

order is present, this should be coded as V71.09. If an Axis II diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9.

Axis II may also be used to indicate prominent maladaptive personality features that do not meet the threshold for a Personality Disorder (in such instances, no code number should be used—see Example 3 on p. 37). The habitual use of maladaptive defense mechanisms may also be indicated on Axis II (see Appendix B, p. 811, for definitions and Example 1 on p. 37).

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<b>Axis II</b>	
<b>Personality Disorders</b>	
<b>Mental Retardation</b>	
Paranoid Personality Disorder	Narcissistic Personality Disorder
Schizoid Personality Disorder	Avoidant Personality Disorder
Schizotypal Personality Disorder	Dependent Personality Disorder
Antisocial Personality Disorder	Obsessive-Compulsive Personality Disorder
Borderline Personality Disorder	Personality Disorder Not Otherwise Specified
Histrionic Personality Disorder	Mental Retardation

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### Axis III: General Medical Conditions

Axis III is for reporting current general medical conditions that are potentially relevant to the understanding or management of the individual's mental disorder. These conditions are classified outside the "Mental Disorders" chapter of ICD-9-CM (and outside Chapter V of ICD-10). A listing of the broad categories of general medical conditions is given in the box below. (For a more detailed listing including the specific ICD-9-CM codes, refer to Appendix G.)

As discussed in the "Introduction," the multiaxial distinction among Axis I, Axis II, and Axis III disorders does not imply that there are fundamental differences in their conceptualization, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes. The purpose of distinguishing general medical conditions is to encourage thoroughness in evaluation and to enhance communication among health care providers.

General medical conditions can be related to mental disorders in a variety of ways. In some cases it is clear that the general medical condition is directly etiological to the development or worsening of mental symptoms and that the mechanism for this effect is physiological. When a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis I and the general medical condition should be recorded on both Axis I and Axis III. For example, when hypothyroidism is a direct cause of depressive symptoms, the designation on Axis I is 293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features, and the hypothyroidism is listed again and coded on Axis III as 244.9 (see Example 3, p. 37). For a further discussion, see p. 181.

In those instances in which the etiological relationship between the general medical condition and the mental symptoms is insufficiently clear to warrant an Axis I diagnosis of Mental Disorder Due to a General Medical Condition, the appropriate mental disorder (e.g., Major Depressive Disorder) should be listed and coded on Axis I; the general medical condition should only be coded on Axis III.

There are other situations in which general medical conditions are recorded on Axis III because of their importance to the overall understanding or treatment of the individual with the mental disorder. An Axis I disorder may be a psychological reaction to an Axis III general medical condition (e.g., the development of 309.0 Adjustment Disorder With Depressed Mood as a reaction to the diagnosis of carcinoma of the breast). Some general medical conditions may not be directly related to the mental disorder but nonetheless have important prognostic or treatment implications (e.g., when the diagnosis on Axis I is 296.30 Major Depressive Disorder, Recurrent, and on Axis III is 427.9 arrhythmia, the choice of pharmacotherapy is influenced by the general medical condition; or when a person with diabetes mellitus is admitted to the hospital for an exacerbation of Schizophrenia and insulin management must be monitored).

When an individual has more than one clinically relevant Axis III diagnosis, all should be reported. For examples, see p. 35. If no Axis III disorder is present, this should be indicated by the notation "Axis III: None." If an Axis III diagnosis is deferred, pending the gathering of additional information, this should be indicated by the notation "Axis III: Deferred."

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### Axis III

#### **General Medical Conditions (with ICD-9-CM codes)**

- Infectious and Parasitic Diseases (001–139)
  - Neoplasms (140–239)
  - Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240–279)
  - Diseases of the Blood and Blood-Forming Organs (280–289)
  - Diseases of the Nervous System and Sense Organs (320–389)
  - Diseases of the Circulatory System (390–459)
  - Diseases of the Respiratory System (460–519)
  - Diseases of the Digestive System (520–579)
  - Diseases of the Genitourinary System (580–629)
  - Complications of Pregnancy, Childbirth, and the Puerperium (630–676)
  - Diseases of the Skin and Subcutaneous Tissue (680–709)
  - Diseases of the Musculoskeletal System and Connective Tissue (710–739)
  - Congenital Anomalies (740–759)
  - Certain Conditions Originating in the Perinatal Period (760–779)
  - Symptoms, Signs, and Ill-Defined Conditions (780–799)
  - Injury and Poisoning (800–999)
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## Axis IV: Psychosocial and Environmental Problems

Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II). A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

When an individual has multiple psychosocial or environmental problems, the clinician may note as many as are judged to be relevant. In general, the clinician should note only those psychosocial and environmental problems that have been present during the year preceding the current evaluation. However, the clinician may choose to note psychosocial and environmental problems occurring prior to the previous year if these clearly contribute to the mental disorder or have become a focus of treatment—for example, previous combat experiences leading to Posttraumatic Stress Disorder.

In practice, most psychosocial and environmental problems will be indicated on Axis IV. However, when a psychosocial or environmental problem is the primary focus of clinical attention, it should also be recorded on Axis I, with a code derived from the section "Other Conditions That May Be a Focus of Clinical Attention" (see p. 731).

For convenience, the problems are grouped together in the following categories:

- **Problems with primary support group**—e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling
- **Problems related to the social environment**—e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement)
- **Educational problems**—e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment
- **Occupational problems**—e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers
- **Housing problems**—e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord
- **Economic problems**—e.g., extreme poverty; inadequate finances; insufficient welfare support
- **Problems with access to health care services**—e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance

- **Problems related to interaction with the legal system/crime**—e.g., arrest; incarceration; litigation; victim of crime
- **Other psychosocial and environmental problems**—e.g., exposure to disasters, war, other hostilities; discord with nonfamily caregivers such as counselor, social worker, or physician; unavailability of social service agencies

When using the Multiaxial Evaluation Report Form (see p. 36), the clinician should identify the relevant categories of psychosocial and environmental problems and indicate the specific factors involved. If a recording form with a checklist of problem categories is not used, the clinician may simply list the specific problems on Axis IV. (See examples on p. 35.)

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## Axis IV

### Psychosocial and Environmental Problems

- Problems with primary support group
  - Problems related to the social environment
  - Educational problems
  - Occupational problems
  - Housing problems
  - Economic problems
  - Problems with access to health care services
  - Problems related to interaction with the legal system/crime
  - Other psychosocial and environmental problems
- 

## Axis V: Global Assessment of Functioning

Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and in predicting outcome.

The reporting of overall functioning on Axis V can be done using the Global Assessment of Functioning (GAF) Scale. The GAF Scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical (or environmental) limitations."

The GAF scale is divided into 10 ranges of functioning. Making a GAF rating involves picking a single value that best reflects the individual's overall level of functioning. The description of each 10-point range in the GAF scale has two components: the first part covers symptom severity, and the second part covers functioning. The GAF rating is within a particular decile if **either** the symptom severity **or** the level of functioning falls within the range. For example, the first part of the range 41–50 describes "serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting)" and the second part includes "any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)." It should be noted

that in situations where the individual's symptom severity and level of functioning are discordant, the final GAF rating always reflects the worse of the two. For example, the GAF rating for an individual who is a significant danger to self but is otherwise functioning well would be below 20. Similarly, the GAF rating for an individual with minimal psychological symptomatology but significant impairment in functioning (e.g., an individual whose excessive preoccupation with substance use has resulted in loss of job and friends but no other psychopathology) would be 40 or lower.

In most instances, ratings on the GAF Scale should be for the current period (i.e., the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. In order to account for day-to-day variability in functioning, the GAF rating for the "current period" is sometimes operationalized as the lowest level of functioning for the past week. In some settings, it may be useful to note the GAF Scale rating both at time of admission and at time of discharge. The GAF Scale may also be rated for other time periods (e.g., the highest level of functioning for at least a few months during the past year). The GAF Scale is reported on Axis V as follows: "GAF = ," followed by the GAF rating from 0 to 100, followed by the time period reflected by the rating in parentheses—for example, "(current)," "(highest level in past year)," "(at discharge)." (See examples on p. 35.)

In order to ensure that no elements of the GAF scale are overlooked when a GAF rating is being made, the following method for determining a GAF rating may be applied:

**STEP 1:** Starting at the top level, evaluate each range by asking "is **either** the individual's symptom severity **OR** level of functioning worse than what is indicated in the range description?"

**STEP 2:** Keep moving down the scale until the range that best matches the individual's symptom severity **OR** the level of functioning is reached, **whichever is worse**.

**STEP 3:** Look at the next lower range as a double-check against having stopped prematurely. This range should be too severe on **both** symptom severity **and** level of functioning. If it is, the appropriate range has been reached (continue with step 4). If not, go back to step 2 and continue moving down the scale.

**STEP 4:** To determine the specific GAF rating within the selected 10-point range, consider whether the individual is functioning at the higher or lower end of the 10-point range. For example, consider an individual who hears voices that do not influence his behavior (e.g., someone with long-standing Schizophrenia who accepts his hallucinations as part of his illness). If the voices occur relatively infrequently (once a week or less), a rating of 39 or 40 might be most appropriate. In contrast, if the individual hears voices almost continuously, a rating of 31 or 32 would be more appropriate.

In some settings, it may be useful to assess social and occupational disability and to track progress in rehabilitation independent of the severity of the psychological symptoms. For this purpose, a proposed Social and Occupational Functioning Assessment Scale (SOFAS) (see p. 817) is included in Appendix B. Two additional proposed scales that may be useful in some settings—the Global Assessment of Relational Functioning (GARF) Scale (see p. 814) and the Defensive Functioning Scale (see p. 807)—are also included in Appendix B.

## Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health–illness. Do not include impairment in functioning due to physical (or environmental) limitations.

**Code** (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)

- 100 **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**
- 91
- 90 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).
- 81
- 80 **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork).
- 71
- 70 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**
- 61
- 60 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).
- 51
- 50 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).
- 41
- 40 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
- 31
- 30 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).
- 21
- 20 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).
- 11
- 10 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
- 1
- 0 Inadequate information.

The rating of overall psychological functioning on a scale of 0–100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: "Clinicians' Judgments of Mental Health." *Archives of General Psychiatry* 7:407–417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J, Spitzer RL, Fleiss JL, Cohen J: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Psychiatry* 33:766–771, 1976). A modified version of the GAS was included in DSM-III-R as the Global Assessment of Functioning (GAF) Scale.