6. Inappropriate or constricted affect.
7. Behavior or appearance that is odd, eccentric, or peculiar.
8. Lack of close friends or confidants other than first-degree relatives.
9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder.

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," e.g., "schizotypal personality disorder (premorbid)."

Diagnostic Features

The essential feature of schizotypal personality disorder is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with schizotypal personality disorder often have ideas of reference (i.e., incorrect interpretations of casual incidents and external events as having a particular and unusual meaning specifically for the person) (Criterion A1). These should be distinguished from delusions of reference, in which the beliefs are held with delusional conviction. These individuals may be superstitious or preoccupied with paranormal phenomena that are outside the norms of their subculture (Criterion A2). They may feel that they have special powers to sense events before they happen or to read others' thoughts. They may believe that they have magical control over others, which can be implemented directly (e.g., believing that their spouse's taking the dog out for a walk is the direct result of thinking an hour earlier it should be done) or indirectly through compliance with magical rituals (e.g., walking past a specific object three times to avoid a certain harmful outcome). Perceptual alterations may be present (e.g., sensing that another person is present or hearing a voice murmuring his or her name) (Criterion A3). Their speech may include unusual or idiosyncratic phrasing and construction. It is often loose, digressive, or vague, but without actual derailment or incoherence (Criterion A4). Responses can be either overly concrete or overly abstract, and words or concepts are sometimes applied in unusual ways (e.g., the individual may state that he or she was not "talkable" at work).

Individuals with this disorder are often suspicious and may have paranoid ideation (e.g., believing their colleagues at work are intent on undermining their reputation with the boss) (Criterion A5). They are usually not able to negotiate the full range of affects and interpersonal cuing required for successful relationships and thus often appear to interact with others in an inappropriate, stiff, or constricted fashion (Criterion A6). These individuals are often considered to be odd or eccentric because of unusual mannerisms, an often unkempt manner of dress that does not quite "fit together," and inattention to the usual social conventions (e.g., the individual may avoid eye contact, wear clothes that are ink stained and ill-fitting, and be unable to join in the give-and-take banter of co-workers) (Criterion A7).

Individuals with schizotypal personality disorder experience interpersonal relatedness as problematic and are uncomfortable relating to other people. Although they may express unhappiness about their lack of relationships, their behavior suggests a decreased desire for intimate contacts. As a result, they usually have no or few close friends or confidants other than a first-degree relative (Criterion A8). They are anxious in social situations, particularly those involving unfamiliar people (Criterion A9). They will interact with other individuals when they have to but prefer to keep to themselves because they feel that they are different and just do not "fit in." Their social anxiety does not easily abate,

even when they spend more time in the setting or become more familiar with the other people, because their anxiety tends to be associated with suspiciousness regarding others' motivations. For example, when attending a dinner party, the individual with schizotypal personality disorder will not become more relaxed as time goes on, but rather may become increasingly tense and suspicious.

Schizotypal personality disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of schizophrenia, a bipolar or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder (Criterion B).

Associated Features Supporting Diagnosis

Individuals with schizotypal personality disorder often seek treatment for the associated symptoms of anxiety or depression rather than for the personality disorder features per se. Particularly in response to stress, individuals with this disorder may experience transient psychotic episodes (lasting minutes to hours), although they usually are insufficient in duration to warrant an additional diagnosis such as brief psychotic disorder or schizophreniform disorder. In some cases, clinically significant psychotic symptoms may develop that meet criteria for brief psychotic disorder, schizophreniform disorder, delusional disorder, or schizophrenia. Over half may have a history of at least one major depressive episode. From 30% to 50% of individuals diagnosed with this disorder have a concurrent diagnosis of major depressive disorder when admitted to a clinical setting. There is considerable co-occurrence with schizoid, paranoid, avoidant, and borderline personality disorders.

Prevalence

In community studies of schizotypal personality disorder, reported rates range from 0.6% in Norwegian samples to 4.6% in a U.S. community sample. The prevalence of schizotypal personality disorder in clinical populations seems to be infrequent (0%–1.9%), with a higher estimated prevalence in the general population (3.9%) found in the National Epidemiologic Survey on Alcohol and Related Conditions.

Development and Course

Schizotypal personality disorder has a relatively stable course, with only a small proportion of individuals going on to develop schizophrenia or another psychotic disorder. Schizotypal personality disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, social anxiety, underachievement in school, hypersensitivity, peculiar thoughts and language, and bizarre fantasies. These children may appear "odd" or "eccentric" and attract teasing.

Risk and Prognostic Factors

Genetic and physiological. Schizotypal personality disorder appears to aggregate familially and is more prevalent among the first-degree biological relatives of individuals with schizophrenia than among the general population. There may also be a modest increase in schizophrenia and other psychotic disorders in the relatives of probands with schizotypal personality disorder.

Cultural-Related Diagnostic Issues

Cognitive and perceptual distortions must be evaluated in the context of the individual's cultural milieu. Pervasive culturally determined characteristics, particularly those regarding religious beliefs and rituals, can appear to be schizotypal to the uninformed outsider (e.g., voodoo, speaking in tongues, life beyond death, shamanism, mind reading, sixth sense, evil eye, magical beliefs related to health and illness).

Gender-Related Diagnostic Issues

Schizotypal personality disorder may be slightly more common in males.

Differential Diagnosis

Other mental disorders with psychotic symptoms. Schizotypal personality disorder can be distinguished from delusional disorder, schizophrenia, and a bipolar or depressive disorder with psychotic features because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). To give an additional diagnosis of schizotypal personality disorder, the personality disorder must have been present before the onset of psychotic symptoms and persist when the psychotic symptoms are in remission. When an individual has a persistent psychotic disorder (e.g., schizophrenia) that was preceded by schizotypal personality disorder, schizotypal personality disorder should also be recorded, followed by "premorbid" in parentheses.

Neurodevelopmental disorders. There may be great difficulty differentiating children with schizotypal personality disorder from the heterogeneous group of solitary, odd children whose behavior is characterized by marked social isolation, eccentricity, or peculiarities of language and whose diagnoses would probably include milder forms of autism spectrum disorder or language communication disorders. Communication disorders may be differentiated by the primacy and severity of the disorder in language and by the characteristic features of impaired language found in a specialized language assessment. Milder forms of autism spectrum disorder are differentiated by the even greater lack of social awareness and emotional reciprocity and stereotyped behaviors and interests.

Personality change due to another medical condition. Schizotypal personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are attributable to the effects of another medical condition on the central nervous system.

Substance use disorders. Schizotypal personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use.

Other personality disorders and personality traits. Other personality disorders may be confused with schizotypal personality disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to schizotypal personality disorder, all can be diagnosed. Although paranoid and schizoid personality disorders may also be characterized by social detachment and restricted affect, schizotypal personality disorder can be distinguished from these two diagnoses by the presence of cognitive or perceptual distortions and marked eccentricity or oddness. Close relationships are limited in both schizotypal personality disorder and avoidant personality disorder; however, in avoidant personality disorder an active desire for relationships is constrained by a fear of rejection, whereas in schizotypal personality disorder there is a lack of desire for relationships and persistent detachment. Individuals with narcissistic personality disorder may also display suspiciousness, social withdrawal, or alienation, but in narcissistic personality disorder these qualities derive primarily from fears of having imperfections or flaws revealed. Individuals with borderline personality disorder may also have transient, psychotic-like symptoms, but these are usually more closely related to affective shifts in response to stress (e.g., intense anger, anxiety, disappointment) and are usually more dissociative (e.g., derealization, depersonalization). In contrast, individuals with schizotypal personality disorder are more likely to have enduring psychotic-like symptoms that may worsen under stress but are less likely to be invariably associated with pronounced affective symptoms. Although social isolation may occur in borderline personality

disorder, it is usually secondary to repeated interpersonal failures due to angry outbursts and frequent mood shifts, rather than a result of a persistent lack of social contacts and desire for intimacy. Furthermore, individuals with schizotypal personality disorder do not usually demonstrate the impulsive or manipulative behaviors of the individual with borderline personality disorder. However, there is a high rate of co-occurrence between the two disorders, so that making such distinctions is not always feasible. Schizotypal features during adolescence may be reflective of transient emotional turmoil, rather than an enduring personality disorder.

Cluster B Personality Disorders

Antisocial Personality Disorder

Diagnostic Criteria **301.7 (F60.2)**

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
   1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
   2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
   3. Impulsivity or failure to plan ahead.
   4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
   5. Reckless disregard for safety of self or others.
   6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
   7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

Diagnostic Features

The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern has also been referred to as *psychopathy*, *sociopathy*, or *dyssocial personality disorder*. Because deceit and manipulation are central features of antisocial personality disorder, it may be especially helpful to integrate information acquired from systematic clinical assessment with information collected from collateral sources.

For this diagnosis to be given, the individual must be at least age 18 years (Criterion B) and must have had a history of some symptoms of conduct disorder before age 15 years (Criterion C). Conduct disorder involves a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. The specific behaviors characteristic of conduct disorder fall into one of four categories: aggression to people and animals, destruction of property, deceitfulness or theft, or serious violation of rules.

The pattern of antisocial behavior continues into adulthood. Individuals with antisocial personality disorder fail to conform to social norms with respect to lawful behavior (Criterion A1). They may repeatedly perform acts that are grounds for arrest (whether they are arrested or not), such as destroying property, harassing others, stealing, or pursuing illegal occupations. Persons with this disorder disregard the wishes, rights, or feelings of others. They are frequently deceitful and manipulative in order to gain personal profit or pleasure (e.g., to obtain money, sex, or power) (Criterion A2). They may repeatedly lie, use an alias, con others, or malinger. A pattern of impulsivity may be manifested by a failure to plan ahead (Criterion A3). Decisions are made on the spur of the moment, without forethought and without consideration for the consequences to self or others; this may lead to sudden changes of jobs, residences, or relationships. Individuals with antisocial personality disorder tend to be irritable and aggressive and may repeatedly get into physical fights or commit acts of physical assault (including spouse beating or child beating) (Criterion A4). (Aggressive acts that are required to defend oneself or someone else are not considered to be evidence for this item.) These individuals also display a reckless disregard for the safety of themselves or others (Criterion A5). This may be evidenced in their driving behavior (i.e., recurrent speeding, driving while intoxicated, multiple accidents). They may engage in sexual behavior or substance use that has a high risk for harmful consequences. They may neglect or fail to care for a child in a way that puts the child in danger.

Individuals with antisocial personality disorder also tend to be consistently and extremely irresponsible (Criterion A6). Irresponsible work behavior may be indicated by significant periods of unemployment despite available job opportunities, or by abandonment of several jobs without a realistic plan for getting another job. There may also be a pattern of repeated absences from work that are not explained by illness either in themselves or in their family. Financial irresponsibility is indicated by acts such as defaulting on debts, failing to provide child support, or failing to support other dependents on a regular basis. Individuals with antisocial personality disorder show little remorse for the consequences of their acts (Criterion A7). They may be indifferent to, or provide a superficial rationalization for, having hurt, mistreated, or stolen from someone (e.g., "life's unfair," "losers deserve to lose"). These individuals may blame the victims for being foolish, helpless, or deserving their fate (e.g., "he had it coming anyway"); they may minimize the harmful consequences of their actions; or they may simply indicate complete indifference. They generally fail to compensate or make amends for their behavior. They may believe that everyone is out to "help number one" and that one should stop at nothing to avoid being pushed around.

The antisocial behavior must not occur exclusively during the course of schizophrenia or bipolar disorder (Criterion D).

Associated Features Supporting Diagnosis

Individuals with antisocial personality disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others. They may have an inflated and arrogant self-appraisal (e.g., feel that ordinary work is beneath them or lack a realistic concern about their current problems or their future) and may be excessively opinionated, self-assured, or cocky. They may display a glib, superficial charm and can be quite voluble and verbally facile (e.g., using technical terms or jargon that might impress someone who is unfamiliar with the topic). Lack of empathy, inflated self-appraisal, and superficial charm are features that have been commonly included in traditional conceptions of psychopathy that may be particularly distinguishing of the disorder and more predictive of recidivism in prison or forensic settings, where criminal, delinquent, or aggressive acts are likely to be nonspecific. These individuals may also be irresponsible and exploitative in their sexual relationships. They may have a history of many

sexual partners and may never have sustained a monogamous relationship. They may be irresponsible as parents, as evidenced by malnutrition of a child, an illness in the child resulting from a lack of minimal hygiene, a child's dependence on neighbors or nonresident relatives for food or shelter, a failure to arrange for a caretaker for a young child when the individual is away from home, or repeated squandering of money required for household necessities. These individuals may receive dishonorable discharges from the armed services, may fail to be self-supporting, may become impoverished or even homeless, or may spend many years in penal institutions. Individuals with antisocial personality disorder are more likely than people in the general population to die prematurely by violent means (e.g., suicide, accidents, homicides).

Individuals with antisocial personality disorder may also experience dysphoria, including complaints of tension, inability to tolerate boredom, and depressed mood. They may have associated anxiety disorders, depressive disorders, substance use disorders, somatic symptom disorder, gambling disorder, and other disorders of impulse control. Individuals with antisocial personality disorder also often have personality features that meet criteria for other personality disorders, particularly borderline, histrionic, and narcissistic personality disorders. The likelihood of developing antisocial personality disorder in adult life is increased if the individual experienced childhood onset of conduct disorder (before age 10 years) and accompanying attention-deficit/hyperactivity disorder. Child abuse or neglect, unstable or erratic parenting, or inconsistent parental discipline may increase the likelihood that conduct disorder will evolve into antisocial personality disorder.

Prevalence

Twelve-month prevalence rates of antisocial personality disorder, using criteria from previous DSMs, are between 0.2% and 3.3%. The highest prevalence of antisocial personality disorder (greater than 70%) is among most severe samples of males with alcohol use disorder and from substance abuse clinics, prisons, or other forensic settings. Prevalence is higher in samples affected by adverse socioeconomic (i.e., poverty) or sociocultural (i.e., migration) factors.

Development and Course

Antisocial personality disorder has a chronic course but may become less evident or remit as the individual grows older, particularly by the fourth decade of life. Although this remission tends to be particularly evident with respect to engaging in criminal behavior, there is likely to be a decrease in the full spectrum of antisocial behaviors and substance use. By definition, antisocial personality cannot be diagnosed before age 18 years.

Risk and Prognostic Factors

Genetic and physiological. Antisocial personality disorder is more common among the first-degree biological relatives of those with the disorder than in the general population. The risk to biological relatives of females with the disorder tends to be higher than the risk to biological relatives of males with the disorder. Biological relatives of individuals with this disorder are also at increased risk for somatic symptom disorder and substance use disorders. Within a family that has a member with antisocial personality disorder, males more often have antisocial personality disorder and substance use disorders, whereas females more often have somatic symptom disorder. However, in such families, there is an increase in prevalence of all of these disorders in both males and females compared with the general population. Adoption studies indicate that both genetic and environmental factors contribute to the risk of developing antisocial personality disorder. Both adopted and biological children of parents with antisocial personality disorder have an increased

risk of developing antisocial personality disorder, somatic symptom disorder, and substance use disorders. Adopted-away children resemble their biological parents more than their adoptive parents, but the adoptive family environment influences the risk of developing a personality disorder and related psychopathology.

Culture-Related Diagnostic Issues

Antisocial personality disorder appears to be associated with low socioeconomic status and urban settings. Concerns have been raised that the diagnosis may at times be misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy. In assessing antisocial traits, it is helpful for the clinician to consider the social and economic context in which the behaviors occur.

Gender-Related Diagnostic Issues

Antisocial personality disorder is much more common in males than in females. There has been some concern that antisocial personality disorder may be underdiagnosed in females, particularly because of the emphasis on aggressive items in the definition of conduct disorder.

Differential Diagnosis

The diagnosis of antisocial personality disorder is not given to individuals younger than 18 years and is given only if there is a history of some symptoms of conduct disorder before age 15 years. For individuals older than 18 years, a diagnosis of conduct disorder is given only if the criteria for antisocial personality disorder are not met.

Substance use disorders. When antisocial behavior in an adult is associated with a substance use disorder, the diagnosis of antisocial personality disorder is not made unless the signs of antisocial personality disorder were also present in childhood and have continued into adulthood. When substance use and antisocial behavior both began in childhood and continued into adulthood, both a substance use disorder and antisocial personality disorder should be diagnosed if the criteria for both are met, even though some antisocial acts may be a consequence of the substance use disorder (e.g., illegal selling of drugs, thefts to obtain money for drugs).

Schizophrenia and bipolar disorders. Antisocial behavior that occurs exclusively during the course of schizophrenia or a bipolar disorder should not be diagnosed as antisocial personality disorder.

Other personality disorders. Other personality disorders may be confused with antisocial personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to antisocial personality disorder, all can be diagnosed. Individuals with antisocial personality disorder and narcissistic personality disorder share a tendency to be tough-minded, glib, superficial, exploitative, and lack empathy. However, narcissistic personality disorder does not include characteristics of impulsivity, aggression, and deceit. In addition, individuals with antisocial personality disorder may not be as needy of the admiration and envy of others, and persons with narcissistic personality disorder usually lack the history of conduct disorder in childhood or criminal behavior in adulthood. Individuals with antisocial personality disorder and histrionic personality disorder share a tendency to be impulsive, superficial, excitement seeking, reckless, seductive, and manipulative, but persons with histrionic personality disorder tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behaviors. Individuals with histrionic and borderline personality disorders are

manipulative to gain nurturance, whereas those with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification. Individuals with antisocial personality disorder tend to be less emotionally unstable and more aggressive than those with borderline personality disorder. Although antisocial behavior may be present in some individuals with paranoid personality disorder, it is not usually motivated by a desire for personal gain or to exploit others as in antisocial personality disorder, but rather is more often attributable to a desire for revenge.

Criminal behavior not associated with a personality disorder. Antisocial personality disorder must be distinguished from criminal behavior undertaken for gain that is not accompanied by the personality features characteristic of this disorder. Only when antisocial personality traits are inflexible, maladaptive, and persistent and cause significant functional impairment or subjective distress do they constitute antisocial personality disorder.

Borderline Personality Disorder

Diagnostic Criteria **301.83 (F60.3)**

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Diagnostic Features

The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician's announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this "abandonment" implies they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic

efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors, which are described separately in Criterion 5.

Individuals with borderline personality disorder have a pattern of unstable and intense relationships (Criterion 2). They may idealize potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, or is not "there" enough. These individuals can empathize with and nurture other people, but only with the expectation that the other person will "be there" in return to meet their own needs on demand. These individuals are prone to sudden and dramatic shifts in their view of others, who may alternatively be seen as beneficent supports or as cruelly punitive. Such shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected.

There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self (Criterion 3). There are sudden and dramatic shifts in self-image, characterized by shifting goals, values, and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values, and types of friends. These individuals may suddenly change from the role of a needy supplicant for help to that of a righteous avenger of past mistreatment. Although they usually have a self-image that is based on being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing, and support. These individuals may show worse performance in unstructured work or school situations.

Individuals with borderline personality disorder display impulsivity in at least two areas that are potentially self-damaging (Criterion 4). They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex, or drive recklessly. Individuals with this disorder display recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (Criterion 5). Completed suicide occurs in 8%–10% of such individuals, and self-mutilative acts (e.g., cutting or burning) and suicide threats and attempts are very common. Recurrent suicidality is often the reason that these individuals present for help. These self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that the individual assumes increased responsibility. Self-mutilation may occur during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual's sense of being evil.

Individuals with borderline personality disorder may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) (Criterion 6). The basic dysphoric mood of those with borderline personality disorder is often disrupted by periods of anger, panic, or despair and is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual's extreme reactivity to interpersonal stresses. Individuals with borderline personality disorder may be troubled by chronic feelings of emptiness (Criterion 7). Easily bored, they may constantly seek something to do. Individuals with this disorder frequently express inappropriate, intense anger or have difficulty controlling their anger (Criterion 8). They may display extreme sarcasm, enduring bitterness, or verbal outbursts. The anger is often elicited when a caregiver or lover is seen as neglectful, withholding, uncaring, or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil. During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g., depersonalization) may occur (Criterion 9), but these are generally of insufficient severity or duration to warrant an additional diagnosis. These episodes occur most frequently in response to a real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived return of the caregiver's nurturance may result in a remission of symptoms.

Associated Features Supporting Diagnosis

Individuals with borderline personality disorder may have a pattern of undermining themselves at the moment a goal is about to be realized (e.g., dropping out of school just before graduation; regressing severely after a discussion of how well therapy is going; destroying a good relationship just when it is clear that the relationship could last). Some individuals develop psychotic-like symptoms (e.g., hallucinations, body-image distortions, ideas of reference, hypnagogic phenomena) during times of stress. Individuals with this disorder may feel more secure with transitional objects (i.e., a pet or inanimate possession) than in interpersonal relationships. Premature death from suicide may occur in individuals with this disorder, especially in those with co-occurring depressive disorders or substance use disorders. Physical handicaps may result from self-inflicted abuse behaviors or failed suicide attempts. Recurrent job losses, interrupted education, and separation or divorce are common. Physical and sexual abuse, neglect, hostile conflict, and early parental loss are more common in the childhood histories of those with borderline personality disorder. Common co-occurring disorders include depressive and bipolar disorders, substance use disorders, eating disorders (notably bulimia nervosa), posttraumatic stress disorder, and attention-deficit/hyperactivity disorder. Borderline personality disorder also frequently co-occurs with the other personality disorders.

Prevalence

The median population prevalence of borderline personality disorder is estimated to be 1.6% but may be as high as 5.9%. The prevalence of borderline personality disorder is about 6% in primary care settings, about 10% among individuals seen in outpatient mental health clinics, and about 20% among psychiatric inpatients. The prevalence of borderline personality disorder may decrease in older age groups.

Development and Course

There is considerable variability in the course of borderline personality disorder. The most common pattern is one of chronic instability in early adulthood, with episodes of serious affective and impulsive dyscontrol and high levels of use of health and mental health resources. The impairment from the disorder and the risk of suicide are greatest in the young-adult years and gradually wane with advancing age. Although the tendency toward intense emotions, impulsivity, and intensity in relationships is often lifelong, individuals who engage in therapeutic intervention often show improvement beginning sometime during the first year. During their 30s and 40s, the majority of individuals with this disorder attain greater stability in their relationships and vocational functioning. Follow-up studies of individuals identified through outpatient mental health clinics indicate that after about 10 years, as many as half of the individuals no longer have a pattern of behavior that meets full criteria for borderline personality disorder.

Risk and Prognostic Factors

Genetic and physiological. Borderline personality disorder is about five times more common among first-degree biological relatives of those with the disorder than in the general population. There is also an increased familial risk for substance use disorders, antisocial personality disorder, and depressive or bipolar disorders.

Culture-Related Diagnostic Issues

The pattern of behavior seen in borderline personality disorder has been identified in many settings around the world. Adolescents and young adults with identity problems (especially when accompanied by substance use) may transiently display behaviors that misleadingly

give the impression of borderline personality disorder. Such situations are characterized by emotional instability, "existential" dilemmas, uncertainty, anxiety-provoking choices, conflicts about sexual orientation, and competing social pressures to decide on careers.

Gender-Related Diagnostic Issues

Borderline personality disorder is diagnosed predominantly (about 75%) in females.

Differential Diagnosis

Depressive and bipolar disorders. Borderline personality disorder often co-occurs with depressive or bipolar disorders, and when criteria for both are met, both may be diagnosed. Because the cross-sectional presentation of borderline personality disorder can be mimicked by an episode of depressive or bipolar disorder, the clinician should avoid giving an additional diagnosis of borderline personality disorder based only on cross-sectional presentation without having documented that the pattern of behavior had an early onset and a long-standing course.

Other personality disorders. Other personality disorders may be confused with borderline personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to borderline personality disorder, all can be diagnosed. Although histrionic personality disorder can also be characterized by attention seeking, manipulative behavior, and rapidly shifting emotions, borderline personality disorder is distinguished by self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and loneliness. Paranoid ideas or illusions may be present in both borderline personality disorder and schizotypal personality disorder, but these symptoms are more transient, interpersonally reactive, and responsive to external structuring in borderline personality disorder. Although paranoid personality disorder and narcissistic personality disorder may also be characterized by an angry reaction to minor stimuli, the relative stability of self-image, as well as the relative lack of self-destructiveness, impulsivity, and abandonment concerns, distinguishes these disorders from borderline personality disorder. Although antisocial personality disorder and borderline personality disorder are both characterized by manipulative behavior, individuals with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification, whereas the goal in borderline personality disorder is directed more toward gaining the concern of caretakers. Both dependent personality disorder and borderline personality disorder are characterized by fear of abandonment; however, the individual with borderline personality disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with dependent personality disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support. Borderline personality disorder can further be distinguished from dependent personality disorder by the typical pattern of unstable and intense relationships.

Personality change due to another medical condition. Borderline personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are attributable to the effects of another medical condition on the central nervous system.

Substance use disorders. Borderline personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use.

Identity problems. Borderline personality disorder should be distinguished from an identity problem, which is reserved for identity concerns related to a developmental phase (e.g., adolescence) and does not qualify as a mental disorder.

Histrionic Personality Disorder

Diagnostic Criteria **301.50 (F60.4)**

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Is uncomfortable in situations in which he or she is not the center of attention.
2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
3. Displays rapidly shifting and shallow expression of emotions.
4. Consistently uses physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion.
7. Is suggestible (i.e., easily influenced by others or circumstances).
8. Considers relationships to be more intimate than they actually are.

Diagnostic Features

The essential feature of histrionic personality disorder is pervasive and excessive emotionality and attention-seeking behavior. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with histrionic personality disorder are uncomfortable or feel unappreciated when they are not the center of attention (Criterion 1). Often lively and dramatic, they tend to draw attention to themselves and may initially charm new acquaintances by their enthusiasm, apparent openness, or flirtatiousness. These qualities wear thin, however, as these individuals continually demand to be the center of attention. They commandeer the role of "the life of the party." If they are not the center of attention, they may do something dramatic (e.g., make up stories, create a scene) to draw the focus of attention to themselves. This need is often apparent in their behavior with a clinician (e.g., being flattering, bringing gifts, providing dramatic descriptions of physical and psychological symptoms that are replaced by new symptoms each visit).

The appearance and behavior of individuals with this disorder are often inappropriately sexually provocative or seductive (Criterion 2). This behavior not only is directed toward persons in whom the individual has a sexual or romantic interest but also occurs in a wide variety of social, occupational, and professional relationships beyond what is appropriate for the social context. Emotional expression may be shallow and rapidly shifting (Criterion 3). Individuals with this disorder consistently use physical appearance to draw attention to themselves (Criterion 4). They are overly concerned with impressing others by their appearance and expend an excessive amount of time, energy, and money on clothes and grooming. They may "fish for compliments" regarding appearance and may be easily and excessively upset by a critical comment about how they look or by a photograph that they regard as unflattering.

These individuals have a style of speech that is excessively impressionistic and lacking in detail (Criterion 5). Strong opinions are expressed with dramatic flair, but underlying reasons are usually vague and diffuse, without supporting facts and details. For example, an individual with histrionic personality disorder may comment that a certain individual is a wonderful human being, yet be unable to provide any specific examples of good qualities to support this opinion. Individuals with this disorder are characterized by self-dramatization, theatricality, and an exaggerated expression of emotion (Criterion 6). They may embarrass friends and acquaintances by an excessive public display of emotions (e.g., embracing casual acquaintances with excessive ardor, sobbing uncontrollably on minor

sentimental occasions, having temper tantrums). However, their emotions often seem to be turned on and off too quickly to be deeply felt, which may lead others to accuse the individual of faking these feelings.

Individuals with histrionic personality disorder have a high degree of suggestibility (Criterion 7). Their opinions and feelings are easily influenced by others and by current fads. They may be overly trusting, especially of strong authority figures whom they see as magically solving their problems. They have a tendency to play hunches and to adopt convictions quickly. Individuals with this disorder often consider relationships more intimate than they actually are, describing almost every acquaintance as "my dear, dear friend" or referring to physicians met only once or twice under professional circumstances by their first names (Criterion 8).

Associated Features Supporting Diagnosis

Individuals with histrionic personality disorder may have difficulty achieving emotional intimacy in romantic or sexual relationships. Without being aware of it, they often act out a role (e.g., "victim" or "princess") in their relationships to others. They may seek to control their partner through emotional manipulation or seductiveness on one level, while displaying a marked dependency on them at another level. Individuals with this disorder often have impaired relationships with same-sex friends because their sexually provocative interpersonal style may seem a threat to their friends' relationships. These individuals may also alienate friends with demands for constant attention. They often become depressed and upset when they are not the center of attention. They may crave novelty, stimulation, and excitement and have a tendency to become bored with their usual routine. These individuals are often intolerant of, or frustrated by, situations that involve delayed gratification, and their actions are often directed at obtaining immediate satisfaction. Although they often initiate a job or project with great enthusiasm, their interest may lag quickly. Longer-term relationships may be neglected to make way for the excitement of new relationships.

The actual risk of suicide is not known, but clinical experience suggests that individuals with this disorder are at increased risk for suicidal gestures and threats to get attention and coerce better caregiving. Histrionic personality disorder has been associated with higher rates of somatic symptom disorder, conversion disorder (functional neurological symptom disorder), and major depressive disorder. Borderline, narcissistic, antisocial, and dependent personality disorders often co-occur.

Prevalence

Data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions suggest a prevalence of histrionic personality of 1.84%.

Culture-Related Diagnostic Issues

Norms for interpersonal behavior, personal appearance, and emotional expressiveness vary widely across cultures, genders, and age groups. Before considering the various traits (e.g., emotionality, seductiveness, dramatic interpersonal style, novelty seeking, sociability, charm, impressionability, a tendency to somatization) to be evidence of histrionic personality disorder, it is important to evaluate whether they cause clinically significant impairment or distress.

Gender-Related Diagnostic Issues

In clinical settings, this disorder has been diagnosed more frequently in females; however, the sex ratio is not significantly different from the sex ratio of females within the respective clinical setting. In contrast, some studies using structured assessments report similar prevalence rates among males and females.

Differential Diagnosis

Other personality disorders and personality traits. Other personality disorders may be confused with histrionic personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to histrionic personality disorder, all can be diagnosed. Although borderline personality disorder can also be characterized by attention seeking, manipulative behavior, and rapidly shifting emotions, it is distinguished by self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and identity disturbance. Individuals with antisocial personality disorder and histrionic personality disorder share a tendency to be impulsive, superficial, excitement seeking, reckless, seductive, and manipulative, but persons with histrionic personality disorder tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behaviors. Individuals with histrionic personality disorder are manipulative to gain nurturance, whereas those with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification. Although individuals with narcissistic personality disorder also crave attention from others, they usually want praise for their "superiority," whereas individuals with histrionic personality disorder are willing to be viewed as fragile or dependent if this is instrumental in getting attention. Individuals with narcissistic personality disorder may exaggerate the intimacy of their relationships with other people, but they are more apt to emphasize the "VIP" status or wealth of their friends. In dependent personality disorder, the individual is excessively dependent on others for praise and guidance, but is without the flamboyant, exaggerated, emotional features of individuals with histrionic personality disorder.

Many individuals may display histrionic personality traits. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute histrionic personality disorder.

Personality change due to another medical condition. Histrionic personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are attributable to the effects of another medical condition on the central nervous system.

Substance use disorders. The disorder must also be distinguished from symptoms that may develop in association with persistent substance use.

Narcissistic Personality Disorder

Diagnostic Criteria **301.81 (F60.81)**

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.
5. Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations).

6. Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends).
7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of him or her.
9. Shows arrogant, haughty behaviors or attitudes.

Diagnostic Features

The essential feature of narcissistic personality disorder is a pervasive pattern of grandiosity, need for admiration, and lack of empathy that begins by early adulthood and is present in a variety of contexts.

Individuals with this disorder have a grandiose sense of self-importance (Criterion 1). They routinely overestimate their abilities and inflate their accomplishments, often appearing boastful and pretentious. They may blithely assume that others attribute the same value to their efforts and may be surprised when the praise they expect and feel they deserve is not forthcoming. Often implicit in the inflated judgments of their own accomplishments is an underestimation (devaluation) of the contributions of others. Individuals with narcissistic personality disorder are often preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love (Criterion 2). They may ruminate about "long overdue" admiration and privilege and compare themselves favorably with famous or privileged people.

Individuals with narcissistic personality disorder believe that they are superior, special, or unique and expect others to recognize them as such (Criterion 3). They may feel that they can only be understood by, and should only associate with, other people who are special or of high status and may attribute "unique," "perfect," or "gifted" qualities to those with whom they associate. Individuals with this disorder believe that their needs are special and beyond the ken of ordinary people. Their own self-esteem is enhanced (i.e., "mirrored") by the idealized value that they assign to those with whom they associate. They are likely to insist on having only the "top" person (doctor, lawyer, hairdresser, instructor) or being affiliated with the "best" institutions but may devalue the credentials of those who disappoint them.

Individuals with this disorder generally require excessive admiration (Criterion 4). Their self-esteem is almost invariably very fragile. They may be preoccupied with how well they are doing and how favorably they are regarded by others. This often takes the form of a need for constant attention and admiration. They may expect their arrival to be greeted with great fanfare and are astonished if others do not covet their possessions. They may constantly fish for compliments, often with great charm. A sense of entitlement is evident in these individuals' unreasonable expectation of especially favorable treatment (Criterion 5). They expect to be catered to and are puzzled or furious when this does not happen. For example, they may assume that they do not have to wait in line and that their priorities are so important that others should defer to them, and then get irritated when others fail to assist "in their very important work." This sense of entitlement, combined with a lack of sensitivity to the wants and needs of others, may result in the conscious or unwitting exploitation of others (Criterion 6). They expect to be given whatever they want or feel they need, no matter what it might mean to others. For example, these individuals may expect great dedication from others and may overwork them without regard for the impact on their lives. They tend to form friendships or romantic relationships only if the other person seems likely to advance their purposes or otherwise enhance their self-esteem. They often usurp special privileges and extra resources that they believe they deserve because they are so special.

Individuals with narcissistic personality disorder generally have a lack of empathy and have difficulty recognizing the desires, subjective experiences, and feelings of others (Criterion 7). They may assume that others are totally concerned about their welfare. They tend to discuss their own concerns in inappropriate and lengthy detail, while failing to recognize that others also have feelings and needs. They are often contemptuous and impatient with

others who talk about their own problems and concerns. These individuals may be oblivious to the hurt their remarks may inflict (e.g., exuberantly telling a former lover that "I am now in the relationship of a lifetime!"; boasting of health in front of someone who is sick). When recognized, the needs, desires, or feelings of others are likely to be viewed disparagingly as signs of weakness or vulnerability. Those who relate to individuals with narcissistic personality disorder typically find an emotional coldness and lack of reciprocal interest.

These individuals are often envious of others or believe that others are envious of them (Criterion 8). They may begrudge others their successes or possessions, feeling that they better deserve those achievements, admiration, or privileges. They may harshly devalue the contributions of others, particularly when those individuals have received acknowledgment or praise for their accomplishments. Arrogant, haughty behaviors characterize these individuals; they often display snobbish, disdainful, or patronizing attitudes (Criterion 9). For example, an individual with this disorder may complain about a clumsy waiter's "rudeness" or "stupidity" or conclude a medical evaluation with a condescending evaluation of the physician.

Associated Features Supporting Diagnosis

Vulnerability in self-esteem makes individuals with narcissistic personality disorder very sensitive to "injury" from criticism or defeat. Although they may not show it outwardly, criticism may haunt these individuals and may leave them feeling humiliated, degraded, hollow, and empty. They may react with disdain, rage, or defiant counterattack. Such experiences often lead to social withdrawal or an appearance of humility that may mask and protect the grandiosity. Interpersonal relations are typically impaired because of problems derived from entitlement, the need for admiration, and the relative disregard for the sensitivities of others. Though overweening ambition and confidence may lead to high achievement, performance may be disrupted because of intolerance of criticism or defeat. Sometimes vocational functioning can be very low, reflecting an unwillingness to take a risk in competitive or other situations in which defeat is possible. Sustained feelings of shame or humiliation and the attendant self-criticism may be associated with social withdrawal, depressed mood, and persistent depressive disorder (dysthymia) or major depressive disorder. In contrast, sustained periods of grandiosity may be associated with a hypomanic mood. Narcissistic personality disorder is also associated with anorexia nervosa and substance use disorders (especially related to cocaine). Histrionic, borderline, antisocial, and paranoid personality disorders may be associated with narcissistic personality disorder.

Prevalence

Prevalence estimates for narcissistic personality disorder, based on DSM-IV definitions, range from 0% to 6.2% in community samples.

Development and Course

Narcissistic traits may be particularly common in adolescents and do not necessarily indicate that the individual will go on to have narcissistic personality disorder. Individuals with narcissistic personality disorder may have special difficulties adjusting to the onset of physical and occupational limitations that are inherent in the aging process.

Gender-Related Diagnostic Issues

Of those diagnosed with narcissistic personality disorder, 50%–75% are male.

Differential Diagnosis

Other personality disorders and personality traits. Other personality disorders may be confused with narcissistic personality disorder because they have certain features in

common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to narcissistic personality disorder, all can be diagnosed. The most useful feature in discriminating narcissistic personality disorder from histrionic, antisocial, and borderline personality disorders, in which the interactive styles are coquettish, callous, and needy, respectively, is the grandiosity characteristic of narcissistic personality disorder. The relative stability of self-image as well as the relative lack of self-destructiveness, impulsivity, and abandonment concerns also help distinguish narcissistic personality disorder from borderline personality disorder. Excessive pride in achievements, a relative lack of emotional display, and disdain for others' sensitivities help distinguish narcissistic personality disorder from histrionic personality disorder. Although individuals with borderline, histrionic, and narcissistic personality disorders may require much attention, those with narcissistic personality disorder specifically need that attention to be admiring. Individuals with antisocial and narcissistic personality disorders share a tendency to be tough-minded, glib, superficial, exploitative, and unempathic. However, narcissistic personality disorder does not necessarily include characteristics of impulsivity, aggression, and deceit. In addition, individuals with antisocial personality disorder may not be as needy of the admiration and envy of others, and persons with narcissistic personality disorder usually lack the history of conduct disorder in childhood or criminal behavior in adulthood. In both narcissistic personality disorder and obsessive-compulsive personality disorder, the individual may profess a commitment to perfectionism and believe that others cannot do things as well. In contrast to the accompanying self-criticism of those with obsessive-compulsive personality disorder, individuals with narcissistic personality disorder are more likely to believe that they have achieved perfection. Suspiciousness and social withdrawal usually distinguish those with schizotypal or paranoid personality disorder from those with narcissistic personality disorder. When these qualities are present in individuals with narcissistic personality disorder, they derive primarily from fears of having imperfections or flaws revealed.

Many highly successful individuals display personality traits that might be considered narcissistic. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute narcissistic personality disorder.

Mania or hypomania. Grandiosity may emerge as part of manic or hypomanic episodes, but the association with mood change or functional impairments helps distinguish these episodes from narcissistic personality disorder.

Substance use disorders. Narcissistic personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use.

Cluster C Personality Disorders

Avoidant Personality Disorder

Diagnostic Criteria **301.82 (F60.6)**

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.

2. Is unwilling to get involved with people unless certain of being liked.
3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.
4. Is preoccupied with being criticized or rejected in social situations.
5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
6. Views self as socially inept, personally unappealing, or inferior to others.
7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

Diagnostic Features

The essential feature of avoidant personality disorder is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation that begins by early adulthood and is present in a variety of contexts.

Individuals with avoidant personality disorder avoid work activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection (Criterion 1). Offers of job promotions may be declined because the new responsibilities might result in criticism from co-workers. These individuals avoid making new friends unless they are certain they will be liked and accepted without criticism (Criterion 2). Until they pass stringent tests proving the contrary, other people are assumed to be critical and disapproving. Individuals with this disorder will not join in group activities unless there are repeated and generous offers of support and nurturance. Interpersonal intimacy is often difficult for these individuals, although they are able to establish intimate relationships when there is assurance of uncritical acceptance. They may act with restraint, have difficulty talking about themselves, and withhold intimate feelings for fear of being exposed, ridiculed, or shamed (Criterion 3).

Because individuals with this disorder are preoccupied with being criticized or rejected in social situations, they may have a markedly low threshold for detecting such reactions (Criterion 4). If someone is even slightly disapproving or critical, they may feel extremely hurt. They tend to be shy, quiet, inhibited, and "invisible" because of the fear that any attention would be degrading or rejecting. They expect that no matter what they say, others will see it as "wrong," and so they may say nothing at all. They react strongly to subtle cues that are suggestive of mockery or derision. Despite their longing to be active participants in social life, they fear placing their welfare in the hands of others. Individuals with avoidant personality disorder are inhibited in new interpersonal situations because they feel inadequate and have low self-esteem (Criterion 5). Doubts concerning social competence and personal appeal become especially manifest in settings involving interactions with strangers. These individuals believe themselves to be socially inept, personally unappealing, or inferior to others (Criterion 6). They are unusually reluctant to take personal risks or to engage in any new activities because these may prove embarrassing (Criterion 7). They are prone to exaggerate the potential dangers of ordinary situations, and a restricted lifestyle may result from their need for certainty and security. Someone with this disorder may cancel a job interview for fear of being embarrassed by not dressing appropriately. Marginal somatic symptoms or other problems may become the reason for avoiding new activities.

Associated Features Supporting Diagnosis

Individuals with avoidant personality disorder often vigilantly appraise the movements and expressions of those with whom they come into contact. Their fearful and tense demeanor may elicit ridicule and derision from others, which in turn confirms their self-doubts. These individuals are very anxious about the possibility that they will react to criticism with blushing or crying. They are described by others as being "shy," "timid,"

"lonely," and "isolated." The major problems associated with this disorder occur in social and occupational functioning. The low self-esteem and hypersensitivity to rejection are associated with restricted interpersonal contacts. These individuals may become relatively isolated and usually do not have a large social support network that can help them weather crises. They desire affection and acceptance and may fantasize about idealized relationships with others. The avoidant behaviors can also adversely affect occupational functioning because these individuals try to avoid the types of social situations that may be important for meeting the basic demands of the job or for advancement.

Other disorders that are commonly diagnosed with avoidant personality disorder include depressive, bipolar, and anxiety disorders, especially social anxiety disorder (social phobia). Avoidant personality disorder is often diagnosed with dependent personality disorder, because individuals with avoidant personality disorder become very attached to and dependent on those few other people with whom they are friends. Avoidant personality disorder also tends to be diagnosed with borderline personality disorder and with the Cluster A personality disorders (i.e., paranoid, schizoid, or schizotypal personality disorders).

Prevalence

Data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions suggest a prevalence of about 2.4% for avoidant personality disorder.

Development and Course

The avoidant behavior often starts in infancy or childhood with shyness, isolation, and fear of strangers and new situations. Although shyness in childhood is a common precursor of avoidant personality disorder, in most individuals it tends to gradually dissipate as they get older. In contrast, individuals who go on to develop avoidant personality disorder may become increasingly shy and avoidant during adolescence and early adulthood, when social relationships with new people become especially important. There is some evidence that in adults, avoidant personality disorder tends to become less evident or to remit with age. This diagnosis should be used with great caution in children and adolescents, for whom shy and avoidant behavior may be developmentally appropriate.

Culture-Related Diagnostic Issues

There may be variation in the degree to which different cultural and ethnic groups regard diffidence and avoidance as appropriate. Moreover, avoidant behavior may be the result of problems in acculturation following immigration.

Gender-Related Diagnostic Issues

Avoidant personality disorder appears to be equally frequent in males and females.

Differential Diagnosis

Anxiety disorders. There appears to be a great deal of overlap between avoidant personality disorder and social anxiety disorder (social phobia), so much so that they may be alternative conceptualizations of the same or similar conditions. Avoidance also characterizes both avoidant personality disorder and agoraphobia, and they often co-occur.

Other personality disorders and personality traits. Other personality disorders may be confused with avoidant personality disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to avoidant personality dis-

order, all can be diagnosed. Both avoidant personality disorder and dependent personality disorder are characterized by feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance. Although the primary focus of concern in avoidant personality disorder is avoidance of humiliation and rejection, in dependent personality disorder the focus is on being taken care of. However, avoidant personality disorder and dependent personality disorder are particularly likely to co-occur. Like avoidant personality disorder, schizoid personality disorder and schizotypal personality disorder are characterized by social isolation. However, individuals with avoidant personality disorder want to have relationships with others and feel their loneliness deeply, whereas those with schizoid or schizotypal personality disorder may be content with and even prefer their social isolation. Paranoid personality disorder and avoidant personality disorder are both characterized by a reluctance to confide in others. However, in avoidant personality disorder, this reluctance is attributable more to a fear of being embarrassed or being found inadequate than to a fear of others' malicious intent.

Many individuals display avoidant personality traits. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute avoidant personality disorder.

Personality change due to another medical condition. Avoidant personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are attributable to the effects of another medical condition on the central nervous system.

Substance use disorders. Avoidant personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use.

Dependent Personality Disorder

Diagnostic Criteria **301.6 (F60.7)**

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of his or her life.
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval. (**Note:** Do not include realistic fears of retribution.)
4. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
7. Urgently seeks another relationship as a source of care and support when a close relationship ends.
8. Is unrealistically preoccupied with fears of being left to take care of himself or herself.

Diagnostic Features

The essential feature of dependent personality disorder is a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation. This pattern begins by early adulthood and is present in a variety of contexts. The dependent

and submissive behaviors are designed to elicit caregiving and arise from a self-perception of being unable to function adequately without the help of others.

Individuals with dependent personality disorder have great difficulty making everyday decisions (e.g., what color shirt to wear to work or whether to carry an umbrella) without an excessive amount of advice and reassurance from others (Criterion 1). These individuals tend to be passive and to allow other people (often a single other person) to take the initiative and assume responsibility for most major areas of their lives (Criterion 2). Adults with this disorder typically depend on a parent or spouse to decide where they should live, what kind of job they should have, and which neighbors to befriend. Adolescents with this disorder may allow their parent(s) to decide what they should wear, with whom they should associate, how they should spend their free time, and what school or college they should attend. This need for others to assume responsibility goes beyond age-appropriate and situation-appropriate requests for assistance from others (e.g., the specific needs of children, elderly persons, and handicapped persons). Dependent personality disorder may occur in an individual who has a serious medical condition or disability, but in such cases the difficulty in taking responsibility must go beyond what would normally be associated with that condition or disability.

Because they fear losing support or approval, individuals with dependent personality disorder often have difficulty expressing disagreement with other individuals, especially those on whom they are dependent (Criterion 3). These individuals feel so unable to function alone that they will agree with things that they feel are wrong rather than risk losing the help of those to whom they look for guidance. They do not get appropriately angry at others whose support and nurturance they need for fear of alienating them. If the individual's concerns regarding the consequences of expressing disagreement are realistic (e.g., realistic fears of retribution from an abusive spouse), the behavior should not be considered to be evidence of dependent personality disorder.

Individuals with this disorder have difficulty initiating projects or doing things independently (Criterion 4). They lack self-confidence and believe that they need help to begin and carry through tasks. They will wait for others to start things because they believe that as a rule others can do them better. These individuals are convinced that they are incapable of functioning independently and present themselves as inept and requiring constant assistance. They are, however, likely to function adequately if given the assurance that someone else is supervising and approving. There may be a fear of becoming or appearing to be more competent, because they may believe that this will lead to abandonment. Because they rely on others to handle their problems, they often do not learn the skills of independent living, thus perpetuating dependency.

Individuals with dependent personality disorder may go to excessive lengths to obtain nurturance and support from others, even to the point of volunteering for unpleasant tasks if such behavior will bring the care they need (Criterion 5). They are willing to submit to what others want, even if the demands are unreasonable. Their need to maintain an important bond will often result in imbalanced or distorted relationships. They may make extraordinary self-sacrifices or tolerate verbal, physical, or sexual abuse. (It should be noted that this behavior should be considered evidence of dependent personality disorder only when it can clearly be established that other options are available to the individual.) Individuals with this disorder feel uncomfortable or helpless when alone, because of their exaggerated fears of being unable to care for themselves (Criterion 6). They will "tag along" with important others just to avoid being alone, even if they are not interested or involved in what is happening.

When a close relationship ends (e.g., a breakup with a lover; the death of a caregiver), individuals with dependent personality disorder may urgently seek another relationship to provide the care and support they need (Criterion 7). Their belief that they are unable to function in the absence of a close relationship motivates these individuals to become quickly and indiscriminately attached to another individual. Individuals with this disorder are often

preoccupied with fears of being left to care for themselves (Criterion 8). They see themselves as so totally dependent on the advice and help of an important other person that they worry about being abandoned by that person when there are no grounds to justify such fears. To be considered as evidence of this criterion, the fears must be excessive and unrealistic. For example, an elderly man with cancer who moves into his son's household for care is exhibiting dependent behavior that is appropriate given this person's life circumstances.

Associated Features Supporting Diagnosis

Individuals with dependent personality disorder are often characterized by pessimism and self-doubt, tend to belittle their abilities and assets, and may constantly refer to themselves as "stupid." They take criticism and disapproval as proof of their worthlessness and lose faith in themselves. They may seek overprotection and dominance from others. Occupational functioning may be impaired if independent initiative is required. They may avoid positions of responsibility and become anxious when faced with decisions. Social relations tend to be limited to those few people on whom the individual is dependent. There may be an increased risk of depressive disorders, anxiety disorders, and adjustment disorders. Dependent personality disorder often co-occurs with other personality disorders, especially borderline, avoidant, and histrionic personality disorders. Chronic physical illness or separation anxiety disorder in childhood or adolescence may predispose the individual to the development of this disorder.

Prevalence

Data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions yielded an estimated prevalence of dependent personality disorder of 0.49%, and dependent personality was estimated, based on a probability subsample from Part II of the National Comorbidity Survey Replication, to be 0.6%.

Development and Course

This diagnosis should be used with great caution, if at all, in children and adolescents, for whom dependent behavior may be developmentally appropriate.

Culture-Related Diagnostic Issues

The degree to which dependent behaviors are considered to be appropriate varies substantially across different age and sociocultural groups. Age and cultural factors need to be considered in evaluating the diagnostic threshold of each criterion. Dependent behavior should be considered characteristic of the disorder only when it is clearly in excess of the individual's cultural norms or reflects unrealistic concerns. An emphasis on passivity, politeness, and deferential treatment is characteristic of some societies and may be misinterpreted as traits of dependent personality disorder. Similarly, societies may differentially foster and discourage dependent behavior in males and females.

Gender-Related Diagnostic Issues

In clinical settings, dependent personality disorder has been diagnosed more frequently in females, although some studies report similar prevalence rates among males and females.

Differential Diagnosis

Other mental disorders and medical conditions. Dependent personality disorder must be distinguished from dependency arising as a consequence of other mental disorders (e.g., depressive disorders, panic disorder, agoraphobia) and as a result of other medical conditions.

Other personality disorders and personality traits. Other personality disorders may be confused with dependent personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to dependent personality disorder, all can be diagnosed. Although many personality disorders are characterized by dependent features, dependent personality disorder can be distinguished by its predominantly submissive, reactive, and clinging behavior. Both dependent personality disorder and borderline personality disorder are characterized by fear of abandonment; however, the individual with borderline personality disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with dependent personality disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support. Borderline personality disorder can further be distinguished from dependent personality disorder by a typical pattern of unstable and intense relationships. Individuals with histrionic personality disorder, like those with dependent personality disorder, have a strong need for reassurance and approval and may appear childlike and clinging. However, unlike dependent personality disorder, which is characterized by self-effacing and docile behavior, histrionic personality disorder is characterized by gregarious flamboyance with active demands for attention. Both dependent personality disorder and avoidant personality disorder are characterized by feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance; however, individuals with avoidant personality disorder have such a strong fear of humiliation and rejection that they withdraw until they are certain they will be accepted. In contrast, individuals with dependent personality disorder have a pattern of seeking and maintaining connections to important others, rather than avoiding and withdrawing from relationships.

Many individuals display dependent personality traits. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute dependent personality disorder.

Personality change due to another medical condition. Dependent personality disorder must be distinguished from personality change due to another medical condition, in which the traits that emerge are attributable to the effects of another medical condition on the central nervous system.

Substance use disorders. Dependent personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use.

Obsessive-Compulsive Personality Disorder

Diagnostic Criteria **301.4 (F60.5)**

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
2. Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met).
3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).
4. Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).

5. Is unable to discard worn-out or worthless objects even when they have no sentimental value.
6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.
7. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.
8. Shows rigidity and stubbornness.

Diagnostic Features

The essential feature of obsessive-compulsive personality disorder is a preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with obsessive-compulsive personality disorder attempt to maintain a sense of control through painstaking attention to rules, trivial details, procedures, lists, schedules, or form to the extent that the major point of the activity is lost (Criterion 1). They are excessively careful and prone to repetition, paying extraordinary attention to detail and repeatedly checking for possible mistakes. They are oblivious to the fact that other people tend to become very annoyed at the delays and inconveniences that result from this behavior. For example, when such individuals misplace a list of things to be done, they will spend an inordinate amount of time looking for the list rather than spending a few moments re-creating it from memory and proceeding to accomplish the tasks. Time is poorly allocated, and the most important tasks are left to the last moment. The perfectionism and self-imposed high standards of performance cause significant dysfunction and distress in these individuals. They may become so involved in making every detail of a project absolutely perfect that the project is never finished (Criterion 2). For example, the completion of a written report is delayed by numerous time-consuming rewrites that all come up short of "perfection." Deadlines are missed, and aspects of the individual's life that are not the current focus of activity may fall into disarray.

Individuals with obsessive-compulsive personality disorder display excessive devotion to work and productivity to the exclusion of leisure activities and friendships (Criterion 3). This behavior is not accounted for by economic necessity. They often feel that they do not have time to take an evening or a weekend day off to go on an outing or to just relax. They may keep postponing a pleasurable activity, such as a vacation, so that it may never occur. When they do take time for leisure activities or vacations, they are very uncomfortable unless they have taken along something to work on so they do not "waste time." There may be a great concentration on household chores (e.g., repeated excessive cleaning so that "one could eat off the floor"). If they spend time with friends, it is likely to be in some kind of formally organized activity (e.g., sports). Hobbies or recreational activities are approached as serious tasks requiring careful organization and hard work to master. The emphasis is on perfect performance. These individuals turn play into a structured task (e.g., correcting an infant for not putting rings on the post in the right order; telling a toddler to ride his or her tricycle in a straight line; turning a baseball game into a harsh "lesson").

Individuals with obsessive-compulsive personality disorder may be excessively conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (Criterion 4). They may force themselves and others to follow rigid moral principles and very strict standards of performance. They may also be mercilessly self-critical about their own mistakes. Individuals with this disorder are rigidly deferential to authority and rules and insist on quite literal compliance, with no rule bending for extenuating circumstances. For example, the individual will not lend a quarter to a friend who needs one to make a telephone call because "neither a borrower nor a lender be" or because it would be "bad" for

the person's character. These qualities should not be accounted for by the individual's cultural or religious identification.

Individuals with this disorder may be unable to discard worn-out or worthless objects, even when they have no sentimental value (Criterion 5). Often these individuals will admit to being "pack rats." They regard discarding objects as wasteful because "you never know when you might need something" and will become upset if someone tries to get rid of the things they have saved. Their spouses or roommates may complain about the amount of space taken up by old parts, magazines, broken appliances, and so on.

Individuals with obsessive-compulsive personality disorder are reluctant to delegate tasks or to work with others (Criterion 6). They stubbornly and unreasonably insist that everything be done their way and that people conform to their way of doing things. They often give very detailed instructions about how things should be done (e.g., there is one and only one way to mow the lawn, wash the dishes, build a doghouse) and are surprised and irritated if others suggest creative alternatives. At other times they may reject offers of help even when behind schedule because they believe no one else can do it right.

Individuals with this disorder may be miserly and stingy and maintain a standard of living far below what they can afford, believing that spending must be tightly controlled to provide for future catastrophes (Criterion 7). Obsessive-compulsive personality disorder is characterized by rigidity and stubbornness (Criterion 8). Individuals with this disorder are so concerned about having things done the one "correct" way that they have trouble going along with anyone else's ideas. These individuals plan ahead in meticulous detail and are unwilling to consider changes. Totally wrapped up in their own perspective, they have difficulty acknowledging the viewpoints of others. Friends and colleagues may become frustrated by this constant rigidity. Even when individuals with obsessive-compulsive personality disorder recognize that it may be in their interest to compromise, they may stubbornly refuse to do so, arguing that it is "the principle of the thing."

Associated Features Supporting Diagnosis

When rules and established procedures do not dictate the correct answer, decision making may become a time-consuming, often painful process. Individuals with obsessive-compulsive personality disorder may have such difficulty deciding which tasks take priority or what is the best way of doing some particular task that they may never get started on anything. They are prone to become upset or angry in situations in which they are not able to maintain control of their physical or interpersonal environment, although the anger is typically not expressed directly. For example, an individual may be angry when service in a restaurant is poor, but instead of complaining to the management, the individual ruminates about how much to leave as a tip. On other occasions, anger may be expressed with righteous indignation over a seemingly minor matter. Individuals with this disorder may be especially attentive to their relative status in dominance-submission relationships and may display excessive deference to an authority they respect and excessive resistance to authority they do not respect.

Individuals with this disorder usually express affection in a highly controlled or stilted fashion and may be very uncomfortable in the presence of others who are emotionally expressive. Their everyday relationships have a formal and serious quality, and they may be stiff in situations in which others would smile and be happy (e.g., greeting a lover at the airport). They carefully hold themselves back until they are sure that whatever they say will be perfect. They may be preoccupied with logic and intellect, and intolerant of affective behavior in others. They often have difficulty expressing tender feelings, rarely paying compliments. Individuals with this disorder may experience occupational difficulties and distress, particularly when confronted with new situations that demand flexibility and compromise.

Individuals with anxiety disorders, including generalized anxiety disorder, social anxiety disorder (social phobia), and specific phobias, and obsessive-compulsive disorder (OCD)

have an increased likelihood of having a personality disturbance that meets criteria for obsessive-compulsive personality disorder. Even so, it appears that the majority of individuals with OCD do not have a pattern of behavior that meets criteria for this personality disorder. Many of the features of obsessive-compulsive personality disorder overlap with "type A" personality characteristics (e.g., preoccupation with work, competitiveness, time urgency), and these features may be present in people at risk for myocardial infarction. There may be an association between obsessive-compulsive personality disorder and depressive and bipolar disorders and eating disorders.

Prevalence

Obsessive-compulsive personality disorder is one of the most prevalent personality disorders in the general population, with estimated prevalence ranging from 2.1% to 7.9%.

Culture-Related Diagnostic Issues

In assessing an individual for obsessive-compulsive personality disorder, the clinician should not include those behaviors that reflect habits, customs, or interpersonal styles that are culturally sanctioned by the individual's reference group. Certain cultures place substantial emphasis on work and productivity; the resulting behaviors in members of those societies need not be considered indications of obsessive-compulsive personality disorder.

Gender-Related Diagnostic Issues

In systematic studies, obsessive-compulsive personality disorder appears to be diagnosed about twice as often among males.

Differential Diagnosis

Obsessive-compulsive disorder. Despite the similarity in names, OCD is usually easily distinguished from obsessive-compulsive personality disorder by the presence of true obsessions and compulsions in OCD. When criteria for both obsessive-compulsive personality disorder and OCD are met, both diagnoses should be recorded.

Hoarding disorder. A diagnosis of hoarding disorder should be considered especially when hoarding is extreme (e.g., accumulated stacks of worthless objects present a fire hazard and make it difficult for others to walk through the house). When criteria for both obsessive-compulsive personality disorder and hoarding disorder are met, both diagnoses should be recorded.

Other personality disorders and personality traits. Other personality disorders may be confused with obsessive-compulsive personality disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to obsessive-compulsive personality disorder, all can be diagnosed. Individuals with narcissistic personality disorder may also profess a commitment to perfectionism and believe that others cannot do things as well, but these individuals are more likely to believe that they have achieved perfection, whereas those with obsessive-compulsive personality disorder are usually self-critical. Individuals with narcissistic or antisocial personality disorder lack generosity but will indulge themselves, whereas those with obsessive-compulsive personality disorder adopt a miserly spending style toward both self and others. Both schizoid personality disorder and obsessive-compulsive personality disorder may be characterized by an apparent formality and social detachment. In obsessive-compulsive personality disorder, this stems from discomfort with emotions and excessive devotion to work, whereas in schizoid personality disorder there is a fundamental lack of capacity for intimacy.

Obsessive-compulsive personality traits in moderation may be especially adaptive, particularly in situations that reward high performance. Only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress do they constitute obsessive-compulsive personality disorder.

Personality change due to another medical condition. Obsessive-compulsive personality disorder must be distinguished from personality change due to another medical condition, in which the traits emerge attributable to the effects of another medical condition on the central nervous system.

Substance use disorders. Obsessive-compulsive personality disorder must also be distinguished from symptoms that may develop in association with persistent substance use.

Other Personality Disorders

Personality Change Due to Another Medical Condition

Diagnostic Criteria **310.1 (F07.0)**

A. A persistent personality disturbance that represents a change from the individual's previous characteristic personality pattern.

   Note: In children, the disturbance involves a marked deviation from normal development or a significant change in the child's usual behavior patterns, lasting at least 1 year.

B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.

C. The disturbance is not better explained by another mental disorder (including another mental disorder due to another medical condition).

D. The disturbance does not occur exclusively during the course of a delirium.

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

Specify whether:

Labile type: If the predominant feature is affective lability.

Disinhibited type: If the predominant feature is poor impulse control as evidenced by sexual indiscretions, etc.

Aggressive type: If the predominant feature is aggressive behavior.

Apathetic type: If the predominant feature is marked apathy and indifference.

Paranoid type: If the predominant feature is suspiciousness or paranoid ideation.

Other type: If the presentation is not characterized by any of the above subtypes.

Combined type: If more than one feature predominates in the clinical picture.

Unspecified type

Coding note: Include the name of the other medical condition (e.g., 310.1 [F07.0] personality change due to temporal lobe epilepsy). The other medical condition should be coded and listed separately immediately before the personality disorder due to another medical condition (e.g., 345.40 [G40.209] temporal lobe epilepsy; 310.1 [F07.0] personality change due to temporal lobe epilepsy).

Subtypes

The particular personality change can be specified by indicating the symptom presentation that predominates in the clinical presentation.

Diagnostic Features

The essential feature of a personality change due to another medical condition is a persistent personality disturbance that is judged to be due to the direct pathophysiological effects of a medical condition. The personality disturbance represents a change from the individual's previous characteristic personality pattern. In children, this condition may be manifested as a marked deviation from normal development rather than as a change in a stable personality pattern (Criterion A). There must be evidence from the history, physical examination, or laboratory findings that the personality change is the direct physiological consequence of another medical condition (Criterion B). The diagnosis is not given if the disturbance is better explained by another mental disorder (Criterion C). The diagnosis is not given if the disturbance occurs exclusively during the course of a delirium (Criterion D). The disturbance must also cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E).

Common manifestations of the personality change include affective instability, poor impulse control, outbursts of aggression or rage grossly out of proportion to any precipitating psychosocial stressor, marked apathy, suspiciousness, or paranoid ideation. The phenomenology of the change is indicated using the subtypes listed in the criteria set. An individual with the disorder is often characterized by others as "not himself [or herself]." Although it shares the term "personality" with the other personality disorders, this diagnosis is distinct by virtue of its specific etiology, different phenomenology, and more variable onset and course.

The clinical presentation in a given individual may depend on the nature and localization of the pathological process. For example, injury to the frontal lobes may yield symptoms such as lack of judgment or foresight, facetiousness, disinhibition, and euphoria. Right hemisphere strokes have often been shown to evoke personality changes in association with unilateral spatial neglect, anosognosia (i.e., inability of the individual to recognize a bodily or functional deficit, such as the existence of hemiparesis), motor impersistence, and other neurological deficits.

Associated Features Supporting Diagnosis

A variety of neurological and other medical conditions may cause personality changes, including central nervous system neoplasms, head trauma, cerebrovascular disease, Huntington's disease, epilepsy, infectious conditions with central nervous system involvement (e.g., HIV), endocrine conditions (e.g., hypothyroidism, hypo- and hyperadrenocorticism), and autoimmune conditions with central nervous system involvement (e.g., systemic lupus erythematosus). The associated physical examination findings, laboratory findings, and patterns of prevalence and onset reflect those of the neurological or other medical condition involved.

Differential Diagnosis

Chronic medical conditions associated with pain and disability. Chronic medical conditions associated with pain and disability can also be associated with changes in personality. The diagnosis of personality change due to another medical condition is given only if a direct pathophysiological mechanism can be established. This diagnosis is not given if the change is due to a behavioral or psychological adjustment or response to another medical condition (e.g., dependent behaviors that result from a need for the assistance of others following a severe head trauma, cardiovascular disease, or dementia).

Delirium or major neurocognitive disorder. Personality change is a frequently associated feature of a delirium or major neurocognitive disorder. A separate diagnosis of personality change due to another medical condition is not given if the change occurs exclusively during the course of a delirium. However, the diagnosis of personality change due to another medical condition may be given in addition to the diagnosis of major neurocognitive disorder if the personality change is a prominent part of the clinical presentation.

Another mental disorder due to another medical condition. The diagnosis of personality change due to another medical condition is not given if the disturbance is better explained by another mental disorder due to another medical condition (e.g., depressive disorder due to brain tumor).

Substance use disorders. Personality changes may also occur in the context of substance use disorders, especially if the disorder is long-standing. The clinician should inquire carefully about the nature and extent of substance use. If the clinician wishes to indicate an etiological relationship between the personality change and substance use, the unspecified category for the specific substance (e.g., unspecified stimulant-related disorder) can be used.

Other mental disorders. Marked personality changes may also be an associated feature of other mental disorders (e.g., schizophrenia; delusional disorder; depressive and bipolar disorders; other specified and unspecified disruptive behavior, impulse-control, and conduct disorders; panic disorder). However, in these disorders, no specific physiological factor is judged to be etiologically related to the personality change.

Other personality disorders. Personality change due to another medical condition can be distinguished from a personality disorder by the requirement for a clinically significant change from baseline personality functioning and the presence of a specific etiological medical condition.

Other Specified Personality Disorder

301.89 (F60.89)

This category applies to presentations in which symptoms characteristic of a personality disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the personality disorders diagnostic class. The other specified personality disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific personality disorder. This is done by recording "other specified personality disorder" followed by the specific reason (e.g., "mixed personality features").

Unspecified Personality Disorder

301.9 (F60.9)

This category applies to presentations in which symptoms characteristic of a personality disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the personality disorders diagnostic class. The unspecified personality disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific personality disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis.

Paraphilic Disorders

Paraphilic disorders included in this manual are voyeuristic disorder (spying on others in private activities), exhibitionistic disorder (exposing the genitals), frotteuristic disorder (touching or rubbing against a nonconsenting individual), sexual masochism disorder (undergoing humiliation, bondage, or suffering), sexual sadism disorder (inflicting humiliation, bondage, or suffering), pedophilic disorder (sexual focus on children), fetishistic disorder (using nonliving objects or having a highly specific focus on nongenital body parts), and transvestic disorder (engaging in sexually arousing cross-dressing). These disorders have traditionally been selected for specific listing and assignment of explicit diagnostic criteria in DSM for two main reasons: they are relatively common, in relation to other paraphilic disorders, and some of them entail actions for their satisfaction that, because of their noxiousness or potential harm to others, are classed as criminal offenses. The eight listed disorders do not exhaust the list of possible paraphilic disorders. Many dozens of distinct paraphilias have been identified and named, and almost any of them could, by virtue of its negative consequences for the individual or for others, rise to the level of a paraphilic disorder. The diagnoses of the other specified and unspecified paraphilic disorders are therefore indispensable and will be required in many cases.

In this chapter, the order of presentation of the listed paraphilic disorders generally corresponds to common classification schemes for these conditions. The first group of disorders is based on *anomalous activity preferences.* These disorders are subdivided into *courtship disorders,* which resemble distorted components of human courtship behavior (voyeuristic disorder, exhibitionistic disorder, and frotteuristic disorder), and *algolagnic disorders,* which involve pain and suffering (sexual masochism disorder and sexual sadism disorder). The second group of disorders is based on *anomalous target preferences.* These disorders include one directed at other humans (pedophilic disorder) and two directed elsewhere (fetishistic disorder and transvestic disorder).

The term *paraphilia* denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners. In some circumstances, the criteria "intense and persistent" may be difficult to apply, such as in the assessment of persons who are very old or medically ill and who may not have "intense" sexual interests of any kind. In such circumstances, the term *paraphilia* may be defined as any sexual interest greater than or equal to normophilic sexual interests. There are also specific paraphilias that are generally better described as *preferential* sexual interests than as intense sexual interests.

Some paraphilias primarily concern the individual's erotic activities, and others primarily concern the individual's erotic targets. Examples of the former would include intense and persistent interests in spanking, whipping, cutting, binding, or strangulating another person, or an interest in these activities that equals or exceeds the individual's interest in copulation or equivalent interaction with another person. Examples of the latter would include intense or preferential sexual interest in children, corpses, or amputees (as a class), as well as intense or preferential interest in nonhuman animals, such as horses or dogs, or in inanimate objects, such as shoes or articles made of rubber.

A *paraphilic disorder* is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to

others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention.

In the diagnostic criteria set for each of the listed paraphilic disorders, Criterion A specifies the qualitative nature of the paraphilia (e.g., an erotic focus on children or on exposing the genitals to strangers), and Criterion B specifies the negative consequences of the paraphilia (i.e., distress, impairment, or harm to others). In keeping with the distinction between paraphilias and paraphilic disorders, the term *diagnosis* should be reserved for individuals who meet both Criteria A and B (i.e., individuals who have a paraphilic disorder). If an individual meets Criterion A but not Criterion B for a particular paraphilia—a circumstance that might arise when a benign paraphilia is discovered during the clinical investigation of some other condition—then the individual may be said to have that paraphilia but not a paraphilic disorder.

It is not rare for an individual to manifest two or more paraphilias. In some cases, the paraphilic foci are closely related and the connection between the paraphilias is intuitively comprehensible (e.g., foot fetishism and shoe fetishism). In other cases, the connection between the paraphilias is not obvious, and the presence of multiple paraphilias may be coincidental or else related to some generalized vulnerability to anomalies of psychosexual development. In any event, comorbid diagnoses of separate paraphilic disorders may be warranted if more than one paraphilia is causing suffering to the individual or harm to others.

Because of the two-pronged nature of diagnosing paraphilic disorders, clinician-rated or self-rated measures and severity assessments could address either the strength of the paraphilia itself or the seriousness of its consequences. Although the distress and impairment stipulated in the Criterion B are special in being the immediate or ultimate result of the paraphilia and not primarily the result of some other factor, the phenomena of reactive depression, anxiety, guilt, poor work history, impaired social relations, and so on are not unique in themselves and may be quantified with multipurpose measures of psychosocial functioning or quality of life.

The most widely applicable framework for assessing the strength of a paraphilia itself is one in which examinees' paraphilic sexual fantasies, urges, or behaviors are evaluated in relation to their normophilic sexual interests and behaviors. In a clinical interview or on self-administered questionnaires, examinees can be asked whether their paraphilic sexual fantasies, urges, or behaviors are weaker than, approximately equal to, or stronger than their normophilic sexual interests and behaviors. This same type of comparison can be, and usually is, employed in psychophysiological measures of sexual interest, such as penile plethysmography in males or viewing time in males and females.

Voyeuristic Disorder

Diagnostic Criteria **302.82 (F65.3)**

A. Over a period of at least 6 months, recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity, as manifested by fantasies, urges, or behaviors.
B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The individual experiencing the arousal and/or acting on the urges is at least 18 years of age.

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in voyeuristic behavior are restricted.

In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Specifiers

The "in full remission" specifier does not address the continued presence or absence of voyeurism per se, which may still be present after behaviors and distress have remitted.

Diagnostic Features

The diagnostic criteria for voyeuristic disorder can apply both to individuals who more or less freely disclose this paraphilic interest and to those who categorically deny any sexual arousal from observing an unsuspecting person who is naked, disrobing, or engaged in sexual activity despite substantial objective evidence to the contrary. If disclosing individuals also report distress or psychosocial problems because of their voyeuristic sexual preferences, they could be diagnosed with voyeuristic disorder. On the other hand, if they declare no distress, demonstrated by lack of anxiety, obsessions, guilt, or shame, about these paraphilic impulses and are not impaired in other important areas of functioning because of this sexual interest, and their psychiatric or legal histories indicate that they do not act on it, they could be ascertained as having voyeuristic sexual interest but should *not* be diagnosed with voyeuristic disorder.

Nondisclosing individuals include, for example, individuals known to have been spying repeatedly on unsuspecting persons who are naked or engaging in sexual activity on separate occasions but who deny any urges or fantasies concerning such sexual behavior, and who may report that known episodes of watching unsuspecting naked or sexually active persons were all accidental and nonsexual. Others may disclose past episodes of observing unsuspecting naked or sexually active persons but contest any significant or sustained sexual interest in this behavior. Since these individuals deny having fantasies or impulses about watching others nude or involved in sexual activity, it follows that they would also reject feeling subjectively distressed or socially impaired by such impulses. Despite their nondisclosing stance, such individuals may be diagnosed with voyeuristic disorder. Recurrent voyeuristic behavior constitutes sufficient support for voyeurism (by fulfilling Criterion A) and simultaneously demonstrates that this paraphilically motivated behavior is causing harm to others (by fulfilling Criterion B).

"Recurrent" spying on unsuspecting persons who are naked or engaging in sexual activity (i.e., multiple victims, each on a separate occasion) may, as a general rule, be interpreted as three or more victims on separate occasions. Fewer victims can be interpreted as satisfying this criterion if there were multiple occasions of watching the same victim or if there is corroborating evidence of a distinct or preferential interest in secret watching of naked or sexually active unsuspecting persons. Note that multiple victims, as suggested earlier, are a sufficient but not a necessary condition for diagnosis; the criteria may also be met if the individual acknowledges intense voyeuristic sexual interest.

The Criterion A time frame, indicating that signs or symptoms of voyeurism must have persisted for at least 6 months, should also be understood as a general guideline, not a strict threshold, to ensure that the sexual interest in secretly watching unsuspecting naked or sexually active others is not merely transient.

Adolescence and puberty generally increase sexual curiosity and activity. To alleviate the risk of pathologizing normative sexual interest and behavior during pubertal adolescence, the minimum age for the diagnosis of voyeuristic disorder is 18 years (Criterion C).

Prevalence

Voyeuristic acts are the most common of potentially law-breaking sexual behaviors. The population prevalence of voyeuristic disorder is unknown. However, based on voyeuris-

tic sexual acts in nonclinical samples, the highest possible lifetime prevalence for voyeuristic disorder is approximately 12% in males and 4% in females.

Development and Course

Adult males with voyeuristic disorder often first become aware of their sexual interest in secretly watching unsuspecting persons during adolescence. However, the minimum age for a diagnosis of voyeuristic disorder is 18 years because there is substantial difficulty in differentiating it from age-appropriate puberty-related sexual curiosity and activity. The persistence of voyeurism over time is unclear. Voyeuristic disorder, however, per definition requires one or more contributing factors that may change over time with or without treatment: subjective distress (e.g., guilt, shame, intense sexual frustration, loneliness), psychiatric morbidity, hypersexuality, and sexual impulsivity; psychosocial impairment; and/or the propensity to act out sexually by spying on unsuspecting naked or sexually active persons. Therefore, the course of voyeuristic disorder is likely to vary with age.

Risk and Prognostic Factors

Temperamental. Voyeurism is a necessary precondition for voyeuristic disorder; hence, risk factors for voyeurism should also increase the rate of voyeuristic disorder.

Environmental. Childhood sexual abuse, substance misuse, and sexual preoccupation/hypersexuality have been suggested as risk factors, although the causal relationship to voyeurism is uncertain and the specificity unclear.

Gender-Related Diagnostic Issues

Voyeuristic disorder is very uncommon among females in clinical settings, while the male-to-female ratio for single sexually arousing voyeuristic acts might be 3:1.

Differential Diagnosis

Conduct disorder and antisocial personality disorder. Conduct disorder in adolescents and antisocial personality disorder would be characterized by additional norm-breaking and antisocial behaviors, and the specific sexual interest in secretly watching unsuspecting others who are naked or engaging in sexual activity should be lacking.

Substance use disorders. Substance use disorders might involve single voyeuristic episodes by intoxicated individuals but should not involve the typical sexual interest in secretly watching unsuspecting persons being naked or engaging in sexual activity. Hence, recurrent voyeuristic sexual fantasies, urges, or behaviors that occur also when the individual is not intoxicated suggest that voyeuristic disorder might be present.

Comorbidity

Known comorbidities in voyeuristic disorder are largely based on research with males suspected of or convicted for acts involving the secret watching of unsuspecting nude or sexually active persons. Hence, these comorbidities might not apply to all individuals with voyeuristic disorder. Conditions that occur comorbidly with voyeuristic disorder include hypersexuality and other paraphilic disorders, particularly exhibitionistic disorder. Depressive, bipolar, anxiety, and substance use disorders; attention-deficit/hyperactivity disorder; and conduct disorder and antisocial personality disorder are also frequent comorbid conditions.

Exhibitionistic Disorder

Diagnostic Criteria **302.4 (F65.2)**

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person, as manifested by fantasies, urges, or behaviors.

B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify whether:

Sexually aroused by exposing genitals to prepubertal children

Sexually aroused by exposing genitals to physically mature individuals

Sexually aroused by exposing genitals to prepubertal children and to physically mature individuals

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to expose one's genitals are restricted.

In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Subtypes

The subtypes for exhibitionistic disorder are based on the age or physical maturity of the nonconsenting individuals to whom the individual prefers to expose his or her genitals. The nonconsenting individuals could be prepubescent children, adults, or both. This specifier should help draw adequate attention to characteristics of victims of individuals with exhibitionistic disorder to prevent co-occurring pedophilic disorder from being overlooked. However, indications that the individual with exhibitionistic disorder is sexually attracted to exposing his or her genitals to children should not preclude a diagnosis of pedophilic disorder.

Specifiers

The "in full remission" specifier does not address the continued presence or absence of exhibitionism per se, which may still be present after behaviors and distress have remitted.

Diagnostic Features

The diagnostic criteria for exhibitionistic disorder can apply both to individuals who more or less freely disclose this paraphilia and to those who categorically deny any sexual attraction to exposing their genitals to unsuspecting persons despite substantial objective evidence to the contrary. If disclosing individuals also report psychosocial difficulties because of their sexual attractions or preferences for exposing, they may be diagnosed with exhibitionistic disorder. In contrast, if they declare no distress (exemplified by absence of anxiety, obsessions, and guilt or shame about these paraphilic impulses) and are not impaired by this sexual interest in other important areas of functioning, and their self-reported, psychiatric, or legal histories indicate that they do not act on them, they could be ascertained as having exhibitionistic sexual interest but *not* be diagnosed with exhibitionistic disorder.

Examples of nondisclosing individuals include those who have exposed themselves repeatedly to unsuspecting persons on separate occasions but who deny any urges or fan-

tasies about such sexual behavior and who report that known episodes of exposure were all accidental and nonsexual. Others may disclose past episodes of sexual behavior involving genital exposure but refute any significant or sustained sexual interest in such behavior. Since these individuals deny having urges or fantasies involving genital exposure, it follows that they would also deny feeling subjectively distressed or socially impaired by such impulses. Such individuals may be diagnosed with exhibitionistic disorder despite their negative self-report. Recurrent exhibitionistic behavior constitutes sufficient support for exhibitionism (Criterion A) and simultaneously demonstrates that this paraphilically motivated behavior is causing harm to others (Criterion B).

"Recurrent" genital exposure to unsuspecting others (i.e., multiple victims, each on a separate occasion) may, as a general rule, be interpreted as three or more victims on separate occasions. Fewer victims can be interpreted as satisfying this criterion if there were multiple occasions of exposure to the same victim, or if there is corroborating evidence of a strong or preferential interest in genital exposure to unsuspecting persons. Note that multiple victims, as suggested earlier, are a sufficient but not a necessary condition for diagnosis, as criteria may be met by an individual's acknowledging intense exhibitionistic sexual interest with distress and/or impairment.

The Criterion A time frame, indicating that signs or symptoms of exhibitionism must have persisted for at least 6 months, should also be understood as a general guideline, not a strict threshold, to ensure that the sexual interest in exposing one's genitals to unsuspecting others is not merely transient. This might be expressed in clear evidence of repeated behaviors or distress over a nontransient period shorter than 6 months.

Prevalence

The prevalence of exhibitionistic disorder is unknown. However, based on exhibitionistic sexual acts in nonclinical or general populations, the highest possible prevalence for exhibitionistic disorder in the male population is 2%–4%. The prevalence of exhibitionistic disorder in females is even more uncertain but is generally believed to be much lower than in males.

Development and Course

Adult males with exhibitionistic disorder often report that they first became aware of sexual interest in exposing their genitals to unsuspecting persons during adolescence, at a somewhat later time than the typical development of normative sexual interest in women or men. Although there is no minimum age requirement for the diagnosis of exhibitionistic disorder, it may be difficult to differentiate exhibitionistic behaviors from age-appropriate sexual curiosity in adolescents. Whereas exhibitionistic impulses appear to emerge in adolescence or early adulthood, very little is known about persistence over time. By definition, exhibitionistic disorder requires one or more contributing factors, which may change over time with or without treatment; subjective distress (e.g., guilt, shame, intense sexual frustration, loneliness), mental disorder comorbidity, hypersexuality, and sexual impulsivity; psychosocial impairment; and/or the propensity to act out sexually by exposing the genitals to unsuspecting persons. Therefore, the course of exhibitionistic disorder is likely to vary with age. As with other sexual preferences, advancing age may be associated with decreasing exhibitionistic sexual preferences and behavior.

Risk and Prognostic Factors

Temperamental. Since exhibitionism is a necessary precondition for exhibitionistic disorder, risk factors for exhibitionism should also increase the rate of exhibitionistic disorder. Antisocial history, antisocial personality disorder, alcohol misuse, and pedophilic sexual preference might increase risk of sexual recidivism in exhibitionistic offenders.

Hence, antisocial personality disorder, alcohol use disorder, and pedophilic interest may be considered risk factors for exhibitionistic disorder in males with exhibitionistic sexual preferences.

Environmental. Childhood sexual and emotional abuse and sexual preoccupation/hypersexuality have been suggested as risk factors for exhibitionism, although the causal relationship to exhibitionism is uncertain and the specificity unclear.

Gender-Related Diagnostic Issues

Exhibitionistic disorder is highly unusual in females, whereas single sexually arousing exhibitionistic acts might occur up to half as often among women compared with men.

Functional Consequences of Exhibitionistic Disorder

The functional consequences of exhibitionistic disorder have not been addressed in research involving individuals who have not acted out sexually by exposing their genitals to unsuspecting strangers but who fulfill Criterion B by experiencing intense emotional distress over these preferences.

Differential Diagnosis

Potential differential diagnoses for exhibitionistic disorder sometimes occur also as comorbid disorders. Therefore, it is generally necessary to evaluate the evidence for exhibitionistic disorder and other possible conditions as separate questions.

Conduct disorder and antisocial personality disorder. Conduct disorder in adolescents and antisocial personality disorder would be characterized by additional norm-breaking and antisocial behaviors, and the specific sexual interest in exposing the genitals should be lacking.

Substance use disorders. Alcohol and substance use disorders might involve single exhibitionistic episodes by intoxicated individuals but should not involve the typical sexual interest in exposing the genitals to unsuspecting persons. Hence, recurrent exhibitionistic sexual fantasies, urges, or behaviors that occur also when the individual is not intoxicated suggest that exhibitionistic disorder might be present.

Comorbidity

Known comorbidities in exhibitionistic disorder are largely based on research with individuals (almost all males) convicted for criminal acts involving genital exposure to nonconsenting individuals. Hence, these comorbidities might not apply to all individuals who qualify for a diagnosis of exhibitionistic disorder. Conditions that occur comorbidly with exhibitionistic disorder at high rates include depressive, bipolar, anxiety, and substance use disorders; hypersexuality; attention-deficit/hyperactivity disorder; other paraphilic disorders; and antisocial personality disorder.

Frotteuristic Disorder

Diagnostic Criteria **302.89 (F65.81)**

A. Over a period of at least 6 months, recurrent and intense sexual arousal from touching or rubbing against a nonconsenting person, as manifested by fantasies, urges, or behaviors.

B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to touch or rub against a nonconsenting person are restricted.

In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Specifiers

The "in remission" specifier does not address the continued presence or absence of frotteurism per se, which may still be present after behaviors and distress have remitted.

Diagnostic Features

The diagnostic criteria for frotteuristic disorder can apply both to individuals who relatively freely disclose this paraphilia and to those who firmly deny any sexual attraction from touching or rubbing against a nonconsenting individual regardless of considerable objective evidence to the contrary. If disclosing individuals also report psychosocial impairment due to their sexual preferences for touching or rubbing against a nonconsenting individual, they could be diagnosed with frotteuristic disorder. In contrast, if they declare no distress (demonstrated by lack of anxiety, obsessions, guilt, or shame) about these paraphilic impulses and are not impaired in other important areas of functioning because of this sexual interest, and their psychiatric or legal histories indicate that they do not act on it, they could be ascertained as having frotteuristic sexual interest but should *not* be diagnosed with frotteuristic disorder.

Nondisclosing individuals include, for instance, individuals known to have been touching or rubbing against nonconsenting individuals on separate occasions but who contest any urges or fantasies concerning such sexual behavior. Such individuals may report that identified episodes of touching or rubbing against an unwilling individual were all unintentional and nonsexual. Others may disclose past episodes of touching or rubbing against nonconsenting individuals but contest any major or persistent sexual interest in this. Since these individuals deny having fantasies or impulses about touching or rubbing, they would consequently reject feeling distressed or psychosocially impaired by such impulses. Despite their nondisclosing position, such individuals may be diagnosed with frotteuristic disorder. *Recurrent* frotteuristic behavior constitutes satisfactory support for frotteurism (by fulfilling Criterion A) and concurrently demonstrates that this paraphilically motivated behavior is causing harm to others (by fulfilling Criterion B).

"Recurrent" touching or rubbing against a nonconsenting individual (i.e., multiple victims, each on a separate occasion) may, as a general rule, be interpreted as three or more victims on separate occasions. Fewer victims can be interpreted as satisfying this criterion if there were multiple occasions of touching or rubbing against the same unwilling individual, or corroborating evidence of a strong or preferential interest in touching or rubbing against nonconsenting individuals. Note that multiple victims are a sufficient but not a necessary condition for diagnosis; criteria may also be met if the individual acknowledges intense frotteuristic sexual interest with clinically significant distress and/or impairment.

The Criterion A time frame, indicating that signs or symptoms of frotteurism must persist for at least 6 months, should also be interpreted as a general guideline, not a strict threshold, to ensure that the sexual interest in touching or rubbing against a nonconsenting individual is not transient. Hence, the duration part of Criterion A may also be met if there is clear evidence of recurrent behaviors or distress over a shorter but nontransient time period.

Prevalence

Frotteuristic acts, including the uninvited sexual touching of or rubbing against another individual, may occur in up to 30% of adult males in the general population. Approximately

10%–14% of adult males seen in outpatient settings for paraphilic disorders and hypersexuality have a presentation that meets diagnostic criteria for frotteuristic disorder. Hence, whereas the population prevalence of frotteuristic *disorder* is unknown, it is not likely that it exceeds the rate found in selected clinical settings.

Development and Course

Adult males with frotteuristic disorder often report first becoming aware of their sexual interest in surreptitiously touching unsuspecting persons during late adolescence or emerging adulthood. However, children and adolescents may also touch or rub against unwilling others in the absence of a diagnosis of frotteuristic disorder. Although there is no minimum age for the diagnosis, frotteuristic disorder can be difficult to differentiate from conduct-disordered behavior without sexual motivation in individuals at younger ages. The persistence of frotteurism over time is unclear. Frotteuristic disorder, however, by definition requires one or more contributing factors that may change over time with or without treatment: subjective distress (e.g., guilt, shame, intense sexual frustration, loneliness); psychiatric morbidity; hypersexuality and sexual impulsivity; psychosocial impairment; and/or the propensity to act out sexually by touching or rubbing against unconsenting persons. Therefore, the course of frotteuristic disorder is likely to vary with age. As with other sexual preferences, advancing age may be associated with decreasing frotteuristic sexual preferences and behavior.

Risk and Prognostic Factors

Temperamental. Nonsexual antisocial behavior and sexual preoccupation/hypersexuality might be nonspecific risk factors, although the causal relationship to frotteurism is uncertain and the specificity unclear. However, frotteurism is a necessary precondition for frotteuristic disorder, so risk factors for frotteurism should also increase the rate of frotteuristic disorder.

Gender-Related Diagnostic Issues

There appear to be substantially fewer females with frotteuristic sexual preferences than males.

Differential Diagnosis

Conduct disorder and antisocial personality disorder. Conduct disorder in adolescents and antisocial personality disorder would be characterized by additional norm-breaking and antisocial behaviors, and the specific sexual interest in touching or rubbing against a nonconsenting individual should be lacking.

Substance use disorders. Substance use disorders, particularly those involving stimulants such as cocaine and amphetamines, might involve single frotteuristic episodes by intoxicated individuals but should not involve the typical sustained sexual interest in touching or rubbing against unsuspecting persons. Hence, recurrent frotteuristic sexual fantasies, urges, or behaviors that occur also when the individual is not intoxicated suggest that frotteuristic disorder might be present.

Comorbidity

Known comorbidities in frotteuristic disorder are largely based on research with males suspected of or convicted for criminal acts involving sexually motivated touching of or rubbing against a nonconsenting individual. Hence, these comorbidities might not apply to other individuals with a diagnosis of frotteuristic disorder based on subjective distress over their sexual interest. Conditions that occur comorbidly with frotteuristic disorder include hypersexuality and other paraphilic disorders, particularly exhibitionistic disorder and voyeuristic disorder. Conduct disorder, antisocial personality disorder, depressive

disorders, bipolar disorders, anxiety disorders, and substance use disorders also co-occur. Potential differential diagnoses for frotteuristic disorder sometimes occur also as comorbid disorders. Therefore, it is generally necessary to evaluate the evidence for frotteuristic disorder and possible comorbid conditions as separate questions.

Sexual Masochism Disorder

Diagnostic Criteria **302.83 (F65.51)**

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With asphyxiophilia: If the individual engages in the practice of achieving sexual arousal related to restriction of breathing.

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in masochistic sexual behaviors are restricted.

In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at last 5 years while in an uncontrolled environment.

Diagnostic Features

The diagnostic criteria for sexual masochism disorder are intended to apply to individuals who freely admit to having such paraphilic interests. Such individuals openly acknowledge intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors. If these individuals also report psychosocial difficulties because of their sexual attractions or preferences for being humiliated, beaten, bound, or otherwise made to suffer, they may be diagnosed with sexual masochism disorder. In contrast, if they declare no distress, exemplified by anxiety, obsessions, guilt, or shame, about these paraphilic impulses, and are not hampered by them in pursuing other personal goals, they could be ascertained as having masochistic sexual interest but should *not* be diagnosed with sexual masochism disorder.

The Criterion A time frame, indicating that the signs or symptoms of sexual masochism must have persisted for at least 6 months, should be understood as a general guideline, not a strict threshold, to ensure that the sexual interest in being humiliated, beaten, bound, or otherwise made to suffer is not merely transient. However, the disorder can be diagnosed in the context of a clearly sustained but shorter time period.

Associated Features Supporting Diagnosis

The extensive use of pornography involving the act of being humiliated, beaten, bound, or otherwise made to suffer is sometimes an associated feature of sexual masochism disorder.

Prevalence

The population prevalence of sexual masochism disorder is unknown. In Australia, it has been estimated that 2.2% of males and 1.3% of females had been involved in bondage and discipline, sadomasochism, or dominance and submission in the past 12 months.

Development and Course

Community individuals with paraphilias have reported a mean age at onset for masochism of 19.3 years, although earlier ages, including puberty and childhood, have also been reported for the onset of masochistic fantasies. Very little is known about persistence over time. Sexual masochism disorder per definition requires one or more contributing factors, which may change over time with or without treatment. These include subjective distress (e.g., guilt, shame, intense sexual frustration, loneliness), psychiatric morbidity, hypersexuality and sexual impulsivity, and psychosocial impairment. Therefore, the course of sexual masochism disorder is likely to vary with age. Advancing age is likely to have the same reducing effect on sexual preference involving sexual masochism as it has on other paraphilic or normophilic sexual behavior.

Functional Consequences of Sexual Masochism Disorder

The functional consequences of sexual masochism disorder are unknown. However, masochists are at risk of accidental death while practicing asphyxiophilia or other autoerotic procedures.

Differential Diagnosis

Many of the conditions that could be differential diagnoses for sexual masochism disorder (e.g., transvestic fetishism, sexual sadism disorder, hypersexuality, alcohol and substance use disorders) sometimes occur also as comorbid diagnoses. Therefore, it is necessary to carefully evaluate the evidence for sexual masochism disorder, keeping the possibility of other paraphilias or other mental disorders as part of the differential diagnosis. Sexual masochism in the absence of distress (i.e., no disorder) is also included in the differential, as individuals who conduct the behaviors may be satisfied with their masochistic interest.

Comorbidity

Known comorbidities with sexual masochism disorder are largely based on individuals in treatment. Disorders that occur comorbidly with sexual masochism disorder typically include other paraphilic disorders, such as transvestic fetishism.

Sexual Sadism Disorder

Diagnostic Criteria **302.84 (F65.52)**

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors.

B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in sadistic sexual behaviors are restricted.

In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Diagnostic Features

The diagnostic criteria for sexual sadism disorder are intended to apply both to individuals who freely admit to having such paraphilic interests and to those who deny any sexual interest in the physical or psychological suffering of another individual despite substantial objective evidence to the contrary. Individuals who openly acknowledge intense sexual interest in the physical or psychological suffering of others are referred to as "admitting individuals." If these individuals also report psychosocial difficulties because of their sexual attractions or preferences for the physical or psychological suffering of another individual, they may be diagnosed with sexual sadism disorder. In contrast, if admitting individuals declare no distress, exemplified by anxiety, obsessions, guilt, or shame, about these paraphilic impulses, and are not hampered by them in pursuing other goals, and their self-reported, psychiatric, or legal histories indicate that they do not act on them, then they could be ascertained as having sadistic sexual interest but they would *not* meet criteria for sexual sadism disorder.

Examples of individuals who deny any interest in the physical or psychological suffering of another individual include individuals known to have inflicted pain or suffering on multiple victims on separate occasions but who deny any urges or fantasies about such sexual behavior and who may further claim that known episodes of sexual assault were either unintentional or nonsexual. Others may admit past episodes of sexual behavior involving the infliction of pain or suffering on a nonconsenting individual but do not report any significant or sustained sexual interest in the physical or psychological suffering of another individual. Since these individuals deny having urges or fantasies involving sexual arousal to pain and suffering, it follows that they would also deny feeling subjectively distressed or socially impaired by such impulses. Such individuals may be diagnosed with sexual sadism disorder despite their negative self-report. Their recurrent behavior constitutes clinical support for the presence of the paraphilia of sexual sadism (by satisfying Criterion A) and simultaneously demonstrates that their paraphilically motivated behavior is causing clinically significant distress, harm, or risk of harm to others (satisfying Criterion B).

"Recurrent" sexual sadism involving nonconsenting others (i.e., multiple victims, each on a separate occasion) may, as general rule, be interpreted as three or more victims on separate occasions. Fewer victims can be interpreted as satisfying this criterion, if there are multiple instances of infliction of pain and suffering to the same victim, or if there is corroborating evidence of a strong or preferential interest in pain and suffering involving multiple victims. Note that multiple victims, as suggested earlier, are a sufficient but not a necessary condition for diagnosis, as the criteria may be met if the individual acknowledges intense sadistic sexual interest.

The Criterion A time frame, indicating that the signs or symptoms of sexual sadism must have persisted for at least 6 months, should also be understood as a general guideline, not a strict threshold, to ensure that the sexual interest in inflicting pain and suffering on nonconsenting victims is not merely transient. However, the diagnosis may be met if there is a clearly sustained but shorter period of sadistic behaviors.

Associated Features Supporting Diagnosis

The extensive use of pornography involving the infliction of pain and suffering is sometimes an associated feature of sexual sadism disorder.

Prevalence

The population prevalence of sexual sadism disorder is unknown and is largely based on individuals in forensic settings. Depending on the criteria for sexual sadism, prevalence varies widely, from 2% to 30%. Among civilly committed sexual offenders in the United States, less than 10% have sexual sadism. Among individuals who have committed sexually motivated homicides, rates of sexual sadism disorder range from 37% to 75%.

Development and Course

Individuals with sexual sadism in forensic samples are almost exclusively male, but a representative sample of the population in Australia reported that 2.2% of men and 1.3% of women said they had been involved in bondage and discipline, "sadomasochism," or dominance and submission in the previous year. Information on the development and course of sexual sadism disorder is extremely limited. One study reported that females became aware of their sadomasochistic interest as young adults, and another reported that the mean age at onset of sadism in a group of males was 19.4 years. Whereas sexual sadism per se is probably a lifelong characteristic, sexual sadism disorder may fluctuate according to the individual's subjective distress or his or her propensity to harm nonconsenting others. Advancing age is likely to have the same reducing effect on this disorder as it has on other paraphilic or normophilic sexual behavior.

Differential Diagnosis

Many of the conditions that could be differential diagnoses for sexual sadism disorder (e.g., antisocial personality disorder, sexual masochism disorder, hypersexuality, substance use disorders) sometimes occur also as comorbid diagnoses. Therefore, it is necessary to carefully evaluate the evidence for sexual sadism disorder, keeping the possibility of other paraphilias or mental disorders as part of the differential diagnosis. The majority of individuals who are active in community networks that practice sadistic and masochistic behaviors do not express any dissatisfaction with their sexual interests, and their behavior would not meet DSM-5 criteria for sexual sadism disorder. Sadistic interest, but not the disorder, may be considered in the differential diagnosis.

Comorbidity

Known comorbidities with sexual sadism disorder are largely based on individuals (almost all males) convicted for criminal acts involving sadistic acts against nonconsenting victims. Hence, these comorbidities might not apply to all individuals who never engaged in sadistic activity with a nonconsenting victim but who qualify for a diagnosis of sexual sadism disorder based on subjective distress over their sexual interest. Disorders that are commonly comorbid with sexual sadism disorder include other paraphilic disorders.

Pedophilic Disorder

Diagnostic Criteria **302.2 (F65.4)**

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).

B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

C. The individual is at least age 16 years and at least 5 years older than the child or children in Criterion A.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

Specify whether:

Exclusive type (attracted only to children)

Nonexclusive type

Specify if:

Sexually attracted to males
Sexually attracted to females
Sexually attracted to both

Specify if:

Limited to incest

Diagnostic Features

The diagnostic criteria for pedophilic disorder are intended to apply both to individuals who freely disclose this paraphilia and to individuals who deny any sexual attraction to prepubertal children (generally age 13 years or younger), despite substantial objective evidence to the contrary. Examples of disclosing this paraphilia include candidly acknowledging an intense sexual interest in children and indicating that sexual interest in children is greater than or equal to sexual interest in physically mature individuals. If individuals also complain that their sexual attractions or preferences for children are causing psychosocial difficulties, they may be diagnosed with pedophilic disorder. However, if they report an absence of feelings of guilt, shame, or anxiety about these impulses and are not functionally limited by their paraphilic impulses (according to self-report, objective assessment, or both), and their self-reported and legally recorded histories indicate that they have never acted on their impulses, then these individuals have a pedophilic sexual interest but not pedophilic disorder.

Examples of individuals who deny attraction to children include individuals who are known to have sexually approached multiple children on separate occasions but who deny any urges or fantasies about sexual behavior involving children, and who may further claim that the known episodes of physical contact were all unintentional and nonsexual. Other individuals may acknowledge past episodes of sexual behavior involving children but deny any significant or sustained sexual interest in children. Since these individuals may deny experiences impulses or fantasies involving children, they may also deny feeling subjectively distressed. Such individuals may still be diagnosed with pedophilic disorder despite the absence of self-reported distress, provided that there is evidence of recurrent behaviors persisting for 6 months (Criterion A) and evidence that the individual has acted on sexual urges or experienced interpersonal difficulties as a consequence of the disorder (Criterion B).

Presence of multiple victims, as discussed above, is sufficient but not necessary for diagnosis; that is, the individual can still meet Criterion A by merely acknowledging intense or preferential sexual interest in children.

The Criterion A clause, indicating that the signs or symptoms of pedophilia have persisted for 6 months or longer, is intended to ensure that the sexual attraction to children is not merely transient. However, the diagnosis may be made if there is clinical evidence of sustained persistence of the sexual attraction to children even if the 6-month duration cannot be precisely determined.

Associated Features Supporting Diagnosis

The extensive use of pornography depicting prepubescent children is a useful diagnostic indicator of pedophilic disorder. This is a specific instance of the general case that individuals are likely to choose the kind of pornography that corresponds to their sexual interests.

Prevalence

The population prevalence of pedophilic disorder is unknown. The highest possible prevalence for pedophilic disorder in the male population is approximately 3%–5%. The population prevalence of pedophilic disorder in females is even more uncertain, but it is likely a small fraction of the prevalence in males.

Development and Course

Adult males with pedophilic disorder may indicate that they become aware of strong or preferential sexual interest in children around the time of puberty—the same time frame in which males who later prefer physically mature partners became aware of their sexual interest in women or men. Attempting to diagnose pedophilic disorder at the age at which it first manifests is problematic because of the difficulty during adolescent development in differentiating it from age-appropriate sexual interest in peers or from sexual curiosity. Hence, Criterion C requires for diagnosis a minimum age of 16 years and at least 5 years older than the child or children in Criterion A.

Pedophilia per se appears to be a lifelong condition. Pedophilic disorder, however, necessarily includes other elements that may change over time with or without treatment: subjective distress (e.g., guilt, shame, intense sexual frustration, or feelings of isolation) or psychosocial impairment, or the propensity to act out sexually with children, or both. Therefore, the course of pedophilic disorder may fluctuate, increase, or decrease with age.

Adults with pedophilic disorder may report an awareness of sexual interest in children that preceded engaging in sexual behavior involving children or self-identification as a pedophile. Advanced age is as likely to similarly diminish the frequency of sexual behavior involving children as it does other paraphilically motivated and normophilic sexual behavior.

Risk and Prognostic Factors

Temperamental. There appears to be an interaction between pedophilia and antisociality, such that males with both traits are more likely to act out sexually with children. Thus, antisocial personality disorder may be considered a risk factor for pedophilic disorder in males with pedophilia.

Environmental. Adult males with pedophilia often report that they were sexually abused as children. It is unclear, however, whether this correlation reflects a causal influence of childhood sexual abuse on adult pedophilia.

Genetic and physiological. Since pedophilia is a necessary condition for pedophilic disorder, any factor that increases the probability of pedophilia also increases the risk of pedophilic disorder. There is some evidence that neurodevelopmental perturbation in utero increases the probability of development of a pedophilic interest.

Gender-Related Diagnostic Issues

Psychophysiological laboratory measures of sexual interest, which are sometimes useful in diagnosing pedophilic disorder in males, are not necessarily useful in diagnosing this disorder in females, even when an identical procedure (e.g., viewing time) or analogous procedures (e.g., penile plethysmography and vaginal photoplethysmography) are available.

Diagnostic Markers

Psychophysiological measures of sexual interest may sometimes be useful when an individual's history suggests the possible presence of pedophilic disorder but the individual denies strong or preferential attraction to children. The most thoroughly researched and longest used of such measures is *penile plethysmography*, although the sensitivity and specificity of diagnosis may vary from one site to another. *Viewing time,* using photographs of nude or minimally clothed persons as visual stimuli, is also used to diagnose pedophilic disorder, especially in combination with self-report measures. Mental health professionals in the United States, however, should be aware that possession of such visual stimuli, even for diagnostic purposes, may violate American law regarding possession of child pornography and leave the mental health professional susceptible to criminal prosecution.

Differential Diagnosis

Many of the conditions that could be differential diagnoses for pedophilic disorder also sometimes occur as comorbid diagnoses. It is therefore generally necessary to evaluate the evidence for pedophilic disorder and other possible conditions as separate questions.

Antisocial personality disorder. This disorder increases the likelihood that a person who is primarily attracted to the mature physique will approach a child, on one or a few occasions, on the basis of relative availability. The individual often shows other signs of this personality disorder, such as recurrent law-breaking.

Alcohol and substance use disorders. The disinhibiting effects of intoxication may also increase the likelihood that a person who is primarily attracted to the mature physique will sexually approach a child.

Obsessive-compulsive disorder. There are occasional individuals who complain about ego-dystonic thoughts and worries about possible attraction to children. Clinical interviewing usually reveals an absence of sexual thoughts about children during high states of sexual arousal (e.g., approaching orgasm during masturbation) and sometimes additional ego-dystonic, intrusive sexual ideas (e.g., concerns about homosexuality).

Comorbidity

Psychiatric comorbidity of pedophilic disorder includes substance use disorders; depressive, bipolar, and anxiety disorders; antisocial personality disorder; and other paraphilic disorders. However, findings on comorbid disorders are largely among individuals convicted for sexual offenses involving children (almost all males) and may not be generalizable to other individuals with pedophilic disorder (e.g., individuals who have never approached a child sexually but who qualify for the diagnosis of pedophilic disorder on the basis of subjective distress).

Fetishistic Disorder

Diagnostic Criteria **302.81 (F65.0)**

A. Over a period of at least 6 months, recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on nongenital body part(s), as manifested by fantasies, urges, or behaviors.
B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The fetish objects are not limited to articles of clothing used in cross-dressing (as in transvestic disorder) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator).

Specify:

Body part(s)
Nonliving object(s)
Other

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in fetishistic behaviors are restricted.

In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at least 5 years while in an uncontrolled environment.

Specifiers

Although individuals with fetishistic disorder may report intense and recurrent sexual arousal to inanimate objects or a specific body part, it is not unusual for non–mutually exclusive combinations of fetishes to occur. Thus, an individual may have fetishistic disorder associated with an inanimate object (e.g., female undergarments) or an exclusive focus on an intensely eroticized body part (e.g., feet, hair), or their fetishistic interest may meet criteria for various combinations of these specifiers (e.g., socks, shoes and feet).

Diagnostic Features

The paraphilic focus of fetishistic disorder involves the persistent and repetitive use of or dependence on nonliving objects or a highly specific focus on a (typically nongenital) body part as primary elements associated with sexual arousal (Criterion A). A diagnosis of fetishistic disorder must include clinically significant personal distress or psychosocial role impairment (Criterion B). Common fetish objects include female undergarments, male or female footwear, rubber articles, leather clothing, or other wearing apparel. Highly eroticized body parts associated with fetishistic disorder include feet, toes, and hair. It is not uncommon for sexualized fetishes to include both inanimate objects and body parts (e.g., dirty socks and feet), and for this reason the definition of fetishistic disorder now re-incorporates *partialism* (i.e., an exclusive focus on a body part) into its boundaries. Partialism, previously considered a paraphilia not otherwise specified disorder, had historically been subsumed in fetishism prior to DSM-III.

Many individuals who self-identify as fetishist practitioners do not necessarily report clinical impairment in association with their fetish-associated behaviors. Such individuals could be considered as having a fetish but not fetishistic disorder. A diagnosis of fetishistic disorder requires concurrent fulfillment of both the behaviors in Criterion A and the clinically significant distress or impairment in functioning noted in Criterion B.

Associated Features Supporting Diagnosis

Fetishistic disorder can be a multisensory experience, including holding, tasting, rubbing, inserting, or smelling the fetish object while masturbating, or preferring that a sexual partner wear or utilize a fetish object during sexual encounters. Some individuals may acquire extensive collections of highly desired fetish objects.

Development and Course

Usually paraphilias have an onset during puberty, but fetishes can develop prior to adolescence. Once established, fetishistic disorder tends to have a continuous course that fluctuates in intensity and frequency of urges or behavior.

Culture-Related Diagnostic Issues

Knowledge of and appropriate consideration for normative aspects of sexual behavior are important factors to explore to establish a clinical diagnosis of fetishistic disorder and to distinguish a clinical diagnosis from a socially acceptable sexual behavior.

Gender-Related Diagnostic Issues

Fetishistic disorder has not been systematically reported to occur in females. In clinical samples, fetishistic disorder is nearly exclusively reported in males.

Functional Consequences of Fetishistic Disorder

Typical impairments associated with fetishistic disorder include sexual dysfunction during romantic reciprocal relationships when the preferred fetish object or body part is

unavailable during foreplay or coitus. Some individuals with fetishistic disorder may prefer solitary sexual activity associated with their fetishistic preference(s) even while involved in a meaningful reciprocal and affectionate relationship.

Although fetishistic disorder is relatively uncommon among arrested sexual offenders with paraphilias, males with fetishistic disorder may steal and collect their particular fetishistic objects of desire. Such individuals have been arrested and charged for nonsexual antisocial behaviors (e.g., breaking and entering, theft, burglary) that are primarily motivated by the fetishistic disorder.

Differential Diagnosis

Transvestic disorder. The nearest diagnostic neighbor of fetishistic disorder is transvestic disorder. As noted in the diagnostic criteria, fetishistic disorder is not diagnosed when fetish objects are limited to articles of clothing exclusively worn during cross-dressing (as in transvestic disorder), or when the object is genitally stimulating because it has been designed for that purpose (e.g., a vibrator).

Sexual masochism disorder or other paraphilic disorders. Fetishes can co-occur with other paraphilic disorders, especially "sadomasochism" and transvestic disorder. When an individual fantasizes about or engages in "forced cross-dressing" and is primarily sexually aroused by the domination or humiliation associated with such fantasy or repetitive activity, the diagnosis of sexual masochism disorder should be made.

Fetishistic behavior without fetishistic disorder. Use of a fetish object for sexual arousal without any associated distress or psychosocial role impairment or other adverse consequence would not meet criteria for fetishistic disorder, as the threshold required by Criterion B would not be met. For example, an individual whose sexual partner either shares or can successfully incorporate his interest in caressing, smelling, or licking feet or toes as an important element of foreplay would not be diagnosed with fetishistic disorder; nor would an individual who prefers, and is not distressed or impaired by, solitary sexual behavior associated with wearing rubber garments or leather boots.

Comorbidity

Fetishistic disorder may co-occur with other paraphilic disorders as well as hypersexuality. Rarely, fetishistic disorder may be associated with neurological conditions.

Transvestic Disorder

Diagnostic Criteria **302.3 (F65.1)**

A. Over a period of at least 6 months, recurrent and intense sexual arousal from cross-dressing, as manifested by fantasies, urges, or behaviors.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With fetishism: If sexually aroused by fabrics, materials, or garments.

With autogynephilia: If sexually aroused by thoughts or images of self as female.

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to cross-dress are restricted.

In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at least 5 years while in an uncontrolled environment.

Specifiers

The presence of fetishism decreases the likelihood of gender dysphoria in men with transvestic disorder. The presence of autogynephilia increases the likelihood of gender dysphoria in men with transvestic disorder.

Diagnostic Features

The diagnosis of transvestic disorder does not apply to all individuals who dress as the opposite sex, even those who do so habitually. It applies to individuals whose cross-dressing or thoughts of cross-dressing are always or often accompanied by sexual excitement (Criterion A) and who are emotionally distressed by this pattern or feel it impairs social or interpersonal functioning (Criterion B). The cross-dressing may involve only one or two articles of clothing (e.g., for men, it may pertain only to women's undergarments), or it may involve dressing completely in the inner and outer garments of the other sex and (in men) may include the use of women's wigs and make-up. Transvestic disorder is nearly exclusively reported in males. Sexual arousal, in its most obvious form of penile erection, may co-occur with cross-dressing in various ways. In younger males, cross-dressing often leads to masturbation, following which any female clothing is removed. Older males often learn to avoid masturbating or doing anything to stimulate the penis so that the avoidance of ejaculation allows them to prolong their cross-dressing session. Males with female partners sometimes complete a cross-dressing session by having intercourse with their partners, and some have difficulty maintaining a sufficient erection for intercourse without cross-dressing (or private fantasies of cross-dressing).

Clinical assessment of distress or impairment, like clinical assessment of transvestic sexual arousal, is usually dependent on the individual's self-report. The pattern of behavior "purging and acquisition" often signifies the presence of distress in individuals with transvestic disorder. During this behavioral pattern, an individual (usually a man) who has spent a great deal of money on women's clothes and other apparel (e.g., shoes, wigs) discards the items (i.e., purges them) in an effort to overcome urges to cross-dress, and then begins acquiring a woman's wardrobe all over again.

Associated Features Supporting Diagnosis

Transvestic disorder in men is often accompanied by *autogynephilia* (i.e., a male's paraphilic tendency to be sexually aroused by the thought or image of himself as a woman). Autogynephilic fantasies and behaviors may focus on the idea of exhibiting female physiological functions (e.g., lactation, menstruation), engaging in stereotypically feminine behavior (e.g., knitting), or possessing female anatomy (e.g., breasts).

Prevalence

The prevalence of transvestic disorder is unknown. Transvestic disorder is rare in males and extremely rare in females. Fewer than 3% of males report having ever been sexually aroused by dressing in women's attire. The percentage of individuals who have cross-dressed with sexual arousal more than once or a few times in their lifetimes would be even lower. The majority of males with transvestic disorder identify as heterosexual, although some individuals have occasional sexual interaction with other males, especially when they are cross-dressed.

Development and Course

In males, the first signs of transvestic disorder may begin in childhood, in the form of strong fascination with a particular item of women's attire. Prior to puberty, cross-dressing produces generalized feelings of pleasurable excitement. With the arrival of puberty, dressing in women's clothes begins to elicit penile erection and, in some cases, leads di-

rectly to first ejaculation. In many cases, cross-dressing elicits less and less sexual excitement as the individual grows older; eventually it may produce no discernible penile response at all. The desire to cross-dress, at the same time, remains the same or grows even stronger. Individuals who report such a diminution of sexual response typically report that the sexual excitement of cross-dressing has been replaced by feelings of comfort or well-being.

In some cases, the course of transvestic disorder is continuous, and in others it is episodic. It is not rare for men with transvestic disorder to lose interest in cross-dressing when they first fall in love with a woman and begin a relationship, but such abatement usually proves temporary. When the desire to cross-dress returns, so does the associated distress.

Some cases of transvestic disorder progress to gender dysphoria. The males in these cases, who may be indistinguishable from others with transvestic disorder in adolescence or early childhood, gradually develop desires to remain in the female role for longer periods and to feminize their anatomy. The development of gender dysphoria is usually accompanied by a (self-reported) reduction or elimination of sexual arousal in association with cross-dressing.

The manifestation of transvestism in penile erection and stimulation, like the manifestation of other paraphilic as well as normophilic sexual interests, is most intense in adolescence and early adulthood. The severity of transvestic disorder is highest in adulthood, when the transvestic drives are most likely to conflict with performance in heterosexual intercourse and desires to marry and start a family. Middle-age and older men with a history of transvestism are less likely to present with transvestic disorder than with gender dysphoria.

Functional Consequences of Transvestic Disorder

Engaging in transvestic behaviors can interfere with, or detract from, heterosexual relationships. This can be a source of distress to men who wish to maintain conventional marriages or romantic partnerships with women.

Differential Diagnosis

Fetishistic disorder. This disorder may resemble transvestic disorder, in particular, in men with fetishism who put on women's undergarments while masturbating with them. Distinguishing transvestic disorder depends on the individual's specific thoughts during such activity (e.g., are there any ideas of being a woman, being like a woman, or being dressed as a woman?) and on the presence of other fetishes (e.g., soft, silky fabrics, whether these are used for garments or for something else).

Gender dysphoria. Individuals with transvestic disorder do not report an incongruence between their experienced gender and assigned gender nor a desire to be of the other gender; and they typically do not have a history of childhood cross-gender behaviors, which would be present in individuals with gender dysphoria. Individuals with a presentation that meets full criteria for transvestic disorder as well as gender dysphoria should be given both diagnoses.

Comorbidity

Transvestism (and thus transvestic disorder) is often found in association with other paraphilias. The most frequently co-occurring paraphilias are fetishism and masochism. One particularly dangerous form of masochism, *autoerotic asphyxia,* is associated with transvestism in a substantial proportion of fatal cases.

Other Specified Paraphilic Disorder

302.89 (F65.89)

This category applies to presentations in which symptoms characteristic of a paraphilic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the paraphilic disorders diagnostic class. The other specified paraphilic disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific paraphilic disorder. This is done by recording "other specified paraphilic disorder" followed by the specific reason (e.g., "zoophilia").

Examples of presentations that can be specified using the "other specified" designation include, but are not limited to, recurrent and intense sexual arousal involving *telephone scatologia* (obscene phone calls), *necrophilia* (corpses), *zoophilia* (animals), *coprophilia* (feces), *klismaphilia* (enemas), or *urophilia* (urine) that has been present for at least 6 months and causes marked distress or impairment in social, occupational, or other important areas of functioning. Other specified paraphilic disorder can be specified as in remission and/or as occurring in a controlled environment.

Unspecified Paraphilic Disorder

302.9 (F65.9)

This category applies to presentations in which symptoms characteristic of a paraphilic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the paraphilic disorders diagnostic class. The unspecified paraphilic disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific paraphilic disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis.

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Other Mental Disorders

Four disorders are included in this chapter: other specified mental disorder due to another medical condition; unspecified mental disorder due to another medical condition; other specified mental disorder; and unspecified mental disorder. This residual category applies to presentations in which symptoms characteristic of a mental disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any other mental disorder in DSM-5. For other specified and unspecified mental disorders due to another medical condition, it must be established that the disturbance is caused by the physiological effects of another medical condition. If other specified and unspecified mental disorders are due to another medical condition, it is necessary to code and list the medical condition first (e.g., 042 [B20] HIV disease), followed by the other specified or unspecified mental disorder (use appropriate code).

Other Specified Mental Disorder Due to Another Medical Condition

294.8 (F06.8)

This category applies to presentations in which symptoms characteristic of a mental disorder due to another medical condition that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any specific mental disorder attributable to another medical condition. The other specified mental disorder due to another medical condition category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific mental disorder attributable to another medical condition. This is done by recording the name of the disorder, with the specific etiological medical condition inserted in place of "another medical condition," followed by the specific symptomatic manifestation that does not meet the criteria for any specific mental disorder due to another medical condition. Furthermore, the diagnostic code for the specific medical condition must be listed immediately before the code for the other specified mental disorder due to another medical condition. For example, dissociative symptoms due to complex partial seizures would be coded and recorded as 345.40 (G40.209), complex partial seizures 294.8 (F06.8) other specified mental disorder due to complex partial seizures, dissociative symptoms.

An example of a presentation that can be specified using the "other specified" designation is the following:

Dissociative symptoms: This includes symptoms occurring, for example, in the context of complex partial seizures.

Unspecified Mental Disorder Due to Another Medical Condition

294.9 (F09)

This category applies to presentations in which symptoms characteristic of a mental disorder due to another medical condition that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any specific mental disorder due to another medical condition. The unspecified mental disorder due to another medical condition category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific mental disorder due to another medical condition, and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings). This is done by recording the name of the disorder, with the specific etiological medical condition inserted in place of "another medical condition." Furthermore, the diagnostic code for the specific medical condition must be listed immediately before the code for the unspecified mental disorder due to another medical condition. For example, dissociative symptoms due to complex partial seizures would be coded and recorded as 345.40 (G40.209) complex partial seizures, 294.9 (F06.9) unspecified mental disorder due to complex partial seizures.

Other Specified Mental Disorder

300.9 (F99)

This category applies to presentations in which symptoms characteristic of a mental disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any specific mental disorder. The other specified mental disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific mental disorder. This is done by recording "other specified mental disorder" followed by the specific reason.

Unspecified Mental Disorder

300.9 (F99)

This category applies to presentations in which symptoms characteristic of a mental disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any mental disorder. The unspecified mental disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific mental disorder, and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Medication-induced movement disorders are included in Section II because of their frequent importance in 1) the management by medication of mental disorders or other medical conditions and 2) the differential diagnosis of mental disorders (e.g., anxiety disorder versus neuroleptic-induced akathisia; malignant catatonia versus neuroleptic malignant syndrome). Although these movement disorders are labeled "medication induced," it is often difficult to establish the causal relationship between medication exposure and the development of the movement disorder, especially because some of these movement disorders also occur in the absence of medication exposure. The conditions and problems listed in this chapter are not mental disorders.

The term *neuroleptic* is becoming outdated because it highlights the propensity of antipsychotic medications to cause abnormal movements, and it is being replaced with the term *antipsychotic* in many contexts. Nevertheless, the term *neuroleptic* remains appropriate in this context. Although newer antipsychotic medications may be less likely to cause some medication-induced movement disorders, those disorders still occur. Neuroleptic medications include so-called conventional, "typical," or first-generation antipsychotic agents (e.g., chlorpromazine, haloperidol, fluphenazine); "atypical" or second-generation antipsychotic agents (e.g., clozapine, risperidone, olanzapine, quetiapine); certain dopamine receptor–blocking drugs used in the treatment of symptoms such as nausea and gastroparesis (e.g., prochlorperazine, promethazine, trimethobenzamide, thiethylperazine, metoclopramide); and amoxapine, which is marketed as an antidepressant.

Neuroleptic-Induced Parkinsonism
Other Medication-Induced Parkinsonism

332.1 (G21.11) Neuroleptic-Induced Parkinsonism
332.1 (G21.19) Other Medication-Induced Parkinsonism

Parkinsonian tremor, muscular rigidity, akinesia (i.e., loss of movement or difficulty initiating movement), or bradykinesia (i.e., slowing movement) developing within a few weeks of starting or raising the dosage of a medication (e.g., a neuroleptic) or after reducing the dosage of a medication used to treat extrapyramidal symptoms.

Neuroleptic Malignant Syndrome

333.92 (G21.0) Neuroleptic Malignant Syndrome

Although neuroleptic malignant syndrome is easily recognized in its classic full-blown form, it is often heterogeneous in onset, presentation, progression, and outcome. The clinical features described below are those considered most important in making the diagnosis of neuroleptic malignant syndrome based on consensus recommendations.

Diagnostic Features

Patients have generally been exposed to a dopamine antagonist within 72 hours prior to symptom development. Hyperthermia (>100.4°F or >38.0°C on at least two occasions, measured orally), associated with profuse diaphoresis, is a distinguishing feature of neuroleptic malignant syndrome, setting it apart from other neurological side effects of antipsychotic medications. Extreme elevations in temperature, reflecting a breakdown in central thermoregulation, are more likely to support the diagnosis of neuroleptic malignant syndrome. Generalized rigidity, described as "lead pipe" in its most severe form and usually unresponsive to antiparkinsonian agents, is a cardinal feature of the disorder and may be associated with other neurological symptoms (e.g., tremor, sialorrhea, akinesia, dystonia, trismus, myoclonus, dysarthria, dysphagia, rhabdomyolysis). Creatine kinase elevation of at least four times the upper limit of normal is commonly seen. Changes in mental status, characterized by delirium or altered consciousness ranging from stupor to coma, are often an early sign. Affected individuals may appear alert but dazed and unresponsive, consistent with catatonic stupor. Autonomic activation and instability—manifested by tachycardia (rate>25% above baseline), diaphoresis, blood pressure elevation (systolic or diastolic ≥25% above baseline) or fluctuation (≥20 mmHg diastolic change or ≥25 mmHg systolic change within 24 hours), urinary incontinence, and pallor—may be seen at any time but provide an early clue to the diagnosis. Tachypnea (rate >50% above baseline) is common, and respiratory distress—resulting from metabolic acidosis, hypermetabolism, chest wall restriction, aspiration pneumonia, or pulmonary emboli—can occur and lead to sudden respiratory arrest.

A workup, including laboratory investigation, to exclude other infectious, toxic, metabolic, and neuropsychiatric etiologies or complications is essential (see the section "Differential Diagnosis" later in this discussion). Although several laboratory abnormalities are associated with neuroleptic malignant syndrome, no single abnormality is specific to the diagnosis. Individuals with neuroleptic malignant syndrome may have leukocytosis, metabolic acidosis, hypoxia, decreased serum iron concentrations, and elevations in serum muscle enzymes and catecholamines. Findings from cerebrospinal fluid analysis and neuroimaging studies are generally normal, whereas electroencephalography shows generalized slowing. Autopsy findings in fatal cases have been nonspecific and variable, depending on complications.

Development and Course

Evidence from database studies suggests incidence rates for neuroleptic malignant syndrome of 0.01%–0.02% among individuals treated with antipsychotics. The temporal progression of signs and symptoms provides important clues to the diagnosis and prognosis of neuroleptic malignant syndrome. Alteration in mental status and other neurological signs typically precede systemic signs. The onset of symptoms varies from hours to days after drug initiation. Some cases develop within 24 hours after drug initiation, most within the first week, and virtually all cases within 30 days. Once the syndrome is diagnosed and oral antipsychotic drugs are discontinued, neuroleptic malignant syndrome is self-limited in most cases. The mean recovery time after drug discontinuation is 7–10 days, with most individuals recovering within 1 week and nearly all within 30 days. The duration may be prolonged when long-acting antipsychotics are implicated. There have been reports of individuals in whom residual neurological signs persisted for weeks after the acute hypermetabolic symptoms resolved. Total resolution of symptoms can be obtained in most cases of neuroleptic malignant syndrome; however, fatality rates of 10%–20% have been reported when the disorder is not recognized. Although many individuals do not experience a recurrence of neuroleptic malignant syndrome when rechallenged with antipsychotic medication, some do, especially when antipsychotics are reinstituted soon after an episode.

Risk and Prognostic Factors

Neuroleptic malignant syndrome is a potential risk in any individual after antipsychotic drug administration. It is not specific to any neuropsychiatric diagnosis and may occur in individuals without a diagnosable mental disorder who receive dopamine antagonists. Clinical, systemic, and metabolic factors associated with a heightened risk of neuroleptic malignant syndrome include agitation, exhaustion, dehydration, and iron deficiency. A prior episode associated with antipsychotics has been described in 15%–20% of index cases, suggesting underlying vulnerability in some patients; however, genetic findings based on neurotransmitter receptor polymorphisms have not been replicated consistently.

Nearly all dopamine antagonists have been associated with neuroleptic malignant syndrome, although high-potency antipsychotics pose a greater risk compared with low-potency agents and newer atypical antipsychotics. Partial or milder forms may be associated with newer antipsychotics, but neuroleptic malignant syndrome varies in severity even with older drugs. Dopamine antagonists used in medical settings (e.g., metoclopramide, prochlorperazine) have also been implicated. Parenteral administration routes, rapid titration rates, and higher total drug dosages have been associated with increased risk; however, neuroleptic malignant syndrome usually occurs within the therapeutic dosage range of antipsychotics.

Differential Diagnosis

Neuroleptic malignant syndrome must be distinguished from other serious neurological or medical conditions, including central nervous system infections, inflammatory or autoimmune conditions, status epilepticus, subcortical structural lesions, and systemic conditions (e.g., pheochromocytoma, thyrotoxicosis, tetanus, heat stroke).

Neuroleptic malignant syndrome also must be distinguished from similar syndromes resulting from the use of other substances or medications, such as serotonin syndrome; parkinsonian hyperthermia syndrome following abrupt discontinuation of dopamine agonists; alcohol or sedative withdrawal; malignant hyperthermia occurring during anesthesia; hyperthermia associated with abuse of stimulants and hallucinogens; and atropine poisoning from anticholinergics.

In rare instances, individuals with schizophrenia or a mood disorder may present with malignant catatonia, which may be indistinguishable from neuroleptic malignant syndrome. Some investigators consider neuroleptic malignant syndrome to be a drug-induced form of malignant catatonia.

Medication-Induced Acute Dystonia

333.72 (G24.02) Medication-Induced Acute Dystonia

Abnormal and prolonged contraction of the muscles of the eyes (oculogyric crisis), head, neck (torticollis or retrocollis), limbs, or trunk developing within a few days of starting or raising the dosage of a medication (such as a neuroleptic) or after reducing the dosage of a medication used to treat extrapyramidal symptoms.

Medication-Induced Acute Akathisia

333.99 (G25.71) Medication-Induced Acute Akathisia

Subjective complaints of restlessness, often accompanied by observed excessive movements (e.g., fidgety movements of the legs, rocking from foot to foot, pacing, inability to sit or stand still), developing within a few weeks of starting or raising the dosage of a medication (such as a neuroleptic) or after reducing the dosage of a medication used to treat extrapyramidal symptoms.

Tardive Dyskinesia

333.85 (G24.01) Tardive Dyskinesia
Involuntary athetoid or choreiform movements (lasting at least a few weeks) generally of the tongue, lower face and jaw, and extremities (but sometimes involving the pharyngeal, diaphragmatic, or trunk muscles) developing in association with the use of a neuroleptic medication for at least a few months.

Symptoms may develop after a shorter period of medication use in older persons. In some patients, movements of this type may appear after discontinuation, or after change or reduction in dosage, of neuroleptic medications, in which case the condition is called *neuroleptic withdrawal-emergent dyskinesia.* Because withdrawal-emergent dyskinesia is usually time-limited, lasting less than 4–8 weeks, dyskinesia that persists beyond this window is considered to be tardive dyskinesia.

Tardive Dystonia
Tardive Akathisia

333.72 (G24.09) Tardive Dystonia
333.99 (G25.71) Tardive Akathisia
Tardive syndrome involving other types of movement problems, such as dystonia or akathisia, which are distinguished by their late emergence in the course of treatment and their potential persistence for months to years, even in the face of neuroleptic discontinuation or dosage reduction.

Medication-Induced Postural Tremor

333.1 (G25.1) Medication-Induced Postural Tremor
Fine tremor (usually in the range of 8–12 Hz) occurring during attempts to maintain a posture and developing in association with the use of medication (e.g., lithium, antidepressants, valproate). This tremor is very similar to the tremor seen with anxiety, caffeine, and other stimulants.

Other Medication-Induced Movement Disorder

333.99 (G25.79) Other Medication-Induced Movement Disorder
This category is for medication-induced movement disorders not captured by any of the specific disorders listed above. Examples include 1) presentations resembling neuroleptic malignant syndrome that are associated with medications other than neuroleptics and 2) other medication-induced tardive conditions.

Antidepressant Discontinuation Syndrome

995.29 (T43.205A) Initial encounter

995.29 (T43.205D) Subsequent encounter

995.29 (T43.205S) Sequelae
Antidepressant discontinuation syndrome is a set of symptoms that can occur after an abrupt cessation (or marked reduction in dose) of an antidepressant medication that was taken continuously for at least 1 month. Symptoms generally begin within 2–4 days and typically include specific sensory, somatic, and cognitive-emotional manifestations. Fre-

quently reported sensory and somatic symptoms include flashes of lights, "electric shock" sensations, nausea, and hyperresponsivity to noises or lights. Nonspecific anxiety and feelings of dread may also be reported. Symptoms are alleviated by restarting the same medication or starting a different medication that has a similar mechanism of action—for example, discontinuation symptoms after withdrawal from a serotonin-norepinephrine reuptake inhibitor may be alleviated by starting a tricyclic antidepressant. To qualify as antidepressant discontinuation syndrome, the symptoms should not have been present before the antidepressant dosage was reduced and are not better explained by another mental disorder (e.g., manic or hypomanic episode, substance intoxication, substance withdrawal, somatic symptom disorder).

Diagnostic Features

Discontinuation symptoms may occur following treatment with tricyclic antidepressants (e.g., imipramine, amitriptyline, desipramine), serotonin reuptake inhibitors (e.g., fluoxetine, paroxetine, sertraline), and monoamine oxidase inhibitors (e.g., phenelzine, selegiline, pargyline). The incidence of this syndrome depends on the dosage and half-life of the medication being taken, as well as the rate at which the medication is tapered. Short-acting medications that are stopped abruptly rather than tapered gradually may pose the greatest risk. The short-acting selective serotonin reuptake inhibitor (SSRI) paroxetine is the agent most commonly associated with discontinuation symptoms, but such symptoms occur for all types of antidepressants.

Unlike withdrawal syndromes associated with opioids, alcohol, and other substances of abuse, antidepressant discontinuation syndrome has no pathognomonic symptoms. Instead, the symptoms tend to be vague and variable and typically begin 2–4 days after the last dose of the antidepressant. For SSRIs (e.g., paroxetine), symptoms such as dizziness, ringing in the ears, "electric shocks in the head," an inability to sleep, and acute anxiety are described. The antidepressant use prior to discontinuation must not have incurred hypomania or euphoria (i.e., there should be confidence that the discontinuation syndrome is not the result of fluctuations in mood stability associated with the previous treatment). The antidepressant discontinuation syndrome is based solely on pharmacological factors and is not related to the reinforcing effects of an antidepressant. Also, in the case of stimulant augmentation of an antidepressant, abrupt cessation may result in stimulant withdrawal symptoms (see "Stimulant Withdrawal" in the chapter "Substance-Related and Addictive Disorders") rather than the antidepressant discontinuation syndrome described here.

Prevalence

The prevalence of antidepressant discontinuation syndrome is unknown but is thought to vary according to the dosage prior to discontinuation, the half-life and receptor-binding affinity of the medication, and possibly the individual's genetically influenced rate of metabolism for this medication.

Course and Development

Because longitudinal studies are lacking, little is known about the clinical course of antidepressant discontinuation syndrome. Symptoms appear to abate over time with very gradual dosage reductions. After an episode, some individuals may prefer to resume medication indefinitely if tolerated.

Differential Diagnosis

The differential diagnosis of antidepressant discontinuation syndrome includes anxiety and depressive disorders, substance use disorders, and tolerance to medications.

Anxiety and depressive disorders. Discontinuation symptoms often resemble symptoms of a persistent anxiety disorder or a return of somatic symptoms of depression for which the medication was initially given.

Substance use disorders. Antidepressant discontinuation syndrome differs from substance withdrawal in that antidepressants themselves have no reinforcing or euphoric effects. The medication dosage has usually not been increased without the clinician's permission, and the individual generally does not engage in drug-seeking behavior to obtain additional medication. Criteria for a substance use disorder are not met.

Tolerance to medications. Tolerance and discontinuation symptoms can occur as a normal physiological response to stopping medication after a substantial duration of exposure. Most cases of medication tolerance can be managed through carefully controlled tapering.

Comorbidity

Typically, the individual was initially started on the medication for a major depressive disorder; the original symptoms may return during the discontinuation syndrome.

Other Adverse Effect of Medication

995.20 (T50.905A) Initial encounter

995.20 (T50.905D) Subsequent encounter

995.20 (T50.905S) Sequelae

This category is available for optional use by clinicians to code side effects of medication (other than movement symptoms) when these adverse effects become a main focus of clinical attention. Examples include severe hypotension, cardiac arrhythmias, and priapism.

Other Conditions That May Be a Focus of Clinical Attention

This discussion covers other conditions and problems that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis, or treatment of a patient's mental disorder. These conditions are presented with their corresponding codes from ICD-9-CM (usually V codes) and ICD-10-CM (usually Z codes). A condition or problem in this chapter may be coded if it is a reason for the current visit or helps to explain the need for a test, procedure, or treatment. Conditions and problems in this chapter may also be included in the medical record as useful information on circumstances that may affect the patient's care, regardless of their relevance to the current visit.

The conditions and problems listed in this chapter are not mental disorders. Their inclusion in DSM-5 is meant to draw attention to the scope of additional issues that may be encountered in routine clinical practice and to provide a systematic listing that may be useful to clinicians in documenting these issues.

Relational Problems

Key relationships, especially intimate adult partner relationships and parent/caregiver-child relationships, have a significant impact on the health of the individuals in these relationships. These relationships can be health promoting and protective, neutral, or detrimental to health outcomes. In the extreme, these close relationships can be associated with maltreatment or neglect, which has significant medical and psychological consequences for the affected individual. A relational problem may come to clinical attention either as the reason that the individual seeks health care or as a problem that affects the course, prognosis, or treatment of the individual's mental or other medical disorder.

Problems Related to Family Upbringing

V61.20 (Z62.820) Parent-Child Relational Problem

For this category, the term *parent* is used to refer to one of the child's primary caregivers, who may be a biological, adoptive, or foster parent or may be another relative (such as a grandparent) who fulfills a parental role for the child. This category should be used when the main focus of clinical attention is to address the quality of the parent-child relationship or when the quality of the parent-child relationship is affecting the course, prognosis, or treatment of a mental or other medical disorder. Typically, the parent-child relational problem is associated with impaired functioning in behavioral, cognitive, or affective domains. Examples of behavioral problems include inadequate parental control, supervision, and involvement with the child; parental overprotection; excessive parental pressure; arguments that escalate to threats of physical violence; and avoidance without resolution of problems. Cognitive problems may include negative attributions of the other's intentions, hostility toward or scapegoating of the other, and unwarranted feelings of estrangement. Affective problems may include feelings of sadness, apathy, or anger about the other individual in the relationship. Clinicians should take into account the developmental needs of the child and the cultural context.

V61.8 (Z62.891) Sibling Relational Problem
This category should be used when the focus of clinical attention is a pattern of interaction among siblings that is associated with significant impairment in individual or family functioning or with development of symptoms in one or more of the siblings, or when a sibling relational problem is affecting the course, prognosis, or treatment of a sibling's mental or other medical disorder. This category can be used for either children or adults if the focus is on the sibling relationship. Siblings in this context include full, half-, step-, foster, and adopted siblings.

V61.8 (Z62.29) Upbringing Away From Parents
This category should be used when the main focus of clinical attention pertains to issues regarding a child being raised away from the parents or when this separate upbringing affects the course, prognosis, or treatment of a mental or other medical disorder. The child could be one who is under state custody and placed in kin care or foster care. The child could also be one who is living in a nonparental relative's home, or with friends, but whose out-of-home placement is not mandated or sanctioned by the courts. Problems related to a child living in a group home or orphanage are also included. This category excludes issues related to V60.6 (Z59.3) children in boarding schools.

V61.29 (Z62.898) Child Affected by Parental Relationship Distress
This category should be used when the focus of clinical attention is the negative effects of parental relationship discord (e.g., high levels of conflict, distress, or disparagement) on a child in the family, including effects on the child's mental or other medical disorders.

Other Problems Related to Primary Support Group

V61.10 (Z63.0) Relationship Distress With Spouse or Intimate Partner
This category should be used when the major focus of the clinical contact is to address the quality of the intimate (spouse or partner) relationship or when the quality of that relationship is affecting the course, prognosis, or treatment of a mental or other medical disorder. Partners can be of the same or different genders. Typically, the relationship distress is associated with impaired functioning in behavioral, cognitive, or affective domains. Examples of behavioral problems include conflict resolution difficulty, withdrawal, and overinvolvement. Cognitive problems can manifest as chronic negative attributions of the other's intentions or dismissals of the partner's positive behaviors. Affective problems would include chronic sadness, apathy, and/or anger about the other partner.

> **Note:** This category excludes clinical encounters for V61.1x (Z69.1x) mental health services for spousal or partner abuse problems and V65.49 (Z70.9) sex counseling.

V61.03 (Z63.5) Disruption of Family by Separation or Divorce
This category should be used when partners in an intimate adult couple are living apart due to relationship problems or are in the process of divorce.

V61.8 (Z63.8) High Expressed Emotion Level Within Family
Expressed emotion is a construct used as a qualitative measure of the "amount" of emotion—in particular, hostility, emotional overinvolvement, and criticism directed toward a family member who is an identified patient—displayed in the family environment. This category should be used when a family's high level of expressed emotion is the focus of clinical attention or is affecting the course, prognosis, or treatment of a family member's mental or other medical disorder.

V62.82 (Z63.4) Uncomplicated Bereavement
This category can be used when the focus of clinical attention is a normal reaction to the death of a loved one. As part of their reaction to such a loss, some grieving individuals present with symptoms characteristic of a major depressive episode—for example, feel-

ings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss. The bereaved individual typically regards the depressed mood as "normal," although the individual may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of "normal" bereavement vary considerably among different cultural groups. Further guidance in distinguishing grief from a major depressive episode is provided in the criteria for major depressive episode.

Abuse and Neglect

Maltreatment by a family member (e.g., caregiver, intimate adult partner) or by a nonrelative can be the area of current clinical focus, or such maltreatment can be an important factor in the assessment and treatment of patients with mental or other medical disorders. Because of the legal implications of abuse and neglect, care should be used in assessing these conditions and assigning these codes. Having a past history of abuse or neglect can influence diagnosis and treatment response in a number of mental disorders, and may also be noted along with the diagnosis.

For the following categories, in addition to listings of the confirmed or suspected event of abuse or neglect, other codes are provided for use if the current clinical encounter is to provide mental health services to either the victim or the perpetrator of the abuse or neglect. A separate code is also provided for designating a past history of abuse or neglect.

Coding Note for ICD-10-CM Abuse and Neglect Conditions
For T codes only, the 7th character should be coded as follows:

> **A (initial encounter)**—Use while the patient is receiving active treatment for the condition (e.g., surgical treatment, emergency department encounter, evaluation and treatment by a new clinician); or
> **D (subsequent encounter)**—Use for encounters after the patient has received active treatment for the condition and when he or she is receiving routine care for the condition during the healing or recovery phase (e.g., cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow-up visits).

Child Maltreatment and Neglect Problems

Child Physical Abuse

Child physical abuse is nonaccidental physical injury to a child—ranging from minor bruises to severe fractures or death—occurring as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or any other method that is inflicted by a parent, caregiver, or other individual who has responsibility for the child. Such injury is considered abuse regardless of whether the caregiver intended to hurt the child. Physical discipline, such as spanking or paddling, is not considered abuse as long as it is reasonable and causes no bodily injury to the child.

Child Physical Abuse, Confirmed

995.54 (T74.12XA) Initial encounter

995.54 (T74.12XD) Subsequent encounter

Child Physical Abuse, Suspected

995.54 (T76.12XA) Initial encounter

995.54 (T76.12XD) Subsequent encounter

Other Circumstances Related to Child Physical Abuse

V61.21 (Z69.010) Encounter for mental health services for victim of child abuse by parent

V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child abuse

V15.41 (Z62.810) Personal history (past history) of physical abuse in childhood

V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child abuse

V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child abuse

Child Sexual Abuse

Child sexual abuse encompasses any sexual act involving a child that is intended to provide sexual gratification to a parent, caregiver, or other individual who has responsibility for the child. Sexual abuse includes activities such as fondling a child's genitals, penetration, incest, rape, sodomy, and indecent exposure. Sexual abuse also includes noncontact exploitation of a child by a parent or caregiver—for example, forcing, tricking, enticing, threatening, or pressuring a child to participate in acts for the sexual gratification of others, without direct physical contact between child and abuser.

Child Sexual Abuse, Confirmed

995.53 (T74.22XA) Initial encounter

995.53 (T74.22XD) Subsequent encounter

Child Sexual Abuse, Suspected

995.53 (T76.22XA) Initial encounter

995.53 (T76.22XD) Subsequent encounter

Other Circumstances Related to Child Sexual Abuse

V61.21 (Z69.010) Encounter for mental health services for victim of child sexual abuse by parent

V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child sexual abuse

V15.41 (Z62.810) Personal history (past history) of sexual abuse in childhood

V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child sexual abuse

V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child sexual abuse

Child Neglect

Child neglect is defined as any confirmed or suspected egregious act or omission by a child's parent or other caregiver that deprives the child of basic age-appropriate needs and thereby results, or has reasonable potential to result, in physical or psychological harm to the child. Child neglect encompasses abandonment; lack of appropriate supervision; failure to attend to necessary emotional or psychological needs; and failure to provide necessary education, medical care, nourishment, shelter, and/or clothing.

Child Neglect, Confirmed

995.52 (T74.02XA) Initial encounter

995.52 (T74.02XD) Subsequent encounter

Child Neglect, Suspected

995.52 (T76.02XA) Initial encounter

995.52 (T76.02XD) Subsequent encounter

Other Circumstances Related to Child Neglect

V61.21 (Z69.010) Encounter for mental health services for victim of child neglect by parent

V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child neglect

V15.42 (Z62.812) Personal history (past history) of neglect in childhood

V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child neglect

V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child neglect

Child Psychological Abuse

Child psychological abuse is nonaccidental verbal or symbolic acts by a child's parent or caregiver that result, or have reasonable potential to result, in significant psychological harm to the child. (Physical and sexual abusive acts are not included in this category.) Examples of psychological abuse of a child include berating, disparaging, or humiliating the child; threatening the child; harming/abandoning—or indicating that the alleged offender will harm/abandon—people or things that the child cares about; confining the child (as by tying a child's arms or legs together or binding a child to furniture or another object, or confining a child to a small enclosed area [e.g., a closet]); egregious scapegoating of the child; coercing the child to inflict pain on himself or herself; and disciplining the child excessively (i.e., at an extremely high frequency or duration, even if not at a level of physical abuse) through physical or nonphysical means.

Child Psychological Abuse, Confirmed

995.51 (T74.32XA) Initial encounter

995.51 (T74.32XD) Subsequent encounter

Child Psychological Abuse, Suspected

995.51 (T76.32XA) Initial encounter

995.51 (T76.32XD) Subsequent encounter

Other Circumstances Related to Child Psychological Abuse

V61.21 (Z69.010) Encounter for mental health services for victim of child psychological abuse by parent

V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child psychological abuse

V15.42 (Z62.811) Personal history (past history) of psychological abuse in childhood

V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child psychological abuse

V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child psychological abuse

Adult Maltreatment and Neglect Problems

Spouse or Partner Violence, Physical

This category should be used when nonaccidental acts of physical force that result, or have reasonable potential to result, in physical harm to an intimate partner or that evoke significant fear in the partner have occurred during the past year. Nonaccidental acts of physical force include shoving, slapping, hair pulling, pinching, restraining, shaking, throwing, biting, kicking, hitting with the fist or an object, burning, poisoning, applying force to the throat, cutting off the air supply, holding the head under water, and using a weapon. Acts for the purpose of physically protecting oneself or one's partner are excluded.

Spouse or Partner Violence, Physical, Confirmed

995.81 (T74.11XA) Initial encounter

995.81 (T74.11XD) Subsequent encounter

Spouse or Partner Violence, Physical, Suspected

995.81 (T76.11XA) Initial encounter

995.81 (T76.11XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Violence, Physical

V61.11 (Z69.11) Encounter for mental health services for victim of spouse or partner violence, physical

V15.41 (Z91.410) Personal history (past history) of spouse or partner violence, physical

V61.12 (Z69.12) Encounter for mental health services for perpetrator of spouse or partner violence, physical

Spouse or Partner Violence, Sexual

This category should be used when forced or coerced sexual acts with an intimate partner have occurred during the past year. Sexual violence may involve the use of physical force or psychological coercion to compel the partner to engage in a sexual act against his or her will, whether or not the act is completed. Also included in this category are sexual acts with an intimate partner who is unable to consent.

Spouse or Partner Violence, Sexual, Confirmed

995.83 (T74.21XA) Initial encounter

995.83 (T74.21XD) Subsequent encounter

Spouse or Partner Violence, Sexual, Suspected

995.83 (T76.21XA) Initial encounter

995.83 (T76.21XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Violence, Sexual

V61.11 (Z69.81) Encounter for mental health services for victim of spouse or partner violence, sexual

V15.41 (Z91.410) Personal history (past history) of spouse or partner violence, sexual

V61.12 (Z69.12) Encounter for mental health services for perpetrator of spouse or partner violence, sexual

Spouse or Partner Neglect

Partner neglect is any egregious act or omission in the past year by one partner that deprives a dependent partner of basic needs and thereby results, or has reasonable potential to result, in physical or psychological harm to the dependent partner. This category is used in the context of relationships in which one partner is extremely dependent on the other partner for care or for assistance in navigating ordinary daily activities—for example, a partner who is incapable of self-care owing to substantial physical, psychological/intellectual, or cultural limitations (e.g., inability to communicate with others and manage everyday activities due to living in a foreign culture).

Spouse or Partner Neglect, Confirmed

995.85 (T74.01XA) Initial encounter

995.85 (T74.01XD) Subsequent encounter

Spouse or Partner Neglect, Suspected

995.85 (T76.01XA) Initial encounter

995.85 (T76.01XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Neglect

V61.11 (Z69.11) Encounter for mental health services for victim of spouse or partner neglect

V15.42 (Z91.412) Personal history (past history) of spouse or partner neglect

V61.12 (Z69.12) Encounter for mental health services for perpetrator of spouse or partner neglect

Spouse or Partner Abuse, Psychological

Partner psychological abuse encompasses nonaccidental verbal or symbolic acts by one partner that result, or have reasonable potential to result, in significant harm to the other partner. This category should be used when such psychological abuse has occurred during the past year. Acts of psychological abuse include berating or humiliating the victim; interrogating the victim; restricting the victim's ability to come and go freely; obstructing the victim's access to assistance (e.g., law enforcement; legal, protective, or medical resources); threatening the victim with physical harm or sexual assault; harming, or threatening to harm, people or things that the victim cares about; unwarranted restriction of the victim's access to or use of economic resources; isolating the victim from family, friends, or social support resources; stalking the victim; and trying to make the victim think that he or she is crazy.

Spouse or Partner Abuse, Psychological, Confirmed

995.82 (T74.31XA) Initial encounter

995.82 (T74.31XD) Subsequent encounter

Spouse or Partner Abuse, Psychological, Suspected

995.82 (T76.31XA) Initial encounter

995.82 (T76.31XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Abuse, Psychological

V61.11 (Z69.11) Encounter for mental health services for victim of spouse or partner psychological abuse

V15.42 (Z91.411) Personal history (past history) of spouse or partner psychological abuse

V61.12 (Z69.12) Encounter for mental health services for perpetrator of spouse or partner psychological abuse

Adult Abuse by Nonspouse or Nonpartner

These categories should be used when an adult has been abused by another adult who is not an intimate partner. Such maltreatment may involve acts of physical, sexual, or emotional abuse. Examples of adult abuse include nonaccidental acts of physical force (e.g., pushing/shoving, scratching, slapping, throwing something that could hurt, punching, biting) that have resulted—or have reasonable potential to result—in physical harm or have caused significant fear; forced or coerced sexual acts; and verbal or symbolic acts with the potential to cause psychological harm (e.g., berating or humiliating the person; interrogating the person; restricting the person's ability to come and go freely; obstructing the person's access to assistance; threatening the person; harming or threatening to harm people or things that the person cares about; restricting the person's access to or use of economic resources; isolating the person from family, friends, or social support resources; stalking the person; trying to make the person think that he or she is crazy). Acts for the purpose of physically protecting oneself or the other person are excluded.

Adult Physical Abuse by Nonspouse or Nonpartner, Confirmed

995.81 (T74.11XA) Initial encounter

995.81 (T74.11XD) Subsequent encounter

Adult Physical Abuse by Nonspouse or Nonpartner, Suspected

995.81 (T76.11XA) Initial encounter

995.81 (T76.11XD) Subsequent encounter

Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed

995.83 (T74.21XA) Initial encounter

995.83 (T74.21XD) Subsequent encounter

Adult Sexual Abuse by Nonspouse or Nonpartner, Suspected

995.83 (T76.21XA) Initial encounter

995.83 (T76.21XD) Subsequent encounter

Adult Psychological Abuse by Nonspouse or Nonpartner, Confirmed

995.82 (T74.31XA) Initial encounter

995.82 (T74.31XD) Subsequent encounter

Adult Psychological Abuse by Nonspouse or Nonpartner, Suspected

995.82 (T76.31XA) Initial encounter

995.82 (T76.31XD) Subsequent encounter

Other Circumstances Related to Adult Abuse by Nonspouse or Nonpartner

V65.49 (Z69.81) Encounter for mental health services for victim of nonspousal or nonpartner adult abuse

V62.83 (Z69.82) Encounter for mental health services for perpetrator of nonspousal or nonpartner adult abuse

Educational and Occupational Problems

Educational Problems

V62.3 (Z55.9) Academic or Educational Problem
This category should be used when an academic or educational problem is the focus of clinical attention or has an impact on the individual's diagnosis, treatment, or prognosis. Problems to be considered include illiteracy or low-level literacy; lack of access to schooling owing to unavailability or unattainability; problems with academic performance (e.g., failing school examinations, receiving failing marks or grades) or underachievement (below what would be expected given the individual's intellectual capacity); discord with teachers, school staff, or other students; and any other problems related to education and/or literacy.

Occupational Problems

V62.21 (Z56.82) Problem Related to Current Military Deployment Status
This category should be used when an occupational problem directly related to an individual's military deployment status is the focus of clinical attention or has an impact on the individual's diagnosis, treatment, or prognosis. Psychological reactions to deployment are not included in this category; such reactions would be better captured as an adjustment disorder or another mental disorder.

V62.29 (Z56.9) Other Problem Related to Employment
This category should be used when an occupational problem is the focus of clinical attention or has an impact on the individual's treatment or prognosis. Areas to be considered include problems with employment or in the work environment, including unemployment; recent change of job; threat of job loss; job dissatisfaction; stressful work schedule; uncertainty about career choices; sexual harassment on the job; other discord with boss, supervisor, co-workers, or others in the work environment; uncongenial or hostile work environments; other psychosocial stressors related to work; and any other problems related to employment and/or occupation.

Housing and Economic Problems

Housing Problems

V60.0 (Z59.0) Homelessness
This category should be used when lack of a regular dwelling or living quarters has an impact on an individual's treatment or prognosis. An individual is considered to be homeless if his or her primary nighttime residence is a homeless shelter, a warming shelter, a domestic violence shelter, a public space (e.g., tunnel, transportation station, mall), a building not intended for residential use (e.g., abandoned structure, unused factory), a cardboard box or cave, or some other ad hoc housing situation.

V60.1 (Z59.1) Inadequate Housing
This category should be used when lack of adequate housing has an impact on an individual's treatment or prognosis. Examples of inadequate housing conditions include lack of heat (in cold temperatures) or electricity, infestation by insects or rodents, inadequate plumbing and toilet facilities, overcrowding, lack of adequate sleeping space, and excessive noise. It is important to consider cultural norms before assigning this category.

V60.89 (Z59.2) Discord With Neighbor, Lodger, or Landlord
This category should be used when discord with neighbors, lodgers, or a landlord is a focus of clinical attention or has an impact on the individual's treatment or prognosis.

V60.6 (Z59.3) Problem Related to Living in a Residential Institution
This category should be used when a problem (or problems) related to living in a residential institution is a focus of clinical attention or has an impact on the individual's treatment or prognosis. Psychological reactions to a change in living situation are not included in this category; such reactions would be better captured as an adjustment disorder.

Economic Problems

V60.2 (Z59.4) Lack of Adequate Food or Safe Drinking Water

V60.2 (Z59.5) Extreme Poverty

V60.2 (Z59.6) Low Income

V60.2 (Z59.7) Insufficient Social Insurance or Welfare Support
This category should be used for individuals who meet eligibility criteria for social or welfare support but are not receiving such support, who receive support that is insufficient to address their needs, or who otherwise lack access to needed insurance or support programs. Examples include inability to qualify for welfare support owing to lack of proper documentation or evidence of address, inability to obtain adequate health insurance because of age or a preexisting condition, and denial of support owing to excessively stringent income or other requirements.

V60.9 (Z59.9) Unspecified Housing or Economic Problem
This category should be used when there is a problem related to housing or economic circumstances other than as specified above.

Other Problems Related to the Social Environment

V62.89 (Z60.0) Phase of Life Problem
This category should be used when a problem adjusting to a life-cycle transition (a particular developmental phase) is the focus of clinical attention or has an impact on the individual's treatment or prognosis. Examples of such transitions include entering or completing school, leaving parental control, getting married, starting a new career, becoming a parent, adjusting to an "empty nest" after children leave home, and retiring.

V60.3 (Z60.2) Problem Related to Living Alone
This category should be used when a problem associated with living alone is the focus of clinical attention or has an impact on the individual's treatment or prognosis. Examples of such problems include chronic feelings of loneliness, isolation, and lack of structure in carrying out activities of daily living (e.g., irregular meal and sleep schedules, inconsistent performance of home maintenance chores).

V62.4 (Z60.3) Acculturation Difficulty
This category should be used when difficulty in adjusting to a new culture (e.g., following migration) is the focus of clinical attention or has an impact on the individual's treatment or prognosis.

V62.4 (Z60.4) Social Exclusion or Rejection
This category should be used when there is an imbalance of social power such that there is recurrent social exclusion or rejection by others. Examples of social rejection include bullying, teasing, and intimidation by others; being targeted by others for verbal abuse and humiliation; and being purposefully excluded from the activities of peers, workmates, or others in one's social environment.

V62.4 (Z60.5) Target of (Perceived) Adverse Discrimination or Persecution
This category should be used when there is perceived or experienced discrimination against or persecution of the individual based on his or her membership (or perceived

membership) in a specific category. Typically, such categories include gender or gender identity, race, ethnicity, religion, sexual orientation, country of origin, political beliefs, disability status, caste, social status, weight, and physical appearance.

V62.9 (Z60.9) Unspecified Problem Related to Social Environment
This category should be used when there is a problem related to the individual's social environment other than as specified above.

Problems Related to Crime or Interaction With the Legal System

V62.89 (Z65.4) Victim of Crime

V62.5 (Z65.0) Conviction in Civil or Criminal Proceedings Without Imprisonment

V62.5 (Z65.1) Imprisonment or Other Incarceration

V62.5 (Z65.2) Problems Related to Release From Prison

V62.5 (Z65.3) Problems Related to Other Legal Circumstances

Other Health Service Encounters for Counseling and Medical Advice

V65.49 (Z70.9) Sex Counseling
This category should be used when the individual seeks counseling related to sex education, sexual behavior, sexual orientation, sexual attitudes (embarrassment, timidity), others' sexual behavior or orientation (e.g., spouse, partner, child), sexual enjoyment, or any other sex-related issue.

V65.40 (Z71.9) Other Counseling or Consultation
This category should be used when counseling is provided or advice/consultation is sought for a problem that is not specified above or elsewhere in this chapter. Examples include spiritual or religious counseling, dietary counseling, and counseling on nicotine use.

Problems Related to Other Psychosocial, Personal, and Environmental Circumstances

V62.89 (Z65.8) Religious or Spiritual Problem
This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution.

V61.7 (Z64.0) Problems Related to Unwanted Pregnancy

V61.5 (Z64.1) Problems Related to Multiparity

V62.89 (Z64.4) Discord With Social Service Provider, Including Probation Officer, Case Manager, or Social Services Worker

V62.89 (Z65.4) Victim of Terrorism or Torture

V62.22 (Z65.5) Exposure to Disaster, War, or Other Hostilities

V62.89 (Z65.8) Other Problem Related to Psychosocial Circumstances

V62.9 (Z65.9) Unspecified Problem Related to Unspecified Psychosocial Circumstances

Other Circumstances of Personal History

V15.49 (Z91.49) Other Personal History of Psychological Trauma

V15.59 (Z91.5) Personal History of Self-Harm

V62.22 (Z91.82) Personal History of Military Deployment

V15.89 (Z91.89) Other Personal Risk Factors

V69.9 (Z72.9) Problem Related to Lifestyle

This category should be used when a lifestyle problem is a specific focus of treatment or directly affects the course, prognosis, or treatment of a mental or other medical disorder. Examples of lifestyle problems include lack of physical exercise, inappropriate diet, high-risk sexual behavior, and poor sleep hygiene. A problem that is attributable to a symptom of a mental disorder should not be coded unless that problem is a specific focus of treatment or directly affects the course, prognosis, or treatment of the individual. In such cases, both the mental disorder and the lifestyle problem should be coded.

V71.01 (Z72.811) Adult Antisocial Behavior

This category can be used when the focus of clinical attention is adult antisocial behavior that is not due to a mental disorder (e.g., conduct disorder, antisocial personality disorder). Examples include the behavior of some professional thieves, racketeers, or dealers in illegal substances.

V71.02 (Z72.810) Child or Adolescent Antisocial Behavior

This category can be used when the focus of clinical attention is antisocial behavior in a child or adolescent that is not due to a mental disorder (e.g., intermittent explosive disorder, conduct disorder). Examples include isolated antisocial acts by children or adolescents (not a pattern of antisocial behavior).

Problems Related to Access to Medical and Other Health Care

V63.9 (Z75.3) Unavailability or Inaccessibility of Health Care Facilities

V63.8 (Z75.4) Unavailability or Inaccessibility of Other Helping Agencies

Nonadherence to Medical Treatment

V15.81 (Z91.19) Nonadherence to Medical Treatment

This category can be used when the focus of clinical attention is nonadherence to an important aspect of treatment for a mental disorder or another medical condition. Reasons for such nonadherence may include discomfort resulting from treatment (e.g., medication side effects), expense of treatment, personal value judgments or religious or cultural beliefs about the proposed treatment, age-related debility, and the presence of a mental disorder (e.g., schizophrenia, personality disorder). This category should be used only when the problem is sufficiently severe to warrant independent clinical attention and does not meet diagnostic criteria for psychological factors affecting other medical conditions.

278.00 (E66.9) Overweight or Obesity

This category may be used when overweight or obesity is a focus of clinical attention.

V65.2 (Z76.5) Malingering

The essential feature of malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Under some circumstances, malingering may repre-

sent adaptive behavior—for example, feigning illness while a captive of the enemy during wartime. Malingering should be strongly suspected if any combination of the following is noted:

1. Medicolegal context of presentation (e.g., the individual is referred by an attorney to the clinician for examination, or the individual self-refers while litigation or criminal charges are pending).
2. Marked discrepancy between the individual's claimed stress or disability and the objective findings and observations.
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen.
4. The presence of antisocial personality disorder.

Malingering differs from factitious disorder in that the motivation for the symptom production in malingering is an external incentive, whereas in factitious disorder external incentives are absent. Malingering is differentiated from conversion disorder and somatic symptom–related mental disorders by the intentional production of symptoms and by the obvious external incentives associated with it. Definite evidence of feigning (such as clear evidence that loss of function is present during the examination but not at home) would suggest a diagnosis of factitious disorder if the individual's apparent aim is to assume the sick role, or malingering if it is to obtain an incentive, such as money.

V40.31 (Z91.83) Wandering Associated With a Mental Disorder

This category is used for individuals with a mental disorder whose desire to walk about leads to significant clinical management or safety concerns. For example, individuals with major neurocognitive or neurodevelopmental disorders may experience a restless urge to wander that places them at risk for falls and causes them to leave supervised settings without needed accompaniment. This category excludes individuals whose intent is to escape an unwanted housing situation (e.g., children who are running away from home, patients who no longer wish to remain in the hospital) or those who walk or pace as a result of medication-induced akathisia.

Coding note: First code associated mental disorder (e.g., major neurocognitive disorder, autism spectrum disorder), then code V40.31 (Z91.83) wandering associated with [specific mental disorder].

V62.89 (R41.83) Borderline Intellectual Functioning

This category can be used when an individual's borderline intellectual functioning is the focus of clinical attention or has an impact on the individual's treatment or prognosis. Differentiating borderline intellectual functioning and mild intellectual disability (intellectual developmental disorder) requires careful assessment of intellectual and adaptive functions and their discrepancies, particularly in the presence of co-occurring mental disorders that may affect patient compliance with standardized testing procedures (e.g., schizophrenia or attention-deficit/hyperactivity disorder with severe impulsivity).

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SECTION III
Emerging Measures and Models

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This section contains tools and techniques to enhance the clinical decision-making process, understand the cultural context of mental disorders, and recognize emerging diagnoses for further study. It provides strategies to enhance clinical practice and new criteria to stimulate future research, representing a dynamic DSM-5 that will evolve with advances in the field.

Among the tools in Section III is a Level 1 cross-cutting self/informant-rated measure that serves as a review of systems across mental disorders. A clinician-rated severity scale for schizophrenia and other psychotic disorders also is provided, as well as the World Health Organization Disability Assessment Schedule, Version 2 (WHODAS 2.0). Level 2 severity measures are available online (www.psychiatry.org/dsm5) and may be used to explore significant responses to the Level 1 screen. A comprehensive review of the cultural context of mental disorders, and the Cultural Formulation Interview (CFI) for clinical use, are provided.

Proposed disorders for future study are provided, which include a new model for the diagnosis of personality disorders as an alternative to the established diagnostic criteria; the proposed model incorporates impairments in personality functioning as well as pathological personality traits. Also included are new conditions that are the focus of active research, such as attenuated psychosis syndrome and nonsuicidal self-injury.

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Assessment Measures

A growing body of scientific evidence favors dimensional concepts in the diagnosis of mental disorders. The limitations of a categorical approach to diagnosis include the failure to find zones of rarity between diagnoses (i.e., delineation of mental disorders from one another by natural boundaries), the need for intermediate categories like schizoaffective disorder, high rates of comorbidity, frequent not-otherwise-specified (NOS) diagnoses, relative lack of utility in furthering the identification of unique antecedent validators for most mental disorders, and lack of treatment specificity for the various diagnostic categories.

From both clinical and research perspectives, there is a need for a more dimensional approach that can be combined with DSM's set of categorical diagnoses. Such an approach incorporates variations of features within an individual (e.g., differential severity of individual symptoms both within and outside of a disorder's diagnostic criteria as measured by intensity, duration, or number of symptoms, along with other features such as type and severity of disabilities) rather than relying on a simple yes-or-no approach. For diagnoses for which all symptoms are needed for a diagnosis (a monothetic criteria set), different severity levels of the constituent symptoms may be noted. If a threshold endorsement of multiple symptoms is needed, such as at least five of nine symptoms for major depressive disorder (a polythetic criteria set), both severity levels and different combinations of the criteria may identify more homogeneous diagnostic groups.

A dimensional approach depending primarily on an individual's subjective reports of symptom experiences along with the clinician's interpretation is consistent with current diagnostic practice. It is expected that as our understanding of basic disease mechanisms based on pathophysiology, neurocircuitry, gene-environment interactions, and laboratory tests increases, approaches that integrate both objective and subjective patient data will be developed to supplement and enhance the accuracy of the diagnostic process.

Cross-cutting symptom measures modeled on general medicine's review of systems can serve as an approach for reviewing critical psychopathological domains. The general medical review of systems is crucial to detecting subtle changes in different organ systems that can facilitate diagnosis and treatment. A similar review of various mental functions can aid in a more comprehensive mental status assessment by drawing attention to symptoms that may not fit neatly into the diagnostic criteria suggested by the individual's presenting symptoms, but may nonetheless be important to the individual's care. The cross-cutting measures have two levels: Level 1 questions are a brief survey of 13 symptom domains for adult patients and 12 domains for child and adolescent patients. Level 2 questions provide a more in-depth assessment of certain domains. These measures were developed to be administered both at initial interview and over time to track the patient's symptom status and response to treatment.

Severity measures are disorder-specific, corresponding closely to the criteria that constitute the disorder definition. They may be administered to individuals who have received a diagnosis or who have a clinically significant syndrome that falls short of meeting full criteria for a diagnosis. Some of the assessments are self-completed by the individual, while others require a clinician to complete. As with the cross-cutting symptom measures, these measures were developed to be administered both at initial interview and over time to track the severity of the individual's disorder and response to treatment.

The World Health Organization Disability Assessment Schedule, Version 2.0 (WHODAS 2.0) was developed to assess a patient's ability to perform activities in six areas: understanding and communicating; getting around; self-care; getting along with people; life activities (e.g., household, work/school); and participation in society. The scale is self-administered and was developed to be used in patients with any medical disorder. It corresponds to concepts contained in the WHO International Classification of Functioning, Disability and Health. This assessment can also be used over time to track changes in a patient's disabilities.

This chapter focuses on the DSM-5 Level 1 Cross-Cutting Symptom Measure (adult self-rated and parent/guardian versions); the Clinician-Rated Dimensions of Psychosis Symptom Severity; and the WHODAS 2.0. Clinician instructions, scoring information, and interpretation guidelines are included for each. These measures and additional dimensional assessments, including those for diagnostic severity, can be found online at www.psychiatry.org/dsm5.

Cross-Cutting Symptom Measures

Level 1 Cross-Cutting Symptom Measure

The DSM-5 Level 1 Cross-Cutting Symptom Measure is a patient- or informant-rated measure that assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the individual's treatment and prognosis. In addition, the measure may be used to track changes in the individual's symptom presentation over time.

The adult version of the measure consists of 23 questions that assess 13 psychiatric domains, including depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors, dissociation, personality functioning, and substance use (Table 1). Each domain consists of one to three questions. Each item inquires about how much (or how often) the individual has been bothered by the specific symptom during the past 2 weeks. If the individual is of impaired capacity and unable to complete the form (e.g., an individual with dementia), a knowledgeable adult informant may complete this measure. The measure was found to be clinically useful and to have good reliability in the DSM-5 field trials that were conducted in adult clinical samples across the United States and in Canada.

The parent/guardian-rated version of the measure (for children ages 6–17) consists of 25 questions that assess 12 psychiatric domains, including depression, anger, irritability, mania, anxiety, somatic symptoms, inattention, suicidal ideation/attempt, psychosis, sleep disturbance, repetitive thoughts and behaviors, and substance use (Table 2). Each item asks the parent or guardian to rate how much (or how often) his or her child has been bothered by the specific psychiatric symptom during the past 2 weeks. The measure was also found to be clinically useful and to have good reliability in the DSM-5 field trials that were conducted in pediatric clinical samples across the United States. For children ages 11–17, along with the parent/guardian rating of the child's symptoms, the clinician may consider having the child complete the child-rated version of the measure. The child-rated version of the measure can be found online at www.psychiatry.org/dsm5.

Scoring and interpretation. On the adult self-rated version of the measure, each item is rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day). The score on each item within a domain should be reviewed. However, a rating of mild (i.e., 2) or greater on any item within a domain, except for substance use, suicidal ideation, and psychosis, may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment is necessary, which may include the Level 2 cross-cutting symptom assessment for the domain (see Table 1). For substance use, suicidal ideation, and psychosis, a

TABLE 1 Adult DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: 13 domains, thresholds for further inquiry, and associated DSM-5 Level 2 measures

Domain	Domain name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure[a]
I.	Depression	Mild or greater	Level 2—Depression—Adult (PROMIS Emotional Distress—Short Form)
II.	Anger	Mild or greater	Level 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form)
III.	Mania	Mild or greater	Level 2—Mania—Adult (Altman Self-Rating Mania Scale [ASRM])
IV.	Anxiety	Mild or greater	Level 2—Anxiety—Adult (PROMIS Emotional Distress—Anxiety—Short Form)
V.	Somatic symptoms	Mild or greater	Level 2—Somatic Symptom—Adult (Patient Health Questionnaire–15 [PHQ-15] Somatic Symptom Severity Scale)
VI.	Suicidal ideation	Slight or greater	None
VII.	Psychosis	Slight or greater	None
VIII.	Sleep problems	Mild or greater	Level 2—Sleep Disturbance—Adult (PROMIS Sleep Disturbance—Short Form)
IX.	Memory	Mild or greater	None
X.	Repetitive thoughts and behaviors	Mild or greater	Level 2—Repetitive Thoughts and Behaviors—Adult (Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale)
XI.	Dissociation	Mild or greater	None
XII.	Personality functioning	Mild or greater	None
XIII.	Substance use	Slight or greater	Level 2—Substance Use—Adult (adapted from the NIDA-Modified ASSIST)

Note. NIDA = National Institute on Drug Abuse.
[a]Available at www.psychiatry.org/dsm5.

rating of slight (i.e., 1) or greater on any item within the domain may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment is needed. As such, indicate the highest score within a domain in the "Highest domain score" column. Table 1 outlines threshold scores that may guide further inquiry for the remaining domains.

On the parent/guardian-rated version of the measure (for children ages 6–17), 19 of the 25 items are each rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day). The suicidal ideation, suicide attempt, and substance abuse items are each rated on a "Yes, No, or Don't Know" scale. The score on each item within a domain should be reviewed. However, with the exception of inattention and psychosis, a rating of mild (i.e., 2) or greater on any item within a domain that is scored on the 5-point scale may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment is necessary, which may include the Level 2 cross-cutting symptom assessment for the domain (see Table 2). For inattention or psychosis, a rating of slight or greater (i.e., 1 or greater) may be

TABLE 2 Parent/guardian-rated DSM-5 Level 1 Cross-Cutting Symptom Measure for child age 6–17: 12 domains, thresholds for further inquiry, and associated Level 2 measures

Domain	Domain name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure[a]
I.	Somatic symptoms	Mild or greater	Level 2—Somatic Symptoms—Parent/Guardian of Child Age 6–17 (Patient Health Questionnaire–15 Somatic Symptom Severity Scale [PHQ-15])
II.	Sleep problems	Mild or greater	Level 2—Sleep Disturbance—Parent/Guardian of Child Age 6–17 (PROMIS Sleep Disturbance—Short Form)
III.	Inattention	Slight or greater	Level 2—Inattention—Parent/Guardian of Child Age 6–17 (Swanson, Nolan, and Pelham, Version IV [SNAP-IV])
IV.	Depression	Mild or greater	Level 2—Depression—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Depression—Parent Item Bank)
V.	Anger	Mild or greater	Level 2—Anger—Parent/Guardian of Child (PROMIS Calibrated Anger Measure—Parent)
VI.	Irritability	Mild or greater	Level 2—Irritability—Parent/Guardian of Child (Affective Reactivity Index [ARI])
VII.	Mania	Mild or greater	Level 2—Mania—Parent/Guardian of Child Age 6–17 (Altman Self-Rating Mania Scale [ASRM])
VIII.	Anxiety	Mild or greater	Level 2—Anxiety—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Anxiety—Parent Item Bank)
IX.	Psychosis	Slight or greater	None
X.	Repetitive thoughts and behaviors	Mild or greater	None
XI.	Substance use	Yes	Level 2—Substance Use—Parent/Guardian of Child Age 6–17 (adapted from the NIDA-modified ASSIST)
		Don't Know	NIDA-modified ASSIST (adapted)—Child-Rated (age 11–17 years)
XII.	Suicidal ideation/suicide attempts	Yes	None
		Don't Know	None

Note. NIDA = National Institute on Drug Abuse.
[a]Available at www.psychiatry.org/dsm5.

used as an indicator for additional inquiry. A parent or guardian's rating of "Don't Know" on the suicidal ideation, suicide attempt, and any of the substance use items, especially for children ages 11–17 years, may result in additional probing of the issues with the child, including using the child-rated Level 2 Cross-Cutting Symptom Measure for the relevant domain. Because additional inquiry is made on the basis of the highest score on any item within a domain, clinicians should indicate that score in the "Highest Domain Score" column. Table 2 outlines threshold scores that may guide further inquiry for the remaining domains.

Level 2 Cross-Cutting Symptom Measures

Any threshold scores on the Level 1 Cross-Cutting Symptom Measure (as noted in Tables 1 and 2 and described in "Scoring and Interpretation" indicate a possible need for detailed clinical inquiry. Level 2 Cross-Cutting Symptom Measures provide one method of obtaining more in-depth information on potentially significant symptoms to inform diagnosis, treatment planning, and follow-up. They are available online at www.psychiatry.org/dsm5. Tables 1 and 2 outline each Level 1 domain and identify the domains for which DSM-5 Level 2 Cross-Cutting Symptom Measures are available for more detailed assessments. Adult and pediatric (parent and child) versions are available online for most Level 1 symptom domains at www.psychiatry.org/dsm5.

Frequency of Use of the Cross-Cutting Symptom Measures

To track change in the individual's symptom presentation over time, the Level 1 and relevant Level 2 cross-cutting symptom measures may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. For individuals with impaired capacity and for children ages 6–17 years, it is preferable for the measures to be completed at follow-up appointments by the same knowledgeable informant and by the same parent or guardian. Consistently high scores on a particular domain may indicate significant and problematic symptoms for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name:_____ **Age:** _____ **Sex: [ ] Male [ ] Female** **Date:**_____

If the measure is being completed by an informant, **what is your relationship with the individual?:** _____

In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Little interest or pleasure in doing things?	0	1	2	3	4	
	2.	Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3.	Feeling more irritated, grouchy, angry than usual?	0	1	2	3	4	
III.	4.	Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5.	Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6.	Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7.	Feeling panic or being frightened?	0	1	2	3	4	
	8.	Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9.	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10.	Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11.	Thoughts of actually hurting yourself?	0	1	2	3	4	

VII.	12.	Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13.	Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14.	Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15.	Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17.	Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19.	Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20.	Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21.	Drink at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22.	Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco?	0	1	2	3	4	
	23.	Use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name:_____ **Age:** _____ **Sex: [ ] Male [ ] Female** **Date:**_____

Relationship to the child: _____

Instructions (*to parent or guardian of child*): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during t**he past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS,** how much (or how often) has your child…		**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. and VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
	10.	Sleeping less than usual for him/her but still has lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done because they made him/her feel nervous?	0	1	2	3	4	

IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
	In the past **TWO (2) WEEKS,** has your child…							
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes	❑ No	❑ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes	❑ No	❑ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	❑ Yes	❑ No	❑ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	❑ Yes	❑ No	❑ Don't Know			
XII.	24.	In the **past TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	❑ Yes	❑ No	❑ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	❑ Yes	❑ No	❑ Don't Know			

Clinician-Rated Dimensions of Psychosis Symptom Severity

As described in the chapter "Schizophrenia Spectrum and Other Psychotic Disorders," psychotic disorders are heterogeneous, and symptom severity can predict important aspects of the illness, such as the degree of cognitive and/or neurobiological deficits. Dimensional assessments capture meaningful variation in the severity of symptoms, which may help with treatment planning, prognostic decision-making, and research on pathophysiological mechanisms. The Clinician-Rated Dimensions of Psychosis Symptom Severity provides scales for the dimensional assessment of the primary symptoms of psychosis, including hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, and negative symptoms. A scale for the dimensional assessment of cognitive impairment is also included. Many individuals with psychotic disorders have impairments in a range of cognitive domains, which predict functional abilities. In addition, scales for dimensional assessment of depression and mania are provided, which may alert clinicians to mood pathology. The severity of mood symptoms in psychosis has prognostic value and guides treatment.

The Clinician-Rated Dimensions of Psychosis Symptom Severity is an 8-item measure that may be completed by the clinician at the time of the clinical assessment. Each item asks the clinician to rate the severity of each symptom as experienced by the individual during the past 7 days.

Scoring and Interpretation

Each item on the measure is rated on a 5-point scale (0=none; 1=equivocal; 2=present, but mild; 3=present and moderate; and 4=present and severe) with a symptom-specific definition of each rating level. The clinician may review all of the individual's available information and, based on clinical judgment, select (with checkmark) the level that most accurately describes the severity of the individual's condition. The clinician then indicates the score for each item in the "Score" column provided.

Frequency of Use

To track changes in the individual's symptom severity over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making.

Clinician-Rated Dimensions of Psychosis Symptom Severity

Name:_____ **Age:** _____ **Sex: [ ] Male [ ] Female** **Date:**_____

Instructions: Based on all the information you have on the individual and using your clinical judgment, please rate (with checkmark) the presence and severity of the following symptoms as experienced by the individual in the past seven (7) days.

Domain	0	1	2	3	4	Score
I. Hallucinations	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered psychosis)	❑ Present, but mild (little pressure to act upon voices, not very bothered by voices)	❑ Present and moderate (some pressure to respond to voices, or is somewhat bothered by voices)	❑ Present and severe (severe pressure to respond to voices, or is very bothered by voices)	
II. Delusions	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered psychosis)	❑ Present, but mild (little pressure to act upon delusional beliefs, not very bothered by beliefs)	❑ Present and moderate (some pressure to act upon beliefs, or is somewhat bothered by beliefs)	❑ Present and severe (severe pressure to act upon beliefs, or is very bothered by beliefs)	
III. Disorganized speech	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered disorganization)	❑ Present, but mild (some difficulty following speech)	❑ Present and moderate (speech often difficult to follow)	❑ Present and severe (speech almost impossible to follow)	
IV. Abnormal psychomotor behavior	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered abnormal psychomotor behavior)	❑ Present, but mild (occasional abnormal or bizarre motor behavior or catatonia)	❑ Present and moderate (frequent abnormal or bizarre motor behavior or catatonia)	❑ Present and severe (abnormal or bizarre motor behavior or catatonia almost constant)	
V. Negative symptoms (restricted emotional expression or avolition)	❑ Not present	❑ Equivocal decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present, but mild decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present and moderate decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present and severe decrease in facial expressivity, prosody, gestures, or self-initiated behavior	

Domain	0	1	2	3	4	Score
VI. Impaired cognition	❑ Not present	❑ Equivocal (cognitive function not clearly outside the range expected for age or SES; i.e., within 0.5 SD of mean)	❑ Present, but mild (some reduction in cognitive function; below expected for age and SES, 0.5–1 SD from mean)	❑ Present and moderate (clear reduction in cognitive function; below expected for age and SES, 1–2 SD from mean)	❑ Present and severe (severe reduction in cognitive function; below expected for age and SES, >2 SD from mean)	
VII. Depression	❑ Not present	❑ Equivocal (occasionally feels sad, down, depressed, or hopeless; concerned about having failed someone or at something but not preoccupied)	❑ Present, but mild (frequent periods of feeling very sad, down, moderately depressed, or hopeless; concerned about having failed someone or at something, with some preoccupation)	❑ Present and moderate (frequent periods of deep depression or hopelessness; preoccupation with guilt, having done wrong)	❑ Present and severe (deeply depressed or hopeless daily; delusional guilt or unreasonable self-reproach grossly out of proportion to circumstances)	
VIII. Mania	❑ Not present	❑ Equivocal (occasional elevated, expansive, or irritable mood or some restlessness)	❑ Present, but mild (frequent periods of somewhat elevated, expansive, or irritable mood or restlessness)	❑ Present and moderate (frequent periods of extensively elevated, expansive, or irritable mood or restlessness)	❑ Present and severe (daily and extensively elevated, expansive, or irritable mood or restlessness)	

Note. SD=standard deviation; SES=socioeconomic status.

World Health Organization Disability Assessment Schedule 2.0

The adult self-administered version of the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) is a 36-item measure that assesses disability in adults age 18 years and older. It assesses disability across six domains, including understanding and communicating, getting around, self-care, getting along with people, life activities (i.e., household, work, and/or school activities), and participation in society. If the adult individual is of impaired capacity and unable to complete the form (e.g., a patient with dementia), a knowledgeable informant may complete the proxy-administered version of the measure, which is available at www.psychiatry.org/dsm5. Each item on the self-administered version of the WHODAS 2.0 asks the individual to rate how much difficulty he or she has had in specific areas of functioning during the past 30 days.

WHODAS 2.0 Scoring Instructions Provided by WHO

WHODAS 2.0 summary scores. There are two basic options for computing the summary scores for the WHODAS 2.0 36-item full version.

Simple: The scores assigned to each of the items—"none" (1), "mild" (2), "moderate" (3), "severe" (4), and "extreme" (5)—are summed. This method is referred to as simple scoring because the scores from each of the items are simply added up without recoding or collapsing of response categories; thus, there is no weighting of individual items. This approach is practical to use as a hand-scoring approach, and may be the method of choice in busy clinical settings or in paper-and-pencil interview situations. As a result, the simple sum of the scores of the items across all domains constitutes a statistic that is sufficient to describe the degree of functional limitations.

Complex: The more complex method of scoring is called "item-response-theory" (IRT)–based scoring. It takes into account multiple levels of difficulty for each WHODAS 2.0 item. It takes the coding for each item response as "none," "mild," "moderate," "severe," and "extreme" separately, and then uses a computer to determine the summary score by differentially weighting the items and the levels of severity. The computer program is available from the WHO Web site. The scoring has three steps:

- Step 1—Summing of recoded item scores within each domain.
- Step 2—Summing of all six domain scores.
- Step 3—Converting the summary score into a metric ranging from 0 to 100 (where 0=no disability; 100=full disability).

WHODAS 2.0 domain scores. WHODAS 2.0 produces domain-specific scores for six different functioning domains: cognition, mobility, self-care, getting along, life activities (household and work/school), and participation.

WHODAS 2.0 population norms. For the population norms for IRT-based scoring of the WHODAS 2.0 and for the population distribution of IRT-based scores for WHODAS 2.0, please see www.who.int/classifications/icf/Pop_norms_distrib_IRT_scores.pdf.

Additional Scoring and Interpretation Guidance for DSM-5 Users

The clinician is asked to review the individual's response on each item on the measure during the clinical interview and to indicate the self-reported score for each item in the section provided for "Clinician Use Only." However, if the clinician determines that the score on an item should be different based on the clinical interview and other information avail-

able, he or she may indicate a corrected score in the raw item score box. Based on findings from the DSM-5 Field Trials in adult patient samples across six sites in the United States and one in Canada, *DSM-5 recommends calculation and use of average scores for each domain and for general disability.* The average scores are comparable to the WHODAS 5-point scale, which allows the clinician to think of the individual's disability in terms of none (1), mild (2), moderate (3), severe (4), or extreme (5). The average domain and general disability scores were found to be reliable, easy to use, and clinically useful to the clinicians in the DSM-5 Field Trials. The *average domain score* is calculated by dividing the raw domain score by the number of items in the domain (e.g., if all the items within the "understanding and communicating" domain are rated as being moderate then the average domain score would be 18/6=3, indicating moderate disability). The *average general disability score* is calculated by dividing the raw overall score by number of items in the measure (i.e., 36). The individual should be encouraged to complete all of the items on the WHODAS 2.0. If no response is given on 10 or more items of the measure (i.e., more than 25% of the 36 total items), calculation of the simple and average general disability scores may not be helpful. If 10 or more of the total items on the measure are missing but the items for some of the domains are 75%–100% complete, the simple or average domain scores may be used for those domains.

Frequency of use. To track change in the individual's level of disability over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the individual that might warrant further assessment and intervention.

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

36-item version, self-administered

Patient Name: _____ **Age:** _____ **Sex:** ❑ Male ❑ Female **Date:** _____

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include **diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.** Think back over the **past 30 days** and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only **one** response.

							Clinician Use Only		
Numeric scores assigned to each of the items:		1	2	3	4	5	Raw Item Score	Raw Domain Score	Average Domain Score
In the last 30 days, how much difficulty did you have in:									
Understanding and communicating									
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do		___ 30	___ 5
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.3	Analyzing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do			
Getting around									
D2.1	Standing for long periods, such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do		___ 25	___ 5
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.5	Walking a long distance, such as a kilometer (or equivalent)?	None	Mild	Moderate	Severe	Extreme or cannot do			
Self-care									
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do		___ 20	___ 5
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do			
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme or cannot do			
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme or cannot do			
Getting along with people									
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do		___ 25	___ 5
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do			
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme or cannot do			
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme or cannot do			
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme or cannot do			

							Clinician Use Only		
Numeric scores assigned to each of the items:		1	2	3	4	5	Raw Item Score	Raw Domain Score	Average Domain Score
In the last 30 days, how much difficulty did you have in:									
Life activities—Household									
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.3	Getting all of the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do		___ 20	___ 5
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do			
Life activities—School/Work									
If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.									
Because of your health condition, in the past 30 days, how much difficulty did you have in:									
D5.5	Your day-to-day work/school?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme or cannot do			
D5.7	Getting all of the work done that you need to do?	None	Mild	Moderate	Severe	Extreme or cannot do		___ 20	___ 5
D5.8	Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme or cannot do			
Participation in society									
In the past 30 days:									
D6.1	How much of a problem did you have in joining in community activities (for example, festivities, religious, or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.2	How much of a problem did you have because of barriers or hindrances around you?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.3	How much of a problem did you have living with dignity because of the attitudes and actions of others?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.4	How much time did you spend on your health condition or its consequences?	None	Some	Moderate	A Lot	Extreme or cannot do		___ 40	___ 5
D6.5	How much have you been emotionally affected by your health condition?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.6	How much has your health been a drain on the financial resources of you or your family?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.7	How much of a problem did your family have because of your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do			
D6.8	How much of a problem did you have in doing things by yourself for relaxation or pleasure?	None	Mild	Moderate	Severe	Extreme or cannot do			
						General Disability Score (Total):		___ 180	___ 5

Cultural Formulation

Understanding the cultural context of illness experience is essential for effective diagnostic assessment and clinical management. *Culture* refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience. These features of culture make it crucial not to overgeneralize cultural information or stereotype groups in terms of fixed cultural traits.

Race is a culturally constructed category of identity that divides humanity into groups based on a variety of superficial physical traits attributed to some hypothetical intrinsic, biological characteristics. Racial categories and constructs have varied widely over history and across societies. The construct of race has no consistent biological definition, but it is socially important because it supports racial ideologies, racism, discrimination, and social exclusion, which can have strong negative effects on mental health. There is evidence that racism can exacerbate many psychiatric disorders, contributing to poor outcome, and that racial biases can affect diagnostic assessment.

Ethnicity is a culturally constructed group identity used to define peoples and communities. It may be rooted in a common history, geography, language, religion, or other shared characteristics of a group, which distinguish that group from others. Ethnicity may be self-assigned or attributed by outsiders. Increasing mobility, intermarriage, and intermixing of cultures has defined new mixed, multiple, or hybrid ethnic identities.

Culture, race, and ethnicity are related to economic inequities, racism, and discrimination that result in health disparities. Cultural, ethnic, and racial identities can be sources of strength and group support that enhance resilience, but they may also lead to psychological, interpersonal, and intergenerational conflict or difficulties in adaptation that require diagnostic assessment.

Outline for Cultural Formulation

The Outline for Cultural Formulation introduced in DSM-IV provided a framework for assessing information about cultural features of an individual's mental health problem and how it relates to a social and cultural context and history. DSM-5 not only includes an updated version of the Outline but also presents an approach to assessment, using the Cultural Formulation Interview (CFI), which has been field-tested for diagnostic usefulness among clinicians and for acceptability among patients.

The revised Outline for Cultural Formulation calls for systematic assessment of the following categories:

- **Cultural identity of the individual:** Describe the individual's racial, ethnic, or cultural reference groups that may influence his or her relationships with others, access to re-

sources, and developmental and current challenges, conflicts, or predicaments. For immigrants and racial or ethnic minorities, the degree and kinds of involvement with both the culture of origin and the host culture or majority culture should be noted separately. Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and the need for an interpreter. Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation.

- **Cultural conceptualizations of distress:** Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs may include cultural syndromes, idioms of distress, and explanatory models or perceived causes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.
- **Psychosocial stressors and cultural features of vulnerability and resilience:** Identify key stressors and supports in the individual's social environment (which may include both local and distant events) and the role of religion, family, and other social networks (e.g., friends, neighbors, coworkers) in providing emotional, instrumental, and informational support. Social stressors and social supports vary with cultural interpretations of events, family structure, developmental tasks, and social context. Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural reference groups.
- **Cultural features of the relationship between the individual and the clinician:** Identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance.
- **Overall cultural assessment:** Summarize the implications of the components of the cultural formulation identified in earlier sections of the Outline for diagnosis and other clinically relevant issues or problems as well as appropriate management and treatment intervention.

Cultural Formulation Interview (CFI)

The Cultural Formulation Interview (CFI) is a set of 16 questions that clinicians may use to obtain information during a mental health assessment about the impact of culture on key aspects of an individual's clinical presentation and care. In the CFI, *culture* refers to

- The values, orientations, knowledge, and practices that individuals derive from membership in diverse social groups (e.g., ethnic groups, faith communities, occupational groups, veterans groups).
- Aspects of an individual's background, developmental experiences, and current social contexts that may affect his or her perspective, such as geographical origin, migration, language, religion, sexual orientation, or race/ethnicity.
- The influence of family, friends, and other community members (the individual's *social network*) on the individual's illness experience.

The CFI is a brief semistructured interview for systematically assessing cultural factors in the clinical encounter that may be used with any individual. The CFI focuses on the individual's experience and the social contexts of the clinical problem. The CFI follows a person-centered approach to cultural assessment by eliciting information from the individual about his or her own views and those of others in his or her social network. This approach is designed to avoid stereotyping, in that each individual's cultural knowledge affects how he or she interprets illness experience and guides how he or she seeks help. Because the CFI concerns the individual's personal views, there are no right or wrong answers to these questions. The interview follows and is available online at www.psychiatry.org/dsm5.

The CFI is formatted as two text columns. The left-hand column contains the instructions for administering the CFI and describes the goals for each interview domain. The questions in the right-hand column illustrate how to explore these domains, but they are not meant to be exhaustive. Follow-up questions may be needed to clarify individuals' answers. Questions may be rephrased as needed. The CFI is intended as a guide to cultural assessment and should be used flexibly to maintain a natural flow of the interview and rapport with the individual.

The CFI is best used in conjunction with demographic information obtained prior to the interview in order to tailor the CFI questions to address the individual's background and current situation. Specific demographic domains to be explored with the CFI will vary across individuals and settings. A comprehensive assessment may include place of birth, age, gender, racial/ethnic origin, marital status, family composition, education, language fluencies, sexual orientation, religious or spiritual affiliation, occupation, employment, income, and migration history.

The CFI can be used in the initial assessment of individuals in all clinical settings, regardless of the cultural background of the individual or of the clinician. Individuals and clinicians who appear to share the same cultural background may nevertheless differ in ways that are relevant to care. The CFI may be used in its entirety, or components may be incorporated into a clinical evaluation as needed. The CFI may be especially helpful when there is

- Difficulty in diagnostic assessment owing to significant differences in the cultural, religious, or socioeconomic backgrounds of clinician and the individual.
- Uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria.
- Difficulty in judging illness severity or impairment.
- Disagreement between the individual and clinician on the course of care.
- Limited engagement in and adherence to treatment by the individual.

The CFI emphasizes four domains of assessment: Cultural Definition of the Problem (questions 1–3); Cultural Perceptions of Cause, Context, and Support (questions 4–10); Cultural Factors Affecting Self-Coping and Past Help Seeking (questions 11–13); and Cultural Factors Affecting Current Help Seeking (questions 14–16). Both the person-centered process of conducting the CFI and the information it elicits are intended to enhance the cultural validity of diagnostic assessment, facilitate treatment planning, and promote the individual's engagement and satisfaction. To achieve these goals, the information obtained from the CFI should be integrated with all other available clinical material into a comprehensive clinical and contextual evaluation. An Informant version of the CFI can be used to collect collateral information on the CFI domains from family members or caregivers.

Supplementary modules have been developed that expand on each domain of the CFI and guide clinicians who wish to explore these domains in greater depth. Supplementary modules have also been developed for specific populations, such as children and adolescents, elderly individuals, and immigrants and refugees. These supplementary modules are referenced in the CFI under the pertinent subheadings and are available online at www.psychiatry.org/dsm5.

Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	**INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

Cultural Definition of the Problem

(Explanatory Model, Level of Functioning)

Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?
Ask how individual frames the problem for members of the social network.	2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
Focus on the aspects of the problem that matter most to the individual.	3. What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

Causes

(Explanatory Model, Social Network, Older Adults)

This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. *Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.*	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.	5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

Cultural Formulation Interview (CFI) *(continued)*

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	**INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.***

STRESSORS AND SUPPORTS

(Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)

Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from coworkers, from participation in religion or spirituality).	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

ROLE OF CULTURAL IDENTITY

(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

SELF-COPING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)

Clarify self-coping for the problem.	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

Cultural Formulation Interview (CFI) *(continued)*

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	**INSTRUCTIONS TO THE INTERVIEWER ARE *ITALICIZED.***

PAST HELP SEEKING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing).

Probe as needed (e.g., "What other sources of help have you used?").

Clarify the individual's experience and regard for previous help.

12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?

    PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:

    What types of help or treatment were most useful? Not useful?

BARRIERS

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment.

Probe details as needed (e.g., "What got in the way?").

13. Has anything prevented you from getting the help you need?

    PROBE AS NEEDED:

    For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

PREFERENCES

(Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)

Clarify individual's current perceived needs and expectations of help, broadly defined.

Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").

Focus on the views of the social network regarding help seeking.

Now let's talk some more about the help you need.

14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?

15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?

CLINICIAN-PATIENT RELATIONSHIP

(Clinician-Patient Relationship, Older Adults)

Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery.

Probe details as needed (e.g., "In what way?").

Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.

Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.

16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

Cultural Formulation Interview (CFI)—Informant Version

The CFI–Informant Version collects collateral information from an informant who is knowledgeable about the clinical problems and life circumstances of the identified individual. This version can be used to supplement information obtained from the core CFI or can be used instead of the core CFI when the individual is unable to provide information—as might occur, for example, with children or adolescents, floridly psychotic individuals, or persons with cognitive impairment.

Cultural Formulation Interview (CFI)—Informant Version

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the informant's point of view. This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INFORMANT:* I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers.
	RELATIONSHIP WITH THE PATIENT
Clarify the informant's relationship with the individual and/or the individual's family.	1. How would you describe your relationship to [INDIVIDUAL OR TO FAMILY]? *PROBE IF NOT CLEAR:* How often do you see [INDIVIDUAL]?
	CULTURAL DEFINITION OF THE PROBLEM
Elicit the informant's view of core problems and key concerns. *Focus on the informant's way of understanding the individual's problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "her conflict with her son").*	2. What brings your family member/friend here today? *IF INFORMANT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand problems in their own way, which may be similar or different from how doctors describe the problem. How would ***you*** describe [INDIVIDUAL'S] problem?
Ask how informant frames the problem for members of the social network.	3. Sometimes people have different ways of describing the problem to family, friends, or others in their community. How would ***you*** describe [INDIVIDUAL'S] problem to them?
Focus on the aspects of the problem that matter most to the informant.	4. What troubles you most about [INDIVIDUAL'S] problem?