Using DSM-IV-TR

Health care providers often use language unfamiliar to clients and their families. Explain the term *cognitive deficit* to make it easier for your clients and their family members to understand.

# DSM-IV-TR Diagnostic Criteria for Cognitive Disorders

## Diagnostic Criteria for Delirium Due to . . . [Indicate the General Medical Condition]

A. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.

B. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.

C. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.

D. There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.

## Diagnostic Criteria for Dementia of the Alzheimer’s Type (DAT)

A. The development of multiple cognitive deficits manifested by both

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

2. One (or more) of the following cognitive disturbances:
   a. Aphasia (language disturbance)
   b. Apraxia (impaired ability to carry out motor activities despite intact motor function)
   c. Agnosia (failure to recognize or identify objects despite intact sensory function)
   d. Disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)

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

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

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

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

2. Systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B₁₂ or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis, HIV infection)

3. Substance-induced conditions

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

F. The disturbance is not better accounted for by another Axis I disorder (e.g., major depressive disorder, schizophrenia).


Sleep–wake cycle, with hour-to-hour variation. Interestingly, delirium and dreaming are both characterized by the same electroencephalographic (EEG) changes. The person with delirium is then caught between dreaming and hallucinating, sleeping and wakefulness.

**Psychomotor Behavior**

The delirious client is either hyperactive or hypoactive, often alternating between the two extremes. Speech may be slurred and disjointed, with aimless vocalizations and repetitions. Tremors and irregular spasmodic (choreiform) movements may be present, as illustrated in the following Clinical Examples of delirium.

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**CLINICAL EXAMPLE**

Mr. Robio, an 80-year-old bachelor with bilateral cataracts, lived alone in a small midwestern town with his pet cat Suzy. Mr. Robio was admitted to the community hospital for a hernia repair that he had been putting off for several months. Never hospitalized before, he was extremely anxious on admission and became more so with each preoperative procedure that day. At 10:00 that evening, Mr. Robio was found wandering in the hallway, looking and calling for Suzy. The nurse assisted him to return to his room. Three hours later he was again found wandering, this time he was nude and more disoriented than before. He was sedated with a nonbenzodi-