatives, hypnotics or anxiolytics, unspecified****6C45****Disorders due to use of cocaine**

Disorders due to use of cocaine are characterised by the pattern and consequences of cocaine use. Cocaine is a compound found in the leaves of the coca plant, *Erythroxylum coca*, which is indigenous to countries in northern regions of South America. Cocaine has a limited place in medical treatment as an anaesthetic and vasoconstrictive agent. It is commonly used illicitly and widely available across the world, where it is found in two main forms: cocaine hydrochloride and cocaine freebase (also known as 'crack'). Cocaine is a central nervous system stimulant, and Cocaine Intoxication typically includes a state of euphoria and hyperactivity. Cocaine has potent dependence-producing properties and Cocaine Dependence is a common cause of morbidity and of clinical presentations. Cocaine Withdrawal has a characteristic course that includes lethargy and depressed mood. A range of Cocaine-Induced Mental Disorders is described.

**Exclusions:** Disorders due to use of stimulants including amphetamines, methamphetamine or methcathinone (6C46)

Hazardous use of cocaine (QE11.3)

**6C45.0 Episode of harmful use of cocaine**

An episode of use of cocaine that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to cocaine intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of cocaine use.

**Exclusions:** Cocaine dependence (6C45.2)  
Harmful pattern of use of cocaine (6C45.1)

**6C45.1 Harmful pattern of use of cocaine**

A pattern of use of cocaine that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of cocaine use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to cocaine intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of cocaine applies.

**Exclusions:** Cocaine dependence (6C45.2)  
Episode of harmful use of cocaine (6C45.0)

**6C45.10 Harmful pattern of use of cocaine, episodic**

A pattern of episodic or intermittent cocaine use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic cocaine use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to cocaine intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of cocaine applies.

**Exclusions:** Episode of harmful use of cocaine (6C45.0)  
Cocaine dependence (6C45.2)

- 6C45.11** Harmful pattern of use of cocaine, continuous  
 A pattern of continuous (daily or almost daily) cocaine use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous cocaine use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to cocaine intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of cocaine applies.
- Exclusions:** Episode of harmful use of cocaine (6C45.0)  
 Cocaine dependence (6C45.2)
- 6C45.1Z** Harmful pattern of use of cocaine, unspecified
- 6C45.2** **Cocaine dependence**  
 Cocaine dependence is a disorder of regulation of cocaine use arising from repeated or continuous use of cocaine. The characteristic feature is a strong internal drive to use cocaine, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use cocaine. Physiological features of dependence may also be present, including tolerance to the effects of cocaine, withdrawal symptoms following cessation or reduction in use of cocaine, or repeated use of cocaine or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if cocaine use is continuous (daily or almost daily) for at least 3 months.
- Exclusions:** Episode of harmful use of cocaine (6C45.0)  
 Harmful pattern of use of cocaine (6C45.1)
- 6C45.20** Cocaine dependence, current use  
 Current cocaine dependence with cocaine use within the past month.
- Exclusions:** Episode of harmful use of cocaine (6C45.0)  
 Harmful pattern of use of cocaine (6C45.1)
- 6C45.21** Cocaine dependence, early full remission  
 After a diagnosis of Cocaine dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from cocaine during a period lasting from between 1 and 12 months.
- Exclusions:** Episode of harmful use of cocaine (6C45.0)  
 Harmful pattern of use of cocaine (6C45.1)

- 6C45.22** Cocaine dependence, sustained partial remission  
 After a diagnosis of Cocaine dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in cocaine consumption for more than 12 months, such that even though cocaine use has occurred during this period, the definitional requirements for dependence have not been met.
- Exclusions:** Episode of harmful use of cocaine (6C45.0)  
 Harmful pattern of use of cocaine (6C45.1)
- 6C45.23** Cocaine dependence, sustained full remission  
 After a diagnosis of cocaine dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from cocaine for 12 months or longer.
- Exclusions:** Episode of harmful use of cocaine (6C45.0)  
 Harmful pattern of use of cocaine (6C45.1)
- 6C45.2Z** Cocaine dependence, unspecified
- 6C45.3** **Cocaine intoxication**  
 Cocaine intoxication is a clinically significant transient condition that develops during or shortly after the consumption of cocaine that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of cocaine and their intensity is closely related to the amount of cocaine consumed. They are time-limited and abate as cocaine is cleared from the body. Presenting features may include inappropriate euphoria, anxiety, anger, impaired attention, hypervigilance, psychomotor agitation, paranoid ideation (sometimes of delusional intensity), auditory hallucinations, confusion, and changes in sociability. Perspiration or chills, nausea or vomiting, and palpitations and chest pain may be experienced. Physical signs may include tachycardia, elevated blood pressure, and pupillary dilatation. In rare instances, usually in severe intoxication, cocaine use can result in seizures, muscle weakness, dyskinesia, or dystonia.
- Coding Note:** Code also the causing condition
- Exclusions:** cocaine poisoning (NE60)  
 Possession trance disorder (6B63)
- 6C45.4** **Cocaine withdrawal**  
 Cocaine withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of cocaine in individuals who have developed Cocaine dependence or have used cocaine for a prolonged period or in large amounts. Presenting features of Cocaine withdrawal may include dysphoric mood, irritability, fatigue, psychomotor retardation, vivid unpleasant dreams, insomnia or hypersomnia, increased appetite, anxiety, psychomotor agitation or retardation, and craving for cocaine.
- Coding Note:** Code also the causing condition

**6C45.5 Cocaine-induced delirium**

Cocaine-induced delirium is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of cocaine. The amount and duration of cocaine use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural, and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

**6C45.6 Cocaine-induced psychotic disorder**

Cocaine-induced psychotic disorder is characterised by psychotic symptoms (e.g. delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with or withdrawal from cocaine. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Cocaine intoxication or Cocaine withdrawal. The amount and duration of cocaine use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g. Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the cocaine use, if the symptoms persist for a substantial period of time after cessation of the cocaine use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g. a history of prior episodes not associated with cocaine use).

**Coding Note:** Code also the causing condition

**6C45.60 Cocaine-induced psychotic disorder with hallucinations**

Cocaine-induced psychotic disorder with hallucinations is characterised by the presence of hallucinations that are judged to be the direct consequence of cocaine use. Neither delusions nor other psychotic symptoms are present. The symptoms do not occur exclusively during hypnogogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).

**Coding Note:** Code also the causing condition

**6C45.61 Cocaine-induced psychotic disorder with delusions**

Cocaine-induced psychotic disorder with delusions is characterised by the presence of delusions that are judged to be the direct consequence of cocaine use. Neither hallucinations nor other psychotic symptoms are present. The symptoms do not occur exclusively during hypnogogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).

**Coding Note:** Code also the causing condition

- 6C45.62** Cocaine-induced psychotic disorder with mixed psychotic symptoms  
Cocaine-induced psychotic disorder with mixed psychotic symptoms is characterised by the presence of multiple psychotic symptoms, primarily hallucinations and delusions, when these are judged to be the direct consequence of cocaine use. The symptoms do not occur exclusively during hypnagogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., Schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).
- Coding Note:** Code also the causing condition
- 6C45.6Z** Cocaine-induced psychotic disorder, unspecified
- Coding Note:** Code also the causing condition
- 6C45.7** **Certain specified cocaine-induced mental or behavioural disorders**
- Coding Note:** Code also the causing condition
- 6C45.70** Cocaine-induced mood disorder  
Cocaine-induced mood disorder is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from cocaine. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of Cocaine intoxication or Cocaine withdrawal. The amount and duration of cocaine use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the cocaine use, if the symptoms persist for a substantial period of time after cessation of the cocaine use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with cocaine use).
- Coding Note:** Code also the causing condition
- 6C45.71** Cocaine-induced anxiety disorder  
Cocaine-induced anxiety disorder is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from cocaine. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of Cocaine intoxication or Cocaine withdrawal. The amount and duration of cocaine use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and fear-related disorder, a Depressive disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the cocaine use, if the symptoms persist for a substantial period of time after cessation of the cocaine use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with cocaine use).
- Coding Note:** Code also the causing condition

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

Cocaine-induced obsessive-compulsive or related disorder is characterised by either repetitive intrusive thoughts or preoccupations, normally associated with anxiety and typically accompanied by repetitive behaviours performed in response, or by recurrent and habitual actions directed at the integument (e.g., hair pulling, skin picking) that develop during or soon after intoxication with or withdrawal from cocaine. The intensity or duration of the symptoms is substantially in excess of analogous disturbances that are characteristic of Cocaine intoxication or Cocaine withdrawal. The amount and duration of cocaine use must be capable of producing obsessive-compulsive or related symptoms. The symptoms are not better explained by a primary mental disorder (in particular an Obsessive-compulsive or related disorder), as might be the case if the symptoms preceded the onset of the cocaine use, if the symptoms persist for a substantial period of time after cessation of the cocaine use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with obsessive-compulsive or related symptoms (e.g., a history of prior episodes not associated with cocaine use).

**Coding Note:** Code also the causing condition

**6C45.73****Cocaine-induced impulse control disorder**

Cocaine-induced impulse control disorder is characterised by persistently repeated behaviours in which there is recurrent failure to resist an impulse, drive, or urge to perform an act that is rewarding to the person, at least in the short-term, despite longer-term harm either to the individual or to others (e.g., fire setting or stealing without apparent motive, repetitive sexual behaviour, aggressive outbursts) that develop during or soon after intoxication with or withdrawal from cocaine. The intensity or duration of the symptoms is substantially in excess of disturbances of impulse control that are characteristic of Cocaine intoxication or Cocaine withdrawal. The amount and duration of cocaine use must be capable of producing disturbances of impulse control. The symptoms are not better explained by a primary mental disorder (e.g., an Impulse control disorder, a Disorder due to addictive behaviours), as might be the case if the impulse control disturbances preceded the onset of the cocaine use, if the symptoms persist for a substantial period of time after cessation of the cocaine use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with impulse control symptoms (e.g., a history of prior episodes not associated with cocaine use).

**Coding Note:** Code also the causing condition

**6C45.Y****Other specified disorders due to use of cocaine****6C45.Z****Disorders due to use of cocaine, unspecified**

**6C46****Disorders due to use of stimulants including amphetamines, methamphetamine or methcathinone**

Disorders due to use of stimulants including amphetamines, methamphetamine or methcathinone are characterised by the pattern and consequences of use of these substances. There is a wide array of naturally occurring and synthetically produced psychostimulants other than cocaine. The most numerous of this group are the amphetamine-type substances, including methamphetamine. Prescribed stimulants including dexamphetamine are indicated for a limited number of conditions such as for Attention Deficit Hyperactivity Disorder. Methcathinone, known in many countries as ephedrone, is a synthetic potent stimulant that is a structural analogue of methamphetamine and is related to cathinone. All these drugs have primarily psychostimulant properties and are also vasoconstrictors to a varying degree. They induce euphoria and hyperactivity as may be seen in Stimulant Intoxication. They have potent dependence-producing properties, which may lead to the diagnosis of Stimulant Dependence and Stimulant Withdrawal following the cessation of use. Several Stimulant-Induced Mental Disorders are described.

**Exclusions:**

- Disorders due to use of synthetic cathinones (6C47)
- Disorders due to use of caffeine (6C48)
- Disorders due to use of cocaine (6C45)
- Hazardous use of stimulants including amphetamines or methamphetamine (QE11.4)

**6C46.0****Episode of harmful use of stimulants including amphetamines, methamphetamine or methcathinone**

An episode of use of a stimulant including amphetamines, methamphetamine and methcathinone that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to stimulant intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of stimulant including amphetamines, methamphetamine and methcathinone use.

**Exclusions:**

- Harmful pattern of use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.1)
- Stimulant dependence including amphetamines, methamphetamine or methcathinone (6C46.2)



**6C46.1****Harmful pattern of use of stimulants including amphetamines, methamphetamine or methcathinone**

A pattern of use of stimulants including amphetamines, methamphetamine and methcathinone but excluding caffeine, cocaine and synthetic cathinones that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of stimulant use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to stimulant intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of stimulants including amphetamines, methamphetamine and methcathinone applies.

**Exclusions:**

- Harmful pattern of use of caffeine (6C48.1)
- Harmful pattern of use of cocaine (6C45.1)
- Harmful pattern of use of synthetic cathinones (6C47.1)
- Episode of harmful use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.0)
- Stimulant dependence including amphetamines, methamphetamine or methcathinone (6C46.2)

**6C46.10**

Harmful pattern of use of stimulants including amphetamines, methamphetamine or methcathinone, episodic

A pattern of episodic or intermittent use of stimulants including amphetamines, methamphetamine and methcathinone but excluding caffeine, cocaine and synthetic cathinones that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic stimulant use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to stimulant intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of stimulants including amphetamines, methamphetamine and methcathinone applies.

**Exclusions:**

- Episode of harmful use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.0)
- Stimulant dependence including amphetamines, methamphetamine or methcathinone (6C46.2)

**6C46.11** Harmful pattern of use of stimulants including amphetamines, methamphetamine or methcathinone, continuous

A pattern of use of stimulants including amphetamines, methamphetamine and methcathinone but excluding caffeine, cocaine and synthetic cathinones that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of stimulant use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to stimulant intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of stimulants including amphetamines, methamphetamine and methcathinone applies.

**Exclusions:** Episode of harmful use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.0)

Stimulant dependence including amphetamines, methamphetamine or methcathinone (6C46.2)

**6C46.1Z** Harmful pattern of use of stimulants including amphetamines, methamphetamine and methcathinone, unspecified

**6C46.2** **Stimulant dependence including amphetamines, methamphetamine or methcathinone**

Stimulant dependence including amphetamines, methamphetamine or methcathinone is a disorder of regulation of stimulant use arising from repeated or continuous use of stimulants. The characteristic feature is a strong internal drive to use stimulants, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use stimulants. Physiological features of dependence may also be present, including tolerance to the effects of stimulants, withdrawal symptoms following cessation or reduction in use of stimulants, or repeated use of stimulants or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if stimulant use is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Cocaine dependence (6C45.2)

Synthetic cathinone dependence (6C47.2)

Episode of harmful use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.0)

Harmful pattern of use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.1)

- 6C46.20** Stimulant dependence including amphetamines, methamphetamine or methcathinone, current use  
 Stimulant dependence including amphetamines, methamphetamine and methcathinone but excluding caffeine, cocaine and synthetic cathinones refers to amphetamine or other stimulant use within the past month.
- Exclusions:** Harmful pattern of use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.1)  
 Episode of harmful use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.0)
- 6C46.21** Stimulant dependence including amphetamines, methamphetamine or methcathinone, early full remission  
 After a diagnosis of Stimulant dependence including amphetamines, methamphetamine and methcathinone but excluding caffeine, cocaine and synthetic cathinones, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from stimulants during a period lasting from between 1 and 12 months.
- Exclusions:** Episode of harmful use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.0)  
 Harmful pattern of use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.1)
- 6C46.22** Stimulant dependence including amphetamines, methamphetamine or methcathinone, sustained partial remission  
 After a diagnosis of Stimulant dependence including amphetamines, methamphetamine and methcathinone but excluding caffeine, cocaine and synthetic cathinones, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in amphetamine or other stimulant consumption for more than 12 months, such that even though amphetamine or other stimulant use has occurred during this period, the definitional requirements for dependence have not been met.
- Exclusions:** Episode of harmful use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.0)  
 Harmful pattern of use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.1)
- 6C46.23** Stimulant dependence including amphetamines, methamphetamine or methcathinone, sustained full remission  
 After a diagnosis of Stimulant dependence including amphetamines, methamphetamine and methcathinone but excluding caffeine, cocaine and synthetic cathinones, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from amphetamine or other stimulants for 12 months or longer.
- Exclusions:** Episode of harmful use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.0)  
 Harmful pattern of use of stimulants including amphetamines, methamphetamine or methcathinone (6C46.1)
- 6C46.2Z** Stimulant dependence including amphetamines, methamphetamine or methcathinone, unspecified

**6C46.3****Stimulant intoxication including amphetamines, methamphetamine or methcathinone**

Stimulant intoxication including amphetamines, methamphetamine and methcathinone but excluding caffeine, cocaine and synthetic cathinones is a clinically significant transient condition that develops during or shortly after the consumption of amphetamine or other stimulants that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of amphetamine or other stimulants and their intensity is closely related to the amount of amphetamine or other stimulant consumed. They are time-limited and abate as amphetamine or another stimulant is cleared from the body. Presenting features may include anxiety, anger, impaired attention, hypervigilance, psychomotor agitation, paranoid ideation (possibly of delusional intensity), transient auditory hallucinations, transitory confusion, and changes in sociability. Perspiration or chills, nausea or vomiting, and palpitations may be experienced. Physical signs may include tachycardia, elevated blood pressure, pupillary dilatation, dyskinesias and dystonias, and skin sores. In rare instances, usually in severe intoxication, use of stimulants including amphetamines, methamphetamine and methcathinone can result in seizures.

**Coding Note:** Code also the causing condition

**Exclusions:**

- amphetamine poisoning (NE60)
- Caffeine intoxication (6C48.2)
- Cocaine intoxication (6C45.3)
- Synthetic cathinone intoxication (6C47.3)
- Possession trance disorder (6B63)

**6C46.4****Stimulant withdrawal including amphetamines, methamphetamine or methcathinone**

Stimulant withdrawal including amphetamines, methamphetamine and methcathinone is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of stimulants in individuals who have developed Stimulant dependence or have used stimulants for a prolonged period or in large amounts. Stimulant withdrawal can also occur when prescribed stimulants have been used in standard therapeutic doses. Presenting features of stimulant withdrawal may include dysphoric mood, irritability, fatigue, insomnia or (more commonly) hypersomnia, vivid and unpleasant dreams, increased appetite, psychomotor agitation or retardation, and craving for amphetamine or related stimulants.

**Coding Note:** Code also the causing condition

**Exclusions:**

- Cocaine withdrawal (6C45.4)
- Caffeine withdrawal (6C48.3)
- Synthetic cathinone withdrawal (6C47.4)

**6C46.5 Stimulant-induced delirium including amphetamines, methamphetamine or methcathinone**

Stimulant-induced delirium including amphetamines, methamphetamine and methcathinone is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of stimulants. The amount and duration of stimulant use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

**Exclusions:** Cocaine-induced delirium (6C45.5)  
Synthetic cathinone-induced delirium (6C47.5)  
Disorders due to use of caffeine (6C48)

**6C46.6 Stimulant-induced psychotic disorder including amphetamines, methamphetamine or methcathinone**

Stimulant-induced psychotic disorder including amphetamines, methamphetamine and methcathinone is characterised by psychotic symptoms (e.g., delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication or withdrawal due to stimulants. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Stimulant intoxication or Stimulant withdrawal. The amount and duration of stimulant use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g., Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the stimulant use, if the symptoms persist for a substantial period of time after cessation of the stimulant use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g., a history of prior episodes not associated with use of stimulants).

**Coding Note:** Code also the causing condition

**Exclusions:** Cocaine-induced psychotic disorder (6C45.6)  
Synthetic cathinone-induced psychotic disorder (6C47.6)  
Disorders due to use of caffeine (6C48)

**6C46.60**

Stimulant-induced psychotic disorder including amphetamines, methamphetamine or methcathinone with hallucinations

Stimulant-induced psychotic disorder with hallucinations is characterised by the presence of hallucinations that are judged to be the direct consequence of stimulant use. Neither delusions nor other psychotic symptoms are present. The symptoms do not occur exclusively during hypnagogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).

**Coding Note:** Code also the causing condition

**Exclusions:** Cocaine-induced psychotic disorder with hallucinations (6C45.60)

Disorders due to use of caffeine (6C48)

Synthetic cathinone-induced psychotic disorder with hallucinations (6C47.60)

**6C46.61**

Stimulant-induced psychotic disorder including amphetamines, methamphetamine or methcathinone with delusions

Stimulant-induced psychotic disorder including amphetamines, methamphetamine and methcathinone is characterised by psychotic symptoms (e.g., delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication or withdrawal due to stimulants. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Stimulant intoxication or Stimulant withdrawal. The amount and duration of stimulant use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g., Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the stimulant use, if the symptoms persist for a substantial period of time after cessation of the stimulant use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g., a history of prior episodes not associated with use of stimulants).

**Coding Note:** Code also the causing condition

**Exclusions:** Disorders due to use of caffeine (6C48)

Cocaine-induced psychotic disorder with delusions (6C45.61)

Synthetic cathinone-induced psychotic disorder with delusions (6C47.61)

**6C46.62** Stimulant-induced psychotic disorder including amphetamines but excluding caffeine or cocaine with mixed psychotic symptoms  
Stimulant-induced psychotic disorder with mixed psychotic symptoms is characterised by the presence of multiple psychotic symptoms, primarily hallucinations and delusions, when these are judged to be the direct consequence of stimulant use. The symptoms do not occur exclusively during hypnagogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., Schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).

**Coding Note:** Code also the causing condition

**Exclusions:** Disorders due to use of caffeine (6C48)  
Cocaine-induced psychotic disorder with mixed psychotic symptoms (6C45.62)  
Synthetic cathinone-induced psychotic disorder with mixed psychotic symptoms (6C47.62)

**6C46.6Z** Stimulant-induced psychotic disorder including amphetamines, methamphetamine or methcathinone, unspecified

**Coding Note:** Code also the causing condition

**6C46.7** **Certain specified stimulant-induced mental or behavioural disorders including amphetamines, methamphetamine or methcathinone**

**Coding Note:** Code also the causing condition

**6C46.70** Stimulant-induced mood disorder including amphetamines, methamphetamine or methcathinone  
Stimulant-induced mood disorder including amphetamines, methamphetamine and methcathinone is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication or withdrawal due to stimulants. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of Stimulant intoxication or Stimulant withdrawal. The amount and duration of stimulant use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the stimulant use, if the symptoms persist for a substantial period of time after cessation of the stimulant use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with use of stimulants).

**Coding Note:** Code also the causing condition

**Exclusions:** Synthetic cathinone-induced mood disorder (6C47.70)  
Cocaine-induced mood disorder (6C45.70)  
Disorders due to use of caffeine (6C48)

**6C46.71**

Stimulant-induced anxiety disorder including amphetamines, methamphetamine or methcathinone

Stimulant-induced anxiety disorder including amphetamines, methamphetamine and methcathinone is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication or withdrawal due to stimulants. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of Stimulant intoxication or Stimulant withdrawal. The amount and duration of stimulant use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and fear-related disorder, a Depressive disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the stimulant use, if the symptoms persist for a substantial period of time after cessation of the stimulant use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with use of stimulants).

**Coding Note:** Code also the causing condition

**Exclusions:** Cocaine-induced anxiety disorder (6C45.71)  
Caffeine-induced anxiety disorder (6C48.40)  
Synthetic cathinone-induced anxiety disorder (6C47.71)

**6C46.72**

Stimulant-induced obsessive-compulsive or related disorder including amphetamines, methamphetamine or methcathinone

Stimulant-induced obsessive-compulsive or related disorder including amphetamines, methamphetamine and methcathinone is characterised by either repetitive intrusive thoughts or preoccupations, normally associated with anxiety and typically accompanied by repetitive behaviours performed in response, or by recurrent and habitual actions directed at the integument (e.g., hair pulling, skin picking) that develop during or soon after intoxication with or withdrawal from stimulants. The intensity or duration of the symptoms is substantially in excess of analogous disturbances that are characteristic of Stimulant intoxication or Stimulant withdrawal. The amount and duration of stimulant use must be capable of producing obsessive-compulsive or related symptoms. The symptoms are not better explained by a primary mental disorder (in particular an Obsessive-compulsive or related disorder), as might be the case if the symptoms preceded the onset of the stimulant use, if the symptoms persist for a substantial period of time after cessation of the stimulant use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with obsessive-compulsive or related symptoms (e.g., a history of prior episodes not associated with stimulant use).

**Coding Note:** Code also the causing condition

**Exclusions:** Cocaine-induced obsessive-compulsive or related disorder (6C45.72)  
Synthetic cathinone-induced obsessive-compulsive or related syndrome (6C47.72)  
Disorders due to use of caffeine (6C48)



**6C46.73**

Stimulant-induced impulse control disorder including amphetamines, methamphetamine or methcathinone

Stimulant-induced impulse control disorder including amphetamines, methamphetamine and methcathinone is characterised by persistently repeated behaviours in which there is recurrent failure to resist an impulse, drive, or urge to perform an act that is rewarding to the person, at least in the short-term, despite longer-term harm either to the individual or to others (e.g., fire setting or stealing without apparent motive, repetitive sexual behaviour, aggressive outbursts) that develop during or soon after intoxication with or withdrawal from stimulants. The intensity or duration of the symptoms is substantially in excess of disturbances of impulse control that are characteristic of Stimulant intoxication or Stimulant withdrawal. The amount and duration of stimulant use must be capable of producing disturbances of impulse control. The symptoms are not better explained by a primary mental disorder (e.g., an Impulse control disorder, a Disorder due to addictive behaviours), as might be the case if the impulse control disturbances preceded the onset of the stimulant use, if the symptoms persist for a substantial period of time after cessation of the stimulant use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with impulse control symptoms (e.g., a history of prior episodes not associated with stimulant use).

**Coding Note:** Code also the causing condition

**6C46.Y**

**Other specified disorders due to use of stimulants including amphetamines, methamphetamine or methcathinone**

**6C46.Z**

**Disorders due to use of stimulants including amphetamines, methamphetamine or methcathinone, unspecified**

**6C47**

**Disorders due to use of synthetic cathinones**

Disorders due to use of synthetic cathinones are characterised by the pattern and consequences of synthetic cathinone use. Synthetic cathinones (also known as 'bath salts') are synthetic compounds with stimulant properties related to cathinone found in the khat plant, *Catha edulis*. The use of synthetic cathinones is common in young populations in many countries. They may produce a range of disorders including Synthetic Cathinone Intoxication, Synthetic Cathinone Dependence and Synthetic Cathinone Withdrawal. Several synthetic cathinone-induced mental disorders are recognised.

**6C47.0**

**Episode of harmful use of synthetic cathinones**

An episode of synthetic cathinone use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to synthetic cathinone intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of synthetic cathinone use.

**Exclusions:** Harmful pattern of use of synthetic cathinones (6C47.1)  
Synthetic cathinone dependence (6C47.2)

**6C47.1 Harmful pattern of use of synthetic cathinones**

A pattern of use of synthetic cathinones that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of synthetic cathinone use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to synthetic cathinone intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of synthetic cathinones applies.

**Exclusions:** Episode of harmful use of synthetic cathinones (6C47.0)  
Synthetic cathinone dependence (6C47.2)

**6C47.10 Harmful pattern of use of synthetic cathinones, episodic**

A pattern of episodic or intermittent use of synthetic cathinones that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic synthetic cathinone use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to synthetic cathinone intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of synthetic cathinones applies.

**Exclusions:** Episode of harmful use of synthetic cathinones (6C47.0)  
Synthetic cathinone dependence (6C47.2)

**6C47.11 Harmful use of synthetic cathinones, continuous**

A pattern of continuous (daily or almost daily) use of synthetic cathinones that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous synthetic cathinone use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to synthetic cathinone intoxication on the part of the person to whom the diagnosis of Harmful use of synthetic cathinones applies.

**Exclusions:** Episode of harmful use of synthetic cathinones (6C47.0)  
Synthetic cathinone dependence (6C47.2)

**6C47.1Y Other specified harmful pattern of use of synthetic cathinones**

**6C47.1Z Harmful pattern of use of synthetic cathinones, unspecified**

- 6C47.2 Synthetic cathinone dependence**  
 Synthetic cathinone dependence is a disorder of regulation of synthetic cathinone use arising from repeated or continuous use of synthetic cathinones. The characteristic feature is a strong internal drive to use synthetic cathinones, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use synthetic cathinones. Physiological features of dependence may also be present, including tolerance to the effects of synthetic cathinones, withdrawal symptoms following cessation or reduction in use of synthetic cathinones, or repeated use of synthetic cathinones or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if synthetic cathinone use is continuous (daily or almost daily) for at least 3 months.
- Exclusions:** Harmful pattern of use of synthetic cathinones (6C47.1)  
 Episode of harmful use of synthetic cathinones (6C47.0)
- 6C47.20 Synthetic cathinone dependence, current use**  
 Current synthetic cathinone dependence with use of synthetic cathinones within the past month.
- Exclusions:** Episode of harmful use of synthetic cathinones (6C47.0)  
 Harmful pattern of use of synthetic cathinones (6C47.1)
- 6C47.21 Synthetic cathinone dependence, early full remission**  
 After a diagnosis of synthetic cathinone dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from synthetic cathinone use during a period lasting from between 1 and 12 months.
- Exclusions:** Episode of harmful use of synthetic cathinones (6C47.0)  
 Harmful pattern of use of synthetic cathinones (6C47.1)
- 6C47.22 Synthetic cathinone dependence, sustained partial remission**  
 After a diagnosis of synthetic cathinone dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in synthetic cathinone consumption for more than 12 months, such that even though synthetic cathinone use has occurred during this period, the definitional requirements for dependence have not been met.
- Exclusions:** Episode of harmful use of synthetic cathinones (6C47.0)  
 Harmful pattern of use of synthetic cathinones (6C47.1)
- 6C47.23 Synthetic cathinone dependence, sustained full remission**  
 After a diagnosis of synthetic cathinone dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from synthetic cathinone use for 12 months or longer.
- Exclusions:** Episode of harmful use of synthetic cathinones (6C47.0)  
 Harmful pattern of use of synthetic cathinones (6C47.1)
- 6C47.2Y Other specified synthetic cathinone dependence**

**6C47.2Z** Synthetic cathinone dependence, unspecified

**6C47.3 Synthetic cathinone intoxication**

Synthetic cathinone intoxication is a clinically significant transient condition that develops during or shortly after the consumption of synthetic cathinones that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of synthetic cathinones and their intensity is closely related to the amount of synthetic cathinones consumed. They are time-limited and abate as the synthetic cathinone is cleared from the body. Presenting features may include anxiety, anger, impaired attention, hypervigilance, psychomotor agitation, paranoid ideation (possibly of delusional intensity), transient auditory hallucinations, transitory confusion, and changes in sociability. Perspiration or chills, nausea or vomiting, and palpitations may be experienced. Physical signs may include tachycardia, elevated blood pressure, pupillary dilatation, dyskinesias and dystonias, and skin sores. In rare instances, usually in severe intoxication, use of synthetic cathinones can result in seizures.

**Coding Note:** Code also the causing condition

**6C47.4 Synthetic cathinone withdrawal**

Synthetic cathinone withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of synthetic cathinones in individuals who have developed Synthetic cathinone dependence or have used synthetic cathinones for a prolonged period or in large amounts. Presenting features of Synthetic cathinone withdrawal may include dysphoric mood, irritability, fatigue, insomnia or (more commonly) hypersomnia, vivid and unpleasant dreams, increased appetite, psychomotor agitation or retardation, and craving for stimulants, including synthetic cathinones.

**Coding Note:** Code also the causing condition

**6C47.5 Synthetic cathinone-induced delirium**

Synthetic cathinone-induced delirium is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of synthetic cathinones. The amount and duration of synthetic cathinone use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

**6C47.6 Synthetic cathinone-induced psychotic disorder**

Synthetic cathinone-induced psychotic disorder is characterised by psychotic symptoms (e.g., delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with or withdrawal from synthetic cathinones. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Synthetic cathinone intoxication or Synthetic cathinone withdrawal. The amount and duration of synthetic cathinone use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g., Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the synthetic cathinone use, if the symptoms persist for a substantial period of time after cessation of the synthetic cathinone use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g., a history of prior episodes not associated with synthetic cathinone use).

**Coding Note:** Code also the causing condition

**6C47.60 Synthetic cathinone-induced psychotic disorder with hallucinations**

Synthetic cathinone-induced psychotic disorder with hallucinations is characterised by the presence of hallucinations that are judged to be the direct consequence of synthetic cathinone use. Neither delusions nor other psychotic symptoms are present. The symptoms do not occur exclusively during hypnogogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).

**Coding Note:** Code also the causing condition

**6C47.61 Synthetic cathinone-induced psychotic disorder with delusions**

Synthetic cathinone psychotic disorder with delusions is characterised by the presence of delusions that are judged to be the direct consequence of synthetic cathinone use. Neither hallucinations nor other psychotic symptoms are present. The symptoms do not occur exclusively during hypnogogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).

**Coding Note:** Code also the causing condition

**6C47.62 Synthetic cathinone-induced psychotic disorder with mixed psychotic symptoms**

Synthetic cathinone-induced psychotic disorder with mixed psychotic symptoms is characterised by the presence of multiple psychotic symptoms, primarily hallucinations and delusions, when these are judged to be the direct consequence of synthetic cathinone use. The symptoms do not occur exclusively during hypnogogic or hypnopompic states, are not better accounted for by another mental and behavioural disorder (e.g., Schizophrenia), and are not due to another disorder or disease classified elsewhere (e.g., epilepsies with visual symptoms).

**Coding Note:** Code also the causing condition

**6C47.6Z Synthetic cathinone-induced psychotic disorder, unspecified**

**Coding Note:** Code also the causing condition

**6C47.7**            **Certain specified synthetic cathinone-induced mental or behavioural disorders**

**Coding Note:**    Code also the causing condition

**6C47.70**            Synthetic cathinone-induced mood disorder

Synthetic cathinone-induced mood disorder is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from synthetic cathinones. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of Synthetic cathinone intoxication or Synthetic cathinone withdrawal. The amount and duration of synthetic cathinone use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the synthetic cathinone use, if the symptoms persist for a substantial period of time after cessation of the synthetic cathinone use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with synthetic cathinone use).

**Coding Note:**    Code also the causing condition

**6C47.71**            Synthetic cathinone-induced anxiety disorder

Synthetic cathinone-induced anxiety disorder is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from synthetic cathinones. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of Synthetic cathinone intoxication or Synthetic cathinone withdrawal. The amount and duration of synthetic cathinone use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and fear-related disorder, a Depressive disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the synthetic cathinone use, if the symptoms persist for a substantial period of time after cessation of the synthetic cathinone use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with synthetic cathinone use).

**Coding Note:**    Code also the causing condition

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

Synthetic cathinone-induced obsessive-compulsive or related disorder is characterised by either repetitive intrusive thoughts or preoccupations, normally associated with anxiety and typically accompanied by repetitive behaviours performed in response, or by recurrent and habitual actions directed at the integument (e.g., hair pulling, skin picking) that develop during or soon after intoxication with or withdrawal from synthetic cathinones. The intensity or duration of the symptoms is substantially in excess of analogous disturbances that are characteristic of Synthetic cathinone intoxication or Synthetic cathinone withdrawal. The amount and duration of synthetic cathinone use must be capable of producing obsessive-compulsive or related symptoms. The symptoms are not better explained by a primary mental disorder (in particular an Obsessive-compulsive or related disorder), as might be the case if the symptoms preceded the onset of the synthetic cathinone use, if the symptoms persist for a substantial period of time after cessation of the synthetic cathinone use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with obsessive-compulsive or related symptoms (e.g., a history of prior episodes not associated with synthetic cathinone use).

**Coding Note:** Code also the causing condition

**6C47.73****Synthetic cathinone-induced impulse control disorder**

Synthetic cathinone-induced impulse control disorder is characterised by persistently repeated behaviours in which there is recurrent failure to resist an impulse, drive, or urge to perform an act that is rewarding to the person, at least in the short-term, despite longer-term harm either to the individual or to others (e.g., fire setting or stealing without apparent motive, repetitive sexual behaviour, aggressive outbursts) that develop during or soon after intoxication with or withdrawal from synthetic cathinones. The intensity or duration of the symptoms is substantially in excess of disturbances of impulse control that are characteristic of Synthetic cathinone intoxication or Synthetic cathinone withdrawal. The amount and duration of synthetic cathinone use must be capable of producing disturbances of impulse control. The symptoms are not better explained by a primary mental disorder (e.g., an Impulse control disorder, a Disorder due to addictive behaviours), as might be the case if the impulse control disturbances preceded the onset of the synthetic cathinone use, if the symptoms persist for a substantial period of time after cessation of the synthetic cathinone use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with impulse control symptoms (e.g., a history of prior episodes not associated with synthetic cathinone use).

**Coding Note:** Code also the causing condition

**6C47.Y****Other specified disorders due to use of synthetic cathinones****6C47.Z****Disorders due to use of synthetic cathinones, unspecified**

**6C48****Disorders due to use of caffeine**

Disorders due to use of caffeine are characterised by the pattern and consequences of caffeine use. Caffeine is a mild psychostimulant and diuretic that is found in the beans of the coffee plant (*Coffea* species) and is a constituent of coffee, cola drinks, chocolate, a range of proprietary 'energy drinks' and weight-loss aids. It is the most commonly used psychoactive substance worldwide and several clinical conditions related to its use are described, although severe disorders are comparatively rare considering its ubiquity. Caffeine Intoxication related to consumption of relatively higher doses (i.e., > 1 g per day) is described. Caffeine Withdrawal is common upon cessation of use among individuals who have used caffeine for a prolonged period or in large amounts. Caffeine-Induced Anxiety Disorder has been described, often following intoxication or heavy use.

**Exclusions:** Disorders due to use of stimulants including amphetamines, methamphetamine or methcathinone (6C46)  
Hazardous use of caffeine (QE11.5)

**6C48.0****Episode of harmful use of caffeine**

An episode of caffeine use that has caused damage to a person's physical or mental health. Harm to health of the individual occurs due to one or more of the following: (1) direct or secondary toxic effects on body organs and systems; or (2) a harmful route of administration. This diagnosis should not be made if the harm is attributed to a known pattern of caffeine use.

**Exclusions:** Harmful pattern of use of caffeine (6C48.1)

**6C48.1****Harmful pattern of use of caffeine**

A pattern of caffeine use that has caused clinically significant harm to a person's physical or mental health or in which caffeine-induced behaviour has caused clinically significant harm to the health of other people. The pattern of caffeine use is evident over a period of at least 12 months if use is episodic and at least one month if use is continuous (i.e., daily or almost daily). Harm may be caused by the intoxicating effects of caffeine, the direct or secondary toxic effects on body organs and systems, or a harmful route of administration.

**Exclusions:** Episode of harmful use of caffeine (6C48.0)

**6C48.10****Harmful pattern of use of caffeine, episodic**

A pattern of episodic or intermittent caffeine use that has caused damage to a person's physical or mental health. The pattern of episodic caffeine use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) direct or secondary toxic effects on body organs and systems; or (2) a harmful route of administration.

**Exclusions:** Episode of harmful use of caffeine (6C48.0)

**6C48.11****Harmful pattern of use of caffeine, continuous**

A pattern of continuous (daily or almost daily) caffeine use that has caused damage to a person's physical or mental health. The pattern of continuous caffeine use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) direct or secondary toxic effects on body organs and systems; or (2) a harmful route of administration.

**Exclusions:** Episode of harmful use of caffeine (6C48.0)



**6C48.1Z** Harmful pattern of use of caffeine, unspecified

**6C48.2 Caffeine intoxication**

Caffeine intoxication is a clinically significant transient condition that develops during or shortly after the consumption of caffeine that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of caffeine and their intensity is closely related to the amount of caffeine consumed. They are time-limited and abate as caffeine is cleared from the body. Presenting features may include restlessness, anxiety, excitement, insomnia, flushed face, tachycardia, diuresis, gastrointestinal disturbances, muscle twitching, psychomotor agitation, perspiration or chills, and nausea or vomiting. Cardiac arrhythmias may occur. Disturbances typical of intoxication tend to occur at relatively higher doses (e.g., > 1 g per day). Very high doses of caffeine (e.g., > 5 g) can result in respiratory distress or seizures and can be fatal.

**Coding Note:** Code also the causing condition

**6C48.3 Caffeine withdrawal**

Caffeine withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of caffeine (typically in the form of coffee, caffeinated drinks, or as an ingredient in certain over-the-counter medications) in individuals who have used caffeine for a prolonged period or in large amounts. Presenting features of Caffeine withdrawal may include headache, marked fatigue or drowsiness, irritability, depressed or dysphoric mood, nausea or vomiting, and difficulty concentrating.

**Coding Note:** Code also the causing condition

**6C48.4 Certain specified caffeine-induced mental or behavioural disorders**

**Coding Note:** Code also the causing condition

**6C48.40 Caffeine-induced anxiety disorder**

Caffeine-induced anxiety disorder is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from caffeine. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of Caffeine intoxication or Caffeine withdrawal. The amount and duration of caffeine use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and fear-related disorder, a Depressive disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the caffeine use, if the symptoms persist for a substantial period of time after cessation of the caffeine use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with caffeine use).

**Coding Note:** Code also the causing condition

**6C48.Y Other specified disorders due to use of caffeine**

**6C48.Z Disorders due to use of caffeine, unspecified**

**6C49****Disorders due to use of hallucinogens**

Disorders due to use of hallucinogens are characterised by the pattern and consequences of hallucinogen use. Several thousand compounds have hallucinogenic properties, many of which are found in plants (e.g., mescaline) and fungi (e.g., psilocybin) or are chemically synthesized (e.g., lysergic acid diethylamide [LSD]). These compounds have primarily hallucinogenic properties, but some may also be stimulants. Much of the morbidity associated with these compounds arises from the acute effects related to Hallucinogen Intoxication. Hallucinogen Dependence is rare and Hallucinogen Withdrawal is not described. Among the mental disorders related to hallucinogen use, Hallucinogen-Induced Psychotic Disorder is the most frequently seen, although worldwide it is still fairly uncommon.

**6C49.0****Episode of harmful use of hallucinogens**

An episode of hallucinogen use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to hallucinogen intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of hallucinogen use.

**Exclusions:** Hallucinogen dependence (6C49.2)  
Harmful pattern of use of hallucinogens (6C49.1)

**6C49.1****Harmful pattern of use of hallucinogens**

A pattern of use of hallucinogens that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of hallucinogen use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to hallucinogen intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of hallucinogens applies.

**Exclusions:** Hallucinogen dependence (6C49.2)  
Episode of harmful use of hallucinogens (6C49.0)

**6C49.10**

## Harmful pattern of use of hallucinogens, episodic

A pattern of episodic or intermittent use of hallucinogens that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic hallucinogen use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to hallucinogen intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of hallucinogens applies.

**Exclusions:** Episode of harmful use of hallucinogens (6C49.0)  
Hallucinogen dependence (6C49.2)

**6C49.11**

## Harmful pattern of use of hallucinogens, continuous

A pattern of continuous (daily or almost daily) use of hallucinogens that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous hallucinogen use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to hallucinogen intoxication on the part of the person to whom the diagnosis of Harmful use of hallucinogens applies.

**Exclusions:** Episode of harmful use of hallucinogens (6C49.0)  
Hallucinogen dependence (6C49.2)

**6C49.1Z**

## Harmful pattern of use of hallucinogens, unspecified

**6C49.2****Hallucinogen dependence**

Hallucinogen dependence is a disorder of regulation of hallucinogen use arising from repeated or continuous use of hallucinogens. The characteristic feature is a strong internal drive to use hallucinogens, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use hallucinogens. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if hallucinogens use is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of hallucinogens (6C49.0)  
Harmful pattern of use of hallucinogens (6C49.1)

**6C49.20**

## Hallucinogen dependence, current use

Current hallucinogen dependence with hallucinogen use within the past month.

**Exclusions:** Episode of harmful use of hallucinogens (6C49.0)  
Harmful pattern of use of hallucinogens (6C49.1)

**6C49.21** Hallucinogen dependence, early full remission  
After a diagnosis of Hallucinogen dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from hallucinogens during a period lasting from between 1 and 12 months.

**Exclusions:** Episode of harmful use of hallucinogens (6C49.0)  
Harmful pattern of use of hallucinogens (6C49.1)

**6C49.22** Hallucinogen dependence, sustained partial remission  
After a diagnosis of Hallucinogen dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in hallucinogen consumption for more than 12 months, such that even though intermittent or continuing hallucinogen use has occurred during this period, the definitional requirements for dependence have not been met.

**Exclusions:** Episode of harmful use of hallucinogens (6C49.0)  
Harmful pattern of use of hallucinogens (6C49.1)

**6C49.23** Hallucinogen dependence, sustained full remission  
After a diagnosis of Hallucinogen dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from hallucinogens for 12 months or longer.

**Exclusions:** Episode of harmful use of hallucinogens (6C49.0)  
Harmful pattern of use of hallucinogens (6C49.1)

**6C49.2Z** Hallucinogen dependence, unspecified

**6C49.3 Hallucinogen intoxication**

Hallucinogen intoxication is a clinically significant transient condition that develops during or shortly after the consumption of hallucinogens that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of hallucinogens and their intensity is closely related to the amount of hallucinogen consumed. They are time-limited and abate as the hallucinogen is cleared from the body. Presenting features may include hallucinations, illusions, perceptual changes such as depersonalisation, derealization, or synesthesias (blending of senses, such as a visual stimulus evoking a smell), anxiety, depressed or dysphoric mood, ideas of reference, paranoid ideation, impaired judgment, palpitations, sweating, blurred vision, tremors and incoordination. Physical signs may include tachycardia, elevated blood pressure, and pupillary dilatation. In rare instances, hallucinogen intoxication may facilitate suicidal ideation and behaviour.

**Coding Note:** Code also the causing condition

**Exclusions:** hallucinogens poisoning (NE60)  
Possession trance disorder (6B63)

**6C49.4 Hallucinogen-induced delirium**

Hallucinogen-induced delirium is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or during the use of hallucinogens. The amount and duration of hallucinogen use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

**6C49.5 Hallucinogen-induced psychotic disorder**

Hallucinogen-induced psychotic disorder is characterised by psychotic symptoms (e.g. delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with hallucinogens. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of hallucinogen intoxication. The amount and duration of hallucinogen use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g. Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the hallucinogen use, if the symptoms persist for a substantial period of time after cessation of the hallucinogen use, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g. a history of prior episodes not associated with hallucinogen use).

**Coding Note:** Code also the causing condition

**Exclusions:** Psychotic disorder induced by other specified psychoactive substance (6C4E.6)

Alcohol-induced psychotic disorder (6C40.6)

**6C49.6 Certain specified hallucinogen-induced mental or behavioural disorders**

**Coding Note:** Code also the causing condition

**6C49.60 Hallucinogen-induced mood disorder**

Hallucinogen-induced mood disorder is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with hallucinogens. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of hallucinogen intoxication. The amount and duration of hallucinogen use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the hallucinogen use, if the symptoms persist for a substantial period of time after cessation of the hallucinogen use, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with hallucinogen use).

**Coding Note:** Code also the causing condition

**6C49.61** Hallucinogen-induced anxiety disorder

Hallucinogen-induced anxiety disorder is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with hallucinogens. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of hallucinogen intoxication. The amount and duration of hallucinogen use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and Fear-Related Disorder, a Depressive Disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the hallucinogen use, if the symptoms persist for a substantial period of time after cessation of the hallucinogen use, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with hallucinogen use).

**Coding Note:** Code also the causing condition

**6C49.Y** Other specified disorders due to use of hallucinogens

**6C49.Z** Disorders due to use of hallucinogens, unspecified

**6C4A** Disorders due to use of nicotine

Disorders due to use of nicotine are characterised by the pattern and consequences of nicotine use. Nicotine is the active dependence-producing constituent of the tobacco plant, *Nicotiana tabacum*. Nicotine is used overwhelmingly through smoking cigarettes. Increasingly, it is also used in electronic cigarettes that vaporize nicotine dissolved in a carrier solvent for inhalation (i.e., “vaping”). Pipe smoking, chewing tobacco and inhaling snuff are minor forms of use. Nicotine is a highly potent addictive compound and is the third most common psychoactive substance used worldwide after caffeine and alcohol. Nicotine Dependence and Nicotine Withdrawal are well described and Nicotine-Induced Mental Disorders are recognized.

**6C4A.0** Episode of harmful use of nicotine

An episode of nicotine use that has caused damage to a person’s physical or mental health. Harm to health of the individual occurs due to one or more of the following: (1) direct or secondary toxic effects on body organs and systems; or (2) a harmful route of administration. This diagnosis should not be made if the harm is attributed to a known pattern of nicotine use.

**Exclusions:** Nicotine dependence (6C4A.2)  
Harmful pattern of use of nicotine (6C4A.1)  
Harmful effects of or exposure to noxious substances, chiefly nonmedicinal as to source, not elsewhere classified (NE61)

**6C4A.1 Harmful pattern of use of nicotine**

A pattern of nicotine use that has caused damage to a person's physical or mental health. The pattern of nicotine use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) direct or secondary toxic effects on body organs and systems; or (2) a harmful route of administration.

**Exclusions:** Nicotine dependence (6C4A.2)  
Episode of harmful use of nicotine (6C4A.0)

**6C4A.10 Harmful pattern of use of nicotine, episodic**

A pattern of episodic or intermittent nicotine use that has caused damage to a person's physical or mental health. The pattern of episodic nicotine use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) direct or secondary toxic effects on body organs and systems; or (2) a harmful route of administration.

**Exclusions:** Episode of harmful use of nicotine (6C4A.0)  
Nicotine dependence (6C4A.2)

**6C4A.11 Harmful pattern of use of nicotine, continuous**

A pattern of continuous (daily or almost daily) nicotine use that has caused damage to a person's physical or mental health. The pattern of continuous nicotine use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) direct or secondary toxic effects on body organs and systems; or (2) a harmful route of administration.

**Exclusions:** Episode of harmful use of nicotine (6C4A.0)  
Nicotine dependence (6C4A.2)

**6C4A.1Z Harmful pattern of use of nicotine, unspecified**

**6C4A.2 Nicotine dependence**

Nicotine dependence is a disorder of regulation of nicotine use arising from repeated or continuous use of nicotine. The characteristic feature is a strong internal drive to use nicotine, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use nicotine. Physiological features of dependence may also be present, including tolerance to the effects of nicotine, withdrawal symptoms following cessation or reduction in use of nicotine, or repeated use of nicotine or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if nicotine use is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of nicotine (6C4A.0)  
Harmful pattern of use of nicotine (6C4A.1)

- 6C4A.20** Nicotine dependence, current use  
Current nicotine dependence with nicotine use within the past month.  
**Exclusions:** Episode of harmful use of nicotine (6C4A.0)  
Harmful pattern of use of nicotine (6C4A.1)
- 6C4A.21** Nicotine dependence, early full remission  
After a diagnosis of nicotine dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from nicotine during a period lasting from between 1 and 12 months.  
**Exclusions:** Episode of harmful use of nicotine (6C4A.0)  
Harmful pattern of use of nicotine (6C4A.1)
- 6C4A.22** Nicotine dependence, sustained partial remission  
After a diagnosis of nicotine dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in nicotine consumption for more than 12 months, such that even though intermittent or continuing nicotine use has occurred during this period, the definitional requirements for dependence have not been met.  
**Exclusions:** Episode of harmful use of nicotine (6C4A.0)  
Harmful pattern of use of nicotine (6C4A.1)
- 6C4A.23** Nicotine dependence, sustained full remission  
After a diagnosis of nicotine dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from nicotine for 12 months or longer.  
**Exclusions:** Episode of harmful use of nicotine (6C4A.0)  
Harmful pattern of use of nicotine (6C4A.1)
- 6C4A.2Z** Nicotine dependence, unspecified
- 6C4A.3** **Nicotine intoxication**  
Nicotine intoxication is a clinically significant transient condition that develops during or shortly after the consumption of nicotine that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of nicotine and their intensity is closely related to the amount of nicotine consumed. They are time-limited and abate as nicotine is cleared from the body. Presenting features may include restlessness, psychomotor agitation, anxiety, cold sweats, headache, insomnia, palpitations, paresthesias, nausea or vomiting, abdominal cramps, confusion, bizarre dreams, burning sensations in the mouth, and salivation. In rare instances, paranoid ideation, perceptual disturbances, convulsions or coma may occur. Nicotine intoxication occurs more commonly in naïve (non-tolerant) users or among those taking higher than accustomed doses.
- Coding Note:** Code also the causing condition  
**Inclusions:** "Bad trips" due to nicotine  
**Exclusions:** intoxication meaning poisoning (NE61)  
Possession trance disorder (6B63)



**6C4A.4 Nicotine withdrawal**

Nicotine withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of nicotine (typically used as a constituent of tobacco) in individuals who have developed Nicotine dependence or have used nicotine for a prolonged period or in large amounts. Presenting features of Nicotine withdrawal may include dysphoric or depressed mood, insomnia, irritability, anger, anxiety, difficulty concentrating, restlessness, bradycardia, increased appetite, and craving for tobacco (or other nicotine-containing products). Other physical symptoms may include increased cough and mouth ulceration.

**Coding Note:** Code also the causing condition

**6C4A.Y Other specified disorders due to use of nicotine**

**6C4A.Z Disorders due to use of nicotine, unspecified**

**6C4B Disorders due to use of volatile inhalants**

Disorders due to use of volatile inhalants are characterised by the pattern and consequences of volatile inhalant use. Volatile inhalants include a range of compounds that are in the gaseous or vapour phase at ambient temperatures and include various organic solvents, glues, gasoline (petrol), nitrites and gases such as nitrous oxide, trichloroethane, butane, toluene, fluorocarbons, ether and halothane. They have a range of pharmacological properties but are predominantly central nervous system depressants, with many also having vasoactive effects. They tend to be used by younger persons and may be used when access to alternative psychoactive substances is difficult or impossible. Volatile Inhalant Intoxication is well recognized. Volatile inhalants have dependence-producing properties and Volatile Inhalant Dependence and Volatile Inhalant Withdrawal is recognized although comparatively uncommon worldwide. Volatile Inhalant-Induced Mental Disorders are described. They may also cause neurocognitive impairment, including Dementia.

**6C4B.0 Episode of harmful use of volatile inhalants**

An episode of volatile inhalant use or unintentional exposure (e.g., occupational exposure) that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to volatile inhalant intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of volatile inhalant use.

**Exclusions:** Harmful pattern of use of volatile inhalants (6C4B.1)  
Volatile inhalant dependence (6C4B.2)

**6C4B.1 Harmful pattern of use of volatile inhalants**

A pattern of volatile inhalant use of that has caused damage to a person's physical or mental health. The pattern of volatile inhalant use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (1) direct or secondary toxic effects on body organs and systems; or (2) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to volatile inhalant intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of volatile inhalants applies.

**Exclusions:** Volatile inhalant dependence (6C4B.2)  
Episode of harmful use of volatile inhalants (6C4B.0)

**6C4B.10 Harmful pattern of use of volatile inhalants, episodic**

A pattern of episodic or intermittent volatile inhalant use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic volatile inhalant use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to volatile inhalant intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of volatile inhalants applies.

**Exclusions:** Episode of harmful use of volatile inhalants (6C4B.0)  
Volatile inhalant dependence (6C4B.2)

**6C4B.11 Harmful pattern of use of volatile inhalants, continuous**

A pattern of continuous (daily or almost daily) volatile inhalant use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous volatile inhalant use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to volatile inhalant intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of volatile inhalants applies.

**Exclusions:** Episode of harmful use of volatile inhalants (6C4B.0)  
Volatile inhalant dependence (6C4B.2)

**6C4B.12 Harmful pattern of use of volatile inhalants, unspecified**

**6C4B.2****Volatile inhalant dependence**

Volatile inhalant dependence is a disorder of regulation of volatile inhalant use arising from repeated or continuous use of volatile inhalants. The characteristic feature is a strong internal drive to use volatile inhalants, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use volatile inhalants. Physiological features of dependence may also be present, including tolerance to the effects of volatile inhalants, withdrawal symptoms following cessation or reduction in use of volatile inhalants, or repeated use of volatile inhalants or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if volatile inhalant use is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of volatile inhalants (6C4B.0)  
Harmful pattern of use of volatile inhalants (6C4B.1)

**6C4B.20**

Volatile inhalant dependence, current use

Current volatile inhalant dependence with volatile inhalant use within the past month.

**Exclusions:** Episode of harmful use of volatile inhalants (6C4B.0)  
Harmful pattern of use of volatile inhalants (6C4B.1)

**6C4B.21**

Volatile inhalant dependence, early full remission

After a diagnosis of volatile inhalant dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from volatile inhalants during a period lasting from between 1 and 12 months.

**Exclusions:** Episode of harmful use of volatile inhalants (6C4B.0)  
Harmful pattern of use of volatile inhalants (6C4B.1)

**6C4B.22**

Volatile inhalant dependence, sustained partial remission

After a diagnosis of Volatile inhalant dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in volatile inhalant consumption for more than 12 months, such that even though intermittent or continuing volatile inhalant use has occurred during this period, the definitional requirements for dependence have not been met.

**Exclusions:** Episode of harmful use of volatile inhalants (6C4B.0)  
Harmful pattern of use of volatile inhalants (6C4B.1)

**6C4B.23**

Volatile inhalant dependence, sustained full remission

After a diagnosis of Volatile inhalant dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from volatile inhalants for 12 months or longer.

**Exclusions:** Episode of harmful use of volatile inhalants (6C4B.0)  
Harmful pattern of use of volatile inhalants (6C4B.1)

**6C4B.2Z**

Volatile inhalant dependence, unspecified

**6C4B.3****Volatile inhalant intoxication**

Volatile inhalant intoxication is a clinically significant transient condition that develops during or shortly after the consumption of a volatile inhalant that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of volatile inhalants and their intensity is closely related to the amount of volatile inhalant consumed. They are time-limited and abate as the volatile inhalant is cleared from the body. Presenting features may include euphoria, impaired judgment, aggression, somnolence, stupor or coma, dizziness, tremor, lack of coordination, slurred speech, unsteady gait, lethargy and apathy, psychomotor retardation, and visual disturbances. Muscle weakness and diplopia may occur. Use of volatile inhalants may cause cardiac arrhythmia, cardiac arrest, and death. Inhalants containing lead (e.g. some forms of petrol/gasoline) may cause confusion, irritability, coma and seizures.

**Coding Note:** Code also the causing condition

**Exclusions:** Possession trance disorder (6B63)

**6C4B.4****Volatile inhalant withdrawal**

Volatile inhalant withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of volatile inhalants in individuals who have developed Volatile inhalant dependence or have used volatile inhalants for a prolonged period or in large amounts. Presenting features of Volatile inhalant withdrawal may include insomnia, anxiety, irritability, dysphoric mood, shakiness, perspiration, nausea, and transient illusions.

**Coding Note:** Code also the causing condition

**6C4B.5****Volatile inhalant-induced delirium**

Volatile inhalant-induced delirium is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of volatile inhalants. The amount and duration of volatile inhalant use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6C4B.6****Volatile inhalant-induced psychotic disorder**

Volatile inhalant-induced psychotic disorder is characterised by psychotic symptoms (e.g. delusions, hallucinations, disorganized thinking, grossly disorganized behaviour) that develop during or soon after intoxication with or withdrawal from volatile inhalants. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Volatile inhalant intoxication or Volatile inhalant withdrawal. The amount and duration of volatile inhalant use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g. Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the volatile inhalant use, if the symptoms persist for a substantial period of time after cessation of the volatile inhalant use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g. a history of prior episodes not associated with volatile inhalant use).

**Coding Note:** Code also the causing condition

**6C4B.7****Certain specified volatile inhalants-induced mental or behavioural disorders**

**Coding Note:** Code also the causing condition

**6C4B.70****Volatile inhalant-induced mood disorder**

Volatile inhalant-induced mood disorder is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from volatile inhalants. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of Volatile inhalant intoxication or Volatile inhalant withdrawal. The amount and duration of volatile inhalant use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the volatile inhalant use, if the symptoms persist for a substantial period of time after cessation of the volatile inhalant use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with volatile inhalant use).

**Coding Note:** Code also the causing condition

**6C4B.71****Volatile inhalant-induced anxiety disorder**

Volatile inhalant-induced anxiety disorder is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from volatile inhalants. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of Volatile inhalant intoxication or Volatile inhalant withdrawal. The amount and duration of volatile inhalant use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and Fear-Related Disorder, a Depressive Disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the volatile inhalant use, if the symptoms persist for a substantial period of time after cessation of the volatile inhalant use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with volatile inhalant use).

**Coding Note:** Code also the causing condition

**6C4B.Y****Other specified disorders due to use of volatile inhalants****6C4B.Z****Disorders due to use of volatile inhalants, unspecified****6C4C****Disorders due to use of MDMA or related drugs, including MDA**

Disorders due to use of MDMA or related drugs, including MDA are characterised by the pattern and consequences of MDMA or related drug use. MDMA is methylene-dioxymethamphetamine and is a common drug of abuse in many countries especially among young people. It is predominantly available in tablet form known as 'ecstasy'. Pharmacologically, MDMA has stimulant and empathogenic properties and these encourage its use among young people for social and other interactions. Considering its wide prevalence in many countries and among many sub-groups of young people, MDMA and Related Drug Dependence and MDMA and Related Drug Withdrawal are comparatively uncommon. Substance-Induced Mental Disorders may arise from its use. Several analogues of MDMA exist, including MDA (methylene-dioxyamphetamine).

**Exclusions:** Hazardous use of MDMA or related drugs (QE11.6)

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

An episode of use of MDMA or related drugs, including MDA, that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to intoxication with MDMA or related drugs, including MDA, on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of use of MDMA or related drugs, including MDA.

**Exclusions:** Harmful pattern of use of MDMA or related drugs, including MDA (6C4C.1)

MDMA or related drug dependence, including MDA (6C4C.2)

**6C4C.1 Harmful pattern of use of MDMA or related drugs, including MDA**

A pattern of use of MDMA or related drugs, including MDA, that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of use of MDMA or related drugs is evident over a period of at least 12 months if use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to MDMA or related drug intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of MDMA or related drugs, including MDA applies.

**Exclusions:** MDMA or related drug dependence, including MDA (6C4C.2)  
Episode of harmful use of MDMA or related drugs, including MDA (6C4C.0)

**6C4C.10 Harmful use of MDMA or related drugs, including MDA, episodic**

A pattern of episodic or intermittent use of MDMA or related drugs, including MDA, that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic use of MDMA or related drugs is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to MDMA or related drug intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of MDMA or related drugs, including MDA applies.

**Exclusions:** Episode of harmful use of MDMA or related drugs, including MDA (6C4C.0)  
MDMA or related drug dependence, including MDA (6C4C.2)

**6C4C.11 Harmful use of MDMA or related drugs, including MDA, continuous**

A pattern of continuous (daily or almost daily) use of MDMA or related drugs, including MDA, that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous use of MDMA or related drugs is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to MDMA or related drug intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of MDMA or related drugs, including MDA applies.

**Exclusions:** Episode of harmful use of MDMA or related drugs, including MDA (6C4C.0)  
MDMA or related drug dependence, including MDA (6C4C.2)

**6C4C.12 Harmful pattern of use of MDMA or related drugs, including MDA, unspecified**

**6C4C.2****MDMA or related drug dependence, including MDA**

MDMA or related drug dependence, including MDA is a disorder of regulation of MDMA or related drug use arising from repeated or continuous use of MDMA or related drugs. The characteristic feature is a strong internal drive to use MDMA or related drugs, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use MDMA or related drugs. Physiological features of dependence may also be present, including tolerance to the effects of MDMA or related drugs, withdrawal symptoms following cessation or reduction in use of MDMA or related drugs, or repeated use of MDMA or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if MDMA or related drug use is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of MDMA or related drugs, including MDA (6C4C.0)

Harmful pattern of use of MDMA or related drugs, including MDA (6C4C.1)

**6C4C.20**

MDMA or related drug dependence, including MDA, current use

Current MDMA or related drug dependence, including MDA, with MDMA or related drug use within the past month.

**Exclusions:** Episode of harmful use of MDMA or related drugs, including MDA (6C4C.0)

Harmful pattern of use of MDMA or related drugs, including MDA (6C4C.1)

**6C4C.21**

MDMA or related drug dependence, including MDA, early full remission

After a diagnosis of MDMA or related drug dependence, including MDA, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from MDMA or related drug dependence, including MDA, during a period lasting from between 1 and 12 months.

**Exclusions:** Episode of harmful use of MDMA or related drugs, including MDA (6C4C.0)

Harmful pattern of use of MDMA or related drugs, including MDA (6C4C.1)

**6C4C.22**

MDMA or related drug dependence, including MDA, sustained partial remission

After a diagnosis of MDMA or related drug dependence, including MDA, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in consumption of MDMA or related drugs, including MDA, for more than 12 months, such that even though intermittent or continuing use of MDMA or related drugs, including MDA, has occurred during this period, the definitional requirements for dependence have not been met.

**Exclusions:** Episode of harmful use of MDMA or related drugs, including MDA (6C4C.0)

Harmful pattern of use of MDMA or related drugs, including MDA (6C4C.1)



**6C4C.23** MDMA or related drug dependence, including MDA, sustained full remission  
After a diagnosis of MDMA or related drug dependence, including MDA, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from MDMA or related drugs, including MDA, for 12 months or longer.

**Exclusions:** Episode of harmful use of MDMA or related drugs, including MDA (6C4C.0)  
Harmful pattern of use of MDMA or related drugs, including MDA (6C4C.1)

**6C4C.2Z** MDMA or related drug dependence, including MDA, unspecified

**6C4C.3 MDMA or related drug intoxication, including MDA**

MDMA or related drug intoxication, including MDA is a clinically significant transient condition that develops during or shortly after the consumption of MDMA or related drugs that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of MDMA or related drugs and their intensity is closely related to the amount of MDMA or a related drug consumed. They are time-limited and abate as MDMA or a related drug is cleared from the body. Presenting features may include increased or inappropriate sexual interest and activity, anxiety, restlessness, agitation, and sweating. In rare instances, usually in severe intoxication, use of MDMA or related drugs, including MDA can result in dystonia and seizures. Sudden death is a rare but recognised complication.

**Coding Note:** Code also the causing condition

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

MDMA or related drug withdrawal, including MDA is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of MDMA or related drugs in individuals who have developed MDMA or related drug dependence or have used MDMA or related drugs for a prolonged period or in large amounts. Presenting features of MDMA or related drug withdrawal may include fatigue, lethargy, hypersomnia or insomnia, depressed mood, anxiety, irritability, craving, difficulty in concentrating, and appetite disturbance.

**Coding Note:** Code also the causing condition

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

MDMA or related drug-induced delirium, including MDA is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or during the use of MDMA or related drugs. The amount and duration of MDMA or related drug use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

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

MDMA or related drug-induced psychotic disorder, including MDA is characterised by psychotic symptoms (e.g., delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with MDMA or related drugs. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of MDMA or related drug intoxication. The amount and duration of MDMA or related drug use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g., Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the MDMA or related drug use, if the symptoms persist for a substantial period of time after cessation of the MDMA or related drug use, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g., a history of prior episodes not associated with MDMA or related drug use, including MDA).

**Coding Note:** Code also the causing condition

**6C4C.7 Certain specified MDMA or related drug-induced mental or behavioural disorders, including MDA**

**Coding Note:** Code also the causing condition

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

MDMA or related drug-induced mood disorder, including MDA is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with MDMA or related drugs. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of MDMA or related drug intoxication, including MDA. The amount and duration of MDMA or related drug use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the MDMA or related drug use, if the symptoms persist for a substantial period of time after cessation of the MDMA or related drug use, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with MDMA or related drug use).

**Coding Note:** Code also the causing condition

**6C4C.71**

MDMA or related drug-induced anxiety disorder

MDMA or related drug-induced anxiety disorder, including MDA is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with MDMA or related drugs. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of MDMA or related drug intoxication, including MDA. The amount and duration of MDMA or related drug use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and fear-related disorder, a Depressive disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the MDMA or related drug use, if the symptoms persist for a substantial period of time after cessation of the MDMA or related drug use, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with MDMA or related drug use).

**Coding Note:** Code also the causing condition

**6C4C.Y****Other specified disorders due to use of MDMA or related drugs, including MDA****6C4C.Z****Disorders due to use of MDMA or related drugs, including MDA, unspecified****6C4D****Disorders due to use of dissociative drugs including ketamine and phencyclidine [PCP]**

Disorders due to use of dissociative drugs including ketamine and phencyclidine [PCP] are characterised by the pattern and consequences of dissociative drug use. Dissociative drugs include ketamine and phencyclidine (PCP) and their (comparatively rare) chemical analogues. Ketamine is an intravenous anaesthetic widely used in low- and middle-income countries, particularly in Africa, and in emergency situations. Ketamine is also undergoing evaluation for treatment of some mental disorders (e.g., treatment resistant Depressive Disorders). It is also a widespread drug of nonmedical use in many countries and may be taken by the oral or nasal routes or injected. It produces a sense of euphoria but depending on the dose, emergent hallucinations and dissociation are recognised as unpleasant side effects. Phencyclidine has a more restricted worldwide distribution and also has euphoric and dissociative effects. Its use may result in bizarre behaviour uncharacteristic for the individual, including self-harm. Dissociative Drug Dependence is described but a withdrawal syndrome is not recognized by most authorities. Several Dissociative Drug-Induced Mental Disorders are recognised.

**Exclusions:** Hazardous use of dissociative drugs including ketamine or PCP (QE11.7)

**6C4D.0****Episode of harmful use of dissociative drugs including ketamine or PCP**

An episode of use of a dissociative drug, including Ketamine and PCP, that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to intoxication with a dissociative drug, including Ketamine and PCP, on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of use of dissociative drugs, including Ketamine and PCP.

**Exclusions:** Dissociative drug dependence including ketamine or PCP (6C4D.2)  
Harmful pattern of use of dissociative drugs, including ketamine or PCP (6C4D.1)

**6C4D.1****Harmful pattern of use of dissociative drugs, including ketamine or PCP**

A pattern of use of dissociative drugs, including ketamine and phencyclidine (PCP), that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of dissociative drug use is evident over a period of at least 12 months if use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to dissociative drug intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of dissociative drugs, including ketamine and PCP applies.

**Exclusions:** Dissociative drug dependence including ketamine or PCP (6C4D.2)  
Episode of harmful use of dissociative drugs including ketamine or PCP (6C4D.0)

**6C4D.10**

Harmful pattern of use of dissociative drugs including ketamine or PCP, episodic

A pattern of episodic or intermittent use of dissociative drugs, including ketamine and phencyclidine (PCP), that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic use of dissociative drugs is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to dissociative drug intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of dissociative drugs, including ketamine and PCP applies.

**Exclusions:** Episode of harmful use of dissociative drugs including ketamine or PCP (6C4D.0)

Dissociative drug dependence including ketamine or PCP (6C4D.2)

**6C4D.11**

Harmful pattern of use of dissociative drugs including ketamine or PCP, continuous

A pattern of continuous (daily or almost daily) use of dissociative drugs, including ketamine and phencyclidine (PCP), that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous use of dissociative drugs is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to dissociative drug intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of dissociative drugs, including ketamine and PCP applies.

**Exclusions:** Episode of harmful use of dissociative drugs including ketamine or PCP (6C4D.0)

Dissociative drug dependence including ketamine or PCP (6C4D.2)

**6C4D.1Z**

Harmful pattern of use of dissociative drugs, including ketamine or PCP, unspecified

**6C4D.2 Dissociative drug dependence including ketamine or PCP**

Dissociative drug dependence including ketamine or PCP is a disorder of regulation of dissociative drug use arising from repeated or continuous use of dissociative drugs. The characteristic feature is a strong internal drive to use dissociative drugs, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use dissociative drugs. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if dissociative drugs use is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of dissociative drugs including ketamine or PCP (6C4D.0)  
Harmful pattern of use of dissociative drugs, including ketamine or PCP (6C4D.1)

**6C4D.20 Dissociative drug dependence including Ketamine or PCP, current use**

Dissociative drug dependence including Ketamine and PCP, current use refers to use of dissociative drugs within the past month.

**Exclusions:** Episode of harmful use of dissociative drugs including ketamine or PCP (6C4D.0)  
Harmful pattern of use of dissociative drugs, including ketamine or PCP (6C4D.1)

**6C4D.21 Dissociative drug dependence including Ketamine or PCP, early full remission**

After a diagnosis of Dissociative drug dependence including Ketamine and PCP, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from dissociative drugs during a period lasting from between 1 and 12 months.

**Exclusions:** Episode of harmful use of dissociative drugs including ketamine or PCP (6C4D.0)  
Harmful pattern of use of dissociative drugs, including ketamine or PCP (6C4D.1)

**6C4D.22 Dissociative drug dependence including Ketamine or PCP, sustained partial remission**

After a diagnosis of Dissociative drug dependence including Ketamine and PCP, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in dissociative drug consumption for more than 12 months, such that even though intermittent or continuing dissociative drug use has occurred during this period, the definitional requirements for dependence have not been met.

**Exclusions:** Episode of harmful use of dissociative drugs including ketamine or PCP (6C4D.0)  
Harmful pattern of use of dissociative drugs, including ketamine or PCP (6C4D.1)

**6C4D.23** Dissociative drug dependence including Ketamine or PCP, sustained full remission  
After a diagnosis of Dissociative drug dependence including Ketamine and PCP, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from dissociative drugs for 12 months or longer.

**Exclusions:** Episode of harmful use of dissociative drugs including ketamine or PCP (6C4D.0)  
Harmful pattern of use of dissociative drugs, including ketamine or PCP (6C4D.1)

**6C4D.2Z** Dissociative drug dependence including ketamine or PCP, unspecified

**6C4D.3 Dissociative drug intoxication including Ketamine or PCP**

Dissociative drug intoxication including Ketamine and PCP is a clinically significant transient condition that develops during or shortly after the consumption of a dissociative drug that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of a dissociative drug and their intensity is closely related to the amount of the dissociative drug consumed. They are time-limited and abate as the dissociative drug is cleared from the body. Presenting features may include aggression, impulsiveness, unpredictability, anxiety, psychomotor agitation, impaired judgment, numbness or diminished responsiveness to pain, slurred speech, and dystonia. Physical signs include nystagmus (repetitive, uncontrolled eye movements), tachycardia, elevated blood pressure, numbness, ataxia, dysarthria, and muscle rigidity. In rare instances, use of dissociative drugs including Ketamine and PCP can result in seizures.

**Coding Note:** Code also the causing condition

**6C4D.4 Dissociative drug-induced delirium including ketamine or PCP**

Dissociative drug-induced delirium including Ketamine or PCP is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or during the use of dissociative drugs. The amount and duration of dissociative drug use must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

**6C4D.5 Dissociative drug-induced psychotic disorder including Ketamine or PCP**

Dissociative drug-induced psychotic disorder including Ketamine or PCP is characterised by psychotic symptoms (e.g., delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with dissociative drugs. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of Dissociative drug intoxication. The amount and duration of Dissociative drug use must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g., Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the dissociative drug use, if the symptoms persist for a substantial period of time after cessation of the dissociative drug use, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g., a history of prior episodes not associated with dissociative drug use).

**Coding Note:** Code also the causing condition

**6C4D.6 Certain specified dissociative drugs -induced mental or behavioural disorders, including ketamine and phencyclidine [PCP]**

**Coding Note:** Code also the causing condition

**6C4D.60 Dissociative drug-induced mood disorder including Ketamine or PCP**

Dissociative drug-induced mood disorder including Ketamine or PCP is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with dissociative drugs. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of Dissociative drug intoxication. The amount and duration of Dissociative drug use must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the dissociative drug use, if the symptoms persist for a substantial period of time after cessation of the dissociative drug use, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with dissociative drug use).

**Coding Note:** Code also the causing condition



**6C4D.61**

Dissociative drug-induced anxiety disorder including Ketamine or PCP

Dissociative drug-induced anxiety disorder including Ketamine or PCP is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with dissociative drugs. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of Dissociative drug intoxication. The amount and duration of Dissociative drug use must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and Fear-Related Disorder, a Depressive Disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the dissociative drug use, if the symptoms persist for a substantial period of time after cessation of the dissociative drug use, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with dissociative drug use).

**Coding Note:** Code also the causing condition

**6C4D.Y**

**Other specified disorders due to use of dissociative drugs including ketamine and phencyclidine [PCP]**

**6C4D.Z**

**Disorders due to use of dissociative drugs including ketamine and phencyclidine [PCP], unspecified**

**6C4E**

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

Disorders due to use of other specified psychoactive substances, including medications are characterised by the pattern and consequences of psychoactive substances that are not included among the major substance classes specifically identified. Examples include khat, anabolic steroids, corticosteroids, antidepressants, medications with anticholinergic properties (e.g., benztropine), and some antihistamines.

**6C4E.0**

**Episode of harmful use of other specified psychoactive substance**

An episode of use of a specified psychoactive substance or medication that is not included in the other substance classes specifically identified under Disorders Due to Substance Use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to substance intoxication or psychoactive medication use; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to substance intoxication or psychoactive medication use on the part of the person to whom the diagnosis of single episode of harmful use of other specified psychoactive substance applies. This diagnosis should not be made if the harm is attributed to a known pattern of use of the specified psychoactive substance.

**Exclusions:** Harmful pattern of use of other specified psychoactive substance (6C4E.1)

Other specified psychoactive substance dependence (6C4E.2)

**6C4E.1****Harmful pattern of use of other specified psychoactive substance**

A pattern of use of a specified psychoactive substance or medication that is not included in the other substance classes specifically identified under Disorders Due to Substance Use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of substance use is evident over a period of at least 12 months if use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to intoxication due to the specified substance or medication on the part of the person to whom the diagnosis of Harmful pattern of use of other specified psychoactive substance applies.

**Exclusions:** Other specified psychoactive substance dependence (6C4E.2)  
Episode of harmful use of other specified psychoactive substance (6C4E.0)

**6C4E.10****Harmful pattern of use of other specified psychoactive substance, episodic**

A pattern of episodic or intermittent use of a specified psychoactive substance or medication that is not included in the other substance classes specifically identified under Disorders Due to Substance Abuse that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic substance use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to intoxication due to the specified substance or medication on the part of the person to whom the diagnosis of Harmful pattern of use of other specified psychoactive substance applies.

**Exclusions:** Episode of harmful use of other specified psychoactive substance (6C4E.0)  
Other specified psychoactive substance dependence (6C4E.2)

**6C4E.11**

Harmful pattern of use of other specified psychoactive substance, continuous

A pattern of continuous (daily or almost daily) use of a specified psychoactive substance or medication that is not included in the other substance classes specifically identified under Disorders Due to Substance Use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous substance use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to intoxication due to the specified substance or medication on the part of the person to whom the diagnosis of Harmful pattern of use of other specified psychoactive substance applies.

**Exclusions:** Episode of harmful use of other specified psychoactive substance (6C4E.0)  
Other specified psychoactive substance dependence (6C4E.2)

**6C4E.1Z**

Harmful pattern of use of other specified psychoactive substance, unspecified

**6C4E.2****Other specified psychoactive substance dependence**

Other specified psychoactive substance dependence is a disorder of regulation of use of a specified substance arising from repeated or continuous use of the specified substance. The characteristic feature is a strong internal drive to use the specified substance, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use the specified substance. Physiological features of dependence may also be present, including tolerance to the effects of the specified substance, withdrawal symptoms following cessation or reduction in use of the specified substance, or repeated use of the specified substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if use of the specified substance is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of other specified psychoactive substance (6C4E.0)  
Harmful pattern of use of other specified psychoactive substance (6C4E.1)

**6C4E.20**

Other specified psychoactive substance dependence, current use

Current Other specified psychoactive substance dependence, with use of the specified psychoactive substance within the past month.

**Exclusions:** Episode of harmful use of other specified psychoactive substance (6C4E.0)  
Harmful pattern of use of other specified psychoactive substance (6C4E.1)

**6C4E.21** Other specified psychoactive substance dependence, early full remission  
After a diagnosis of Other specified psychoactive substance dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from the specified substance during a period lasting from between 1 and 12 months.

**Exclusions:** Episode of harmful use of other specified psychoactive substance (6C4E.0)  
Harmful pattern of use of other specified psychoactive substance (6C4E.1)

**6C4E.22** Other specified psychoactive substance dependence, sustained partial remission  
After a diagnosis of Other specified psychoactive substance dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in consumption of the specified substance for more than 12 months, such that even though intermittent or continuing substance use has occurred during this period, the definitional requirements for dependence have not been met.

**Exclusions:** Episode of harmful use of other specified psychoactive substance (6C4E.0)  
Harmful pattern of use of other specified psychoactive substance (6C4E.1)

**6C4E.23** Other specified psychoactive substance dependence, sustained full remission  
After a diagnosis of Other specified psychoactive substance dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from the specified substance for 12 months or longer.

**Exclusions:** Episode of harmful use of other specified psychoactive substance (6C4E.0)  
Harmful pattern of use of other specified psychoactive substance (6C4E.1)

**6C4E.2Z** Other specified psychoactive substance dependence, unspecified

**6C4E.3 Other specified psychoactive substance intoxication**

Other specified psychoactive substance intoxication is a clinically significant transient condition that develops during or shortly after the consumption of a specified psychoactive substance or medication that is characterised by disturbances in level of consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of the specified psychoactive substance and their intensity is closely related to the amount of the specified psychoactive substance consumed. They are time-limited and abate as the specified substance is cleared from the body.

**Coding Note:** Code also the causing condition

**6C4E.4 Other specified psychoactive substance withdrawal**

Other specified psychoactive substance withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of the specified substance in individuals who have developed dependence or have used the specified substance for a prolonged period or in large amounts. Other specified psychoactive substance withdrawal can also occur when prescribed psychoactive medications have been used in standard therapeutic doses. The specific features of the withdrawal state depend on the pharmacological properties of the specified substance.

**Coding Note:** Code also the causing condition

**6C4E.40 Other specified psychoactive substance withdrawal, uncomplicated**

The development of a withdrawal state not accompanied by perceptual disturbances or seizures following cessation or reduction of use of the specified substance.

**Coding Note:** Code also the causing condition

**6C4E.41 Other specified psychoactive substance withdrawal, with perceptual disturbances**

The development of a withdrawal state accompanied by perceptual disturbances but not by seizures following cessation or reduction of use of the specified substance.

**Coding Note:** Code also the causing condition

**6C4E.42 Other specified psychoactive substance withdrawal, with seizures**

The development of a withdrawal state accompanied by seizures but not by perceptual disturbances following cessation or reduction of use of the specified substance.

**Coding Note:** Code also the causing condition

**6C4E.43 Other specified psychoactive substance withdrawal, with perceptual disturbances and seizures**

The development of a withdrawal state accompanied by both perceptual disturbances and seizures following cessation or reduction of use of the specified substance.

**Coding Note:** Code also the causing condition

**6C4E.4Z Other specified psychoactive substance withdrawal, unspecified**

**Coding Note:** Code also the causing condition

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

Delirium induced by other specified psychoactive substance is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of a specified psychoactive substance. The amount and duration of use of the specified substance must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a different substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.

**Coding Note:** Code also the causing condition

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

Psychotic disorder induced by other specified psychoactive substance is characterised by psychotic symptoms (e.g., delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with or withdrawal from a specified psychoactive substance. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of intoxication with or withdrawal from a specified psychoactive substance. The amount and duration of use of the specified psychoactive substance must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g., Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the use of the specified psychoactive substance, if the symptoms persist for a substantial period of time after cessation of the use of the specified psychoactive substance or withdrawal from the specified psychoactive substance, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g., a history of prior episodes not associated with the use of the specified psychoactive substance).

**Coding Note:** Code also the causing condition

**6C4E.7 Certain other specified psychoactive substance-induced mental or behavioural disorders**

**Coding Note:** Code also the causing condition

**6C4E.70**

## Mood disorder induced by other specified psychoactive substance

Mood disorder induced by other specified psychoactive substance is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from a specified psychoactive substance. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of intoxication with or withdrawal from a specified psychoactive substance. The amount and duration of use of the specified psychoactive substance must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the use of the specified psychoactive substance, if the symptoms persist for a substantial period of time after cessation of the use of the specified psychoactive substance or withdrawal from the specified psychoactive substance, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with the use of the specified psychoactive substance).

**Coding Note:** Code also the causing condition

**6C4E.71**

## Anxiety disorder induced by other specified psychoactive substance

Anxiety disorder induced by other specified psychoactive substance is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from a specified psychoactive substance. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of intoxication with or withdrawal from a specified psychoactive substance. The amount and duration of use of the specified psychoactive substance must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and fear-related disorder, a Depressive disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the use of the specified psychoactive substance, if the symptoms persist for a substantial period of time after cessation of the use of the specified psychoactive substance or withdrawal from the specified psychoactive substance, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with the use of the specified psychoactive substance).

**Coding Note:** Code also the causing condition

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

Obsessive-compulsive or related disorder induced by other specified psychoactive substance is characterised by either repetitive intrusive thoughts or preoccupations, normally associated with anxiety and typically accompanied by repetitive behaviours performed in response, or by recurrent and habitual actions directed at the integument (e.g., hair pulling, skin picking) that develop during or soon after intoxication with or withdrawal from a specified psychoactive substance. The intensity or duration of the symptoms is substantially in excess of analogous disturbances that are characteristic of intoxication with or withdrawal from the specified psychoactive substance. The amount and duration of the specified psychoactive substance use must be capable of producing obsessive-compulsive or related symptoms. The symptoms are not better explained by a primary mental disorder (in particular an Obsessive-compulsive or related disorder), as might be the case if the symptoms preceded the onset of the specified psychoactive substance use, if the symptoms persist for a substantial period of time after cessation of use or withdrawal of the specified psychoactive substance, or if there is other evidence of a pre-existing primary mental disorder with obsessive-compulsive or related symptoms (e.g., a history of prior episodes not associated with specified psychoactive substance use).

**Coding Note:** Code also the causing condition

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

Impulse control disorder induced by other specified psychoactive substance is characterised by persistently repeated behaviours in which there is recurrent failure to resist an impulse, drive, or urge to perform an act that is rewarding to the person, at least in the short-term, despite longer-term harm either to the individual or to others (e.g., fire setting or stealing without apparent motive, repetitive sexual behaviour, aggressive outbursts) that develop during or soon after intoxication with or withdrawal from a specified psychoactive substance. The intensity or duration of the symptoms is substantially in excess of disturbances of impulse control that are characteristic of intoxication with or withdrawal from the specified psychoactive substance. The amount and duration of the specified psychoactive substance use must be capable of producing disturbances of impulse control. The symptoms are not better explained by a primary mental disorder (e.g., an Impulse control disorder, a Disorder due to addictive behaviours), as might be the case if the impulse control disturbances preceded the onset of the specified psychoactive substance use, if the symptoms persist for a substantial period of time after cessation of use or withdrawal of the specified psychoactive substance, or if there is other evidence of a pre-existing primary mental disorder with impulse control symptoms (e.g., a history of prior episodes not associated with specified psychoactive substance use).

**Coding Note:** Code also the causing condition

**6C4E.Y** **Other specified disorders due to use of other specified psychoactive substances, including medications**

**6C4E.Z** **Disorders due to use of other specified psychoactive substances, including medications, unspecified**



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

Disorders due to use of multiple specified psychoactive substances, including medications are characterised by the pattern and consequences of multiple psychoactive substances. Although this grouping is provided for coding purposes, in most clinical situations it is recommended that multiple specific disorders due to substance use be assigned rather than using categories from this grouping.

**6C4F.0****Episode of harmful use of multiple specified psychoactive substances**

An episode of use of multiple specified psychoactive substances or medications that are not included in the other substance classes specifically identified under Disorder Due to Substance Use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to multiple substance intoxication or psychoactive medication use (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to multiple substance intoxication or psychoactive medication use on the part of the person to whom the diagnosis of single episode of harmful use of multiple specified psychoactive substances applies. This diagnosis should not be made if the harm is attributed to a known pattern of use of the multiple psychoactive substances.

**Exclusions:** Harmful pattern of use of multiple specified psychoactive substances (6C4F.1)  
Multiple specified psychoactive substances dependence (6C4F.2)

**6C4F.1****Harmful pattern of use of multiple specified psychoactive substances**

A pattern of use of a multiple specified psychoactive substances or medications that are not included in the other substance classes specifically identified under Disorders Due to Substance Use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of substance use is evident over a period of at least 12 months if use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to multiple substance intoxication or psychoactive medication use; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to multiple substance intoxication or psychoactive medication use on the part of the person to whom the diagnosis of Harmful pattern of use of multiple specified psychoactive substances applies.

**Exclusions:** Episode of harmful use of multiple specified psychoactive substances (6C4F.0)  
Multiple specified psychoactive substances dependence (6C4F.2)

**6C4F.10**

Harmful pattern of use of multiple specified psychoactive substances, episodic

A pattern of episodic or intermittent use of a specified psychoactive substance or medication that is not included in the other substance classes specifically identified under Disorders Due to Substance Use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic substance use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to intoxication due to the specified substance or medication on the part of the person to whom the diagnosis of Harmful pattern of use of other specified psychoactive substance applies.

**Exclusions:** Episode of harmful use of multiple specified psychoactive substances (6C4F.0)  
Multiple specified psychoactive substances dependence (6C4F.2)

**6C4F.11**

Harmful pattern of use of multiple specified psychoactive substances, continuous

A pattern of continuous (daily or almost daily) use of a multiple specified psychoactive substance or medication that is not included in the other substance classes specifically identified under Disorders Due to Substance Use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous substance use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to multiple substance intoxication or psychoactive medication use; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to multiple substance intoxication or psychoactive medication use on the part of the person to whom the diagnosis of Harmful pattern of multiple specified psychoactive substances applies.

**Exclusions:** Episode of harmful use of multiple specified psychoactive substances (6C4F.0)  
Multiple specified psychoactive substances dependence (6C4F.2)

**6C4F.12**

Harmful pattern of use of multiple specified psychoactive substances, unspecified

**6C4F.2 Multiple specified psychoactive substances dependence**

Multiple specified psychoactive substance dependence is a disorder of regulation of use of multiple specified substances arising from repeated or continuous use of the specified substances. The characteristic feature is a strong internal drive to use the specified substances, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use the specified substances. Physiological features of dependence may also be present, including tolerance to the effects of the specified substances, withdrawal symptoms following cessation or reduction in use of the specified substances, or repeated use of the specified substances or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if use of the specified substances is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of multiple specified psychoactive substances (6C4F.0)

Harmful pattern of use of multiple specified psychoactive substances (6C4F.1)

**6C4F.20 Multiple specified psychoactive substances dependence, current use**

**Exclusions:** Episode of harmful use of multiple specified psychoactive substances (6C4F.0)

Harmful pattern of use of multiple specified psychoactive substances (6C4F.1)

**6C4F.21 Multiple specified psychoactive substances dependence, early full remission**

**Exclusions:** Episode of harmful use of multiple specified psychoactive substances (6C4F.0)

Harmful pattern of use of multiple specified psychoactive substances (6C4F.1)

**6C4F.22 Multiple specified psychoactive substances dependence, sustained partial remission**

**Exclusions:** Episode of harmful use of multiple specified psychoactive substances (6C4F.0)

Harmful pattern of use of multiple specified psychoactive substances (6C4F.1)

**6C4F.23 Multiple specified psychoactive substances dependence, sustained full remission**

**Exclusions:** Episode of harmful use of multiple specified psychoactive substances (6C4F.0)

Harmful pattern of use of multiple specified psychoactive substances (6C4F.1)

**6C4F.2Z Multiple specified psychoactive substances dependence, unspecified**

**6C4F.3 Intoxication due to multiple specified psychoactive substances**

Intoxication due to multiple specified psychoactive substances is a clinically significant transient condition that develops during or shortly after the consumption of multiple specified substances or medications that is characterised by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of the multiple specified psychoactive substances and their intensity is closely related to the amount of the substances consumed. They are time-limited and abate as the multiple specified substances are cleared from the body.

**Coding Note:** Code also the causing condition

**6C4F.4 Multiple specified psychoactive substances withdrawal**

Multiple specified psychoactive substance withdrawal is a clinically significant cluster of symptoms, behaviours and physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of multiple specified substances in individuals who have developed dependence or have used the specified substances for a prolonged period or in large amounts. Multiple specified psychoactive substance withdrawal can also occur when prescribed psychoactive medications have been used in standard therapeutic doses. The specific features of the withdrawal state depend on the pharmacological properties of the specified substances and their interactions.

**Coding Note:** Code also the causing condition

**6C4F.40 Multiple specified psychoactive substances withdrawal, uncomplicated**

**Coding Note:** Code also the causing condition

**6C4F.41 Multiple specified psychoactive substances withdrawal, with perceptual disturbances**

**Coding Note:** Code also the causing condition

**6C4F.42 Multiple specified psychoactive substances withdrawal, with seizures**

**Coding Note:** Code also the causing condition

**6C4F.43 Multiple specified psychoactive substances withdrawal, with perceptual disturbances and seizures**

**Coding Note:** Code also the causing condition

**6C4F.4Y Other specified multiple specified psychoactive substances withdrawal**

**Coding Note:** Code also the causing condition

**6C4F.4Z Multiple specified psychoactive substances withdrawal, unspecified**

**Coding Note:** Code also the causing condition

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

Delirium induced by multiple specified psychoactive substances is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of multiple specified substances. The amount and duration of use of the multiple specified substances must be capable of producing delirium. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from a substance other than those specified, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders. Note that this diagnosis applies only to those situations in which delirium is present but it cannot be determined which of multiple psychoactive substances is the cause of the delirium. In cases of multiple psychoactive substance use in which more than one specific substance can be identified as a cause of the delirium, the corresponding specific substance-induced delirium diagnoses should be given instead.

**Coding Note:** Code also the causing condition

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

Psychotic disorder induced by multiple specified psychoactive substances is characterised by psychotic symptoms (e.g., delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with or withdrawal from multiple specified psychoactive substances. The intensity or duration of the symptoms is substantially in excess of psychotic-like disturbances of perception, cognition, or behaviour that are characteristic of intoxication with or withdrawal from multiple specified psychoactive substances. The amount and duration of use of the multiple specified psychoactive substances must be capable of producing psychotic symptoms. The symptoms are not better explained by a primary mental disorder (e.g., Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the use of the multiple specified psychoactive substances, if the symptoms persist for a substantial period of time after cessation of the use of the multiple specified psychoactive substances or withdrawal from the multiple specified psychoactive substances, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g., a history of prior episodes not associated with the use of the multiple specified psychoactive substances).

**Coding Note:** Code also the causing condition

**6C4F.7 Certain multiple specified psychoactive substances-induced mental or behavioural disorders**

**Coding Note:** Code also the causing condition

**6C4F.70**

## Mood disorder induced by multiple specified psychoactive substances

Mood disorder induced by multiple specified psychoactive substances is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from multiple specified psychoactive substances. The intensity or duration of the symptoms is substantially in excess of mood disturbances that are characteristic of intoxication with or withdrawal from multiple specified psychoactive substances. The amount and duration of use of the multiple specified psychoactive substances must be capable of producing mood symptoms. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the use of the multiple specified psychoactive substances, if the symptoms persist for a substantial period of time after cessation of the use of the multiple specified psychoactive substances or withdrawal from the multiple specified psychoactive substances, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with the use of the multiple specified psychoactive substances).

**Coding Note:** Code also the causing condition

**6C4F.71**

## Anxiety disorder induced by multiple specified psychoactive substances

Anxiety disorder induced by multiple specified psychoactive substances is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from multiple specified psychoactive substances. The intensity or duration of the symptoms is substantially in excess of anxiety symptoms that are characteristic of intoxication with or withdrawal from multiple specified psychoactive substances. The amount and duration of use of the multiple specified psychoactive substances must be capable of producing anxiety symptoms. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and fear-related disorder, a Depressive disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the use of the multiple specified psychoactive substances, if the symptoms persist for a substantial period of time after cessation of the use of the multiple specified psychoactive substances or withdrawal from the multiple specified psychoactive substances, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with the use of the multiple specified psychoactive substances).

**Coding Note:** Code also the causing condition

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

Obsessive-compulsive or related disorder induced by multiple specified psychoactive substances is characterised by either repetitive intrusive thoughts or preoccupations, normally associated with anxiety and typically accompanied by repetitive behaviours performed in response, or by recurrent and habitual actions directed at the integument (e.g., hair pulling, skin picking) that develop during or soon after intoxication with or withdrawal from multiple specified psychoactive substances. The intensity or duration of the symptoms is substantially in excess of analogous disturbances that are characteristic of intoxication with or withdrawal from the multiple specified psychoactive substances. The amount and duration of the multiple specified psychoactive substances use must be capable of producing obsessive-compulsive or related symptoms. The symptoms are not better explained by a primary mental disorder (in particular an Obsessive-compulsive or related disorder), as might be the case if the symptoms preceded the onset of the use of multiple specified psychoactive substances, if the symptoms persist for a substantial period of time after cessation of the multiple specified psychoactive substance use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with obsessive-compulsive or related symptoms (e.g., a history of prior episodes not associated with multiple specified psychoactive substances use).

**Coding Note:** Code also the causing condition

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

Impulse control disorder induced by multiple specified psychoactive substances is characterised by persistently repeated behaviours in which there is recurrent failure to resist an impulse, drive, or urge to perform an act that is rewarding to the person, at least in the short-term, despite longer-term harm either to the individual or to others (e.g., fire setting or stealing without apparent motive, repetitive sexual behaviour, aggressive outbursts) that develop during or soon after intoxication with or withdrawal from multiple specified psychoactive substances. The intensity or duration of the symptoms is substantially in excess of disturbances of impulse control that are characteristic of intoxication with or withdrawal from the multiple specified psychoactive substances. The amount and duration of the multiple specified psychoactive substances use must be capable of producing disturbances of impulse control. The symptoms are not better explained by a primary mental disorder (e.g., an Impulse control disorder, a Disorder due to addictive behaviours), as might be the case if the impulse control disturbances preceded the onset of the use of multiple specified psychoactive substances, if the symptoms persist for a substantial period of time after cessation of the multiple specified psychoactive substance use or withdrawal, or if there is other evidence of a pre-existing primary mental disorder with impulse control symptoms (e.g., a history of prior episodes not associated with multiple specified psychoactive substances use).

**Coding Note:** Code also the causing condition

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

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

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

Disorders due to use of unknown or unspecified psychoactive substances are characterised by the pattern and consequences of psychoactive substance use when the specific substance is unknown or unspecified. These categories may be used in clinical situations in which it is clear that the disturbance is due to substance use but the specific class of substance is unknown. Once the relevant substance is identified, the disturbance should be recoded under the appropriate substance class.

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

An episode of use of an unknown or unspecified psychoactive substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication or withdrawal; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to substance intoxication or withdrawal on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of use of the unknown or unspecified psychoactive substance.

**Exclusions:** Harmful pattern of use of unknown or unspecified psychoactive substance (6C4G.1)  
Unknown or unspecified psychoactive substance dependence (6C4G.2)

**6C4G.1****Harmful pattern of use of unknown or unspecified psychoactive substance**

A pattern of use of an unknown or unspecified psychoactive substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of substance use is evident over a period of at least 12 months if use is episodic or at least one month if use is continuous (i.e., daily or almost daily). Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to substance intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of unknown or unspecified psychoactive substance applies.

**Exclusions:** Episode of harmful use of unknown or unspecified psychoactive substances (6C4G.0)  
Unknown or unspecified psychoactive substance dependence (6C4G.2)



**6C4G.10**

Harmful pattern of use of unknown or unspecified psychoactive substance, episodic  
A pattern of episodic or intermittent use of an unknown or unspecified psychoactive substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of episodic substance use is evident over a period of at least 12 months. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to substance intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of unknown or unspecified psychoactive substance applies.

**Exclusions:**

Episode of harmful use of unknown or unspecified psychoactive substances (6C4G.0)

Unknown or unspecified psychoactive substance dependence (6C4G.2)

**6C4G.11**

Harmful pattern of use of unknown or unspecified psychoactive substance, continuous

A pattern of continuous (daily or almost daily) use of an unknown or unspecified psychoactive substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of continuous substance use is evident over a period of at least one month. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to substance intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of unknown or unspecified psychoactive substance applies.

**Exclusions:**

Episode of harmful use of unknown or unspecified psychoactive substances (6C4G.0)

Unknown or unspecified psychoactive substance dependence (6C4G.2)

**6C4G.1Z**

Harmful pattern of use of unknown or unspecified psychoactive substance, unspecified

**6C4G.2 Unknown or unspecified psychoactive substance dependence**

Unknown or unspecified psychoactive substance dependence is a disorder of regulation of use of an unknown or unspecified substance arising from repeated or continuous use of the substance. The characteristic feature is a strong internal drive to use the unknown or unspecified substance, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use the unknown or unspecified substance. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if use of the unknown or unspecified substance is continuous (daily or almost daily) for at least 3 months.

**Exclusions:** Episode of harmful use of unknown or unspecified psychoactive substances (6C4G.0)  
Harmful pattern of use of unknown or unspecified psychoactive substance (6C4G.1)

**6C4G.20 Unknown or unspecified psychoactive substance dependence, current use**

Current dependence on an unknown or unspecified psychoactive substance, with use of the substance within the past month.

**Exclusions:** Episode of harmful use of unknown or unspecified psychoactive substances (6C4G.0)  
Harmful pattern of use of unknown or unspecified psychoactive substance (6C4G.1)

**6C4G.21 Unknown or unspecified psychoactive substance dependence, early full remission**

After a diagnosis of Unknown or unspecified psychoactive substance dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from the substance during a period lasting from between 1 and 12 months.

**Exclusions:** Episode of harmful use of unknown or unspecified psychoactive substances (6C4G.0)  
Harmful pattern of use of unknown or unspecified psychoactive substance (6C4G.1)

**6C4G.22 Unknown or unspecified psychoactive substance dependence, sustained partial remission**

After a diagnosis of Unknown or unspecified psychoactive substance dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in consumption of the substance for more than 12 months, such that even though intermittent or continuing use of the substance has occurred during this period, the definitional requirements for dependence have not been met.

**Exclusions:** Episode of harmful use of unknown or unspecified psychoactive substances (6C4G.0)  
Harmful pattern of use of unknown or unspecified psychoactive substance (6C4G.1)

- 6C4G.23** Unknown or unspecified psychoactive substance dependence, sustained full remission  
 After a diagnosis of Unknown or unspecified psychoactive substance dependence, sustained full remission, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from the substance for 12 months or longer.
- Exclusions:** Episode of harmful use of unknown or unspecified psychoactive substances (6C4G.0)  
 Harmful pattern of use of unknown or unspecified psychoactive substance (6C4G.1)
- 6C4G.2Z** Unknown or unspecified psychoactive substance dependence, substance and state of remission unspecified
- 6C4G.3** **Intoxication due to unknown or unspecified psychoactive substance**  
 Intoxication due to unknown or unspecified psychoactive substance is a transient condition that develops during or shortly after the administration of an unknown or unspecified psychoactive substance that is characterised by disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psychophysiological functions and responses. This diagnosis should be made only when there is strong evidence that an unidentified substance has been taken and the features cannot be accounted for by another disorder or disease.
- Coding Note:** Code also the causing condition
- 6C4G.4** **Withdrawal due to unknown or unspecified psychoactive substance**  
 Withdrawal due to unknown or unspecified psychoactive substance is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of an unknown or unspecified substance in individuals who have developed dependence or have used the unknown or unspecified substance for a prolonged period or in large amounts. Withdrawal due to unknown or unspecified psychoactive substance can also occur when prescribed psychoactive medications have been used in standard therapeutic doses. The specific features of the withdrawal state depend on the pharmacological properties of the unknown or unspecified substance.
- Coding Note:** Code also the causing condition
- 6C4G.40** Withdrawal due to unknown or unspecified psychoactive substance, uncomplicated  
 All diagnostic requirements for Withdrawal due to unknown or unspecified psychoactive substance are met and the withdrawal state is not accompanied by perceptual disturbances or seizures.
- Coding Note:** Code also the causing condition

- 6C4G.41** Withdrawal due to unknown or unspecified psychoactive substance, with perceptual disturbances  
All diagnostic requirements for Withdrawal due to unknown or unspecified psychoactive substance are met and the withdrawal state is accompanied by perceptual disturbances (e.g., visual or tactile hallucinations or illusions) with intact reality testing. There is no evidence of confusion and other diagnostic requirements for Delirium are not met. The withdrawal state is not accompanied by seizures.
- Coding Note:** Code also the causing condition
- 6C4G.42** Withdrawal due to unknown or unspecified psychoactive substance, with seizures  
All diagnostic requirements for Withdrawal due to unknown or unspecified psychoactive substance are met and the withdrawal state is accompanied by seizures (i.e., generalised tonic-clonic seizures) but not by perceptual disturbances.
- Coding Note:** Code also the causing condition
- 6C4G.43** Withdrawal due to unknown or unspecified psychoactive, with perceptual disturbances and seizures  
The development of a withdrawal syndrome accompanied by both perceptual disturbances and seizures following cessation or reduction of use of the unknown or unspecified substance.
- Coding Note:** Code also the causing condition
- 6C4G.4Z** Withdrawal due to unknown or unspecified psychoactive substance, unspecified
- Coding Note:** Code also the causing condition
- 6C4G.5** **Delirium induced by unknown or unspecified psychoactive substance**  
Delirium induced by unknown or unspecified psychoactive substance is characterised by an acute state of disturbed attention and awareness with specific features of delirium that develops during or soon after substance intoxication or withdrawal or during the use of an unknown or unspecified substance. The symptoms are not better explained by a primary mental disorder, by use of or withdrawal from another substance, or by another health condition that is not classified under Mental, behavioural and neurodevelopmental disorders.
- Coding Note:** Code also the causing condition

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

Psychotic disorder induced by unknown or unspecified psychoactive substance is characterised by psychotic symptoms (e.g., delusions, hallucinations, disorganised thinking, grossly disorganised behaviour) that develop during or soon after intoxication with or withdrawal from an unknown or unspecified psychoactive substance. The symptoms are not better explained by a primary mental disorder (e.g., Schizophrenia, a Mood disorder with psychotic symptoms), as might be the case if the psychotic symptoms preceded the onset of the use of the unknown or unspecified psychoactive substance, if the symptoms persist for a substantial period of time after cessation of the use of the unknown or unspecified psychoactive substance or withdrawal from the unknown or unspecified psychoactive substance, or if there is other evidence of a pre-existing primary mental disorder with psychotic symptoms (e.g., a history of prior episodes not associated with the use of the unknown or unspecified psychoactive substance).

**Coding Note:** Code also the causing condition

**6C4G.7 Certain unknown or unspecified psychoactive substance-induced mental or behavioural disorders**

**Coding Note:** Code also the causing condition

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

Mood disorder induced by unknown or unspecified psychoactive substance is characterised by mood symptoms (e.g., depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that develop during or soon after intoxication with or withdrawal from a specified psychoactive substance. The symptoms are not better explained by a primary mental disorder (e.g., a Depressive disorder, a Bipolar disorder, Schizoaffective disorder), as might be the case if the mood symptoms preceded the onset of the use of the unknown or unspecified psychoactive substance, if the symptoms persist for a substantial period of time after cessation of the use of the unknown or unspecified psychoactive substance or withdrawal from the unknown or unspecified psychoactive substance, or if there is other evidence of a pre-existing primary mental disorder with mood symptoms (e.g., a history of prior episodes not associated with the use of the unknown or unspecified psychoactive substance).

**Coding Note:** Code also the causing condition

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

Anxiety disorder induced by unknown or unspecified psychoactive substance is characterised by anxiety symptoms (e.g., apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from an unknown or unspecified psychoactive substance. The symptoms are not better explained by a primary mental disorder (e.g., an Anxiety and fear-related disorder, a Depressive disorder with prominent anxiety symptoms), as might be the case if the anxiety symptoms preceded the onset of the use of the unknown or unspecified psychoactive substance, if the symptoms persist for a substantial period of time after cessation of the use of the unknown or unspecified psychoactive substance or withdrawal from the unknown or unspecified psychoactive substance, or if there is other evidence of a pre-existing primary mental disorder with anxiety symptoms (e.g., a history of prior episodes not associated with the use of the unknown or unspecified psychoactive substance).

**Coding Note:** Code also the causing condition

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

Obsessive-compulsive or related disorder induced by unknown or unspecified psychoactive substance is characterised by either repetitive intrusive thoughts or preoccupations, normally associated with anxiety and typically accompanied by repetitive behaviours performed in response, or by recurrent and habitual actions directed at the integument (e.g., hair pulling, skin picking) that develop during or soon after intoxication with or withdrawal from an unknown or unspecified psychoactive substance. The symptoms are not better explained by a primary mental disorder (in particular an Obsessive-compulsive or related disorder), as might be the case if the symptoms preceded the onset of the unknown or unspecified psychoactive substance use, if the symptoms persist for a substantial period of time after cessation of use or withdrawal of the unknown or unspecified psychoactive substance, or if there is other evidence of a pre-existing primary mental disorder with obsessive-compulsive or related symptoms (e.g., a history of prior episodes not associated with the unknown or unspecified psychoactive substance use).

**Coding Note:** Code also the causing condition

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

Impulse control disorder induced by unknown or unspecified psychoactive substance is characterised by persistently repeated behaviours in which there is recurrent failure to resist an impulse, drive, or urge to perform an act that is rewarding to the person, at least in the short-term, despite longer-term harm either to the individual or to others (e.g., fire setting or stealing without apparent motive, repetitive sexual behaviour, aggressive outbursts) that develop during or soon after intoxication with or withdrawal from an unknown or unspecified psychoactive substance. The symptoms are not better explained by a primary mental disorder (e.g., an Impulse control disorder, a Disorder due to addictive behaviours), as might be the case if the impulse control disturbances preceded the onset of the unknown or unspecified psychoactive substance use, if the symptoms persist for a substantial period of time after cessation of use or withdrawal of the unknown or unspecified psychoactive substance, or if there is other evidence of a pre-existing primary mental disorder with impulse control symptoms (e.g., a history of prior episodes not associated with the unknown or unspecified psychoactive substance use).

**Coding Note:** Code also the causing condition

**6C4G.Y** **Other specified disorders due to use of unknown or unspecified psychoactive substances**

**6C4G.Z** **Disorders due to use of unknown or unspecified psychoactive substances, unspecified**

**6C4H** **Disorders due to use of non-psychoactive substances**

Disorders due to use of non-psychoactive substances are characterised by the pattern and consequences of non-medical use of non-psychoactive substances. Non-psychoactive substances include laxatives, growth hormone, erythropoietin, and non-steroidal anti-inflammatory drugs. They may also include proprietary or over-the-counter medicines and folk remedies. Non-medical use of these substances may be associated with harm to the individual due to the direct or secondary toxic effects of the non-psychoactive substance on body organs and systems, or a harmful route of administration (e.g., infections due to intravenous self-administration). They are not associated with intoxication or with a dependence or withdrawal syndrome and are not recognized causes of substance-induced mental disorders.

**6C4H.0** **Episode of harmful use of non-psychoactive substances**

An episode of use of a non-psychoactive substance that has caused damage to a person's physical or mental health. Harm to health of the individual occurs due to direct or secondary toxic effects on body organs and systems or a harmful route of administration. This diagnosis should not be made if the harm is attributed to a known pattern of non-psychoactive substance use.

**Exclusions:** Harmful pattern of use of non-psychoactive substances (6C4H.1)

- 6C4H.1 Harmful pattern of use of non-psychoactive substances**  
 A pattern of use of non-psychoactive substances that has caused clinically significant harm to a person’s physical or mental health. The pattern of use is evident over a period of at least 12 months if use is episodic and at least one month if use is continuous (i.e., daily or almost daily). Harm may be caused by the direct or secondary toxic effects of the substance on body organs and systems, or a harmful route of administration.
- Exclusions:** Harmful pattern of use of other specified psychoactive substance (6C4E.1)  
 Episode of harmful use of non-psychoactive substances (6C4H.0)
- 6C4H.10 Harmful pattern of use of non-psychoactive substances, episodic**  
 A pattern of episodic or intermittent use of a non-psychoactive substance that has caused damage to a person’s physical or mental health. The pattern of episodic or intermittent use of the non-psychoactive substance is evident over a period of at least 12 months. Harm may be caused by the direct or secondary toxic effects on body organs and systems, or a harmful route of administration.
- 6C4H.11 Harmful pattern of use of non-psychoactive substances, continuous**  
 A pattern of continuous use of a non-psychoactive substance (daily or almost daily) that has caused damage to a person’s physical or mental health. The pattern of continuous use of the non-psychoactive substance is evident over a period of at least one month. Harm may be caused by the direct or secondary toxic effects on body organs and systems, or a harmful route of administration.
- 6C4H.1Z Harmful pattern of use of non-psychoactive substances, unspecified**
- 6C4H.Y Other specified disorders due to use of non-psychoactive substances**
- 6C4H.Z Disorders due to use of non-psychoactive substances, unspecified**
- 6C4Y Other specified disorders due to substance use**
- 6C4Z Disorders due to substance use, unspecified**



## Disorders due to addictive behaviours (6C50-6C5Z)

Disorders due to addictive behaviours are recognizable and clinically significant syndromes associated with distress or interference with personal functions that develop as a result of repetitive rewarding behaviours other than the use of dependence-producing substances. Disorders due to addictive behaviours include gambling disorder and gaming disorder, which may involve both online and offline behaviour.

**Exclusions:** Compulsive sexual behaviour disorder (6C72)  
Paraphilic disorders (6D30-6D3Z)

### **6C50**

#### **Gambling disorder**

Gambling disorder is characterised by a pattern of persistent or recurrent gambling behaviour, which may be online (i.e., over the internet) or offline, manifested by:

1. impaired control over gambling (e.g., onset, frequency, intensity, duration, termination, context);
2. increasing priority given to gambling to the extent that gambling takes precedence over other life interests and daily activities; and
3. continuation or escalation of gambling despite the occurrence of negative consequences.

The pattern of gambling behaviour may be continuous or episodic and recurrent. The pattern of gambling behaviour results in significant distress or in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. The gambling behaviour and other features are normally evident over a period of at least 12 months in order for a diagnosis to be assigned, although the required duration may be shortened if all diagnostic requirements are met and symptoms are severe.

**Inclusions:** Compulsive gambling

**Exclusions:** Bipolar type I disorder (6A60)  
Bipolar type II disorder (6A61)  
Hazardous gambling or betting (QE21)

#### **6C50.0 Gambling disorder, predominantly offline**

Gambling disorder, predominantly offline is characterised by a pattern of persistent or recurrent gambling behaviour that is not primarily conducted over the internet and is manifested by:

1. impaired control over gambling (e.g., onset, frequency, intensity, duration, termination, context);
2. increasing priority given to gambling to the extent that gambling takes precedence over other life interests and daily activities; and
3. continuation or escalation of gambling despite the occurrence of negative consequences. The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

The pattern of gambling behaviour may be continuous or episodic and recurrent. The gambling behaviour and other features are normally evident over a period of at least 12 months in order for a diagnosis to be assigned, although the required duration may be shortened if all diagnostic requirements are met and symptoms are severe.

**Exclusions:** Hazardous gambling or betting (QE21)

### **6C50.1            Gambling disorder, predominantly online**

Gambling disorder, predominantly online is characterised by a pattern of persistent or recurrent gambling behaviour that is primarily conducted over the internet and is manifested by:

1. impaired control over gambling (e.g., onset, frequency, intensity, duration, termination, context);
2. increasing priority given to gambling to the extent that gambling takes precedence over other life interests and daily activities; and
3. continuation or escalation of gambling despite the occurrence of negative consequences. The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

The pattern of gambling behaviour may be continuous or episodic and recurrent. The gambling behaviour and other features are normally evident over a period of at least 12 months in order for a diagnosis to be assigned, although the required duration may be shortened if all diagnostic requirements are met and symptoms are severe.

**Exclusions:**            Hazardous gambling or betting (QE21)

### **6C50.Z            Gambling disorder, unspecified**

#### **6C51**

### **Gaming disorder**

Gaming disorder is characterised by a pattern of persistent or recurrent gaming behaviour ('digital gaming' or 'video-gaming'), which may be online (i.e., over the internet) or offline, manifested by:

1. impaired control over gaming (e.g., onset, frequency, intensity, duration, termination, context);
2. increasing priority given to gaming to the extent that gaming takes precedence over other life interests and daily activities; and
3. continuation or escalation of gaming despite the occurrence of negative consequences.

The pattern of gaming behaviour may be continuous or episodic and recurrent. The pattern of gaming behaviour results in marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. The gaming behaviour and other features are normally evident over a period of at least 12 months in order for a diagnosis to be assigned, although the required duration may be shortened if all diagnostic requirements are met and symptoms are severe.

**Exclusions:**            Hazardous gaming (QE22)  
                                Bipolar type I disorder (6A60)  
                                Bipolar type II disorder (6A61)

### **6C51.0            Gaming disorder, predominantly online**

Gaming disorder, predominantly online is characterised by a pattern of persistent or recurrent gaming behaviour ('digital gaming' or 'video-gaming') that is primarily conducted over the internet and is manifested by:

1. impaired control over gaming (e.g., onset, frequency, intensity, duration, termination, context);
2. increasing priority given to gaming to the extent that gaming takes precedence over other life interests and daily activities; and

3. continuation or escalation of gaming despite the occurrence of negative consequences. The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

The pattern of gaming behaviour may be continuous or episodic and recurrent. The gaming behaviour and other features are normally evident over a period of at least 12 months in order for a diagnosis to be assigned, although the required duration may be shortened if all diagnostic requirements are met and symptoms are severe.

**6C51.1                    Gaming disorder, predominantly offline**

Gaming disorder, predominantly offline is characterised by a pattern of persistent or recurrent gaming behaviour ('digital gaming' or 'video-gaming') that is not primarily conducted over the internet and is manifested by:

1. impaired control over gaming (e.g., onset, frequency, intensity, duration, termination, context);
2. increasing priority given to gaming to the extent that gaming takes precedence over other life interests and daily activities; and
3. continuation or escalation of gaming despite the occurrence of negative consequences. The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

The pattern of gaming behaviour may be continuous or episodic and recurrent. The gaming behaviour and other features are normally evident over a period of at least 12 months in order for a diagnosis to be assigned, although the required duration may be shortened if all diagnostic requirements are met and symptoms are severe.

**6C51.Z                    Gaming disorder, unspecified**

**6C5Y                    Other specified disorders due to addictive behaviours**

**6C5Z                    Disorders due to addictive behaviours, unspecified**

## Impulse control disorders (6C70-6C7Z)

Impulse control disorders are characterised by the repeated failure to resist an impulse, drive, or urge to perform an act that is rewarding to the person, at least in the short-term, despite consequences such as longer-term harm either to the individual or to others, marked distress about the behaviour pattern, or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Impulse Control Disorders involve a range of specific behaviours, including fire-setting, stealing, sexual behaviour, and explosive outbursts.

**Coded Elsewhere:** Substance-induced impulse control disorders

Gambling disorder (6C50)

Gaming disorder (6C51)

Secondary impulse control syndrome (6E66)

Body-focused repetitive behaviour disorders (6B25)

### 6C70

#### Pyromania

Pyromania is characterised by a recurrent failure to control strong impulses to set fires, resulting in multiple acts of, or attempts at, setting fire to property or other objects, in the absence of an apparent motive (e.g., monetary gain, revenge, sabotage, political statement, attracting attention or recognition). There is an increasing sense of tension or affective arousal prior to instances of fire setting, persistent fascination or preoccupation with fire and related stimuli (e.g., watching fires, building fires, fascination with firefighting equipment), and a sense of pleasure, excitement, relief or gratification during, and immediately after the act of setting the fire, witnessing its effects, or participating in its aftermath. The behaviour is not better explained by intellectual impairment, another mental and behavioural disorder, or substance intoxication.

**Inclusions:** pathological fire-setting

**Exclusions:** Conduct-dissocial disorder (6C91)

Bipolar type I disorder (6A60)

Schizophrenia or other primary psychotic disorders  
(6A20-6A2Z)

Fire-setting as the reason for observation for suspected mental or behavioural disorders, ruled out (QA02.3)

### 6C71

#### Kleptomania

Kleptomania is characterised by a recurrent failure to control strong impulses to steal objects in the absence of an apparent motive (e.g., objects are not acquired for personal use or monetary gain). There is an increasing sense of tension or affective arousal before instances of theft and a sense of pleasure, excitement, relief, or gratification during and immediately after the act of stealing. The behaviour is not better explained by intellectual impairment, another mental and behavioural disorder, or substance intoxication.

**Coding Note:** If stealing occurs within the context of conduct-dissocial disorder or a manic episode, Kleptomania should not be diagnosed separately.

**Inclusions:** pathological stealing

**Exclusions:** shoplifting as the reason for observation for suspected mental disorder, ruled out (QA02.3)

**6C72****Compulsive sexual behaviour disorder**

Compulsive sexual behaviour disorder is characterised by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behaviour. Symptoms may include repetitive sexual activities becoming a central focus of the person's life to the point of neglecting health and personal care or other interests, activities and responsibilities; numerous unsuccessful efforts to significantly reduce repetitive sexual behaviour; and continued repetitive sexual behaviour despite adverse consequences or deriving little or no satisfaction from it. The pattern of failure to control intense, sexual impulses or urges and resulting repetitive sexual behaviour is manifested over an extended period of time (e.g., 6 months or more), and causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Distress that is entirely related to moral judgments and disapproval about sexual impulses, urges, or behaviours is not sufficient to meet this requirement.

**Exclusions:** Paraphilic disorders (6D30-6D3Z)

**6C73****Intermittent explosive disorder**

Intermittent explosive disorder is characterised by repeated brief episodes of verbal or physical aggression or destruction of property that represent a failure to control aggressive impulses, with the intensity of the outburst or degree of aggressiveness being grossly out of proportion to the provocation or precipitating psychosocial stressors. The symptoms are not better explained by another mental, behavioural, or neurodevelopmental disorder and are not part of a pattern of chronic anger and irritability (e.g., in oppositional defiant disorder). The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

**Exclusions:** Oppositional defiant disorder (6C90)

**6C7Y****Other specified impulse control disorders****6C7Z****Impulse control disorders, unspecified**

## Disruptive behaviour or dissocial disorders (6C90-6C9Z)

Disruptive behaviour and dissocial disorders are characterised by persistent behaviour problems that range from markedly and persistently defiant, disobedient, provocative or spiteful (i.e., disruptive) behaviours to those that persistently violate the basic rights of others or major age-appropriate societal norms, rules, or laws (i.e., dissocial). Onset of Disruptive and dissocial disorders is commonly, though not always, during childhood.

### **6C90**

#### **Oppositional defiant disorder**

Oppositional defiant disorder is a persistent pattern (e.g., 6 months or more) of markedly defiant, disobedient, provocative or spiteful behaviour that occurs more frequently than is typically observed in individuals of comparable age and developmental level and that is not restricted to interaction with siblings. Oppositional defiant disorder may be manifest in prevailing, persistent angry or irritable mood, often accompanied by severe temper outbursts or in headstrong, argumentative and defiant behaviour. The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning

### **6C90.0**

#### **Oppositional defiant disorder with chronic irritability-anger**

All definitional requirements for oppositional defiant disorder are met. This form of oppositional defiant disorder is characterised by prevailing, persistent angry or irritable mood that may be present independent of any apparent provocation. The negative mood is often accompanied by regularly occurring severe temper outbursts that are grossly out of proportion in intensity or duration to the provocation. Chronic irritability and anger are characteristic of the individual's functioning nearly every day, are observable across multiple settings or domains of functioning (e.g., home, school, social relationships), and are not restricted to the individual's relationship with his/her parents or guardians. The pattern of chronic irritability and anger is not limited to occasional episodes (e.g., developmentally typical irritability) or discrete periods (e.g., irritable mood in the context of manic or depressive episodes).

### **6C90.00**

Oppositional defiant disorder with chronic irritability-anger with limited prosocial emotions

All definitional requirements for oppositional defiant disorder with chronic irritability-anger are met. In addition, the individual exhibits characteristics that are sometimes referred to as 'callous and unemotional'. These characteristics include a lack of empathy or sensitivity to the feelings of others and a lack of concern for others' distress; a lack of remorse, shame or guilt over their own behaviour (unless prompted by being apprehended), a relative indifference to the probability of punishment; a lack of concern over poor performance in school or work; and limited expression of emotions, particularly positive or loving feelings toward others, or only doing so in ways that seem shallow, insincere, or instrumental.

### **6C90.01**

Oppositional defiant disorder with chronic irritability-anger with typical prosocial emotions

All definitional requirements for oppositional defiant disorder with chronic irritability-anger are met. The individual does not exhibit characteristics referred to as 'callous and unemotional', such as lack of empathy or sensitivity to the feelings of others and a lack of concern for others' distress.

### **6C90.0Z**

Oppositional defiant disorder with chronic irritability-anger, unspecified

- 6C90.1**            **Oppositional defiant disorder without chronic irritability-anger**  
 Meets all definitional requirements for oppositional defiant disorder. This form of oppositional defiant disorder is not characterised by prevailing, persistent, angry or irritable mood, but does feature headstrong, argumentative, and defiant behaviour.
- 6C90.10**            Oppositional defiant disorder without chronic irritability-anger with limited prosocial emotions  
 All definitional requirements for oppositional defiant disorder without chronic irritability-anger are met. In addition, the individual exhibits characteristics that are sometimes referred to as ‘callous and unemotional’. These characteristics include a lack of empathy or sensitivity to the feelings of others and a lack of concern for others’ distress; a lack of remorse, shame or guilt over their own behaviour (unless prompted by being apprehended), a relative indifference to the probability of punishment; a lack of concern over poor performance in school or work; and limited expression of emotions, particularly positive or loving feelings toward others, or only doing so in ways that seem shallow, insincere, or instrumental. This pattern is pervasive across situations and relationships (i.e., the qualifier should not be applied based on a single characteristic, a single relationship, or a single instance of behaviour) and is pattern is persistent over time (e.g., at least 1 year).
- 6C90.11**            Oppositional defiant disorder without chronic irritability-anger with typical prosocial emotions  
 All definitional requirements for oppositional defiant disorder without chronic irritability-anger are met. The individual does not exhibit characteristics referred to as ‘callous and unemotional’, such as lack of empathy or sensitivity to the feelings of others and a lack of concern for others’ distress.
- 6C90.1Z**            Oppositional defiant disorder without chronic irritability-anger, unspecified
- 6C90.Z**            **Oppositional defiant disorder, unspecified**
- 6C91**            **Conduct-dissocial disorder**  
 Conduct-dissocial disorder is characterised by a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms, rules, or laws are violated such as aggression towards people or animals; destruction of property; deceitfulness or theft; and serious violations of rules. The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. To be diagnosed, the behaviour pattern must be enduring over a significant period of time (e.g., 12 months or more). Isolated dissocial or criminal acts are thus not in themselves grounds for the diagnosis.
- 6C91.0**            **Conduct-dissocial disorder, childhood onset**  
 Conduct-dissocial disorder, childhood onset is characterised by a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms, rules, or laws are violated such as aggression towards people or animals; destruction of property; deceitfulness or theft; and serious violations of rules. To be diagnosed, features of the disorder must be present during childhood prior to adolescence (e.g., before 10 years of age) and the behaviour pattern must be enduring over a significant period of time (e.g., 12 months or more). Isolated dissocial or criminal acts are thus not in themselves grounds for the diagnosis.

- 6C91.00** Conduct-dissocial disorder, childhood onset with limited prosocial emotions  
Meets all definitional requirements for Conduct-dissocial disorder, childhood onset. In addition, the individual exhibits characteristics that are sometimes referred to as 'callous and unemotional'. These characteristics include a lack of empathy or sensitivity to the feelings of others and a lack of concern for others' distress; a lack of remorse, shame or guilt over their own behaviour (unless prompted by being apprehended), a relative indifference to the probability of punishment; a lack of concern over poor performance in school or work; and limited expression of emotions, particularly positive or loving feelings toward others, or only doing so in ways that seem shallow, insincere, or instrumental.
- 6C91.01** Conduct-dissocial disorder, childhood onset with typical prosocial emotions  
All definitional requirements for conduct-dissocial disorder, childhood onset are met. The individual does not exhibit characteristics referred to as 'callous and unemotional', such as lack of empathy or sensitivity to the feelings of others and a lack of concern for others' distress.
- 6C91.0Z** Conduct-dissocial disorder, childhood onset, unspecified
- 6C91.1** **Conduct-dissocial disorder, adolescent onset**  
Conduct-dissocial disorder, adolescent onset is characterised by a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms, rules, or laws are violated such as aggression towards people or animals; destruction of property; deceitfulness or theft; and serious violations of rules. No features of the disorder are present during childhood prior to adolescence (e.g., before 10 years of age). To be diagnosed, the behaviour pattern must be enduring over a significant period of time (e.g., 12 months or more). Isolated dissocial or criminal acts are thus not in themselves grounds for the diagnosis.
- 6C91.10** Conduct-dissocial disorder, adolescent onset with limited prosocial emotions  
All definitional requirements for conduct-dissocial disorder, adolescent onset are met. In addition, the individual exhibits characteristics that are sometimes referred to as 'callous and unemotional'. These characteristics include a lack of empathy or sensitivity to the feelings of others and a lack of concern for others' distress; a lack of remorse, shame or guilt over their own behaviour (unless prompted by being apprehended), a relative indifference to the probability of punishment; a lack of concern over poor performance in school or work; and limited expression of emotions, particularly positive or loving feelings toward others, or only doing so in ways that seem shallow, insincere, or instrumental.
- 6C91.11** Conduct-dissocial disorder, adolescent onset with typical prosocial emotions  
All definitional requirements for conduct-dissocial disorder, adolescent onset are met. The individual does not exhibit characteristics referred to as 'callous and unemotional', such as lack of empathy or sensitivity to the feelings of others and a lack of concern for others' distress.
- 6C91.1Y** Other specified conduct-dissocial disorder, adolescent onset
- 6C91.Z** **Conduct-dissocial disorder, unspecified**
- 6C9Y** **Other specified disruptive behaviour or dissocial disorders**



## Personality disorders and related traits (6D10-6D11.5)

**Coded Elsewhere:** Secondary personality change (6E68)

## 6D10

**Personality disorder**

Personality disorder is characterised by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships) that have persisted over an extended period of time (e.g., 2 years or more). The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated) and is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles). The patterns of behaviour characterizing the disturbance are not developmentally appropriate and cannot be explained primarily by social or cultural factors, including socio-political conflict. The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

## 6D10.0

**Mild personality disorder**

All general diagnostic requirements for Personality Disorder are met. Disturbances affect some areas of personality functioning but not others (e.g., problems with self-direction in the absence of problems with stability and coherence of identity or self-worth), and may not be apparent in some contexts. There are problems in many interpersonal relationships and/or in performance of expected occupational and social roles, but some relationships are maintained and/or some roles carried out. Specific manifestations of personality disturbances are generally of mild severity. Mild Personality Disorder is typically not associated with substantial harm to self or others, but may be associated with substantial distress or with impairment in personal, family, social, educational, occupational or other important areas of functioning that is either limited to circumscribed areas (e.g., romantic relationships; employment) or present in more areas but milder.

**6D10.1****Moderate personality disorder**

All general diagnostic requirements for Personality Disorder are met. Disturbances affect multiple areas of personality functioning (e.g., identity or sense of self, ability to form intimate relationships, ability to control impulses and modulate behaviour). However, some areas of personality functioning may be relatively less affected. There are marked problems in most interpersonal relationships and the performance of most expected social and occupational roles are compromised to some degree. Relationships are likely to be characterised by conflict, avoidance, withdrawal, or extreme dependency (e.g., few friendships maintained, persistent conflict in work relationships and consequent occupational problems, romantic relationships characterised by serious disruption or inappropriate submissiveness). Specific manifestations of personality disturbance are generally of moderate severity. Moderate Personality Disorder is sometimes associated with harm to self or others, and is associated with marked impairment in personal, family, social, educational, occupational or other important areas of functioning, although functioning in circumscribed areas may be maintained.

**6D10.2****Severe personality disorder**

All general diagnostic requirements for Personality Disorder are met. There are severe disturbances in functioning of the self (e.g., sense of self may be so unstable that individuals report not having a sense of who they are or so rigid that they refuse to participate in any but an extremely narrow range of situations; self view may be characterised by self-contempt or be grandiose or highly eccentric). Problems in interpersonal functioning seriously affect virtually all relationships and the ability and willingness to perform expected social and occupational roles is absent or severely compromised. Specific manifestations of personality disturbance are severe and affect most, if not all, areas of personality functioning. Severe Personality Disorder is often associated with harm to self or others, and is associated with severe impairment in all or nearly all areas of life, including personal, family, social, educational, occupational, and other important areas of functioning.

**6D10.Z****Personality disorder, severity unspecified****6D11****Prominent personality traits or patterns**

Trait domain qualifiers may be applied to Personality Disorders or Personality Difficulty to describe the characteristics of the individual's personality that are most prominent and that contribute to personality disturbance. Trait domains are continuous with normal personality characteristics in individuals who do not have Personality Disorder or Personality Difficulty. Trait domains are not diagnostic categories, but rather represent a set of dimensions that correspond to the underlying structure of personality. As many trait domain qualifiers may be applied as necessary to describe personality functioning. Individuals with more severe personality disturbance tend to have a greater number of prominent trait domains.

**6D11.0 Negative affectivity in personality disorder or personality difficulty**

The core feature of the Negative Affectivity trait domain is the tendency to experience a broad range of negative emotions. Common manifestations of Negative Affectivity, not all of which may be present in a given individual at a given time, include: experiencing a broad range of negative emotions with a frequency and intensity out of proportion to the situation; emotional lability and poor emotion regulation; negativistic attitudes; low self-esteem and self-confidence; and mistrustfulness.

**Coding Note:** This category should ONLY be used in combination with a Personality disorder category (Mild, Moderate, or Severe) or Personality difficulty.

**6D11.1 Detachment in personality disorder or personality difficulty**

The core feature of the Detachment trait domain is the tendency to maintain interpersonal distance (social detachment) and emotional distance (emotional detachment). Common manifestations of Detachment, not all of which may be present in a given individual at a given time, include: social detachment (avoidance of social interactions, lack of friendships, and avoidance of intimacy); and emotional detachment (reserve, aloofness, and limited emotional expression and experience).

**Coding Note:** This category should ONLY be used in combination with a Personality disorder category (Mild, Moderate, or Severe) or Personality difficulty.

**6D11.2 Dissociality in personality disorder or personality difficulty**

The core feature of the Dissociality trait domain is disregard for the rights and feelings of others, encompassing both self-centeredness and lack of empathy. Common manifestations of Dissociality, not all of which may be present in a given individual at a given time, include: self-centeredness (e.g., sense of entitlement, expectation of others' admiration, positive or negative attention-seeking behaviours, concern with one's own needs, desires and comfort and not those of others); and lack of empathy (i.e., indifference to whether one's actions inconvenience hurt others, which may include being deceptive, manipulative, and exploitative of others, being mean and physically aggressive, callousness in response to others' suffering, and ruthlessness in obtaining one's goals).

**Coding Note:** This category should ONLY be used in combination with a Personality disorder category (Mild, Moderate, or Severe) or Personality difficulty.

**6D11.3 Disinhibition in personality disorder or personality difficulty**

The core feature of the Disinhibition trait domain is the tendency to act rashly based on immediate external or internal stimuli (i.e., sensations, emotions, thoughts), without consideration of potential negative consequences. Common manifestations of Disinhibition, not all of which may be present in a given individual at a given time, include: impulsivity; distractibility; irresponsibility; recklessness; and lack of planning.

**Coding Note:** This category should ONLY be used in combination with a Personality disorder category (Mild, Moderate, or Severe) or Personality difficulty.

**6D11.4 Anankastia in personality disorder or personality difficulty**

The core feature of the Anankastia trait domain is a narrow focus on one's rigid standard of perfection and of right and wrong, and on controlling one's own and others' behaviour and controlling situations to ensure conformity to these standards. Common manifestations of Anankastia, not all of which may be present in a given individual at a given time, include: perfectionism (e.g., concern with social rules, obligations, and norms of right and wrong, scrupulous attention to detail, rigid, systematic, day-to-day routines, hyper-scheduling and planfulness, emphasis on organisation, orderliness, and neatness); and emotional and behavioural constraint (e.g., rigid control over emotional expression, stubbornness and inflexibility, risk-avoidance, perseveration, and deliberativeness).

**Coding Note:** This category should ONLY be used in combination with a Personality disorder category (Mild, Moderate, or Severe) or Personality difficulty.

**6D11.5 Borderline pattern**

The Borderline pattern specifier may be applied to individuals whose pattern of personality disturbance is characterised by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, as indicated by many of the following: Frantic efforts to avoid real or imagined abandonment; A pattern of unstable and intense interpersonal relationships; Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self; A tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours; Recurrent episodes of self-harm; Emotional instability due to marked reactivity of mood; Chronic feelings of emptiness; Inappropriate intense anger or difficulty controlling anger; Transient dissociative symptoms or psychotic-like features in situations of high affective arousal.

**Coding Note:** This category should ONLY be used in combination with a Personality disorder category (Mild, Moderate, or Severe) or Personality difficulty.

**Paraphilic disorders (6D30-6D3Z)**

Paraphilic disorders are characterised by persistent and intense patterns of atypical sexual arousal, manifested by sexual thoughts, fantasies, urges, or behaviours, the focus of which involves others whose age or status renders them unwilling or unable to consent and on which the person has acted or by which he or she is markedly distressed. Paraphilic disorders may include arousal patterns involving solitary behaviours or consenting individuals only when these are associated with marked distress that is not simply a result of rejection or feared rejection of the arousal pattern by others or with significant risk of injury or death.

**Inclusions:** paraphilias

**6D30 Exhibitionistic disorder**

Exhibitionistic disorder is characterised by a sustained, focused and intense pattern of sexual arousal—as manifested by persistent sexual thoughts, fantasies, urges, or behaviours—that involves exposing one's genitals to an unsuspecting individual in public places, usually without inviting or intending closer contact. In addition, in order for Exhibitionistic Disorder to be diagnosed, the individual must have acted on these thoughts, fantasies or urges or be markedly distressed by them. Exhibitionistic Disorder specifically excludes consensual exhibitionistic behaviours that occur with the consent of the person or persons involved as well as socially sanctioned forms of exhibitionism.

**6D31****Voyeuristic disorder**

Voyeuristic disorder is characterised by a sustained, focused and intense pattern of sexual arousal—as manifested by persistent sexual thoughts, fantasies, urges, or behaviours—that involves observing an unsuspecting individual who is naked, in the process of disrobing, or engaging in sexual activity. In addition, in order for Voyeuristic Disorder to be diagnosed, the individual must have acted on these thoughts, fantasies or urges or be markedly distressed by them. Voyeuristic Disorder specifically excludes consensual voyeuristic behaviours that occur with the consent of the person or persons being observed.

**6D32****Pedophilic disorder**

Pedophilic disorder is characterised by a sustained, focused, and intense pattern of sexual arousal—as manifested by persistent sexual thoughts, fantasies, urges, or behaviours—involving pre-pubertal children. In addition, in order for Pedophilic Disorder to be diagnosed, the individual must have acted on these thoughts, fantasies or urges or be markedly distressed by them. This diagnosis does not apply to sexual behaviours among pre- or post-pubertal children with peers who are close in age.

**6D33****Coercive sexual sadism disorder**

Coercive sexual sadism disorder is characterised by a sustained, focused and intense pattern of sexual arousal—as manifested by persistent sexual thoughts, fantasies, urges or behaviours—that involves the infliction of physical or psychological suffering on a non-consenting person. In addition, in order for Coercive Sexual Sadism Disorder to be diagnosed, the individual must have acted on these thoughts, fantasies or urges or be markedly distressed by them. Coercive Sexual Sadism Disorder specifically excludes consensual sexual sadism and masochism.

**6D34****Frotteuristic disorder**

Frotteuristic disorder is characterised by a sustained, focused and intense pattern of sexual arousal— as manifested by persistent sexual thoughts, fantasies, urges, or behaviours— that involves touching or rubbing against a non-consenting person in crowded public places. In addition, in order for Frotteuristic Disorder to be diagnosed, the individual must have acted on these thoughts, fantasies or urges or be markedly distressed by them. Frotteuristic Disorder specifically excludes consensual touching or rubbing that occur with the consent of the person or persons involved.

**6D35****Other paraphilic disorder involving non-consenting individuals**

Other paraphilic disorder involving non-consenting individuals is characterised by a persistent and intense pattern of atypical sexual arousal— manifested by sexual thoughts, fantasies, urges, or behaviours— in which the focus of the arousal pattern involves others who are unwilling or unable to consent but that is not specifically described in any of the other named Paraphilic Disorders categories (e.g., arousal patterns involving corpses or animals). The individual must have acted on these thoughts, fantasies or urges or be markedly distressed by them. The disorder specifically excludes sexual behaviours that occur with the consent of the person or persons involved, provided that they are considered able to provide such consent.

**6D36****Paraphilic disorder involving solitary behaviour or consenting individuals**

Paraphilic disorder involving solitary behaviour or consenting individuals is characterised by a persistent and intense pattern of atypical sexual arousal—manifested by sexual thoughts, fantasies, urges, or behaviours— that involves consenting adults or solitary behaviours. One of the following two elements must be present: 1) the person is markedly distressed by the nature of the arousal pattern and the distress is not simply a consequence of rejection or feared rejection of the arousal pattern by others; or 2) the nature of the paraphilic behaviour involves significant risk of injury or death either to the individual or to the partner (e.g., asphyxophilia).

**6D3Z****Paraphilic disorders, unspecified****Factitious disorders (6D50-6D5Z)**

Factitious disorders are characterised by intentionally feigning, falsifying, inducing, or aggravating medical, psychological, or behavioural signs and symptoms or injury in oneself or in another person, most commonly a child dependent, associated with identified deception. A pre-existing disorder or disease may be present, but the individual intentionally aggravates existing symptoms or falsifies or induces additional symptoms. Individuals with factitious disorder seek treatment or otherwise present themselves or another person as ill, injured, or impaired based on the feigned, falsified, or self-induced signs, symptoms, or injuries. The deceptive behaviour is not solely motivated by obvious external rewards or incentives (e.g., obtaining disability payments or evading criminal prosecution). This is in contrast to Malingering, in which obvious external rewards or incentives motivate the behaviour.

**Exclusions:** Malingering (QC30)

**6D50****Factitious disorder imposed on self**

Factitious disorder imposed on self is characterised by feigning, falsifying, or inducing medical, psychological, or behavioural signs and symptoms or injury associated with identified deception. If a pre-existing disorder or disease is present, the individual intentionally aggravates existing symptoms or falsifies or induces additional symptoms. The individual seeks treatment or otherwise presents himself or herself as ill, injured, or impaired based on the feigned, falsified, or self-induced signs, symptoms, or injuries. The deceptive behaviour is not solely motivated by obvious external rewards or incentives (e.g., obtaining disability payments or evading criminal prosecution). This is in contrast to Malingering, in which obvious external rewards or incentives motivate the behaviour

**Inclusions:** Münchhausen syndrome

**Exclusions:** Excoriation disorder (6B25.1)  
Malingering (QC30)

**6D51****Factitious disorder imposed on another**

Factitious disorder imposed on another is characterised by feigning, falsifying, or inducing, medical, psychological, or behavioural signs and symptoms or injury in another person, most commonly a child dependent, associated with identified deception. If a pre-existing disorder or disease is present in the other person, the individual intentionally aggravates existing symptoms or falsifies or induces additional symptoms. The individual seeks treatment for the other person or otherwise presents him or her as ill, injured, or impaired based on the feigned, falsified, or induced signs, symptoms, or injuries. The deceptive behaviour is not solely motivated by obvious external rewards or incentives (e.g., obtaining disability payments or avoiding criminal prosecution for child or elder abuse).

**Coding Note:** The diagnosis of Factitious Disorder Imposed on Another is assigned to the individual who is feigning, falsifying or inducing the symptoms in another person, not to the person who is presented as having the symptoms. Occasionally the individual induces or falsifies symptoms in a pet rather than in another person.

**Exclusions:** Malingering (QC30)

**6D5Z****Factitious disorders, unspecified****Neurocognitive disorders (6D70-6E0Z)**

Neurocognitive disorders are characterised by primary clinical deficits in cognitive functioning that are acquired rather than developmental. That is, neurocognitive disorders do not include disorders characterised by deficits in cognitive function that are present from birth or that typically arise during the developmental period, which are classified in the grouping neurodevelopmental disorders. Rather, neurocognitive disorders represent a decline from a previously attained level of functioning. Although cognitive deficits are present in many mental disorders (e.g., schizophrenia, bipolar disorders), only disorders whose core features are cognitive are included in the neurocognitive Disorders grouping. In cases where the underlying pathology and etiology for neurocognitive disorders can be determined, the identified etiology should be classified separately.

**Exclusions:** Neurodevelopmental disorders (6A00-6A0Z)

**Coded Elsewhere:** Secondary neurocognitive syndrome (6E67)

**6D70****Delirium**

Delirium is characterized by a disturbance of attention, orientation, and awareness that develops within a short period of time, typically presenting as significant confusion or global neurocognitive impairment, with transient symptoms that may fluctuate depending on the underlying causal condition or etiology. Delirium often includes disturbance of behaviour and emotion, and may include impairment in multiple cognitive domains. A disturbance of the sleep-wake cycle, including reduced arousal of acute onset or total sleep loss with reversal of the sleep-wake cycle, may also be present. Delirium may be caused by the direct physiological effects of a medical condition not classified under mental, behavioural or neurodevelopmental disorders, by the direct physiological effects of a substance or medication, including withdrawal, or by multiple or unknown etiological factors.

**6D70.0 Delirium due to disease classified elsewhere**  
All definitional requirements for delirium are met. There is evidence from history, physical examination, or laboratory findings that Delirium is caused by the direct physiological consequences of a disorder or disease classified elsewhere.

**Coding Note:** Identified etiology should be classified separately.

**6D70.1 Delirium due to psychoactive substances including medications**  
All definitional requirements for delirium are met. There is evidence from history, physical examination, or laboratory findings that the delirium is caused by the direct physiological effects of a substance or medication (including withdrawal). If the specific substance inducing the delirium has been identified, it should be classified using the appropriate subcategory (e.g., alcohol-induced delirium).

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

**6D70.2 Delirium due to multiple etiological factors**  
All definitional requirements for delirium are met. There is evidence from history, physical examination, or laboratory findings that the delirium is attributable to multiple etiological factors, which may include disorders or diseases not classified under mental and behavioural disorders, substance intoxication or withdrawal, or a medication.

**Coding Note:** Identified etiologies should be classified separately.

**6D70.Y Delirium, other specified cause**

**6D70.Z Delirium, unspecified or unknown cause**



**6D71****Mild neurocognitive disorder**

Mild neurocognitive disorder is characterized by mild impairment in one or more cognitive domains relative to that expected given the individual's age and general premorbid level of cognitive functioning, which represents a decline from the individual's previous level of functioning. Diagnosis is based on report from the patient, informant, or clinical observation, and is accompanied by objective evidence of impairment by quantified clinical assessment or standardized cognitive testing. Cognitive impairment is not severe enough to significantly interfere with an individual's ability to perform activities related to personal, family, social, educational, and/or occupational functioning or other important functional areas. Cognitive impairment is not attributable to normal aging and may be static, progressive, or may resolve or improve depending on underlying cause or treatment. Cognitive impairment may be attributable to an underlying acquired disease of the nervous system, a trauma, an infection or other disease process affecting the brain, use of specific substances or medications, nutritional deficiency or exposure to toxins, or the etiology may be undetermined. The impairment is not due to current substance intoxication or withdrawal.

**Coding Note:** Code also the causing condition

**6D72****Amnestic disorder**

Amnestic disorder is characterized by prominent memory impairment relative to expectations for age and general premorbid level of cognitive functioning, which represents a decline from the individual's previous level of functioning, in the absence of other significant cognitive impairment. It is manifested by a deficit in acquiring, learning, and/or retaining new information, and may include the inability to recall previously learned information, without disturbance of consciousness, altered mental status, or delirium. Recent memory is typically more disturbed than remote memory, and the ability to immediately recall a limited amount of information is usually relatively preserved. The memory impairment is severe enough to result in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. It is presumed to be attributable to an underlying acquired disease of the nervous system, a trauma, an infection or other disease process affecting the brain, to use of specific substances or medications, nutritional deficiency or exposure to toxins, or the etiology may be undetermined. The impairment is not due to current substance intoxication or withdrawal.

**Exclusions:**

- Delirium (6D70)
- Dementia (6D80-6D8Z)
- Mild neurocognitive disorder (6D71)

**6D72.0 Amnestic disorder due to diseases classified elsewhere**

All definitional requirements for amnestic disorder are met. The memory symptoms are judged to be the direct pathophysiological consequence of a medical condition not classified under mental, behavioural and neurodevelopmental disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not better explained by Delirium, Dementia, another mental disorder (e.g., Schizophrenia or Other Primary Psychotic Disorder, a Mood Disorder) or the effects of a medication or substance, including withdrawal effects. The symptoms are sufficiently severe to be a specific focus of clinical attention. The identified etiological medical condition should be classified separately.

**Coding Note:** Code also the causing condition

**Exclusions:** amnesia: retrograde (MB21.11)  
Korsakoff syndrome, alcohol-induced or unspecified (8D44)  
Dissociative amnesia (6B61)  
Anterograde amnesia (MB21.10)  
amnesia NOS (MB21.1)

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

All definitional requirements for amnestic disorder are met. The memory symptoms are judged to be the direct consequence of psychoactive substance use. The intensity and duration of substance use must be known to be capable of producing memory impairment. The memory impairment may develop during or soon after substance intoxication or withdrawal, but its intensity and duration are substantially in excess of those normally associated with these conditions. The symptoms are not better accounted for by another disorder or medical condition, as might be the case if the amnestic symptoms preceded the onset of substance use.

**Coding Note:** Code also the causing condition

**6D72.10 Amnestic disorder due to use of alcohol**

All definitional requirements for amnestic disorder are met. The memory symptoms are judged to be the direct consequence of alcohol use. The intensity and duration of alcohol use must be known to be capable of producing memory impairment. The memory impairment may develop during or soon after alcohol intoxication or withdrawal, but its intensity and duration are substantially in excess of those normally associated with these conditions. The symptoms are not better accounted for by another disorder or medical condition, as might be the case if the amnestic symptoms preceded the onset of the alcohol use.

**Coding Note:** This category should not be used to describe cognitive changes due to thiamine deficiency associated with chronic alcohol use.

**Exclusions:** Korsakoff syndrome (5B5A.11)  
Wernicke-Korsakoff Syndrome (5B5A.1)

**6D72.11** Amnestic disorder due to use of sedatives, hypnotics or anxiolytics  
All definitional requirements for amnestic disorder are met. The memory symptoms are judged to be the direct consequence of use of sedatives, hypnotics or anxiolytics. The intensity and duration of use of sedatives, hypnotics or anxiolytics must be known to be capable of producing memory impairment. The memory impairment may develop during or soon after sedative, hypnotic or anxiolytic intoxication or withdrawal, but its intensity and duration are substantially in excess of those normally associated with these conditions. The symptoms are not better accounted for by another disorder or medical condition, as might be the case if the amnestic symptoms preceded the onset of use of sedatives, hypnotics or anxiolytics.

**Coding Note:** Code also the causing condition

**6D72.12** Amnestic disorder due to other specified psychoactive substance including medications  
All definitional requirements for amnestic disorder are met. The memory symptoms are judged to be the direct consequence of use of a specified psychoactive substance other than alcohol; sedatives, hypnotics or anxiolytics; or volatile inhalants. The intensity and duration of use of the specified psychoactive substance must be known to be capable of producing memory impairment. The memory impairment may develop during or soon after specified psychoactive substance intoxication or withdrawal, but its intensity and duration are substantially in excess of those normally associated with these conditions. The symptoms are not better accounted for by another disorder or medical condition, as might be the case if the amnestic symptoms preceded the onset of the specified psychoactive substance.

**6D72.13** Amnestic disorder due to use of volatile inhalants  
All definitional requirements for amnestic disorder are met. The memory symptoms are judged to be the direct consequence of use of volatile inhalants. The intensity and duration of use of volatile inhalants must be known to be capable of producing memory impairment. The memory impairment may develop during or soon after volatile inhalant intoxication or withdrawal, but its intensity and duration are substantially in excess of those normally associated with these conditions. The symptoms are not better accounted for by another disorder or medical condition, as might be the case if the amnestic symptoms preceded the onset of use of volatile inhalants.

**6D72.Y** **Amnestic disorder, other specified cause**

**6D72.Z** **Amnestic disorder, unknown or unspecified cause**

## Dementia (6D80-6D8Z)

Dementia is characterized by the presence of marked impairment in two or more cognitive domains relative to that expected given the individual's age and general premorbid level of cognitive functioning, which represents a decline from the individual's previous level of functioning. Memory impairment is present in most forms of dementia, but cognitive impairment is not restricted to memory (i.e., there is impairment in other areas such as executive functions, attention, language, social cognition and judgment, psychomotor speed, visuoperceptual or visuospatial abilities). Neurobehavioural changes may also be present and, in some forms of dementia, may be the presenting symptom. Cognitive impairment is not attributable to normal aging and is severe enough to significantly interfere with independence in an individual's performance of activities of daily living. The cognitive impairment is presumed to be attributable to an underlying acquired disease of the nervous system, a trauma, an infection or other disease process affecting the brain, or to use of specific substances or medications, nutritional deficiency or exposure to toxins, or the etiology may be undetermined. The impairment is not due to current substance intoxication or withdrawal.

**Coding Note:** This category should only be used for primary tabulation, if the aetiology of the dementia is unknown. If the aetiology of the dementia is known code to the aetiology of the dementia for primary tabulation.

When dementia is due to multiple aetiologies, code all that apply.

**Inclusions:** Dementia NOS

**Exclusions:** Coma (MB20.1)

Delirium (6D70)

Disorders of intellectual development (6A00)

Neurodevelopmental disorders (6A00-6A0Z)

Stupor (MB20.0)

Ageing associated decline in intrinsic capacity (MG2A)

### 6D80

#### Dementia due to Alzheimer disease

Dementia due to Alzheimer disease is the most common form of dementia. Onset is insidious with memory impairment typically reported as the initial presenting complaint. The characteristic course is a slow but steady decline from a previous level of cognitive functioning with impairment in additional cognitive domains (such as executive functions, attention, language, social cognition and judgment, psychomotor speed, visuoperceptual or visuospatial abilities) emerging with disease progression. Dementia due to Alzheimer disease may be accompanied by mental and behavioural symptoms such as depressed mood and apathy in the initial stages of the disease and may be accompanied by psychotic symptoms, irritability, aggression, confusion, abnormalities of gait and mobility, and seizures at later stages. Positive genetic testing, family history and gradual cognitive decline are suggestive of Dementia due to Alzheimer disease.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

- 6D80.0**      **Dementia due to Alzheimer disease with early onset**  
Dementia due to Alzheimer disease in which symptoms emerge before the age of 65 years. It is relatively rare, representing less than 5% of all cases, and may be genetically determined (autosomal dominant Alzheimer disease). Clinical presentation may be similar to cases with later onset, but progression of cognitive deficits may be more rapid.
- Coding Note:**    This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.  
When dementia is due to multiple aetiologies, code all that apply.
- 6D80.1**      **Dementia due to Alzheimer disease with late onset**  
Dementia due to Alzheimer disease that develops at the age of 65 years or above. This is the most common pattern, representing more than 95% of all cases.
- Coding Note:**    This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.  
When dementia is due to multiple aetiologies, code all that apply.
- 6D80.2**      **Alzheimer disease dementia, mixed type, with cerebrovascular disease**  
Dementia due to Alzheimer disease and concomitant cerebrovascular disease.
- Coding Note:**    This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.  
When dementia is due to multiple aetiologies, code all that apply.
- 6D80.3**      **Alzheimer disease dementia, mixed type, with other nonvascular aetiologies**  
Dementia due to Alzheimer disease with other concomitant pathology, not including cerebrovascular disease.
- Coding Note:**    This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.  
When dementia is due to multiple aetiologies, code all that apply.
- 6D80.Z**      **Dementia due to Alzheimer disease, onset unknown or unspecified**
- Coding Note:**    This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

**6D81****Dementia due to cerebrovascular disease**

Dementia due to brain parenchyma injury resulting from cerebrovascular disease (ischemic or haemorrhagic). The onset of the cognitive deficits is temporally related to one or more vascular events. Cognitive decline is typically most prominent in speed of information processing, complex attention, and frontal-executive functioning. There is evidence of the presence of cerebrovascular disease considered to be sufficient to account for the neurocognitive deficits from history, physical examination and neuroimaging.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

**Exclusions:** Alzheimer disease dementia, mixed type, with cerebrovascular disease (6D80.2)

**6D82****Dementia due to Lewy body disease**

Dementia preceding or occurring within one year after the onset of motor parkinsonian signs in the setting of Lewy body disease. Characterized by presence of Lewy bodies, which are intraneuronal inclusions containing  $\alpha$ -synuclein and ubiquitin in the brain stem, limbic area, forebrain, and neocortex. Onset is insidious with attentional and executive functioning deficits often present. These cognitive deficits are often accompanied by visual hallucinations and symptoms of REM sleep behaviour disorder. Hallucinations in other sensory modalities, depressive symptoms, and delusions may also be present. The symptom presentation usually varies significantly over the course of days necessitating longitudinal assessment and differentiation from delirium. Spontaneous onset of Parkinsonism within approximately 1 year of the onset of cognitive symptoms is common.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D83****Frontotemporal dementia**

Frontotemporal dementia (FTD) is a group of primary neurodegenerative disorders primarily affecting the frontal and temporal lobes. Onset is typically insidious with a gradual and worsening course. Several syndromic variants (some with an identified genetic basis or familiarity) are described that include presentations with predominantly marked personality and behavioral changes (such as executive dysfunction, apathy, deterioration of social cognition, repetitive behaviours, and dietary changes), predominantly language deficits (that include semantic, agrammatic/nonfluent, and logopenic forms), predominantly movement-related deficits (progressive supranuclear palsy, corticobasal degeneration, multiple systems atrophy, or amyotrophic lateral sclerosis), or a combination of these deficits. Memory function, often remains relatively intact, particularly during the early stages of the disorder.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D84****Dementia due to psychoactive substances including medications**

Dementia due to psychoactive substances including medications includes forms of dementia that are judged to be a direct consequence of substance use and that persist beyond the usual duration of action or withdrawal syndrome associated with the substance. The amount and duration of substance use must be sufficient to produce the cognitive impairment. The cognitive impairment is not better accounted for by a disorder that is not induced by substances such as a dementia due to another medical condition.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**Exclusions:** Dementia due to exposure to heavy metals and other toxins (6D85.2)

**6D84.0****Dementia due to use of alcohol**

Dementia due to use of alcohol is characterised by the development of persistent cognitive impairments (e.g., memory problems, language impairment, and an inability to perform complex motor tasks) that meet the definitional requirements of Dementia that are judged to be a direct consequence of alcohol use and that persist beyond the usual duration of alcohol intoxication or acute withdrawal. The intensity and duration of alcohol use must have been sufficient to produce the cognitive impairment. The cognitive impairment is not better accounted for by a disorder or disease that is not induced by alcohol such as a dementia due to another disorder or disease classified elsewhere.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

This category should not be used to describe cognitive changes due to thiamine deficiency associated with chronic alcohol use.

**Inclusions:** Alcohol-induced dementia

**Exclusions:** Wernicke-Korsakoff Syndrome (5B5A.1)

Korsakoff syndrome (5B5A.11)

**6D84.1 Dementia due to use of sedatives, hypnotics or anxiolytics**

Dementia due to use of sedatives, hypnotics or anxiolytics is characterised by the development of persistent cognitive impairments (e.g., memory problems, language impairment, and an inability to perform complex motor tasks) that meet the definitional requirements of Dementia that are judged to be a direct consequence of sedative, hypnotic, or anxiolytic use and that persist beyond the usual duration of action or withdrawal syndrome associated with the substance. The amount and duration of sedative, hypnotic, or anxiolytic use must be sufficient to produce the cognitive impairment. The cognitive impairment is not better accounted for by a disorder that is not induced by sedatives, hypnotics, or anxiolytics such as a dementia due to another medical condition.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**Inclusions:** Late-onset psychoactive substance-induced psychotic disorder

**6D84.2 Dementia due to use of volatile inhalants**

Dementia due to use of volatile inhalants is characterised by the development of persistent cognitive impairments (e.g., memory problems, language impairment, and an inability to perform complex motor tasks) that meet the definitional requirements of Dementia that are judged to be a direct consequence of inhalant use or exposure and that persist beyond the usual duration of action or withdrawal syndrome associated with the substance. The amount and duration of inhalant use or exposure must be sufficient to be capable of producing the cognitive impairment. The cognitive impairment is not better accounted for by a disorder that is not induced by volatile inhalants such as a dementia due to another medical condition.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D84.Y Dementia due to other specified psychoactive substance**

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D85 Dementia due to diseases classified elsewhere**

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.



**6D85.0 Dementia due to Parkinson disease**

Dementia due to Parkinson disease develops among individuals with idiopathic Parkinson disease and is characterized by impairment in attention, memory, executive and visuo-spatial functions. Mental and behavioral symptoms such as changes in affect, apathy and hallucinations may also be present. Onset is insidious and the course is one of gradual worsening of symptoms.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D85.1 Dementia due to Huntington disease**

Dementia due to Huntington disease occurs as part of a widespread degeneration of the brain due to a trinucleotide repeat expansion in the HTT gene, which is transmitted through autosomal dominance. Onset of symptoms is insidious typically in the third and fourth decade of life with gradual and slow progression. Initial symptoms typically include impairments in executive functions with relative sparing of memory, prior to the onset of motor deficits (bradykinesia and chorea) characteristic of Huntington disease.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**Inclusions:** Dementia in Huntington chorea

**6D85.2 Dementia due to exposure to heavy metals and other toxins**

Dementia due to exposure to heavy metals and other toxins caused by toxic exposure to specific heavy metals such as aluminium from dialysis water, lead, mercury or manganese. The characteristic cognitive impairments in Dementia due to exposure to heavy metals and other toxins depend on the specific heavy metal or toxin that the individual has been exposed to but can affect any cognitive domain. Onset of symptoms is related to exposure and progression can be rapid especially with acute exposure. In many cases, symptoms are reversible when exposure is identified and ceases. Investigations such as brain imaging or neurophysiological testing may be abnormal. Lead poisoning is associated with abnormalities on brain imaging including widespread calcification and increased signal on MRI T2-weighted images of periventricular white matter, basal ganglia hypothalamus and pons. Dementia due to aluminium toxicity may demonstrate characteristic paroxysmal high-voltage delta EEG changes. Examination may make evident other features such as peripheral neuropathy in the case of lead, arsenic, or mercury.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**Exclusions:** Dementia due to psychoactive substances including medications (6D84)

**6D85.3 Dementia due to human immunodeficiency virus**

Dementia due to human immunodeficiency virus develops during the course of confirmed HIV disease, in the absence of a concurrent illness or condition other than HIV infection that could explain the clinical features. Although a variety of patterns of cognitive deficit are possible depending on where the HIV pathogenic processes have occurred, typically deficits follow a subcortical pattern with impairments in executive function, processing speed, attention, and learning new information. The course of Dementia due to human immunodeficiency virus varies including resolution of symptoms, gradual decline in functioning, improvement, or fluctuation in symptoms. Rapid decline in cognitive functioning is rare with the advent of antiretroviral medications.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D85.4 Dementia due to multiple sclerosis**

Dementia due to multiple sclerosis is a neurodegenerative disease due to the cerebral effects of multiple sclerosis, a demyelinating disease. Onset of symptoms is insidious and not secondary to the functional impairment attributable to the primary disease (i.e., multiple sclerosis). Cognitive impairments vary according to the location of demyelination but typically include deficits in processing speed, memory, attention, and aspects of executive functioning.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D85.5 Dementia due to prion disease**

Dementia due to prion disease is a primary neurodegenerative disease caused by a group of spongiform encephalopathies resulting from abnormal prion protein accumulation in the brain. These can be sporadic, genetic (caused by mutations in the prion-protein gene), or transmissible (acquired from an infected individual). Onset is insidious and there is a rapid progression of symptoms and impairment characterised by cognitive deficits, ataxia, and motor symptoms (myoclonus, chorea, or dystonia). Diagnosis is typically made on the basis of brain imaging studies, presence of characteristic proteins in spinal fluid, EEG, or genetic testing.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D85.6 Dementia due to normal pressure hydrocephalus**

Dementia due to normal pressure hydrocephalus results from excess accumulation of cerebrospinal fluid in the brain as a result of idiopathic, non-obstructive causes but can also be secondary to haemorrhage, infection or inflammation. Progression is gradual but intervention (e.g., shunt) may result in improvement of symptoms, especially if administered earlier in the course of the condition. Typically, cognitive impairments include reduced processing speed and deficits in executive functioning and attention. These symptoms are also typically accompanied by gait abnormalities and urinary incontinence. Brain imaging to reveal ventricular volume and characterize brain displacement is often necessary to confirm the diagnosis.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D85.7 Dementia due to injury to the head**

Dementia due to injury to the head is caused by damage inflicted on the tissues of the brain as the direct or indirect result of an external force. Trauma to the brain is known to have resulted in loss of consciousness, amnesia, disorientation and confusion, or neurological signs. The symptoms characteristic of Dementia due to injury to the head must arise immediately following the trauma or after the individual gains consciousness and must persist beyond the acute post-injury period. Cognitive deficits vary depending on the specific brain areas affected and the severity of the injury but can include impairments in attention, memory, executive functioning, personality, processing speed, social cognition, and language abilities.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D85.8 Dementia due to pellagra**

Dementia due to pellagra is caused by persistent lack of vitamin B3 (niacin) or tryptophan either in the diet or due to poor absorption in the gastrointestinal tract due to disease (e.g., Crohn disease) or due to the effects of some medications (e.g., isoniazid). Core signs of pellagra include dermatological changes (sensitivity to sunlight, lesions, alopecia, and oedema) and diarrhoea. With prolonged nutritional deficiency cognitive symptoms that include aggressivity, motor disturbances (ataxia and restlessness), confusion, and weakness are observed. Treatment with nutritional supplementation (e.g., niacin) typically results in reversal of symptoms.

**Coding Note:** Code also the causing condition

**6D85.9 Dementia due to Down syndrome**

Dementia due to Down syndrome is a neurodegenerative disorder related to the impact of abnormal increased production and accumulation of amyloid precursor protein (APP) leading to formation of beta-amyloid plaques and tau tangles. APP gene expression is increased due to its location on chromosome 21, which is abnormally triplicated in Down syndrome. Cognitive deficits and neuropathological features are similar to those observed in Alzheimer disease. Onset is typically after the fourth decade of life with a gradual decline in functioning, and may impact 50% or more of individuals with Down syndrome.

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D85.Y Dementia due to other specified diseases classified elsewhere**

**Coding Note:** This category should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of dementia in diseases classified elsewhere.

When dementia is due to multiple aetiologies, code all that apply.

**6D86**

**Behavioural or psychological disturbances in dementia**

In addition to the cognitive disturbances characteristic of dementia, the current clinical picture includes clinically significant behavioural or psychological disturbances.

**Coding Note:** These categories should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of behavioural or psychological disturbance in dementia.

Code all that apply.

**Exclusions:** Secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere (6E60-6E6Z)

**6D86.0 Psychotic symptoms in dementia**

In addition to the cognitive disturbances characteristic of dementia, the current clinical picture includes clinically significant delusions or hallucinations.

**Exclusions:** Schizophrenia or other primary psychotic disorders (6A20-6A2Z)

Secondary psychotic syndrome (6E61)

**6D86.1 Mood symptoms in dementia**

In addition to the cognitive disturbances characteristic of dementia, the current clinical picture includes clinically significant mood symptoms such as depressed mood, elevated mood, or irritable mood.

**Exclusions:** Mood disorders (6A60-6A8Z)

Secondary mood syndrome (6E62)

- 6D86.2 Anxiety symptoms in dementia**  
 In addition to the cognitive disturbances characteristic of dementia, the current clinical picture includes clinically significant symptoms of anxiety or worry.  
**Exclusions:** Anxiety or fear-related disorders (6B00-6B0Z)  
 Secondary anxiety syndrome (6E63)
- 6D86.3 Apathy in dementia**  
 In addition to the cognitive disturbances characteristic of dementia, the current clinical picture includes clinically significant indifference or lack of interest.  
**Exclusions:** Mood disorders (6A60-6A8Z)  
 Secondary mood syndrome (6E62)
- 6D86.4 Agitation or aggression in dementia**  
 In addition to the cognitive disturbances characteristic of dementia, the current clinical picture includes: 1) clinically significant excessive psychomotor activity accompanied by increased tension; or 2) hostile or violent behaviour.
- 6D86.5 Disinhibition in dementia**  
 In addition to the cognitive disturbances characteristic of dementia, the current clinical picture includes clinically significant lack of restraint manifested in disregard for social conventions, impulsivity, and poor risk assessment.
- 6D86.6 Wandering in dementia**  
 In addition to the cognitive disturbances characteristic of dementia, the current clinical picture includes clinically significant wandering that puts the person at risk of harm.
- 6D86.Y Other specified behavioural or psychological disturbances in dementia**  
**Coding Note:** These categories should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of behavioural or psychological disturbance in dementia.  
 Code all that apply.
- 6D86.Z Behavioural or psychological disturbances in dementia, unspecified**  
**Coding Note:** These categories should never be used in primary tabulation. The codes are provided for use as supplementary or additional codes when it is desired to identify the presence of behavioural or psychological disturbance in dementia.  
 Code all that apply.
- 6D8Y Dementia, other specified cause**  
**Coding Note:** This category should only be used for primary tabulation, if the aetiology of the dementia is unknown. If the aetiology of the dementia is known code to the aetiology of the dementia for primary tabulation.  
 When dementia is due to multiple aetiologies, code all that apply.

**6D8Z****Dementia, unknown or unspecified cause**

**Coding Note:** This category should only be used for primary tabulation, if the aetiology of the dementia is unknown. If the aetiology of the dementia is known code to the aetiology of the dementia for primary tabulation.

When dementia is due to multiple aetiologies, code all that apply.

**6E0Y****Other specified neurocognitive disorders****6E0Z****Neurocognitive disorders, unspecified****Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium (6E20-6E2Z)**

Syndromes associated with pregnancy or the puerperium (commencing within about 6 weeks after delivery) that involve significant mental and behavioural features. If the symptoms meet the diagnostic requirements for a specific mental disorder, that diagnosis should also be assigned.

**Coded Elsewhere:** Psychological disorder related to obstetric fistula (GC04.1Y)

**6E20****Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms**

A syndrome associated with pregnancy or the puerperium (commencing within about 6 weeks after delivery) that involves significant mental and behavioural features, most commonly depressive symptoms. The syndrome does not include delusions, hallucinations, or other psychotic symptoms. If the symptoms meet the diagnostic requirements for a specific mental disorder, that diagnosis should also be assigned. This designation should not be used to describe mild and transient depressive symptoms that do not meet the diagnostic requirements for a depressive episode, which may occur soon after delivery (so-called postpartum blues).

**Coding Note:** Code also the causing condition

**6E21****Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms**

A syndrome associated with pregnancy or the puerperium (commencing within about 6 weeks after delivery) that involves significant mental and behavioural features, including delusions, hallucinations, or other psychotic symptoms. Mood symptoms (depressive and/or manic) are also typically present. If the symptoms meet the diagnostic requirements for a specific mental disorder, that diagnosis should also be assigned.

**Coding Note:** Code also the causing condition

**6E2Z****Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium, unspecified**

**6E40****Psychological or behavioural factors affecting disorders or diseases classified elsewhere**

Psychological and behavioural factors affecting disorders or diseases classified elsewhere are those that may adversely affect the manifestation, treatment, or course of a condition classified in another chapter of the ICD. These factors may adversely affect the manifestation, treatment, or course of the disorder or disease classified in another chapter by: interfering with the treatment of the disorder or disease by affecting treatment adherence or care seeking; constituting an additional health risk; or influencing the underlying pathophysiology to precipitate or exacerbate symptoms or otherwise necessitate medical attention. This diagnosis should be assigned only when the factors increase the risk of suffering, disability, or death and represent a focus of clinical attention, and should be assigned together with the diagnosis for the relevant other condition.

**Inclusions:** Psychological factors affecting physical conditions

**Exclusions:** Mental or behavioural disorders associated with pregnancy, childbirth or the puerperium (6E20-6E2Z)

**6E40.0****Mental disorder affecting disorders or diseases classified elsewhere**

All diagnostic requirements for Psychological or behavioural factors affecting disorders or diseases classified elsewhere are met. The individual is diagnosed with a mental, behavioural, or neurodevelopmental disorder that adversely affects the manifestation, treatment, or course of a disorder or disease classified in another chapter (e.g., a woman with Bulimia Nervosa and Type 1 diabetes mellitus who skips insulin doses as a way to avoid weight gain that would otherwise be caused by her binge eating).

**6E40.1****Psychological symptoms affecting disorders or diseases classified elsewhere**

All diagnostic requirements for Psychological or behavioural factors affecting disorders or diseases classified elsewhere are met. The individual exhibits psychological symptoms that do not meet the diagnostic requirements for a mental, behavioural, or neurodevelopmental disorder that adversely affect the manifestation, treatment, or course of a disorder or disease classified in another chapter (e.g., depressive symptoms interfering with rehabilitation following surgery).

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

All diagnostic requirements for Psychological or behavioural factors affecting disorders or diseases classified elsewhere are met. The individual exhibits personality traits or coping styles that do not meet the diagnostic requirements for a mental, behavioural, or neurodevelopmental disorder that adversely affect the manifestation, treatment, or course of a disorder or disease classified in another chapter (e.g., pathological denial of the need for surgery in a patient with cancer; hostile, pressured behaviour contributing to heart disease).

- 6E40.3 Maladaptive health behaviours affecting disorders or diseases classified elsewhere**  
All diagnostic requirements for Psychological or behavioural factors affecting disorders or diseases classified elsewhere are met. The individual exhibits maladaptive health behaviours that adversely affect the manifestation, treatment, or course of a disorder or disease classified in another chapter (e.g., overeating, lack of exercise).
- 6E40.4 Stress-related physiological response affecting disorders or diseases classified elsewhere**  
All diagnostic requirements for Psychological or behavioural factors affecting disorders or diseases classified elsewhere are met. The individual exhibits stress-related physiological responses that adversely affect the manifestation, treatment, or course of a disorder or disease classified in another chapter (e.g., stress-related exacerbation of ulcer, hypertension, arrhythmia, or tension headache).
- 6E40.Y Other specified psychological or behavioural factors affecting disorders or diseases classified elsewhere**
- 6E40.Z Psychological or behavioural factors affecting disorders or diseases classified elsewhere, unspecified**



## Secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere (6E60-6E6Z)

This grouping includes syndromes characterised by the presence of prominent psychological or behavioural symptoms judged to be direct pathophysiological consequences of a medical condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., adjustment disorder or anxiety symptoms in response to being diagnosed with a life-threatening illness). These categories should be used in addition to the diagnosis for the presumed underlying disorder or disease when the psychological and behavioural symptoms are sufficiently severe to warrant specific clinical attention.

**Exclusions:** Acute pain (MG31)  
Bodily distress disorder (6C20)  
Chronic pain (MG30)

**Coded Elsewhere:** Delirium due to disease classified elsewhere (6D70.0)

### 6E60

#### Secondary neurodevelopmental syndrome

A syndrome that involves significant neurodevelopmental features that do not fulfill the diagnostic requirements of any of the specific neurodevelopmental disorders that is judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders (e.g., autistic-like features in Retts syndrome; aggression and self-mutilation in Lesch-Nyhan syndrome, abnormalities in language development in Williams syndrome), based on evidence from the history, physical examination, or laboratory findings.

This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the neurodevelopmental problems are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Autism spectrum disorder (6A02)  
Disorders of intellectual development (6A00)  
Stereotyped movement disorder (6A06)

### 6E60.0

#### Secondary speech or language syndrome

A syndrome that involves significant features related to speech or language development that do not fulfill the diagnostic requirements of any of the specific developmental speech or language disorders that is judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. Possible etiologies include a disease of the nervous system, sensory impairment, brain injury or infection.

**Coding Note:** This diagnosis should be assigned in addition to the diagnosis for the presumed underlying disorder or disease when the neurodevelopmental problems are sufficiently severe to warrant specific clinical attention.

### 6E60.Y

#### Other specified secondary neurodevelopmental syndrome

**Coding Note:** Code also the causing condition

**6E60.Z            Secondary neurodevelopmental syndrome, unspecified**

**Coding Note:** Code also the causing condition

**6E61**

**Secondary psychotic syndrome**

A syndrome characterised by the presence of prominent hallucinations or delusions judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., an acute stress reaction in response to a life-threatening diagnosis). This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the psychotic symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:**            Acute and transient psychotic disorder (6A23)  
                                 Delirium (6D70)  
                                 Mood disorders (6A60-6A8Z)

**6E61.0            Secondary psychotic syndrome, with hallucinations**

A syndrome characterised by the presence of prominent hallucinations that is judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. Delusions are not a prominent aspect of the clinical presentation. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., an acute stress reaction in response to a life-threatening diagnosis). This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the psychotic symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:**            Delirium (6D70)  
                                 Mood disorders (6A60-6A8Z)

**6E61.1 Secondary psychotic syndrome, with delusions**

A syndrome characterised by the presence of prominent delusions that is judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. Hallucinations are not a prominent aspect of the clinical presentation. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., an acute stress reaction in response to a life-threatening diagnosis). This category should be used in addition the diagnosis for the presumed underlying disorder or disease when the psychotic symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Delirium (6D70)  
Mood disorders (6A60-6A8Z)

**6E61.2 Secondary psychotic syndrome, with hallucinations and delusions**

A syndrome characterised by the presence of both prominent hallucinations and prominent delusions that is judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., an acute stress reaction in response to a life-threatening diagnosis). This category should be used in addition the diagnosis for the presumed underlying disorder or disease when the psychotic symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Delirium (6D70)  
Mood disorders (6A60-6A8Z)

**6E61.3 Secondary psychotic syndrome, with unspecified symptoms**

**Coding Note:** Code also the causing condition

**6E62 Secondary mood syndrome**

A syndrome characterised by the presence of prominent mood symptoms (i.e., depression, elevated mood, irritability) judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., depressive symptoms in response to a life-threatening diagnosis). This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the mood symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Adjustment disorder (6B43)  
Delirium (6D70)

**6E62.0****Secondary mood syndrome, with depressive symptoms**

A syndrome characterised by the presence of prominent depressive symptoms such as persistently depressed mood, loss of interest in previously enjoyable activities, or signs such as tearful and downtrodden appearance that is judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., depressive symptoms in response to a life-threatening diagnosis). This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the mood symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Adjustment disorder (6B43)  
Delirium (6D70)

**6E62.1****Secondary mood syndrome, with manic symptoms**

A syndrome characterised by the presence of prominent manic symptoms such as elevated, euphoric, irritable, or expansive mood states, rapid changes among different mood states (i.e., mood lability), or increased energy or activity that is judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders based on evidence from the history, physical examination, or laboratory findings.

**Coding Note:** Code also the causing condition

**Inclusions:** mood syndrome due to disorders or diseases not classified under Mental and behavioural disorders, with manic symptoms

**Exclusions:** Adjustment disorder (6B43)  
Delirium (6D70)

**6E62.2****Secondary mood syndrome, with mixed symptoms**

A syndrome characterised by the presence of both manic and depressive symptoms, either occurring together or alternating from day to day or over the course of a day that is judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders based on evidence from the history, physical examination, or laboratory findings. Manic symptoms may include elevated, euphoric, irritable, or expansive mood states, rapid changes among different mood states (i.e., mood lability), or increased energy or activity. Depressive symptoms may include persistently depressed mood, loss of interest in previously enjoyable activities, or signs such as tearful or downtrodden appearance. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., depressive symptoms in response to a life-threatening diagnosis). This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the mood symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Adjustment disorder (6B43)  
Delirium (6D70)

**6E62.3****Secondary mood syndrome, with unspecified symptoms**

**Coding Note:** Code also the causing condition

**Exclusions:** Adjustment disorder (6B43)  
Delirium (6D70)

**6E63****Secondary anxiety syndrome**

A syndrome characterised by the presence of prominent anxiety symptoms judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., anxiety symptoms or panic attacks in response to a life-threatening diagnosis). This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the anxiety symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Adjustment disorder (6B43)  
Delirium (6D70)

**6E64****Secondary obsessive-compulsive or related syndrome**

A syndrome characterised by the presence of prominent obsessions, compulsions, hoarding, skin picking, hair pulling, other body-focused repetitive behaviours, or other symptoms characteristic of obsessive-compulsive and related disorder that is judged to be the direct pathophysiological consequence of a disorder or disease not classified under Mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by Delirium or by another Mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., repetitive ruminations in response to a life-threatening diagnosis). This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the obsessive-compulsive or related symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Delirium (6D70)  
Obsessive-compulsive or related disorder induced by other specified psychoactive substance (6C4E.72)  
Tic disorders (8A05)

**6E65****Secondary dissociative syndrome**

A syndrome characterised by the presence of prominent dissociative symptoms (e.g., depersonalization, derealization) that is judged to be the direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., as part of an acute stress reaction in response to a life-threatening diagnosis). This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the dissociative symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Delirium (6D70)  
Acute stress reaction (QE84)

**6E66****Secondary impulse control syndrome**

A syndrome characterised by the presence of prominent symptoms that are characteristic of Impulse Control Disorders or Disorders Due to Addictive Behaviours (e.g., stealing, fire-setting, aggressive outbursts, compulsive sexual behaviour, excessive gambling) that are judged to be a direct pathophysiological consequence of a health condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., as part of an adjustment disorder in response to a life-threatening diagnosis). This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the impulse control symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Delirium (6D70)

**6E67****Secondary neurocognitive syndrome**

A syndrome that involves significant cognitive features that do not fulfill the diagnostic requirements of any of the specific neurocognitive disorders and are judged to be a direct pathophysiological consequence of a health condition or injury not classified under mental and behavioural disorders (e.g., cognitive changes due to a brain tumour), based on evidence from the history, physical examination, or laboratory findings. This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the cognitive symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Disorders with neurocognitive impairment as a major feature (8A20-8A2Z)

**Coded Elsewhere:** Delirium (6D70)

**6E68****Secondary personality change**

A syndrome characterised by a persistent personality disturbance that represents a change from the individual's previous characteristic personality pattern that is judged to be a direct pathophysiological consequence of a health condition not classified under Mental and behavioural disorders, based on evidence from the history, physical examination, or laboratory findings. The symptoms are not accounted for by delirium or by another mental and behavioural disorder, and are not a psychologically mediated response to a severe medical condition (e.g., social withdrawal, avoidance, or dependence in response to a life-threatening diagnosis). This category should be used in addition to the diagnosis for the presumed underlying disorder or disease when the personality symptoms are sufficiently severe to warrant specific clinical attention.

**Coding Note:** Code also the causing condition

**Exclusions:** Personality difficulty (QE50.7)  
Personality disorder (6D10)  
Delirium (6D70)

**6E69**

**Secondary catatonia syndrome**

Secondary catatonia syndrome is a syndrome of primarily psychomotor disturbances, characterized by the co-occurrence of several symptoms of decreased, increased, or abnormal psychomotor activity, which occurs as a direct pathophysiological consequence of a medical condition not classified under Mental, Behavioural or Neurodevelopmental Disorders. Examples of medical conditions that may be associated with Catatonia include diabetic ketoacidosis, hypercalcemia, hepatic encephalopathy, homocystinuria, neoplasms head trauma, cerebrovascular disease, and encephalitis.

**Coding Note:** Use additional code, if desired, for any underlying disorder if known.

**6E6Y**

**Other specified secondary mental or behavioural syndrome**

**Coding Note:** Code also the causing condition

**6E6Z**

**Secondary mental or behavioural syndrome, unspecified**

**Coding Note:** Code also the causing condition

**6E8Y**

**Other specified mental, behavioural or neurodevelopmental disorders**

**6E8Z**

**Mental, behavioural or neurodevelopmental disorders, unspecified**



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International Classification of Diseases, Eleventh Revision (ICD-11)

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