Cultural Formulation Interview (CFI)—Informant Version *(continued)*

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

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

CAUSES

This question indicates the meaning of the condition for the informant, which may be relevant for clinical care.	5. Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]?
Note that informants may identify multiple causes depending on the facet of the problem they are considering.	*PROMPT FURTHER IF REQUIRED:* Some people may explain the 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 informant's.	6. What do others in [INDIVIDUAL'S] family, his/her friends, or others in the community think is causing [INDIVIDUAL'S] [PROBLEM]?

STRESSORS AND SUPPORTS

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).	7. Are there any kinds of supports that make his/her [PROBLEM] better, such as 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.	8. Are there any kinds of stresses that make his/her [PROBLEM] worse, such as difficulties with money, or family problems?

ROLE OF CULTURAL IDENTITY

	Sometimes, aspects of people's background or identity can make the [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, and your faith or religion.
Ask the informant to reflect on the most salient elements of the individual's cultural identity. Use this information to tailor questions 10–11 as needed.	9. For you, what are the most important aspects of [INDIVIDUAL'S] 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).*	10. Are there any aspects of [INDIVIDUAL'S] background or identity that make a difference to his/her [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	11. Are there any aspects of [INDIVIDUAL'S] background or identity that are causing other concerns or difficulties for him/her?

Cultural Formulation Interview (CFI)—Informant Version *(continued)*

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

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

Self-Coping

Clarify individual's self-coping for the problem.

12. Sometimes people have various ways of dealing with problems like [PROBLEM]. What has [INDIVIDUAL] done on his/her own to cope with his/her [PROBLEM]?

Past Help Seeking

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

Probe as needed (e.g., "What other sources of help has he/she used?").

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

13. Often, people also 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 has [INDIVIDUAL] sought for his/her [PROBLEM]?

PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:

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

Barriers

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?").

14. Has anything prevented [INDIVIDUAL] from getting the help he/she needs?

PROBE AS NEEDED:

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

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

Preferences

Clarify individual's current perceived needs and expectations of help, broadly defined, from the point of view of the informant.

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

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

Now let's talk about the help [INDIVIDUAL] needs.

15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]?

16. Are there other kinds of help that [INDIVIDUAL'S] family, friends, or other people have suggested would be helpful for him/her now?

Clinician-Patient Relationship

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.

17. Have you been concerned about this, and is there anything that we can do to provide [INDIVIDUAL] with the care he/she needs?

Cultural Concepts of Distress

Cultural concepts of distress refers to ways that cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions. Three main types of cultural concepts may be distinguished. *Cultural syndromes* are clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience. *Cultural idioms of distress* are ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns. For example, everyday talk about "nerves" or "depression" may refer to widely varying forms of suffering without mapping onto a discrete set of symptoms, syndrome, or disorder. *Cultural explanations* or *perceived causes* are labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress.

These three concepts—syndromes, idioms, and explanations—are more relevant to clinical practice than the older formulation *culture-bound syndrome.* Specifically, the term *culture-bound syndrome* ignores the fact that clinically important cultural differences often involve explanations or experience of distress rather than culturally distinctive configurations of symptoms. Furthermore, the term *culture-bound* overemphasizes the local particularity and limited distribution of cultural concepts of distress. The current formulation acknowledges that *all* forms of distress are locally shaped, including the DSM disorders. From this perspective, many DSM diagnoses can be understood as operationalized prototypes that started out as cultural syndromes, and became widely accepted as a result of their clinical and research utility. Across groups there remain culturally patterned differences in symptoms, ways of talking about distress, and locally perceived causes, which are in turn associated with coping strategies and patterns of help seeking.

Cultural concepts arise from local folk or professional diagnostic systems for mental and emotional distress, and they may also reflect the influence of biomedical concepts. Cultural concepts have four key features in relation to the DSM-5 nosology:

- There is seldom a one-to-one correspondence of any cultural concept with a DSM diagnostic entity; the correspondence is more likely to be one-to-many in either direction. Symptoms or behaviors that might be sorted by DSM-5 into several disorders may be included in a single folk concept, and diverse presentations that might be classified by DSM-5 as variants of a single disorder may be sorted into several distinct concepts by an indigenous diagnostic system.
- Cultural concepts may apply to a wide range of severity, including presentations that do not meet DSM criteria for any mental disorder. For example, an individual with acute grief or a social predicament may use the same idiom of distress or display the same cultural syndrome as another individual with more severe psychopathology.
- In common usage, the same cultural term frequently denotes more than one type of cultural concept. A familiar example may be the concept of "depression," which may be used to describe a syndrome (e.g., major depressive disorder), an idiom of distress (e.g., as in the common expression "I feel depressed"), or a perceived cause (similar to "stress").
- Like culture and DSM itself, cultural concepts may change over time in response to both local and global influences.

Cultural concepts are important to psychiatric diagnosis for several reasons:

- **To avoid misdiagnosis:** Cultural variation in symptoms and in explanatory models associated with these cultural concepts may lead clinicians to misjudge the severity of a

problem or assign the wrong diagnosis (e.g., unfamiliar spiritual explanations may be misunderstood as psychosis).

- **To obtain useful clinical information:** Cultural variations in symptoms and attributions may be associated with particular features of risk, resilience, and outcome.
- **To improve clinical rapport and engagement:** "Speaking the language of the patient," both linguistically and in terms of his or her dominant concepts and metaphors, can result in greater communication and satisfaction, facilitate treatment negotiation, and lead to higher retention and adherence.
- **To improve therapeutic efficacy:** Culture influences the psychological mechanisms of disorder, which need to be understood and addressed to improve clinical efficacy. For example, culturally specific catastrophic cognitions can contribute to symptom escalation into panic attacks.
- **To guide clinical research:** Locally perceived connections between cultural concepts may help identify patterns of comorbidity and underlying biological substrates.
- **To clarify the cultural epidemiology:** Cultural concepts of distress are not endorsed uniformly by everyone in a given culture. Distinguishing syndromes, idioms, and explanations provides an approach for studying the distribution of cultural features of illness across settings and regions, and over time. It also suggests questions about cultural determinants of risk, course, and outcome in clinical and community settings to enhance the evidence base of cultural research.

DSM-5 includes information on cultural concepts in order to improve the accuracy of diagnosis and the comprehensiveness of clinical assessment. Clinical assessment of individuals presenting with these cultural concepts should determine whether they meet DSM-5 criteria for a specified disorder or an *other specified or unspecified* diagnosis. Once the disorder is diagnosed, the cultural terms and explanations should be included in case formulations; they may help clarify symptoms and etiological attributions that could otherwise be confusing. Individuals whose symptoms do not meet DSM criteria for a specific mental disorder may still expect and require treatment; this should be assessed on a case-by-case basis. In addition to the CFI and its supplementary modules, DSM-5 contains the following information and tools that may be useful when integrating cultural information in clinical practice:

- **Data in DSM-5 criteria and text for specific disorders:** The text includes information on cultural variations in prevalence, symptomatology, associated cultural concepts, and other clinical aspects. It is important to emphasize that there is no one-to-one correspondence at the categorical level between DSM disorders and cultural concepts. Differential diagnosis for individuals must therefore incorporate information on cultural variation with information elicited by the CFI.
- **Other Conditions That May Be a Focus of Clinical Attention:** Some of the clinical concerns identified by the CFI may correspond to V codes or Z codes—for example, acculturation problems, parent-child relational problems, or religious or spiritual problems.
- **Glossary of Cultural Concepts of Distress:** Located in the Appendix, this glossary provides examples of well-studied cultural concepts of distress that illustrate the relevance of cultural information for clinical diagnosis and some of the interrelationships among cultural syndromes, idioms of distress, and causal explanations.

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Alternative DSM-5 Model for Personality Disorders

The current approach to personality disorders appears in Section II of DSM-5, and an alternative model developed for DSM-5 is presented here in Section III. The inclusion of both models in DSM-5 reflects the decision of the APA Board of Trustees to preserve continuity with current clinical practice, while also introducing a new approach that aims to address numerous shortcomings of the current approach to personality disorders. For example, the typical patient meeting criteria for a specific personality disorder frequently also meets criteria for other personality disorders. Similarly, other specified or unspecified personality disorder is often the correct (but mostly uninformative) diagnosis, in the sense that patients do not tend to present with patterns of symptoms that correspond with one and only one personality disorder.

In the following alternative DSM-5 model, personality disorders are characterized by impairments in personality *functioning* and pathological personality *traits.* The specific personality disorder diagnoses that may be derived from this model include antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders. This approach also includes a diagnosis of personality disorder—trait specified (PD-TS) that can be made when a personality disorder is considered present but the criteria for a specific disorder are not met.

General Criteria for Personality Disorder

General Criteria for Personality Disorder

The essential features of a personality disorder are

A. Moderate or greater impairment in personality (self/interpersonal) functioning.
B. One or more pathological personality traits.
C. The impairments in personality functioning and the individual's personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations.
D. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood.
E. The impairments in personality functioning and the individual's personality trait expression are not better explained by another mental disorder.
F. The impairments in personality functioning and the individual's personality trait expression are not solely attributable to the physiological effects of a substance or another medical condition (e.g., severe head trauma).
G. The impairments in personality functioning and the individual's personality trait expression are not better understood as normal for an individual's developmental stage or sociocultural environment.

A diagnosis of a personality disorder requires two determinations: 1) an assessment of the level of impairment in personality functioning, which is needed for Criterion A, and 2) an evaluation of pathological personality traits, which is required for Criterion B. The impairments in personality functioning and personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations (Criterion C); relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood (Criterion D); not better explained by another mental disorder (Criterion E); not attributable to the effects of a substance or another medical condition (Criterion F); and not better understood as normal for an individual's developmental stage or sociocultural environment (Criterion G). All Section III personality disorders described by criteria sets, as well as PD-TS, meet these general criteria, by definition.

Criterion A: Level of Personality Functioning

Disturbances in **self** and **interpersonal** functioning constitute the core of personality psychopathology and in this alternative diagnostic model they are evaluated on a continuum. Self functioning involves identity and self-direction; interpersonal functioning involves empathy and intimacy (see Table 1). The Level of Personality Functioning Scale (LPFS; see Table 2, pp. 775–778) uses each of these elements to differentiate five levels of impairment, ranging from little or no impairment (i.e., healthy, adaptive functioning; Level 0) to some (Level 1), moderate (Level 2), severe (Level 3), and extreme (Level 4) impairment.

TABLE 1 Elements of personality functioning

Self:

1. ***Identity:*** Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience.
2. ***Self-direction:*** Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively.

Interpersonal:

1. ***Empathy:*** Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding the effects of one's own behavior on others.
2. ***Intimacy:*** Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior.

Impairment in personality functioning predicts the presence of a personality disorder, and the severity of impairment predicts whether an individual has more than one personality disorder or one of the more typically severe personality disorders. A moderate level of impairment in personality functioning is required for the diagnosis of a personality disorder; this threshold is based on empirical evidence that the moderate level of impairment maximizes the ability of clinicians to accurately and efficiently identify personality disorder pathology.

Criterion B: Pathological Personality Traits

Pathological personality traits are organized into five broad domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. Within the five broad **trait domains** are 25 specific **trait facets** that were developed initially from a review of existing trait models and subsequently through iterative research with samples of persons who sought mental health services. The full trait taxonomy is presented in Table 3 (see pp. 779–781). The B criteria for the specific personality disorders comprise subsets of the 25 trait

facets, based on meta-analytic reviews and empirical data on the relationships of the traits to DSM-IV personality disorder diagnoses.

Criteria C and D: Pervasiveness and Stability

Impairments in personality functioning and pathological personality traits are *relatively* pervasive across a range of personal and social contexts, as personality is defined as a pattern of perceiving, relating to, and thinking about the environment and oneself. The term *relatively* reflects the fact that all except the most extremely pathological personalities show some degree of adaptability. The pattern in personality disorders is maladaptive and relatively inflexible, which leads to disabilities in social, occupational, or other important pursuits, as individuals are unable to modify their thinking or behavior, even in the face of evidence that their approach is not working. The impairments in functioning and personality traits are also *relatively* stable. Personality traits—the dispositions to behave or feel in certain ways—are more stable than the symptomatic expressions of these dispositions, but personality traits can also change. Impairments in personality functioning are more stable than symptoms.

Criteria E, F, and G: Alternative Explanations for Personality Pathology (Differential Diagnosis)

On some occasions, what appears to be a personality disorder may be better explained by another mental disorder, the effects of a substance or another medical condition, or a normal developmental stage (e.g., adolescence, late life) or the individual's sociocultural environment. When another mental disorder is present, the diagnosis of a personality disorder is not made, if the manifestations of the personality disorder clearly are an expression of the other mental disorder (e.g., if features of schizotypal personality disorder are present only in the context of schizophrenia). On the other hand, personality disorders can be accurately diagnosed in the presence of another mental disorder, such as major depressive disorder, and patients with other mental disorders should be assessed for comorbid personality disorders because personality disorders often impact the course of other mental disorders. Therefore, it is always appropriate to assess personality functioning and pathological personality traits to provide a context for other psychopathology.

Specific Personality Disorders

Section III includes diagnostic criteria for antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders. Each personality disorder is defined by typical impairments in personality functioning (Criterion A) and characteristic pathological personality traits (Criterion B):

- Typical features of **antisocial personality disorder** are a failure to conform to lawful and ethical behavior, and an egocentric, callous lack of concern for others, accompanied by deceitfulness, irresponsibility, manipulativeness, and/or risk taking.
- Typical features of **avoidant personality disorder** are avoidance of social situations and inhibition in interpersonal relationships related to feelings of ineptitude and inadequacy, anxious preoccupation with negative evaluation and rejection, and fears of ridicule or embarrassment.
- Typical features of **borderline personality disorder** are instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking, and/or hostility.
- Typical features of **narcissistic personality disorder** are variable and vulnerable self-esteem, with attempts at regulation through attention and approval seeking, and either overt or covert grandiosity.

- Typical features of **obsessive-compulsive personality disorder** are difficulties in establishing and sustaining close relationships, associated with rigid perfectionism, inflexibility, and restricted emotional expression.
- Typical features of **schizotypal personality disorder** are impairments in the capacity for social and close relationships, and eccentricities in cognition, perception, and behavior that are associated with distorted self-image and incoherent personal goals and accompanied by suspiciousness and restricted emotional expression.

The A and B criteria for the six specific personality disorders and for PD-TS follow. All personality disorders also meet criteria C through G of the General Criteria for Personality Disorder.

Antisocial Personality Disorder

Typical features of antisocial personality disorder are a failure to conform to lawful and ethical behavior, and an egocentric, callous lack of concern for others, accompanied by deceitfulness, irresponsibility, manipulativeness, and/or risk taking. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domains of Antagonism and Disinhibition.

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:
   1. ***Identity:*** Egocentrism; self-esteem derived from personal gain, power, or pleasure.
   2. ***Self-direction:*** Goal setting based on personal gratification; absence of prosocial internal standards, associated with failure to conform to lawful or culturally normative ethical behavior.
   3. ***Empathy:*** Lack of concern for feelings, needs, or suffering of others; lack of remorse after hurting or mistreating another.
   4. ***Intimacy:*** Incapacity for mutually intimate relationships, as exploitation is a primary means of relating to others, including by deceit and coercion; use of dominance or intimidation to control others.

B. Six or more of the following seven pathological personality traits:
   1. ***Manipulativeness*** (an aspect of **Antagonism**): Frequent use of subterfuge to influence or control others; use of seduction, charm, glibness, or ingratiation to achieve one's ends.
   2. ***Callousness*** (an aspect of **Antagonism**): Lack of concern for feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others; aggression; sadism.
   3. ***Deceitfulness*** (an aspect of **Antagonism**): Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events.
   4. ***Hostility*** (an aspect of **Antagonism**): Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behavior.
   5. ***Risk taking*** (an aspect of **Disinhibition**): Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard for consequences; boredom proneness and thoughtless initiation of activities to counter boredom; lack of concern for one's limitations and denial of the reality of personal danger.
   6. ***Impulsivity*** (an aspect of **Disinhibition**): Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans.

7. ***Irresponsibility*** (an aspect of **Disinhibition**): Disregard for—and failure to honor—financial and other obligations or commitments; lack of respect for—and lack of follow-through on—agreements and promises.

Note. The individual is at least 18 years of age.

Specify if:

With psychopathic features.

Specifiers. A distinct variant often termed *psychopathy* (or "primary" psychopathy) is marked by a lack of anxiety or fear and by a bold interpersonal style that may mask maladaptive behaviors (e.g., fraudulence). This psychopathic variant is characterized by low levels of anxiousness (Negative Affectivity domain) and withdrawal (Detachment domain) and high levels of attention seeking (Antagonism domain). High attention seeking and low withdrawal capture the social potency (assertive/dominant) component of psychopathy, whereas low anxiousness captures the stress immunity (emotional stability/resilience) component.

In addition to psychopathic features, trait and personality functioning specifiers may be used to record other personality features that may be present in antisocial personality disorder but are not required for the diagnosis. For example, traits of Negative Affectivity (e.g., anxiousness), are not diagnostic criteria for antisocial personality disorder (see Criterion B) but can be specified when appropriate. Furthermore, although moderate or greater impairment in personality functioning is required for the diagnosis of antisocial personality disorder (Criterion A), the level of personality functioning can also be specified.

Avoidant Personality Disorder

Typical features of avoidant personality disorder are avoidance of social situations and inhibition in interpersonal relationships related to feelings of ineptitude and inadequacy, anxious preoccupation with negative evaluation and rejection, and fears of ridicule or embarrassment. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domains of Negative Affectivity and Detachment.

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifest by characteristic difficulties in two or more of the following four areas:
   1. ***Identity:*** Low self-esteem associated with self-appraisal as socially inept, personally unappealing, or inferior; excessive feelings of shame.
   2. ***Self-direction:*** Unrealistic standards for behavior associated with reluctance to pursue goals, take personal risks, or engage in new activities involving interpersonal contact.
   3. ***Empathy:*** Preoccupation with, and sensitivity to, criticism or rejection, associated with distorted inference of others' perspectives as negative.
   4. ***Intimacy:*** Reluctance to get involved with people unless being certain of being liked; diminished mutuality within intimate relationships because of fear of being shamed or ridiculed.

B. Three or more of the following four pathological personality traits, one of which must be (1) Anxiousness:
   1. ***Anxiousness*** (an aspect of **Negative Affectivity**): Intense feelings of nervousness, tenseness, or panic, often in reaction to social situations; worry about the negative effects of past unpleasant experiences and future negative possibilities;

feeling fearful, apprehensive, or threatened by uncertainty; fears of embarrassment.
2. ***Withdrawal*** (an aspect of **Detachment**): Reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.
3. ***Anhedonia*** (an aspect of **Detachment**): Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure or take interest in things.
4. ***Intimacy avoidance*** (an aspect of **Detachment**): Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships.

Specifiers. Considerable heterogeneity in the form of additional personality traits is found among individuals diagnosed with avoidant personality disorder. Trait and level of personality functioning specifiers can be used to record additional personality features that may be present in avoidant personality disorder. For example, other Negative Affectivity traits (e.g., depressivity, separation insecurity, submissiveness, suspiciousness, hostility) are not diagnostic criteria for avoidant personality disorder (see Criterion B) but can be specified when appropriate. Furthermore, although moderate or greater impairment in personality functioning is required for the diagnosis of avoidant personality disorder (Criterion A), the level of personality functioning also can be specified.

Borderline Personality Disorder

Typical features of borderline personality disorder are instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking, and/or hostility. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domain of Negative Affectivity, and also Antagonism and/or Disinhibition.

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:
   1. ***Identity:*** Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
   2. ***Self-direction:*** Instability in goals, aspirations, values, or career plans.
   3. ***Empathy:*** Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.
   4. ***Intimacy:*** Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between overinvolvement and withdrawal.

B. Four or more of the following seven pathological personality traits, at least one of which must be (5) Impulsivity, (6) Risk taking, or (7) Hostility:
   1. ***Emotional lability*** (an aspect of **Negative Affectivity**): Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
   2. ***Anxiousness*** (an aspect of **Negative Affectivity**): Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibili-

ties; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.

3. ***Separation insecurity*** (an aspect of **Negative Affectivity**): Fears of rejection by—and/or separation from—significant others, associated with fears of excessive dependency and complete loss of autonomy.
4. ***Depressivity*** (an aspect of **Negative Affectivity**): Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.
5. ***Impulsivity*** (an aspect of **Disinhibition**): Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.
6. ***Risk taking*** (an aspect of **Disinhibition**): Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger.
7. ***Hostility*** (an aspect of **Antagonism**): Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.

Specifiers. Trait and level of personality functioning specifiers may be used to record additional personality features that may be present in borderline personality disorder but are not required for the diagnosis. For example, traits of Psychoticism (e.g., cognitive and perceptual dysregulation) are not diagnostic criteria for borderline personality disorder (see Criterion B) but can be specified when appropriate. Furthermore, although moderate or greater impairment in personality functioning is required for the diagnosis of borderline personality disorder (Criterion A), the level of personality functioning can also be specified.

Narcissistic Personality Disorder

Typical features of narcissistic personality disorder are variable and vulnerable self-esteem, with attempts at regulation through attention and approval seeking, and either overt or covert grandiosity. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domain of Antagonism.

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:

1. ***Identity:*** Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal inflated or deflated, or vacillating between extremes; emotional regulation mirrors fluctuations in self-esteem.
2. ***Self-direction:*** Goal setting based on gaining approval from others; personal standards unreasonably high in order to see oneself as exceptional, or too low based on a sense of entitlement; often unaware of own motivations.
3. ***Empathy:*** Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- or underestimate of own effect on others.
4. ***Intimacy:*** Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain.

B. Both of the following pathological personality traits:
   1. ***Grandiosity*** (an aspect of **Antagonism**): Feelings of entitlement, either overt or covert; self-centeredness; firmly holding to the belief that one is better than others; condescension toward others.
   2. ***Attention seeking*** (an aspect of **Antagonism**): Excessive attempts to attract and be the focus of the attention of others; admiration seeking.

Specifiers. Trait and personality functioning specifiers may be used to record additional personality features that may be present in narcissistic personality disorder but are not required for the diagnosis. For example, other traits of Antagonism (e.g., manipulativeness, deceitfulness, callousness) are not diagnostic criteria for narcissistic personality disorder (see Criterion B) but can be specified when more pervasive antagonistic features (e.g., "malignant narcissism") are present. Other traits of Negative Affectivity (e.g., depressivity, anxiousness) can be specified to record more "vulnerable" presentations. Furthermore, although moderate or greater impairment in personality functioning is required for the diagnosis of narcissistic personality disorder (Criterion A), the level of personality functioning can also be specified.

Obsessive-Compulsive Personality Disorder

Typical features of obsessive-compulsive personality disorder are difficulties in establishing and sustaining close relationships, associated with rigid perfectionism, inflexibility, and restricted emotional expression. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domains of Negative Affectivity and/or Detachment.

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:
   1. ***Identity:*** Sense of self derived predominantly from work or productivity; constricted experience and expression of strong emotions.
   2. ***Self-direction:*** Difficulty completing tasks and realizing goals, associated with rigid and unreasonably high and inflexible internal standards of behavior; overly conscientious and moralistic attitudes.
   3. ***Empathy:*** Difficulty understanding and appreciating the ideas, feelings, or behaviors of others.
   4. ***Intimacy:*** Relationships seen as secondary to work and productivity; rigidity and stubbornness negatively affect relationships with others.

B. Three or more of the following four pathological personality traits, one of which must be (1) Rigid perfectionism:
   1. ***Rigid perfectionism*** (an aspect of extreme Conscientiousness [the opposite pole of Disinhibition]): Rigid insistence on everything being flawless, perfect, and without errors or faults, including one's own and others' performance; sacrificing of timeliness to ensure correctness in every detail; believing that there is only one right way to do things; difficulty changing ideas and/or viewpoint; preoccupation with details, organization, and order.
   2. ***Perseveration*** (an aspect of **Negative Affectivity**): Persistence at tasks long after the behavior has ceased to be functional or effective; continuance of the same behavior despite repeated failures.
   3. ***Intimacy avoidance*** (an aspect of **Detachment**): Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships.

4. ***Restricted affectivity*** (an aspect of **Detachment**): Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference or coldness.

Specifiers. Trait and personality functioning specifiers may be used to record additional personality features that may be present in obsessive-compulsive personality disorder but are not required for the diagnosis. For example, other traits of Negative Affectivity (e.g., anxiousness) are not diagnostic criteria for obsessive-compulsive personality disorder (see Criterion B) but can be specified when appropriate. Furthermore, although moderate or greater impairment in personality functioning is required for the diagnosis of obsessive-compulsive personality disorder (Criterion A), the level of personality functioning can also be specified.

Schizotypal Personality Disorder

Typical features of schizotypal personality disorder are impairments in the capacity for social and close relationships and eccentricities in cognition, perception, and behavior that are associated with distorted self-image and incoherent personal goals and accompanied by suspiciousness and restricted emotional expression. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, along with specific maladaptive traits in the domains of Psychoticism and Detachment.

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:
   1. ***Identity:*** Confused boundaries between self and others; distorted self-concept; emotional expression often not congruent with context or internal experience.
   2. ***Self-direction:*** Unrealistic or incoherent goals; no clear set of internal standards.
   3. ***Empathy:*** Pronounced difficulty understanding impact of own behaviors on others; frequent misinterpretations of others' motivations and behaviors.
   4. ***Intimacy:*** Marked impairments in developing close relationships, associated with mistrust and anxiety.

B. Four or more of the following six pathological personality traits:
   1. ***Cognitive and perceptual dysregulation*** (an aspect of **Psychoticism**): Odd or unusual thought processes; vague, circumstantial, metaphorical, overelaborate, or stereotyped thought or speech; odd sensations in various sensory modalities.
   2. ***Unusual beliefs and experiences*** (an aspect of **Psychoticism**): Thought content and views of reality that are viewed by others as bizarre or idiosyncratic; unusual experiences of reality.
   3. ***Eccentricity*** (an aspect of **Psychoticism**): Odd, unusual, or bizarre behavior or appearance; saying unusual or inappropriate things.
   4. ***Restricted affectivity*** (an aspect of **Detachment**): Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference or coldness.
   5. ***Withdrawal*** (an aspect of **Detachment**): Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.
   6. ***Suspiciousness*** (an aspect of **Detachment**): Expectations of—and heightened sensitivity to—signs of interpersonal ill-intent or harm; doubts about loyalty and fidelity of others; feelings of persecution.

Specifiers. Trait and personality functioning specifiers may be used to record additional personality features that may be present in schizotypal personality disorder but are not required for the diagnosis. For example, traits of Negative Affectivity (e.g., depressivity, anxiousness) are not diagnostic criteria for schizotypal personality disorder (see Criterion B) but can be specified when appropriate. Furthermore, although moderate or greater impairment in personality functioning is required for the diagnosis of schizotypal personality disorder (Criterion A), the level of personality functioning can also be specified.

Personality Disorder—Trait Specified

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by difficulties in two or more of the following four areas:
   1. ***Identity***
   2. ***Self-direction***
   3. ***Empathy***
   4. ***Intimacy***

B. One or more pathological personality trait domains OR specific trait facets within domains, considering ALL of the following domains:
   1. **Negative Affectivity** (vs. Emotional Stability): Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/shame, worry, anger), and their behavioral (e.g., self-harm) and interpersonal (e.g., dependency) manifestations.
   2. **Detachment** (vs. Extraversion): Avoidance of socioemotional experience, including both withdrawal from interpersonal interactions, ranging from casual, daily interactions to friendships to intimate relationships, as well as restricted affective experience and expression, particularly limited hedonic capacity.
   3. **Antagonism** (vs. Agreeableness): Behaviors that put the individual at odds with other people, including an exaggerated sense of self-importance and a concomitant expectation of special treatment, as well as a callous antipathy toward others, encompassing both unawareness of others' needs and feelings, and a readiness to use others in the service of self-enhancement.
   4. **Disinhibition** (vs. Conscientiousness): Orientation toward immediate gratification, leading to impulsive behavior driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences.
   5. **Psychoticism** (vs. Lucidity): Exhibiting a wide range of culturally incongruent odd, eccentric, or unusual behaviors and cognitions, including both process (e.g., perception, dissociation) and content (e.g., beliefs).

Subtypes. Because personality features vary continuously along multiple trait dimensions, a comprehensive set of potential expressions of PD-TS can be represented by DSM-5's dimensional model of maladaptive personality trait variants (see Table 3, pp. 779–781). Thus, subtypes are unnecessary for PD-TS, and instead, the descriptive elements that constitute personality are provided, arranged in an empirically based model. This arrangement allows clinicians to tailor the description of each individual's personality disorder profile, considering all five broad domains of personality trait variation and drawing on the descriptive features of these domains as needed to characterize the individual.

Specifiers. The specific personality features of individuals are always recorded in evaluating Criterion B, so the combination of personality features characterizing an individual directly constitutes the specifiers in each case. For example, two individuals who are both characterized by emotional lability, hostility, and depressivity may differ such that the first individual is characterized additionally by callousness, whereas the second is not.

Personality Disorder Scoring Algorithms

The requirement for any two of the four A criteria for each of the six personality disorders was based on maximizing the relationship of these criteria to their corresponding personality disorder. Diagnostic thresholds for the B criteria were also set empirically to minimize change in prevalence of the disorders from DSM-IV and overlap with other personality disorders, and to maximize relationships with functional impairment. The resulting diagnostic criteria sets represent clinically useful personality disorders with high fidelity, in terms of core impairments in personality functioning of varying degrees of severity and constellations of pathological personality traits.

Personality Disorder Diagnosis

Individuals who have a pattern of impairment in personality functioning and maladaptive traits that matches one of the six defined personality disorders should be diagnosed with that personality disorder. If an individual also has one or even several prominent traits that may have clinical relevance in addition to those required for the diagnosis (e.g., see narcissistic personality disorder), the option exists for these to be noted as specifiers. Individuals whose personality functioning or trait pattern is substantially different from that of any of the six specific personality disorders should be diagnosed with PD-TS. The individual may not meet the required number of A or B criteria and, thus, have a subthreshold presentation of a personality disorder. The individual may have a mix of features of personality disorder types or some features that are less characteristic of a type and more accurately considered a mixed or atypical presentation. The specific level of impairment in personality functioning and the pathological personality traits that characterize the individual's personality can be specified for PD-TS, using the Level of Personality Functioning Scale (Table 2) and the pathological trait taxonomy (Table 3). The current diagnoses of paranoid, schizoid, histrionic, and dependent personality disorders are represented also by the diagnosis of PD-TS; these are defined by moderate or greater impairment in personality functioning and can be specified by the relevant pathological personality trait combinations.

Level of Personality Functioning

Like most human tendencies, personality functioning is distributed on a continuum. Central to functioning and adaptation are individuals' characteristic ways of thinking about and understanding themselves and their interactions with others. An optimally functioning individual has a complex, fully elaborated, and well-integrated psychological world that includes a mostly positive, volitional, and adaptive self-concept; a rich, broad, and appropriately regulated emotional life; and the capacity to behave as a productive member of society with reciprocal and fulfilling interpersonal relationships. At the opposite end of the continuum, an individual with severe personality pathology has an impoverished, disorganized, and/or conflicted psychological world that includes a weak, unclear, and maladaptive self-concept; a propensity to negative, dysregulated emotions; and a deficient capacity for adaptive interpersonal functioning and social behavior.

Self- and *Interpersonal* Functioning Dimensional Definition

Generalized severity may be the most important single predictor of concurrent and prospective dysfunction in assessing personality psychopathology. Personality disorders are optimally characterized by a generalized personality severity continuum with additional specification of stylistic elements, derived from personality disorder symptom constellations and personality traits. At the same time, the core of personality psychopathology is impairment in ideas and feelings regarding self and interpersonal relationships; this notion is consistent with multiple theories of personality disorder and their research bases. The components of the Level of Personality Functioning Scale—identity, self-direction, empathy, and intimacy (see Table 1)—are particularly central in describing a personality functioning continuum.

Mental representations of the self and interpersonal relationships are reciprocally influential and inextricably tied, affect the nature of interaction with mental health professionals, and can have a significant impact on both treatment efficacy and outcome, underscoring the importance of assessing an individual's characteristic self-concept as well as views of other people and relationships. Although the degree of disturbance in the self and interpersonal functioning is continuously distributed, it is useful to consider the level of impairment in functioning for clinical characterization and for treatment planning and prognosis.

Rating Level of Personality Functioning

To use the Level of Personality Functioning Scale (LPFS), the clinician selects the level that most closely captures the individual's *current overall* level of impairment in personality functioning. The rating is necessary for the diagnosis of a personality disorder (moderate or greater impairment) and can be used to specify the severity of impairment present for an individual with any personality disorder at a given point in time. The LPFS may also be used as a global indicator of personality functioning without specification of a personality disorder diagnosis, or in the event that personality impairment is subthreshold for a disorder diagnosis.

Personality Traits

Definition and Description

Criterion B in the alternative model involves assessments of personality traits that are grouped into five domains. A *personality trait* is a tendency to feel, perceive, behave, and think in relatively consistent ways across time and across situations in which the trait may manifest. For example, individuals with a high level of the personality trait of *anxiousness* would tend to *feel* anxious readily, including in circumstances in which most people would be calm and relaxed. Individuals high in trait anxiousness also would *perceive* situations to be anxiety-provoking more frequently than would individuals with lower levels of this trait, and those high in the trait would tend to *behave* so as to avoid situations that they *think* would make them anxious. They would thereby tend to *think* about the world as more anxiety provoking than other people.

Importantly, individuals high in trait anxiousness would not necessarily be anxious at all times and in all situations. Individuals' trait levels also can and do change throughout life. Some changes are very general and reflect maturation (e.g., teenagers generally are higher on trait impulsivity than are older adults), whereas other changes reflect individuals' life experiences.

Dimensionality of personality traits. All individuals can be located on the spectrum of trait dimensions; that is, personality traits apply to everyone in different degrees rather

than being present versus absent. Moreover, personality traits, including those identified specifically in the Section III model, exist on a spectrum with two opposing poles. For example, the opposite of the trait of *callousness* is the tendency to be empathic and kind-hearted, even in circumstances in which most persons would not feel that way. Hence, although in Section III this trait is labeled *callousness,* because that pole of the dimension is the primary focus, it could be described in full as *callousness versus kind-heartedness.* Moreover, its opposite pole can be recognized and may not be adaptive in all circumstances (e.g., individuals who, due to extreme kind-heartedness, repeatedly allow themselves to be taken advantage of by unscrupulous others).

Hierarchical structure of personality. Some trait terms are quite specific (e.g., "talkative") and describe a narrow range of behaviors, whereas others are quite broad (e.g., Detachment) and characterize a wide range of behavioral propensities. Broad trait dimensions are called *domains,* and specific trait dimensions are called *facets.* Personality trait *domains* comprise a spectrum of more specific personality *facets* that tend to occur together. For example, withdrawal and anhedonia are specific trait *facets* in the trait *domain* of Detachment. Despite some cross-cultural variation in personality trait facets, the broad domains they collectively comprise are relatively consistent across cultures.

The Personality Trait Model

The Section III personality trait system includes five broad domains of personality trait variation—Negative Affectivity (vs. Emotional Stability), Detachment (vs. Extraversion), Antagonism (vs. Agreeableness), Disinhibition (vs. Conscientiousness), and Psychoticism (vs. Lucidity)—comprising 25 specific personality trait facets. Table 3 provides definitions of all personality domains and facets. These five broad domains are maladaptive variants of the five domains of the extensively validated and replicated personality model known as the "Big Five", or Five Factor Model of personality (FFM), and are also similar to the domains of the Personality Psychopathology Five (PSY-5). The specific 25 facets represent a list of personality facets chosen for their clinical relevance.

Although the Trait Model focuses on personality traits associated with psychopathology, there are healthy, adaptive, and resilient personality traits identified as the polar opposites of these traits, as noted in the parentheses above (i.e., Emotional Stability, Extraversion, Agreeableness, Conscientiousness, and Lucidity). Their presence can greatly mitigate the effects of mental disorders and facilitate coping and recovery from traumatic injuries and other medical illness.

Distinguishing Traits, Symptoms, and Specific Behaviors

Although traits are by no means immutable and do change throughout the life span, they show relative consistency compared with symptoms and specific behaviors. For example, a person may behave impulsively at a specific time for a specific reason (e.g., a person who is rarely impulsive suddenly decides to spend a great deal of money on a particular item because of an unusual opportunity to purchase something of unique value), but it is only when behaviors aggregate across time and circumstance, such that a pattern of behavior distinguishes between individuals, that they reflect traits. Nevertheless, it is important to recognize, for example, that even people who are impulsive are not acting impulsively all of the time. A trait is a tendency or disposition toward specific behaviors; a specific behavior is an instance or manifestation of a trait.

Similarly, traits are distinguished from most symptoms because symptoms tend to wax and wane, whereas traits are relatively more stable. For example, individuals with higher levels of *depressivity* have a greater likelihood of experiencing discrete episodes of a depressive disorder and of showing the symptoms of these disorders, such difficulty concentrating. However, even patients who have a trait propensity to *depressivity* typically cycle through distinguishable episodes of mood disturbance, and specific symptoms such as

difficulty concentrating tend to wax and wane in concert with specific episodes, so they do not form part of the trait definition. Importantly, however, symptoms and traits are both amenable to intervention, and many interventions targeted at symptoms can affect the longer term patterns of personality functioning that are captured by personality traits.

Assessment of the DSM-5 Section III Personality Trait Model

The clinical utility of the Section III multidimensional personality trait model lies in its ability to focus attention on multiple relevant areas of personality variation in each individual patient. Rather than focusing attention on the identification of one and only one optimal diagnostic label, clinical application of the Section III personality trait model involves reviewing all five broad personality domains portrayed in Table 3. The clinical approach to personality is similar to the well-known review of systems in clinical medicine. For example, an individual's presenting complaint may focus on a specific neurological symptom, yet during an initial evaluation clinicians still systematically review functioning in all relevant systems (e.g., cardiovascular, respiratory, gastrointestinal), lest an important area of diminished functioning and corresponding opportunity for effective intervention be missed.

Clinical use of the Section III personality trait model proceeds similarly. An initial inquiry reviews all five broad domains of personality. This systematic review is facilitated by the use of formal psychometric instruments designed to measure specific facets and domains of personality. For example, the personality trait model is operationalized in the Personality Inventory for DSM-5 (PID-5), which can be completed in its self-report form by patients and in its informant-report form by those who know the patient well (e.g., a spouse). A detailed clinical assessment would involve collection of both patient- and informant-report data on all 25 facets of the personality trait model. However, if this is not possible, due to time or other constraints, assessment focused at the five-domain level is an acceptable clinical option when only a general (vs. detailed) portrait of a patient's personality is needed (see Criterion B of PD-TS). However, if personality-based problems are the focus of treatment, then it will be important to assess individuals' trait facets as well as domains.

Because personality traits are continuously distributed in the population, an approach to making the judgment that a specific trait is elevated (and therefore is present for diagnostic purposes) could involve comparing individuals' personality trait levels with population norms and/or clinical judgment. If a trait is elevated—that is, formal psychometric testing and/or interview data support the clinical judgment of elevation—then it is considered as contributing to meeting Criterion B of Section III personality disorders.

Clinical Utility of the Multidimensional Personality Functioning and Trait Model

Disorder and trait constructs each add value to the other in predicting important antecedent (e.g., family history, history of child abuse), concurrent (e.g., functional impairment, medication use), and predictive (e.g., hospitalization, suicide attempts) variables. DSM-5 impairments in personality functioning and pathological personality traits each contribute independently to clinical decisions about degree of disability; risks for self-harm, violence, and criminality; recommended treatment type and intensity; and prognosis—all important aspects of the utility of psychiatric diagnoses. Notably, knowing the level of an individual's personality functioning and his or her pathological trait profile also provides the clinician with a rich base of information and is valuable in treatment planning and in predicting the course and outcome of many mental disorders in addition to personality disorders. Therefore, assessment of personality functioning and pathological personality traits may be relevant whether an individual has a personality disorder or not.

TABLE 2 Level of Personality Functioning Scale

	SELF		INTERPERSONAL	
Level of impairment	Identity	Self-direction	Empathy	Intimacy
0—Little or no impairment	Has ongoing awareness of a unique self; maintains role-appropriate boundaries. Has consistent and self-regulated positive self-esteem, with accurate self-appraisal. Is capable of experiencing, tolerating, and regulating a full range of emotions.	Sets and aspires to reasonable goals based on a realistic assessment of personal capacities. Utilizes appropriate standards of behavior, attaining fulfillment in multiple realms. Can reflect on, and make constructive meaning of, internal experience.	Is capable of accurately understanding others' experiences and motivations in most situations. Comprehends and appreciates others' perspectives, even if disagreeing. Is aware of the effect of own actions on others.	Maintains multiple satisfying and enduring relationships in personal and community life. Desires and engages in a number of caring, close, and reciprocal relationships. Strives for cooperation and mutual benefit and flexibly responds to a range of others' ideas, emotions, and behaviors.
1—Some impairment	Has relatively intact sense of self, with some decrease in clarity of boundaries when strong emotions and mental distress are experienced. Self-esteem diminished at times, with overly critical or somewhat distorted self-appraisal. Strong emotions may be distressing, associated with a restriction in range of emotional experience.	Is excessively goal-directed, somewhat goal-inhibited, or conflicted about goals. May have an unrealistic or socially inappropriate set of personal standards, limiting some aspects of fulfillment. Is able to reflect on internal experiences, but may overemphasize a single (e.g., intellectual, emotional) type of self-knowledge.	Is somewhat compromised in ability to appreciate and understand others' experiences; may tend to see others as having unreasonable expectations or a wish for control. Although capable of considering and understanding different perspectives, resists doing so. Has inconsistent awareness of effect of own behavior on others.	Is able to establish enduring relationships in personal and community life, with some limitations on degree of depth and satisfaction. Is capable of forming and desires to form intimate and reciprocal relationships, but may be inhibited in meaningful expression and sometimes constrained if intense emotions or conflicts arise. Cooperation may be inhibited by unrealistic standards; somewhat limited in ability to respect or respond to others' ideas, emotions, and behaviors.

TABLE 2 Level of Personality Functioning Scale *(continued)*

	SELF		INTERPERSONAL	
Level of impairment	Identity	Self-direction	Empathy	Intimacy
2—Moderate impairment	Depends excessively on others for identity definition, with compromised boundary delineation. Has vulnerable self-esteem controlled by exaggerated concern about external evaluation, with a wish for approval. Has sense of incompleteness or inferiority, with compensatory inflated, or deflated, self-appraisal. Emotional regulation depends on positive external appraisal. Threats to self-esteem may engender strong emotions such as rage or shame.	Goals are more often a means of gaining external approval than self-generated, and thus may lack coherence and/or stability. Personal standards may be unreasonably high (e.g., a need to be special or please others) or low (e.g., not consonant with prevailing social values). Fulfillment is compromised by a sense of lack of authenticity. Has impaired capacity to reflect on internal experience.	Is hyperattuned to the experience of others, but only with respect to perceived relevance to self. Is excessively self-referential; significantly compromised ability to appreciate and understand others' experiences and to consider alternative perspectives. Is generally unaware of or unconcerned about effect of own behavior on others, or unrealistic appraisal of own effect.	Is capable of forming and desires to form relationships in personal and community life, but connections may be largely superficial. Intimate relationships are predominantly based on meeting self-regulatory and self-esteem needs, with an unrealistic expectation of being perfectly understood by others. Tends not to view relationships in reciprocal terms, and cooperates predominantly for personal gain.

TABLE 2 Level of Personality Functioning Scale *(continued)*

	SELF		INTERPERSONAL	
Level of impairment	Identity	Self-direction	Empathy	Intimacy
3—Severe impairment	Has a weak sense of autonomy/agency; experience of a lack of identity, or emptiness. Boundary definition is poor or rigid: may show overidentification with others, overemphasis on independence from others, or vacillation between these. Fragile self-esteem is easily influenced by events, and self-image lacks coherence. Self-appraisal is un-nuanced: self-loathing, self-aggrandizing, or an illogical, unrealistic combination. Emotions may be rapidly shifting or a chronic, unwavering feeling of despair.	Has difficulty establishing and/or achieving personal goals. Internal standards for behavior are unclear or contradictory. Life is experienced as meaningless or dangerous. Has significantly compromised ability to reflect on and understand own mental processes.	Ability to consider and understand the thoughts, feelings, and behavior of other people is significantly limited; may discern very specific aspects of others' experience, particularly vulnerabilities and suffering. Is generally unable to consider alternative perspectives; highly threatened by differences of opinion or alternative viewpoints. Is confused about or unaware of impact of own actions on others; often bewildered about peoples' thoughts and actions, with destructive motivations frequently misattributed to others.	Has some desire to form relationships in community and personal life is present, but capacity for positive and enduring connections is significantly impaired. Relationships are based on a strong belief in the absolute need for the intimate other(s), and/or expectations of abandonment or abuse. Feelings about intimate involvement with others alternate between fear/rejection and desperate desire for connection. Little mutuality: others are conceptualized primarily in terms of how they affect the self (negatively or positively); cooperative efforts are often disrupted due to the perception of slights from others.

TABLE 2 Level of Personality Functioning Scale *(continued)*

	SELF		INTERPERSONAL	
Level of impairment	Identity	Self-direction	Empathy	Intimacy
4—Extreme impairment	Experience of a unique self and sense of agency/autonomy are virtually absent, or are organized around perceived external persecution. Boundaries with others are confused or lacking. Has weak or distorted self-image easily threatened by interactions with others; significant distortions and confusion around self-appraisal. Emotions not congruent with context or internal experience. Hatred and aggression may be dominant affects, although they may be disavowed and attributed to others.	Has poor differentiation of thoughts from actions, so goal-setting ability is severely compromised, with unrealistic or incoherent goals. Internal standards for behavior are virtually lacking. Genuine fulfillment is virtually inconceivable. Is profoundly unable to constructively reflect on own experience. Personal motivations may be unrecognized and/or experienced as external to self.	Has pronounced inability to consider and understand others' experience and motivation. Attention to others' perspectives is virtually absent (attention is hypervigilant, focused on need fulfillment and harm avoidance). Social interactions can be confusing and disorienting.	Desire for affiliation is limited because of profound disinterest or expectation of harm. Engagement with others is detached, disorganized, or consistently negative. Relationships are conceptualized almost exclusively in terms of their ability to provide comfort or inflict pain and suffering. Social/interpersonal behavior is not reciprocal; rather, it seeks fulfillment of basic needs or escape from pain.

TABLE 3 Definitions of DSM-5 personality disorder trait domains and facets

DOMAINS (Polar Opposites) and Facets	Definitions
NEGATIVE AFFECTIVITY (vs. Emotional Stability)	Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/ shame, worry, anger) and their behavioral (e.g., self-harm) and interpersonal (e.g., dependency) manifestations.
Emotional lability	Instability of emotional experiences and mood; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
Anxiousness	Feelings of nervousness, tenseness, or panic in reaction to diverse situations; frequent worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and apprehensive about uncertainty; expecting the worst to happen.
Separation insecurity	Fears of being alone due to rejection by—and/or separation from—significant others, based in a lack of confidence in one's ability to care for oneself, both physically and emotionally.
Submissiveness	Adaptation of one's behavior to the actual or perceived interests and desires of others even when doing so is antithetical to one's own interests, needs, or desires.
Hostility	Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behavior. *See also* Antagonism.
Perseveration	Persistence at tasks or in a particular way of doing things long after the behavior has ceased to be functional or effective; continuance of the same behavior despite repeated failures or clear reasons for stopping.
Depressivity	*See* Detachment.
Suspiciousness	*See* Detachment.
Restricted affectivity (lack of)	The ***lack of*** this facet characterizes ***low levels*** of Negative Affectivity. *See* Detachment for definition of this facet.
DETACHMENT (vs. Extraversion)	Avoidance of socioemotional experience, including both withdrawal from interpersonal interactions (ranging from casual, daily interactions to friendships to intimate relationships) and restricted affective experience and expression, particularly limited hedonic capacity.
Withdrawal	Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.
Intimacy avoidance	Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships.
Anhedonia	Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure and take interest in things.
Depressivity	Feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame and/or guilt; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.
Restricted affectivity	Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference and aloofness in normatively engaging situations.
Suspiciousness	Expectations of—and sensitivity to—signs of interpersonal ill-intent or harm; doubts about loyalty and fidelity of others; feelings of being mistreated, used, and/or persecuted by others.

TABLE 3 Definitions of DSM-5 personality disorder trait domains and facets *(continued)*

DOMAINS (Polar Opposites) and Facets	Definitions
ANTAGONISM (vs. Agreeableness)	Behaviors that put the individual at odds with other people, including an exaggerated sense of self-importance and a concomitant expectation of special treatment, as well as a callous antipathy toward others, encompassing both an unawareness of others' needs and feelings and a readiness to use others in the service of self-enhancement.
Manipulativeness	Use of subterfuge to influence or control others; use of seduction, charm, glibness, or ingratiation to achieve one's ends.
Deceitfulness	Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events.
Grandiosity	Believing that one is superior to others and deserves special treatment; self-centeredness; feelings of entitlement; condescension toward others.
Attention seeking	Engaging in behavior designed to attract notice and to make oneself the focus of others' attention and admiration.
Callousness	Lack of concern for the feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others.
Hostility	*See* Negative Affectivity.
DISINHIBITION (vs. Conscientiousness)	Orientation toward immediate gratification, leading to impulsive behavior driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences.
Irresponsibility	Disregard for—and failure to honor—financial and other obligations or commitments; lack of respect for—and lack of follow-through on—agreements and promises; carelessness with others' property.
Impulsivity	Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans; a sense of urgency and self-harming behavior under emotional distress.
Distractibility	Difficulty concentrating and focusing on tasks; attention is easily diverted by extraneous stimuli; difficulty maintaining goal-focused behavior, including both planning and completing tasks.
Risk taking	Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger; reckless pursuit of goals regardless of the level of risk involved.
Rigid perfectionism (lack of)	Rigid insistence on everything being flawless, perfect, and without errors or faults, including one's own and others' performance; sacrificing of timeliness to ensure correctness in every detail; believing that there is only one right way to do things; difficulty changing ideas and/or viewpoint; preoccupation with details, organization, and order. The ***lack of*** this facet characterizes ***low levels*** of Disinhibition.

TABLE 3 Definitions of DSM-5 personality disorder trait domains and facets *(continued)*

DOMAINS (Polar Opposites) and Facets	Definitions
PSYCHOTICISM (vs. Lucidity)	Exhibiting a wide range of culturally incongruent odd, eccentric, or unusual behaviors and cognitions, including both process (e.g., perception, dissociation) and content (e.g., beliefs).
Unusual beliefs and experiences	Belief that one has unusual abilities, such as mind reading, telekinesis, thought-action fusion, unusual experiences of reality, including hallucination-like experiences.
Eccentricity	Odd, unusual, or bizarre behavior, appearance, and/or speech; having strange and unpredictable thoughts; saying unusual or inappropriate things.
Cognitive and perceptual dysregulation	Odd or unusual thought processes and experiences, including depersonalization, derealization, and dissociative experiences; mixed sleep-wake state experiences; thought-control experiences.

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Conditions for Further Study

Proposed criteria sets are presented for conditions on which future research is encouraged. The specific items, thresholds, and durations contained in these research criteria sets were set by expert consensus—informed by literature review, data reanalysis, and field trial results, where available—and are intended to provide a common language for researchers and clinicians who are interested in studying these disorders. It is hoped that such research will allow the field to better understand these conditions and will inform decisions about possible placement in forthcoming editions of DSM. The DSM-5 Task Force and Work Groups subjected each of these proposed criteria sets to a careful empirical review and invited wide commentary from the field as well as from the general public. The Task Force determined that there was insufficient evidence to warrant inclusion of these proposals as official mental disorder diagnoses in Section II. ***These proposed criteria sets are not intended for clinical use; only the criteria sets and disorders in Section II of DSM-5 are officially recognized and can be used for clinical purposes.***

Attenuated Psychosis Syndrome

Proposed Criteria

A. At least one of the following symptoms is present in attenuated form, with relatively intact reality testing, and is of sufficient severity or frequency to warrant clinical attention:
   1. Delusions.
   2. Hallucinations.
   3. Disorganized speech.

B. Symptom(s) must have been present at least once per week for the past month.

C. Symptom(s) must have begun or worsened in the past year.

D. Symptom(s) is sufficiently distressing and disabling to the individual to warrant clinical attention.

E. Symptom(s) is not better explained by another mental disorder, including a depressive or bipolar disorder with psychotic features, and is not attributable to the physiological effects of a substance or another medical condition.

F. Criteria for any psychotic disorder have never been met.

Diagnostic Features

Attenuated psychotic symptoms, as defined in Criterion A, are psychosis-like but below the threshold for a full psychotic disorder. Compared with psychotic disorders, the symptoms are less severe and more transient, and insight is relatively maintained. A diagnosis of attenuated psychosis syndrome requires state psychopathology associated with functional impairment rather than long-standing trait pathology. The psychopathology has not progressed to full psychotic severity. Attenuated psychosis syndrome is a disorder based on the manifest pathology and impaired function and distress. Changes in experiences and behav-

iors are noted by the individual and/or others, suggesting a change in mental state (i.e., the symptoms are of sufficient severity or frequency to warrant clinical attention) (Criterion A). Attenuated delusions (Criterion A1) may have suspiciousness/persecutory ideational content, including persecutory ideas of reference. The individual may have a guarded, distrustful attitude. When the delusions are moderate in severity, the individual views others as untrustworthy and may be hypervigilant or sense ill will in others. When the delusions are severe but still within the attenuated range, the individual entertains loosely organized beliefs about danger or hostile intention, but the delusions do not have the fixed nature that is necessary for the diagnosis of a psychotic disorder. Guarded behavior in the interview can interfere with the ability to gather information. Reality testing and perspective can be elicited with nonconfirming evidence, but the propensity for viewing the world as hostile and dangerous remains strong. Attenuated delusions may have grandiose content presenting as an unrealistic sense of superior capacity. When the delusions are moderate, the individual harbors notions of being gifted, influential, or special. When the delusions are severe, the individual has beliefs of superiority that often alienate friends and worry relatives. Thoughts of being special may lead to unrealistic plans and investments, yet skepticism about these attitudes can be elicited with persistent questioning and confrontation.

Attenuated hallucinations (Criterion A2) include alterations in sensory perceptions, usually auditory and/or visual. When the hallucinations are moderate, the sounds and images are often unformed (e.g., shadows, trails, halos, murmurs, rumbling), and they are experienced as unusual or puzzling. When the hallucinations are severe, these experiences become more vivid and frequent (i.e., recurring illusions or hallucinations that capture attention and affect thinking and concentration). These perceptual abnormalities may disrupt behavior, but skepticism about their reality can still be induced.

Disorganized communication (Criterion A3) may manifest as odd speech (vague, metaphorical, overelaborate, stereotyped), unfocused speech (confused, muddled, too fast or too slow, wrong words, irrelevant context, off track), or meandering speech (circumstantial, tangential). When the disorganization is moderately severe, the individual frequently gets into irrelevant topics but responds easily to clarifying questions. Speech may be odd but understandable. At the moderately severe level, speech becomes meandering and circumstantial, and when the disorganization is severe, the individual fails to get to the point without external guidance (tangential). At the severe level, some thought blocking and/or loose associations may occur infrequently, especially when the individual is under pressure, but reorienting questions quickly return structure and organization to the conversation.

The individual realizes that changes in mental state and/or in relationships are taking place. He or she maintains reasonable insight into the psychotic-like experiences and generally appreciates that altered perceptions are not real and magical ideation is not compelling. The individual must experience distress and/or impaired performance in social or role functioning (Criterion D), and the individual or responsible others must note the changes and express concern, such that clinical care is sought (Criterion A).

Associated Features Supporting Diagnosis

The individual may experience magical thinking, perceptual aberrations, difficulty in concentration, some disorganization in thought or behavior, excessive suspiciousness, anxiety, social withdrawal, and disruption in sleep-wake cycle. Impaired cognitive function and negative symptoms are often observed. Neuroimaging variables distinguish cohorts with attenuated psychosis syndrome from normal control cohorts with patterns similar to, but less severe than, that observed in schizophrenia. However, neuroimaging data is not diagnostic at the individual level.

Prevalence

The prevalence of attenuated psychosis syndrome is unknown. Symptoms in Criterion A are not uncommon in the non-help-seeking population, ranging from 8%–13% for hallu-

cinatory experiences and delusional thinking. There appears to be a slight male preponderance for attenuated psychosis syndrome.

Development and Course

Onset of attenuated psychosis syndrome is usually in mid-to-late adolescence or early adulthood. It may be preceded by normal development or evidence for impaired cognition, negative symptoms, and/or impaired social development. In help-seeking cohorts, approximately 18% in 1 year and 32% in 3 years may progress symptomatically and met criteria for a psychotic disorder. In some cases, the syndrome may transition to a depressive or bipolar disorder with psychotic features, but development to a schizophrenia spectrum disorder is more frequent. It appears that the diagnosis is best applied to individuals ages 15–35 years. Long-term course is not yet described beyond 7–12 years.

Risk and Prognostic Factors

Temperamental. Factors predicting prognosis of attenuated psychosis syndrome have not been definitively characterized, but the presence of negative symptoms, cognitive impairment, and poor functioning are associated with poor outcome and increase risk of transition to psychosis.

Genetic and physiological. A family history of psychosis places the individual with attenuated psychosis syndrome at increased risk for developing a full psychotic disorder. Structural, functional, and neurochemical imaging data are associated with increased risk of transition to psychosis.

Functional Consequences of Attenuated Psychosis Syndrome

Many individuals may experience functional impairments. Modest-to-moderate impairment in social and role functioning may persist even with abatement of symptoms. A substantial portion of individuals with the diagnosis will improve over time; many continue to have mild symptoms and impairment, and many others will have a full recovery.

Differential Diagnosis

Brief psychotic disorder. When symptoms of attenuated psychosis syndrome initially manifest, they may resemble symptoms of brief psychotic disorder. However, in attenuated psychosis syndrome, the symptoms do not cross the psychosis threshold and reality testing/insight remains intact.

Schizotypal personality disorder. Schizotypal personality disorder, although having symptomatic features that are similar to those of attenuated psychosis syndrome, is a relatively stable trait disorder not meeting the state-dependent aspects (Criterion C) of attenuated psychosis syndrome. In addition, a broader array of symptoms is required for schizotypal personality disorder, although in the early stages of presentation it may resemble attenuated psychosis syndrome.

Depressive or bipolar disorders. Reality distortions that are temporally limited to an episode of a major depressive disorder or bipolar disorder and are descriptively more characteristic of those disorders do not meet Criterion E for attenuated psychosis syndrome. For example, feelings of low self-esteem or attributions of low regard from others in the context of major depressive disorder would not qualify for comorbid attenuated psychosis syndrome.

Anxiety disorders. Reality distortions that are temporally limited to an episode of an anxiety disorder and are descriptively more characteristic of an anxiety disorder do not

meet Criterion E for attenuated psychosis syndrome. For example, a feeling of being the focus of undesired attention in the context of social anxiety disorder would not qualify for comorbid attenuated psychosis syndrome.

Bipolar II disorder. Reality distortions that are temporally limited to an episode of mania or hypomania and are descriptively more characteristic of bipolar disorder do not meet Criterion E for attenuated psychosis syndrome. For example, inflated self-esteem in the context of pressured speech and reduced need for sleep would not qualify for comorbid attenuated psychosis syndrome.

Borderline personality disorder. Reality distortions that are concomitant with borderline personality disorder and are descriptively more characteristic of it do not meet Criterion E for attenuated psychosis syndrome. For example, a sense of being unable to experience feelings in the context of an intense fear of real or imagined abandonment and recurrent self-mutilation would not qualify for comorbid attenuated psychosis syndrome.

Adjustment reaction of adolescence. Mild, transient symptoms typical of normal development and consistent with the degree of stress experienced do not qualify for attenuated psychosis syndrome.

Extreme end of perceptual aberration and magical thinking in the non-ill population. This diagnostic possibility should be strongly entertained when reality distortions are not associated with distress and functional impairment and need for care.

Substance/medication-induced psychotic disorder. Substance use is common among individuals whose symptoms meet attenuated psychosis syndrome criteria. When otherwise qualifying characteristic symptoms are strongly temporally related to substance use episodes, Criterion E for attenuated psychosis syndrome may not be met, and a diagnosis of substance/medication-induced psychotic disorder may be preferred.

Attention-deficit/hyperactivity disorder. A history of attentional impairment does not exclude a current attenuated psychosis syndrome diagnosis. Earlier attentional impairment may be a prodromal condition or comorbid attention-deficit/hyperactivity disorder.

Comorbidity

Individuals with attenuated psychosis syndrome often experience anxiety and/or depression. Some individuals with an attenuated psychosis syndrome diagnosis will progress to another diagnosis, including anxiety, depressive, bipolar, and personality disorders. In such cases, the psychopathology associated with the attenuated psychosis syndrome diagnosis is reconceptualized as the prodromal phase of another disorder, not a comorbid condition.

Depressive Episodes With Short-Duration Hypomania

Proposed Criteria

Lifetime experience of at least one major depressive episode meeting the following criteria:

A. Five (or more) of the following criteria have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. (**Note:** Do not include symptoms that are clearly attributable to a medical condition.)

   1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
   2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The disturbance is not attributable to the physiological effects of a substance or another medical condition.
D. The disturbance is not better explained by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

At least two lifetime episodes of hypomanic periods that involve the required criterion symptoms below but are of insufficient duration (at least 2 days but less than 4 consecutive days) to meet criteria for a hypomanic episode. The criterion symptoms are as follows:

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy.
B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:
    1. Inflated self-esteem or grandiosity.
    2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
    3. More talkative than usual or pressured to keep talking.
    4. Flight of ideas or subjective experience that thoughts are racing.
    5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
    6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
    7. Excessive involvement in activities that have a high potential for painful consequences (e.g., the individual engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
D. The disturbance in mood and the change in functioning are observable by others.
E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).

Diagnostic Features

Individuals with short-duration hypomania have experienced at least one major depressive episode as well as at least two episodes of 2–3 days' duration in which criteria for a hypomanic episode were met (except for symptom duration). These episodes are of sufficient intensity to be categorized as a hypomanic episode but do not meet the 4-day duration requirement. Symptoms are present to a significant degree, such that they represent a noticeable change from the individual's normal behavior.

An individual with a history of a syndromal hypomanic episode and a major depressive episode by definition has bipolar II disorder, regardless of current duration of hypomanic symptoms.

Associated Features Supporting Diagnosis

Individuals who have experienced both short-duration hypomania and a major depressive episode, with their increased comorbidity with substance use disorders and a greater family history of bipolar disorder, more closely resemble individuals with bipolar disorder than those with major depressive disorder.

Differences have also been found between individuals with short-duration hypomania and those with syndromal bipolar disorder. Work impairment was greater for individuals with syndromal bipolar disorder, as was the estimated average number of episodes. Individuals with short-duration hypomania may exhibit less severity than individuals with syndromal hypomanic episodes, including less mood lability.

Prevalence

The prevalence of short-duration hypomania is unclear, since the criteria are new as of this edition of the manual. Using somewhat different criteria, however, it has been estimated that short-duration hypomania occurs in 2.8% of the population (compared with hypomania or mania in 5.5% of the population). Short-duration hypomania may be more common in females, who may present with more features of atypical depression.

Risk and Prognostic Factors

Genetic and physiological. A family history of mania is two to three times more common in individuals with short-duration hypomania compared with the general population, but less than half as common as in individuals with a history of syndromal mania or hypomania.

Suicide Risk

Individuals with short-duration hypomania have higher rates of suicide attempts than healthy individuals, although not as high as the rates in individuals with syndromal bipolar disorder.

Functional Consequences of Short-Duration Hypomania

Functional impairments associated specifically with short-duration hypomania are as yet not fully determined. However, research suggests that individuals with this disorder have less work impairment than individuals with syndromal bipolar disorder but more comorbid substance use disorders, particularly alcohol use disorder, than individuals with major depressive disorder.

Differential Diagnosis

Bipolar II disorder. Bipolar II disorder is characterized by a period of at least 4 days of hypomanic symptoms, whereas short-duration hypomania is characterized by periods of

2–3 days of hypomanic symptoms. Once an individual has experienced a hypomanic episode (4 days or more), the diagnosis becomes and remains bipolar II disorder regardless of future duration of hypomanic symptom periods.

Major depressive disorder. Major depressive disorder is also characterized by at least one lifetime major depressive episode. However, the additional presence of at least two lifetime periods of 2–3 days of hypomanic symptoms leads to a diagnosis of short-duration hypomania rather than to major depressive disorder.

Major depressive disorder with mixed features. Both major depressive disorder with mixed features and short-duration hypomania are characterized by the presence of some hypomanic symptoms and a major depressive episode. However, major depressive disorder with mixed features is characterized by hypomanic features present *concurrently* with a major depressive episode, while individuals with short-duration hypomania experience subsyndromal hypomania and fully syndromal major depression at different times.

Bipolar I disorder. Bipolar I disorder is differentiated from short-duration hypomania by at least one lifetime manic episode, which is longer (at least 1 week) and more severe (causes more impaired social functioning) than a hypomanic episode. An episode (of any duration) that involves psychotic symptoms or necessitates hospitalization is by definition a manic episode rather than a hypomanic one.

Cyclothymic disorder. While cyclothymic disorder is characterized by periods of depressive symptoms and periods of hypomanic symptoms, the lifetime presence of a major depressive episode precludes the diagnosis of cyclothymic disorder.

Comorbidity

Short-duration hypomania, similar to full hypomanic episodes, has been associated with higher rates of comorbid anxiety disorders and substance use disorders than are found in the general population.

Persistent Complex Bereavement Disorder

Proposed Criteria

A. The individual experienced the death of someone with whom he or she had a close relationship.
B. Since the death, at least one of the following symptoms is experienced on more days than not and to a clinically significant degree and has persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:
    1. Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behavior, including behaviors that reflect being separated from, and also reuniting with, a caregiver or other attachment figure.
    2. Intense sorrow and emotional pain in response to the death.
    3. Preoccupation with the deceased.
    4. Preoccupation with the circumstances of the death. In children, this preoccupation with the deceased may be expressed through the themes of play and behavior and may extend to preoccupation with possible death of others close to them.
C. Since the death, at least six of the following symptoms are experienced on more days than not and to a clinically significant degree, and have persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:

Reactive distress to the death

1. Marked difficulty accepting the death. In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.
2. Experiencing disbelief or emotional numbness over the loss.
3. Difficulty with positive reminiscing about the deceased.
4. Bitterness or anger related to the loss.
5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame).
6. Excessive avoidance of reminders of the loss (e.g., avoidance of individuals, places, or situations associated with the deceased; in children, this may include avoidance of thoughts and feelings regarding the deceased).

Social/identity disruption

7. A desire to die in order to be with the deceased.
8. Difficulty trusting other individuals since the death.
9. Feeling alone or detached from other individuals since the death.
10. Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased.
11. Confusion about one's role in life, or a diminished sense of one's identity (e.g., feeling that a part of oneself died with the deceased).
12. Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities).

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

E. The bereavement reaction is out of proportion to or inconsistent with cultural, religious, or age-appropriate norms.

Specify if:

With traumatic bereavement: Bereavement due to homicide or suicide with persistent distressing preoccupations regarding the traumatic nature of the death (often in response to loss reminders), including the deceased's last moments, degree of suffering and mutilating injury, or the malicious or intentional nature of the death.

Diagnostic Features

Persistent complex bereavement disorder is diagnosed only if at least 12 months (6 months in children) have elapsed since the death of someone with whom the bereaved had a close relationship (Criterion A). This time frame discriminates normal grief from persistent grief. The condition typically involves a persistent yearning/longing for the deceased (Criterion B1), which may be associated with intense sorrow and frequent crying (Criterion B2) or preoccupation with the deceased (Criterion B3). The individual may also be preoccupied with the manner in which the person died (Criterion B4).

Six additional symptoms are required, including marked difficulty accepting that the individual has died (Criterion C1) (e.g. preparing meals for them), disbelief that the individual is dead (Criterion C2), distressing memories of the deceased (Criterion C3), anger over the loss (Criterion C4), maladaptive appraisals about oneself in relation to the deceased or the death (Criterion C5), and excessive avoidance of reminders of the loss (Criterion C6). Individuals may also report a desire to die because they wish to be with the deceased (Criterion C7); be distrustful of others (Criterion C8); feel isolated (Criterion C9); believe that life has no meaning or purpose without the deceased (Criterion C10); experience a diminished sense of identity in which they feel a part of themselves has died or been lost (Criterion C11); or have difficulty engaging in activities, pursuing relationships, or planning for the future (Criterion C12).

Persistent complex bereavement disorder requires clinically significant distress or impairment in psychosocial functioning (Criterion D). The nature and severity of grief must be beyond expected norms for the relevant cultural setting, religious group, or developmental stage (Criterion E). Although there are variations in how grief can manifest, the symptoms of persistent complex bereavement disorder occur in both genders and in diverse social and cultural groups.

Associated Features Supporting Diagnosis

Some individuals with persistent complex bereavement disorder experience hallucinations of the deceased (auditory or visual) in which they temporarily perceive the deceased's presence (e.g., seeing the deceased sitting in his or her favorite chair). They may also experience diverse somatic complaints (e.g., digestive complaints, pain, fatigue), including symptoms experienced by the deceased.

Prevalence

The prevalence of persistent complex bereavement disorder is approximately 2.4%–4.8%. The disorder is more prevalent in females than in males.

Development and Course

Persistent complex bereavement disorder can occur at any age, beginning after the age of 1 year. Symptoms usually begin within the initial months after the death, although there may be a delay of months, or even years, before the full syndrome appears. Although grief responses commonly appear immediately following bereavement, these reactions are not diagnosed as persistent complex bereavement disorder unless the symptoms persist beyond 12 months (6 months for children).

Young children may experience the loss of a primary caregiver as traumatic, given the disorganizing effects the caregiver's absence can have on a child's coping response. In children, the distress may be expressed in play and behavior, developmental regressions, and anxious or protest behavior at times of separation and reunion. Separation distress may be predominant in younger children, and social/identity distress and risk for comorbid depression can increasingly manifest in older children and adolescents.

Risk and Prognostic Factors

Environmental. Risk for persistent complex bereavement disorder is heightened by increased dependency on the deceased person prior to the death and by the death of a child. Disturbances in caregiver support increase the risk for bereaved children.

Genetic and physiological. Risk for the disorder is heightened by the bereaved individual being female.

Culture-Related Diagnostic Issues

The symptoms of persistent complex bereavement disorder are observed across cultural settings, but grief responses may manifest in culturally specific ways. Diagnosis of the disorder requires that the persistent and severe responses go beyond cultural norms of grief responses and not be better explained by culturally specific mourning rituals.

Suicide Risk

Individuals with persistent complex bereavement disorder frequently report suicidal ideation.

Functional Consequences of Persistent Complex Bereavement Disorder

Persistent complex bereavement disorder is associated with deficits in work and social functioning and with harmful health behaviors, such as increased tobacco and alcohol use. It is also associated with marked increases in risks for serious medical conditions, including cardiac disease, hypertension, cancer, immunological deficiency, and reduced quality of life.

Differential Diagnosis

Normal grief. Persistent complex bereavement disorder is distinguished from normal grief by the presence of severe grief reactions that persist at least 12 months (or 6 months in children) after the death of the bereaved. It is only when severe levels of grief response persist at least 12 months following the death and interfere with the individual's capacity to function that persistent complex bereavement disorder is diagnosed.

Depressive disorders. Persistent complex bereavement disorder, major depressive disorder, and persistent depressive disorder (dysthymia) share sadness, crying, and suicidal thinking. Whereas major depressive disorder and persistent depressive disorder can share depressed mood with persistent complex bereavement disorder, the latter is characterized by a focus on the loss.

Posttraumatic stress disorder. Individuals who experience bereavement as a result of traumatic death may develop both posttraumatic stress disorder (PTSD) and persistent complex bereavement disorder. Both conditions can involve intrusive thoughts and avoidance. Whereas intrusions in PTSD revolve around the traumatic event, intrusive memories in persistent complex bereavement disorder focus on thoughts about many aspects of the relationship with the deceased, including positive aspects of the relationship and distress over the separation. In individuals with the traumatic bereavement specifier of persistent complex bereavement disorder, the distressing thoughts or feelings may be more overtly related to the manner of death, with distressing fantasies of what happened. Both persistent complex bereavement disorder and PTSD can involve avoidance of reminders of distressing events. Whereas avoidance in PTSD is characterized by consistent avoidance of internal and external reminders of the traumatic experience, in persistent complex bereavement disorder, there is also a preoccupation with the loss and yearning for the deceased, which is absent in PTSD.

Separation anxiety disorder. Separation anxiety disorder is characterized by anxiety about separation from current attachment figures, whereas persistent complex bereavement disorder involves distress about separation from a deceased individual.

Comorbidity

The most common comorbid disorders with persistent complex bereavement disorder are major depressive disorder, PTSD, and substance use disorders. PTSD is more frequently comorbid with persistent complex bereavement disorder when the death occurred in traumatic or violent circumstances.

Caffeine Use Disorder

Proposed Criteria

A problematic pattern of caffeine use leading to clinically significant impairment or distress, as manifested by at least the first three of the following criteria occurring within a 12-month period:

1. A persistent desire or unsuccessful efforts to cut down or control caffeine use.
2. Continued caffeine use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by caffeine.

3. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for caffeine.
   b. Caffeine (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
4. Caffeine is often taken in larger amounts or over a longer period than was intended.
5. Recurrent caffeine use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated tardiness or absences from work or school related to caffeine use or withdrawal).
6. Continued caffeine use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of caffeine (e.g., arguments with spouse about consequences of use, medical problems, cost).
7. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of caffeine to achieve desired effect.
   b. Markedly diminished effect with continued use of the same amount of caffeine.
8. A great deal of time is spent in activities necessary to obtain caffeine, use caffeine, or recover from its effects.
9. Craving or a strong desire or urge to use caffeine.

A diagnosis of substance dependence due to caffeine is recognized by the World Health Organization in ICD-10. Since the publication of DSM-IV in 1994, considerable research on caffeine dependence has been published, and several recent reviews provide a current analysis of this literature. There is now sufficient evidence to warrant inclusion of caffeine use disorder as a research diagnosis in DSM-5 to encourage additional research. The working diagnostic algorithm proposed for the study of caffeine use disorder differs from that of the other substance use disorders, reflecting the need to identify only cases that have sufficient clinical importance to warrant the labeling of a mental disorder. A key goal of including caffeine use disorder in this section of DSM-5 is to stimulate research that will determine the reliability, validity, and prevalence of caffeine use disorder based on the proposed diagnostic schema, with particular attention to the association of the diagnosis with functional impairments as part of validity testing.

The proposed criteria for caffeine use disorder reflect the need for a diagnostic threshold higher than that used for the other substance use disorders. Such a threshold is intended to prevent overdiagnosis of caffeine use disorder due to the high rate of habitual nonproblematic daily caffeine use in the general population.

Diagnostic Features

Caffeine use disorder is characterized by the continued use of caffeine and failure to control use despite negative physical and/or psychological consequences. In a survey of the general population, 14% of caffeine users met the criterion of use despite harm, with most reporting that a physician or counselor had advised them to stop or reduce caffeine use within the last year. Medical and psychological problems attributed to caffeine included heart, stomach, and urinary problems, and complaints of anxiety, depression, insomnia, irritability, and difficulty thinking. In the same survey, 45% of caffeine users reported desire or unsuccessful efforts to control caffeine use, 18% reported withdrawal, 8% reported tolerance, 28% used more than intended, and 50% reported spending a great deal of time using caffeine. In addition, 19% reported a strong desire for caffeine that they could not resist, and less than 1% reported that caffeine had interfered with social activities.

Among those seeking treatment for quitting problematic caffeine use, 88% reported having made prior serious attempts to modify caffeine use, and 43% reported having been advised by a medical professional to reduce or eliminate caffeine. Ninety-three percent endorsed signs and symptoms meeting DSM-IV criteria for caffeine dependence, with the

most commonly endorsed criteria being withdrawal (96%), persistent desire or unsuccessful efforts to control use (89%), and use despite knowledge of physical or psychological problems caused by caffeine (87%). The most common reasons for wanting to modify caffeine use were health-related (59%) and a desire to not be dependent on caffeine (35%).

The DSM-5 discussion of caffeine withdrawal in the Section II chapter "Substance-Related and Addictive Disorders" provides information on the features of the withdrawal criterion. It is well documented that habitual caffeine users can experience a well-defined withdrawal syndrome upon acute abstinence from caffeine, and many caffeine-dependent individuals report continued use of caffeine to avoid experiencing withdrawal symptoms.

Prevalence

The prevalence of caffeine use disorder in the general population is unclear. Based on all seven generic DSM-IV-TR criteria for dependence, 30% of current caffeine users may have met DSM-IV criteria for a diagnosis of caffeine dependence, with endorsement of three or more dependence criteria, during the past year. When only four of the seven criteria (the three primary criteria proposed above plus tolerance) are used, the prevalence appears to drop to 9%. Thus, the expected prevalence of caffeine use disorder among regular caffeine users is likely less than 9%. Given that approximately 75%–80% of the general population uses caffeine regularly, the estimated prevalence would be less than 7%. Among regular caffeine drinkers at higher risk for caffeine use problems (e.g., high school and college students, individuals in drug treatment, and individuals at pain clinics who have recent histories of alcohol or illicit drug misuse), approximately 20% may have a pattern of use that meets all three of the proposed criteria in Criterion A.

Development and Course

Individuals whose pattern of use meets criteria for a caffeine use disorder have shown a wide range of daily caffeine intake and have been consumers of various types of caffeinated products (e.g., coffee, soft drinks, tea) and medications. A diagnosis of caffeine use disorder has been shown to prospectively predict a greater incidence of caffeine reinforcement and more severe withdrawal.

There has been no longitudinal or cross-sectional lifespan research on caffeine use disorder. Caffeine use disorder has been identified in both adolescents and adults. Rates of caffeine consumption and overall level of caffeine consumption tend to increase with age until the early to mid-30s and then level off. Age-related factors for caffeine use disorder are unknown, although concern is growing related to excessive caffeine consumption among adolescents and young adults through use of caffeinated energy drinks.

Risk and Prognostic Factors

Genetic and physiological. Heritabilities of heavy caffeine use, caffeine tolerance, and caffeine withdrawal range from 35% to 77%. For caffeine use, alcohol use, and cigarette smoking, a common genetic factor (polysubstance use) underlies the use of these three substances, with 28%–41% of the heritable effects of caffeine use (or heavy use) shared with alcohol and smoking. Caffeine and tobacco use disorders are associated and substantially influenced by genetic factors unique to these licit drugs. The magnitude of heritability for caffeine use disorder markers appears to be similar to that for alcohol and tobacco use disorder markers.

Functional Consequences of Caffeine Use Disorder

Caffeine use disorder may predict greater use of caffeine during pregnancy. Caffeine withdrawal, a key feature of caffeine use disorder, has been shown to produce functional im-

pairment in normal daily activities. Caffeine intoxication may include symptoms of nausea and vomiting, as well as impairment of normal activities. Significant disruptions in normal daily activities may occur during caffeine abstinence.

Differential Diagnosis

Nonproblematic use of caffeine. The distinction between nonproblematic use of caffeine and caffeine use disorder can be difficult to make because social, behavioral, or psychological problems may be difficult to attribute to the substance, especially in the context of use of other substances. Regular, heavy caffeine use that can result in tolerance and withdrawal is relatively common, which by itself should not be sufficient for making a diagnosis.

Other stimulant use disorder. Problems related to use of other stimulant medications or substances may approximate the features of caffeine use disorder.

Anxiety disorders. Chronic heavy caffeine use may mimic generalized anxiety disorder, and acute caffeine consumption may produce and mimic panic attacks.

Comorbidity

There may be comorbidity between caffeine use disorder and daily cigarette smoking, a family or personal history of alcohol use disorder. Features of caffeine use disorder (e.g., tolerance, caffeine withdrawal) may be positively associated with several diagnoses: major depression, generalized anxiety disorder, panic disorder, adult antisocial personality disorder, and alcohol, cannabis, and cocaine use disorders.

Internet Gaming Disorder

Proposed Criteria

Persistent and recurrent use of the Internet to engage in games, often with other players, leading to clinically significant impairment or distress as indicated by five (or more) of the following in a 12-month period:

1. Preoccupation with Internet games. (The individual thinks about previous gaming activity or anticipates playing the next game; Internet gaming becomes the dominant activity in daily life).
   Note: This disorder is distinct from Internet gambling, which is included under gambling disorder.
2. Withdrawal symptoms when Internet gaming is taken away. (These symptoms are typically described as irritability, anxiety, or sadness, but there are no physical signs of pharmacological withdrawal.)
3. Tolerance—the need to spend increasing amounts of time engaged in Internet games.
4. Unsuccessful attempts to control the participation in Internet games.
5. Loss of interests in previous hobbies and entertainment as a result of, and with the exception of, Internet games.
6. Continued excessive use of Internet games despite knowledge of psychosocial problems.
7. Has deceived family members, therapists, or others regarding the amount of Internet gaming.
8. Use of Internet games to escape or relieve a negative mood (e.g., feelings of helplessness, guilt, anxiety).
9. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of participation in Internet games.

Note: Only nongambling Internet games are included in this disorder. Use of the Internet for required activities in a business or profession is not included; nor is the disorder intended to include other recreational or social Internet use. Similarly, sexual Internet sites are excluded.

Specify current severity:

Internet gaming disorder can be mild, moderate, or severe depending on the degree of disruption of normal activities. Individuals with less severe Internet gaming disorder may exhibit fewer symptoms and less disruption of their lives. Those with severe Internet gaming disorder will have more hours spent on the computer and more severe loss of relationships or career or school opportunities.

Subtypes

There are no well-researched subtypes for Internet gaming disorder to date. Internet gaming disorder most often involves specific Internet games, but it could involve non-Internet computerized games as well, although these have been less researched. It is likely that preferred games will vary over time as new games are developed and popularized, and it is unclear if behaviors and consequence associated with Internet gaming disorder vary by game type.

Diagnostic Features

Gambling disorder is currently the only non-substance-related disorder proposed for inclusion with DSM-5 substance-related and addictive disorders. However, there are other behavioral disorders that show some similarities to substance use disorders and gambling disorder for which the word *addiction* is commonly used in nonmedical settings, and the one condition with a considerable literature is the compulsive playing of Internet games. Internet gaming has been reportedly defined as an "addiction" by the Chinese government, and a treatment system has been set up. Reports of treatment of this condition have appeared in medical journals, mostly from Asian countries and some in the United States.

The DSM-5 work group reviewed more than 240 articles and found some behavioral similarities of Internet gaming to gambling disorder and to substance use disorders. The literature suffers, however, from lack of a standard definition from which to derive prevalence data. An understanding of the natural histories of cases, with or without treatment, is also missing. The literature does describe many underlying similarities to substance addictions, including aspects of tolerance, withdrawal, repeated unsuccessful attempts to cut back or quit, and impairment in normal functioning. Further, the seemingly high prevalence rates, both in Asian countries and, to a lesser extent, in the West, justified inclusion of this disorder in Section III of DSM-5.

Internet gaming disorder has significant public health importance, and additional research may eventually lead to evidence that Internet gaming disorder (also commonly referred to as *Internet use disorder, Internet addiction,* or *gaming addiction*) has merit as an independent disorder. As with gambling disorder, there should be epidemiological studies to determine prevalence, clinical course, possible genetic influence, and potential biological factors based on, for example, brain imaging data.

Internet gaming disorder is a pattern of excessive and prolonged Internet gaming that results in a cluster of cognitive and behavioral symptoms, including progressive loss of control over gaming, tolerance, and withdrawal symptoms, analogous to the symptoms of substance use disorders. As with substance-related disorders, individuals with Internet gaming disorder continue to sit at a computer and engage in gaming activities despite neglect of other activities. They typically devote 8–10 hours or more per day to this activity and at least 30 hours per week. If they are prevented from using a computer and returning to the game, they become agitated and angry. They often go for long periods without food or sleep. Nor-

mal obligations, such as school or work, or family obligations are neglected. This condition is separate from gambling disorder involving the Internet because money is not at risk.

The essential feature of Internet gaming disorder is persistent and recurrent participation in computer gaming, typically group games, for many hours. These games involve competition between groups of players (often in different global regions, so that duration of play is encouraged by the time-zone independence) participating in complex structured activities that include a significant aspect of social interactions during play. Team aspects appear to be a key motivation. Attempts to direct the individual toward schoolwork or interpersonal activities are strongly resisted. Thus personal, family, or vocational pursuits are neglected. When individuals are asked, the major reasons given for using the computer are more likely to be "avoiding boredom" rather than communicating or searching for information.

The description of criteria related to this condition is adapted from a study in China. Until the optimal criteria and threshold for diagnosis are determined empirically, conservative definitions ought to be used, such that diagnoses are considered for endorsement of five or more of nine criteria.

Associated Features Supporting Diagnosis

No consistent personality types associated with Internet gaming disorder have been identified. Some authors describe associated diagnoses, such as depressive disorders, attention-deficit/hyperactivity disorder (ADHD), or obsessive-compulsive disorder (OCD). Individuals with compulsive Internet gaming have demonstrated brain activation in specific regions triggered by exposure to the Internet game but not limited to reward system structures

Prevalence

The prevalence of Internet gaming disorder is unclear because of the varying questionnaires, criteria and thresholds employed, but it seems to be highest in Asian countries and in male adolescents 12–20 years of age. There is an abundance of reports from Asian countries, especially China and South Korea, but fewer from Europe and North America, from which prevalence estimates are highly variable. The point prevalence in adolescents (ages 15–19 years) in one Asian study using a threshold of five criteria was 8.4% for males and 4.5% for females.

Risk and Prognostic Factors

Environmental. Computer availability with Internet connection allows access to the types of games with which Internet gaming disorder is most often associated.

Genetic and physiological. Adolescent males seem to be at greatest risk of developing Internet gaming disorder, and it has been speculated that Asian environmental and/or genetic background is another risk factor, but this remains unclear.

Functional Consequences of Internet Gaming Disorder

Internet gaming disorder may lead to school failure, job loss, or marriage failure. The compulsive gaming behavior tends to crowd out normal social, scholastic, and family activities. Students may show declining grades and eventually failure in school. Family responsibilities may be neglected.

Differential Diagnosis

Excessive use of the Internet not involving playing of online games (e.g., excessive use of social media, such as Facebook; viewing pornography online) is not considered analogous

to Internet gaming disorder, and future research on other excessive uses of the Internet would need to follow similar guidelines as suggested herein. Excessive gambling online may qualify for a separate diagnosis of gambling disorder.

Comorbidity

Health may be neglected due to compulsive gaming. Other diagnoses that may be associated with Internet gaming disorder include major depressive disorder, ADHD, and OCD.

Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure

Proposed Criteria

A. More than minimal exposure to alcohol during gestation, including prior to pregnancy recognition. Confirmation of gestational exposure to alcohol may be obtained from maternal self-report of alcohol use in pregnancy, medical or other records, or clinical observation.

B. Impaired neurocognitive functioning as manifested by one or more of the following:
   1. Impairment in global intellectual performance (i.e., IQ of 70 or below, or a standard score of 70 or below on a comprehensive developmental assessment).
   2. Impairment in executive functioning (e.g., poor planning and organization; inflexibility; difficulty with behavioral inhibition).
   3. Impairment in learning (e.g., lower academic achievement than expected for intellectual level; specific learning disability).
   4. Memory impairment (e.g., problems remembering information learned recently; repeatedly making the same mistakes; difficulty remembering lengthy verbal instructions).
   5. Impairment in visual-spatial reasoning (e.g., disorganized or poorly planned drawings or constructions; problems differentiating left from right).

C. Impaired self-regulation as manifested by one or more of the following:
   1. Impairment in mood or behavioral regulation (e.g., mood lability; negative affect or irritability; frequent behavioral outbursts).
   2. Attention deficit (e.g., difficulty shifting attention; difficulty sustaining mental effort).
   3. Impairment in impulse control (e.g., difficulty waiting turn; difficulty complying with rules).

D. Impairment in adaptive functioning as manifested by two or more of the following, one of which must be (1) or (2):
   1. Communication deficit (e.g., delayed acquisition of language; difficulty understanding spoken language).
   2. Impairment in social communication and interaction (e.g., overly friendly with strangers; difficulty reading social cues; difficulty understanding social consequences).
   3. Impairment in daily living skills (e.g., delayed toileting, feeding, or bathing; difficulty managing daily schedule).
   4. Impairment in motor skills (e.g., poor fine motor development; delayed attainment of gross motor milestones or ongoing deficits in gross motor function; deficits in coordination and balance).

E. Onset of the disorder (symptoms in Criteria B, C, and D) occurs in childhood.

F. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.
G. The disorder is not better explained by the direct physiological effects associated with postnatal use of a substance (e.g., a medication, alcohol or other drugs), a general medical condition (e.g., traumatic brain injury, delirium, dementia), another known teratogen (e.g., fetal hydantoin syndrome), a genetic condition (e.g., Williams syndrome, Down syndrome, Cornelia de Lange syndrome), or environmental neglect.

Alcohol is a neurobehavioral teratogen, and prenatal alcohol exposure has teratogenic effects on central nervous system (CNS) development and subsequent function. *Neurobehavioral disorder associated with prenatal alcohol exposure* (ND-PAE) is a new clarifying term, intended to encompass the full range of developmental disabilities associated with exposure to alcohol in utero. The current diagnostic guidelines allow ND-PAE to be diagnosed both in the absence and in the presence of the physical effects of prenatal alcohol exposure (e.g., facial dysmorphology required for a diagnosis of fetal alcohol syndrome).

Diagnostic Features

The essential features of ND-PAE are the manifestation of impairment in neurocognitive, behavioral, and adaptive functioning associated with prenatal alcohol exposure. Impairment can be documented based on past diagnostic evaluations (e.g., psychological or educational assessments) or medical records, reports by the individual or informants, and/or observation by a clinician.

A clinical diagnosis of fetal alcohol syndrome, including specific prenatal alcohol-related facial dysmorphology and growth retardation, can be used as evidence of significant levels of prenatal alcohol exposure. Although both animal and human studies have documented adverse effects of lower levels of drinking, identifying how much prenatal exposure is needed to significantly impact neurodevelopmental outcome remains challenging. Data suggest that a history of more than minimal gestational exposure (e.g., more than light drinking) prior to pregnancy recognition and/or following pregnancy recognition may be required. Light drinking is defined as 1–13 drinks per month during pregnancy with no more than 2 of these drinks consumed on any 1 drinking occasion. Identifying a minimal threshold of drinking during pregnancy will require consideration of a variety of factors known to affect exposure and/or interact to influence developmental outcomes, including stage of prenatal development, gestational smoking, maternal and fetal genetics, and maternal physical status (i.e., age, health, and certain obstetric problems).

Symptoms of ND-PAE include marked impairment in global intellectual performance (IQ) or neurocognitive impairments in any of the following areas: executive functioning, learning, memory, and/or visual-spatial reasoning. Impairments in self-regulation are present and may include impairment in mood or behavioral regulation, attention deficit, or impairment in impulse control. Finally, impairments in adaptive functioning include communication deficits and impairment in social communication and interaction. Impairment in daily living (self-help) skills and impairment in motor skills may be present. As it may be difficult to obtain an accurate assessment of the neurocognitive abilities of very young children, it is appropriate to defer a diagnosis for children 3 years of age and younger.

Associated Features Supporting Diagnosis

Associated features vary depending on age, degree of alcohol exposure, and the individual's environment. An individual can be diagnosed with this disorder regardless of socioeconomic or cultural background. However, ongoing parental alcohol/substance misuse, parental mental illness, exposure to domestic or community violence, neglect or abuse, disrupted caregiving relationships, multiple out-of-home placements, and lack of continuity in medical or mental health care are often present.

Prevalence

The prevalence rates of ND-PAE are unknown. However, estimated prevalence rates of clinical conditions associated with prenatal alcohol exposure are 2%–5% in the United States.

Development and Course

Among individuals with prenatal alcohol exposure, evidence of CNS dysfunction varies according to developmental stage. Although about one-half of young children prenatally exposed to alcohol show marked developmental delay in the first 3 years of life, other children affected by prenatal alcohol exposure may not exhibit signs of CNS dysfunction until they are preschool- or school-age. Additionally, impairments in higher order cognitive processes (i.e., executive functioning), which are often associated with prenatal alcohol exposure, may be more easily assessed in older children. When children reach school age, learning difficulties, impairment in executive function, and problems with integrative language functions usually emerge more clearly, and both social skills deficits and challenging behavior may become more evident. In particular, as school and other requirements become more complex, greater deficits are noted. Because of this, the school years represent the ages at which a diagnosis of ND-PAE would be most likely.

Suicide Risk

Suicide is a high-risk outcome, with rates increasing significantly in late adolescence and early adulthood.

Functional Consequences of Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure

The CNS dysfunction seen in individuals with ND-PAE often leads to decrements in adaptive behavior and to maladaptive behavior with lifelong consequences. Individuals affected by prenatal alcohol exposure have a higher prevalence of disrupted school experiences, poor employment records, trouble with the law, confinement (legal or psychiatric), and dependent living conditions.

Differential Diagnosis

Disorders that are attributable to the physiological effects associated with postnatal use of a substance, another medical condition, or environmental neglect. Other considerations include the physiological effects of postnatal substance use, such as a medication, alcohol, or other substances; disorders due to another medical condition, such as traumatic brain injury or other neurocognitive disorders (e.g., delirium, major neurocognitive disorder [dementia]); or environmental neglect.

Genetic and teratogenic conditions. Genetic conditions such as Williams syndrome, Down syndrome, or Cornelia de Lange syndrome and other teratogenic conditions such as fetal hydantoin syndrome and maternal phenylketonuria may have similar physical and behavioral characteristics. A careful review of prenatal exposure history is needed to clarify the teratogenic agent, and an evaluation by a clinical geneticist may be needed to distinguish physical characteristics associated with these and other genetic conditions.

Comorbidity

Mental health problems have been identified in more than 90% of individuals with histories of significant prenatal alcohol exposure. The most common co-occurring diagnosis is attention-deficit/hyperactivity disorder, but research has shown that individuals with ND-PAE differ in neuropsychological characteristics and in their responsiveness to phar-

macological interventions. Other high- probability co-occurring disorders include oppositional defiant disorder and conduct disorder, but the appropriateness of these diagnoses should be weighed in the context of the significant impairments in general intellectual and executive functioning that are often associated with prenatal alcohol exposure. Mood symptoms, including symptoms of bipolar disorder and depressive disorders, have been described. History of prenatal alcohol exposure is associated with an increased risk for later tobacco, alcohol, and other substance use disorders.

Suicidal Behavior Disorder

Proposed Criteria

A. Within the last 24 months, the individual has made a suicide attempt.
   Note: A suicide attempt is a self-initiated sequence of behaviors by an individual who, at the time of initiation, expected that the set of actions would lead to his or her own death. The "time of initiation" is the time when a behavior took place that involved applying the method.)
B. The act does not meet criteria for nonsuicidal self-injury—that is, it does not involve self-injury directed to the surface of the body undertaken to induce relief from a negative feeling/cognitive state or to achieve a positive mood state.
C. The diagnosis is not applied to suicidal ideation or to preparatory acts.
D. The act was not initiated during a state of delirium or confusion.
E. The act was not undertaken solely for a political or religious objective.

Specify if:

Current: Not more than 12 months since the last attempt.
In early remission: 12–24 months since the last attempt.

Specifiers

Suicidal behavior is often categorized in terms of violence of the method. Generally, overdoses with legal or illegal substances are considered nonviolent in method, whereas jumping, gunshot wounds, and other methods are considered violent. Another dimension for classification is medical consequences of the behavior, with high-lethality attempts being defined as those requiring medical hospitalization beyond a visit to an emergency department. An additional dimension considered includes the degree of planning versus impulsiveness of the attempt, a characteristic that might have consequences for the medical outcome of a suicide attempt.

If the suicidal behavior occurred 12–24 months prior to evaluation, the condition is considered to be in early remission. Individuals remain at higher risk for further suicide attempts and death in the 24 months after a suicide attempt, and the period 12–24 months after the behavior took place is specified as "early remission."

Diagnostic Features

The essential manifestation of suicidal behavior disorder is a suicide attempt. A *suicide attempt* is a behavior that the individual has undertaken with at least some intent to die. The behavior might or might not lead to injury or serious medical consequences. Several factors can influence the medical consequences of the suicide attempt, including poor planning, lack of knowledge about the lethality of the method chosen, low intentionality or ambivalence, or chance intervention by others after the behavior has been initiated. These should not be considered in assigning the diagnosis.

Determining the degree of intent can be challenging. Individuals might not acknowledge intent, especially in situations where doing so could result in hospitalization or cause distress to loved ones. Markers of risk include degree of planning, including selection of a time and place to minimize rescue or interruption; the individual's mental state at the time of the behavior, with acute agitation being especially concerning; recent discharge from inpatient care; or recent discontinuation of a mood stabilizer such as lithium or an antipsychotic such as clozapine in the case of schizophrenia. Examples of environmental "triggers" include recently learning of a potentially fatal medical diagnosis such as cancer, experiencing the sudden and unexpected loss of a close relative or partner, loss of employment, or displacement from housing. Conversely, features such as talking to others about future events or preparedness to sign a contract for safety are less reliable indicators.

In order for the criteria to be met, the individual must have made at least one suicide attempt. Suicide attempts can include behaviors in which, after initiating the suicide attempt, the individual changed his or her mind or someone intervened. For example, an individual might intend to ingest a given amount of medication or poison, but either stop or be stopped by another before ingesting the full amount. If the individual is dissuaded by another or changes his or her mind before initiating the behavior, the diagnosis should not be made. The act must not meet criteria for nonsuicidal self-injury—that is, it should not involve repeated (at least five times within the past 12 months) self-injurious episodes undertaken to induce relief from a negative feeling/cognitive state or to achieve a positive mood state. The act should not have been initiated during a state of delirium or confusion. If the individual deliberately became intoxicated before initiating the behavior, to reduce anticipatory anxiety and to minimize interference with the intended behavior, the diagnosis should be made.

Development and Course

Suicidal behavior can occur at any time in the lifespan but is rarely seen in children under the age of 5. In prepubertal children, the behavior will often consist of a behavior (e.g., sitting on a ledge) that a parent has forbidden because of the risk of accident. Approximately 25%–30% of persons who attempt suicide will go on to make more attempts.There is significant variability in terms of frequency, method, and lethality of attempts. However, this is not different from what is observed in other illnesses, such as major depressive disorder, in which frequency of episode, subtype of episode, and impairment for a given episode can vary significantly.

Culture-Related Diagnostic Issues

Suicidal behavior varies in frequency and form across cultures. Cultural differences might be due to method availability (e.g., poisoning with pesticides in developing countries; gunshot wounds in the southwestern United States) or the presence of culturally specific syndromes (e.g., *ataques de nervios,* which in some Latino groups might lead to behaviors that closely resemble suicide attempts or might facilitate suicide attempts).

Diagnostic Markers

Laboratory abnormalities consequent to the suicidal attempt are often evident. Suicidal behavior that leads to blood loss can be accompanied by anemia, hypotension, or shock. Overdoses might lead to coma or obtundation and associated laboratory abnormalities such as electrolyte imbalances.

Functional Consequences of Suicidal Behavior Disorder

Medical conditions (e.g., lacerations or skeletal trauma, cardiopulmonary instability, inhalation of vomit and suffocation, hepatic failure consequent to use of paracetamol) can occur as a consequence of suicidal behavior.

Comorbidity

Suicidal behavior is seen in the context of a variety of mental disorders, most commonly bipolar disorder, major depressive disorder, schizophrenia, schizoaffective disorder, anxiety disorders (in particular, panic disorders associated with catastrophic content and PTSD flashbacks), substance use disorders (especially alcohol use disorders), borderline personality disorder, antisocial personality disorder, eating disorders, and adjustment disorders. It is rarely manifested by individuals with no discernible pathology, unless it is undertaken because of a painful medical condition with the intention of drawing attention to martyrdom for political or religious reasons, or in partners in a suicide pact, both of which are excluded from this diagnosis, or when third-party informants wish to conceal the nature of the behavior.

Nonsuicidal Self-Injury

Proposed Criteria

A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent).

   Note: The absence of suicidal intent has either been stated by the individual or can be inferred by the individual's repeated engagement in a behavior that the individual knows, or has learned, is not likely to result in death.

B. The individual engages in the self-injurious behavior with one or more of the following expectations:

   1. To obtain relief from a negative feeling or cognitive state.
   2. To resolve an interpersonal difficulty.
   3. To induce a positive feeling state.

   Note: The desired relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behavior suggesting a dependence on repeatedly engaging in it.

C. The intentional self-injury is associated with at least one of the following:

   1. Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.
   2. Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control.
   3. Thinking about self-injury that occurs frequently, even when it is not acted upon.

D. The behavior is not socially sanctioned (e.g., body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to picking a scab or nail biting.

E. The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.

F. The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental disorder or medical condition (e.g., psychotic disorder, autism spectrum disorder, intellectual disability, Lesch-Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania [hair-pulling disorder], excoriation [skin-picking] disorder).

Diagnostic Features

The essential feature of nonsuicidal self-injury is that the individual repeatedly inflicts shallow, yet painful injuries to the surface of his or her body. Most commonly, the purpose is to reduce negative emotions, such as tension, anxiety, and self-reproach, and/or to resolve an interpersonal difficulty. In some cases, the injury is conceived of as a deserved self-punishment. The individual will often report an immediate sensation of relief that occurs during the process. When the behavior occurs frequently, it might be associated with a sense of urgency and craving, the resultant behavioral pattern resembling an addiction. The inflicted wounds can become deeper and more numerous.

The injury is most often inflicted with a knife, needle, razor, or other sharp object. Common areas for injury include the frontal area of the thighs and the dorsal side of the forearm. A single session of injury might involve a series of superficial, parallel cuts—separated by 1 or 2 centimeters—on a visible or accessible location. The resulting cuts will often bleed and will eventually leave a characteristic pattern of scars.

Other methods used include stabbing an area, most often the upper arm, with a needle or sharp, pointed knife; inflicting a superficial burn with a lit cigarette end; or burning the skin by repeated rubbing with an eraser. Engagement in nonsuicidal self-injury with multiple methods is associated with more severe psychopathology, including engagement in suicide attempts.

The great majority of individuals who engage in nonsuicidal self-injury do not seek clinical attention. It is not known if this reflects frequency of engagement in the disorder, because accurate reporting is seen as stigmatizing, or because the behaviors are experienced positively by the individual who engages in them, who is unmotivated to receive treatment. Young children might experiment with these behaviors but not experience relief. In such cases, youths often report that the procedure is painful or distressing and might then discontinue the practice.

Development and Course

Nonsuicidal self-injury most often starts in the early teen years and can continue for many years. Admission to hospital for nonsuicidal self-injury reaches a peak at 20–29 years of age and then declines. However, research that has examined age at hospitalization did not provide information on age at onset of the behavior, and prospective research is needed to outline the natural history of nonsuicidal self-injury and the factors that promote or inhibit its course. Individuals often learn of the behavior on the recommendation or observation of another. Research has shown that when an individual who engages in nonsuicidal self-injury is admitted to an inpatient unit, other individuals may begin to engage in the behavior.

Risk and Prognostic Factors

Male and female prevalence rates of nonsuicidal self-injury are closer to each other than in suicidal behavior disorder, in which the female-to-male ratio is about 3:1 or 4:1.

Two theories of psychopathology—based on functional behavioral analyses—have been proposed: In the first, based on learning theory, either positive or negative reinforcement sustains the behavior. Positive reinforcement might result from punishing oneself in a way that the individual feels is deserved, with the behavior inducing a pleasant and relaxed state or generating attention and help from a significant other, or as an expression of anger. Negative reinforcement results from affect regulation and the reduction of unpleasant emotions or avoiding distressing thoughts, including thinking about suicide. In the second theory, nonsuicidal self-injury is thought to be a form of self-punishment, in which self-punitive actions are engaged in to make up for acts that caused distress or harm to others.

Functional Consequences of Nonsuicidal Self-Injury

The act of cutting might be performed with shared implements, raising the possibility of blood-borne disease transmission.

Differential Diagnosis

Borderline personality disorder. As indicated, nonsuicidal self-injury has long been regarded as a "symptom" of borderline personality disorder, even though comprehensive clinical evaluations have found that most individuals with nonsuicidal self-injury have symptoms that also meet criteria for other diagnoses, with eating disorders and substance use disorders being especially common. Historically, nonsuicidal self-injury was regarded as pathognomonic of borderline personality disorder. Both conditions are associated with several other diagnoses. Although frequently associated, borderline personality disorder is not invariably found in individuals with nonsuicidal self-injury. The two conditions differ in several ways. Individuals with borderline personality disorder often manifest disturbed aggressive and hostile behaviors, whereas nonsuicidal self-injury is more often associated with phases of closeness, collaborative behaviors, and positive relationships. At a more fundamental level, there are differences in the involvement of different neurotransmitter systems, but these will not be apparent on clinical examination.

Suicidal behavior disorder. The differentiation between nonsuicidal self-injury and suicidal behavior disorder is based either on the stated goal of the behavior being a wish to die (suicidal behavior disorder) or, in nonsuicidal self-injury, to experience relief as described in the criteria. Depending on the circumstances, individuals may provide reports of convenience, and several studies report high rates of false intent declaration. Individuals with a history of frequent nonsuicidal self-injury episodes have learned that a session of cutting, while painful, is, in the short-term, largely benign. Because individuals with nonsuicidal self-injury can and do attempt and commit suicide, it is important to check past history of suicidal behavior and to obtain information from a third party concerning any recent change in stress exposure and mood. Likelihood of suicide intent has been associated with the use of multiple previous methods of self-harm.

In a follow-up study of cases of "self-harm" in males treated at one of several multiple emergency centers in the United Kingdom, individuals with nonsuicidal self-injury were significantly more likely to commit suicide than other teenage individuals drawn from the same cohort. Studies that have examined the relationship between nonsuicidal self-injury and suicidal behavior disorder are limited by being retrospective and failing to obtain verified accounts of the method used during previous "attempts." A significant proportion of those who engage in nonsuicidal self-injury have responded positively when asked if they have ever engaged in self-cutting (or their preferred means of self-injury) with an intention to die. It is reasonable to conclude that nonsuicidal self-injury, while not presenting a high risk for suicide when first manifested, is an especially dangerous form of self-injurious behavior.

This conclusion is also supported by a multisite study of depressed adolescents who had previously failed to respond to antidepressant medication, which noted that those with previous nonsuicidal self-injury did not respond to cognitive-behavioral therapy, and by a study that found that nonsuicidal self-injury is a predictor of substance use/misuse.

Trichotillomania (hair-pulling disorder). Trichotillomania is an injurious behavior confined to pulling out one's own hair, most commonly from the scalp, eyebrows, or eyelashes. The behavior occurs in "sessions" that can last for hours. It is most likely to occur during a period of relaxation or distraction.

Stereotypic self-injury. Stereotypic self-injury, which can include head banging, self-biting, or self-hitting, is usually associated with intense concentration or under conditions of low external stimulation and might be associated with developmental delay.

Excoriation (skin-picking) disorder. Excoriation disorder occurs mainly in females and is usually directed to picking at an area of the skin that the individual feels is unsightly or a blemish, usually on the face or the scalp. As in nonsuicidal self-injury, the picking is often preceded by an urge and is experienced as pleasurable, even though the individual realizes that he or she is harming himself or herself. It is not associated with the use of any implement.

APPENDIX

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Highlights of Changes From DSM-IV to DSM-5

Changes made to DSM-5 diagnostic criteria and texts are outlined in this chapter in the same order in which they appear in the DSM-5 classification. This abbreviated description is intended to orient readers to only the most significant changes in each disorder category. An expanded description of nearly all changes (e.g., except minor text or wording changes needed for clarity) is available online (www.psychiatry.org/dsm5). It should also be noted that Section I contains a description of changes pertaining to the chapter organization in DSM-5, the multiaxial system, and the introduction of dimensional assessments.

Neurodevelopmental Disorders

The term *mental retardation* was used in DSM-IV. However, **intellectual disability (intellectual developmental disorder)** is the term that has come into common use over the past two decades among medical, educational, and other professionals, and by the lay public and advocacy groups. Diagnostic criteria emphasize the need for an assessment of both cognitive capacity (IQ) and adaptive functioning. Severity is determined by adaptive functioning rather than IQ score.

The **communication disorders,** which are newly named from DSM-IV phonological disorder and stuttering, respectively, include **language disorder** (which combines the previous expressive and mixed receptive-expressive language disorders), **speech sound disorder** (previously phonological disorder), and **childhood-onset fluency disorder** (previously stuttering). Also included is **social (pragmatic) communication disorder,** a new condition involving persistent difficulties in the social uses of verbal and nonverbal communication.

Autism spectrum disorder is a new DSM-5 disorder encompassing the previous DSM-IV autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, Rett's disorder, and pervasive developmental disorder not otherwise specified. It is characterized by deficits in two core domains: 1) deficits in social communication and social interaction and 2) restricted repetitive patterns of behavior, interests, and activities.

Several changes have been made to the diagnostic criteria for **attention-deficit/hyperactivity disorder** (ADHD). Examples have been added to the criterion items to facilitate application across the life span; the age at onset description has been changed (from "some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years" to "Several inattentive or hyperactive-impulsive symptoms were present prior to age 12"); subtypes have been replaced with presentation specifiers that map directly to the prior subtypes; a comorbid diagnosis with autism spectrum disorder is now allowed; and a symptom threshold change has been made for adults, to reflect the substantial evidence of clinically significant ADHD impairment, with the cutoff for ADHD of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity.

Specific learning disorder combines the DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified. Learning deficits in the areas of reading, written expression, and mathematics are coded as separate specifiers. Acknowledgment is made in the text that specific types of reading deficits are described internationally in various ways as *dyslexia* and specific types of mathematics deficits as *dyscalculia.*

The following **motor disorders** are included in DSM-5: developmental coordination disorder, stereotypic movement disorder, Tourette's disorder, persistent (chronic) motor or vocal tic disorder, provisional tic disorder, other specified tic disorder, and unspecified tic disorder. The tic criteria have been standardized across all of these disorders in this chapter.

Schizophrenia Spectrum and Other Psychotic Disorders

Two changes were made to Criterion A for **schizophrenia:** 1) the elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing), leading to the requirement of at least two Criterion A symptoms for any diagnosis of schizophrenia, and 2) the addition of the requirement that at least one of the Criterion A symptoms must be delusions, hallucinations, or disorganized speech. The DSM-IV subtypes of schizophrenia were eliminated due to their limited diagnostic stability, low reliability, and poor validity. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia is included in DSM-5 Section III to capture the important heterogeneity in symptom type and severity expressed across individuals with psychotic disorders. **Schizoaffective disorder** is reconceptualized as a longitudinal instead of a cross-sectional diagnosis—more comparable to schizophrenia, bipolar disorder, and major depressive disorder, which are bridged by this condition—and requires that a major mood episode be present for a majority of the total disorder's duration after Criterion A has been met. Criterion A for **delusional disorder** no longer has the requirement that the delusions must be nonbizarre; a specifier is now included for bizarre type delusions to provide continuity with DSM-IV. Criteria for **catatonia** are described uniformly across DSM-5. Furthermore, catatonia may be diagnosed with a specifier (for depressive, bipolar, and psychotic disorders, including schizophrenia), in the context of a known medical condition, or as an other specified diagnosis.

Bipolar and Related Disorders

Diagnostic criteria for **bipolar disorders** now include both changes in mood and changes in activity or energy. The DSM-IV diagnosis of bipolar I disorder, mixed episodes—requiring that the individual simultaneously meet full criteria for both mania and major depressive episode—is replaced with a new specifier "with mixed features." Particular conditions can now be diagnosed under **other specified bipolar and related disorder,** including categorization for individuals with a past history of a major depressive disorder whose symptoms meet all criteria for hypomania except the duration criterion is not met (i.e., the episode lasts only 2 or 3 days instead of the required 4 consecutive days or more). A second condition constituting an other specified bipolar and related disorder variant is that too few symptoms of hypomania are present to meet criteria for the full bipolar II syndrome, although the duration, at least 4 consecutive days, is sufficient. Finally, in both this chapter and in the chapter "Depressive Disorders," an anxious distress specifier is delineated.

Depressive Disorders

To address concerns about potential overdiagnosis and overtreatment of bipolar disorder in children, a new diagnosis, **disruptive mood dysregulation disorder,** is included for children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol. **Premenstrual dysphoric disorder** is now promoted from Appendix B, "Criteria Sets and Axes Provided for Further Study," in DSM-IV to the main body of DSM-5. What was referred to as dysthymia in DSM-IV now falls under the category of **persistent depressive disorder,** which includes both chronic major depressive disorder and the previous dysthymic disorder. The coexistence within a **major depressive episode** of at least three manic symptoms (insufficient to satisfy criteria for a manic episode) is now acknowledged by the specifier

"with mixed features." In DSM-IV, there was an exclusion criterion for a major depressive episode that was applied to depressive symptoms lasting less than 2 months following the death of a loved one (i.e., the bereavement exclusion). This exclusion is omitted in DSM-5 for several reasons, including the recognition that bereavement is a severe psychosocial stressor that can precipitate a major depressive episode in a vulnerable individual, generally beginning soon after the loss, and can add an additional risk for suffering, feelings of worthlessness, suicidal ideation, poorer medical health, and worse interpersonal and work functioning. It was critical to remove the implication that bereavement typically lasts only 2 months, when both physicians and grief counselors recognize that the duration is more commonly 1–2 years. A detailed footnote has replaced the more simplistic DSM-IV exclusion to aid clinicians in making the critical distinction between the symptoms characteristic of bereavement and those of a major depressive disorder. Finally, a new specifier to indicate the presence of mixed symptoms has been added across both the bipolar and the depressive disorders.

Anxiety Disorders

The chapter on anxiety disorders no longer includes obsessive-compulsive disorder (which is in the new chapter "Obsessive-Compulsive and Related Disorders") or posttraumatic stress disorder (PTSD) and acute stress disorder (which are in the new chapter "Trauma- and Stressor-Related Disorders"). Changes in criteria for **specific phobia** and **social anxiety disorder (social phobia)** include deletion of the requirement that individuals over age 18 years recognize that their anxiety is excessive or unreasonable. Instead, the anxiety must be out of proportion to the actual danger or threat in the situation, after cultural contextual factors are taken into account. In addition, the 6-month duration is now extended to all ages. **Panic attacks** can now be listed as a specifier that is applicable to all DSM-5 disorders. **Panic disorder** and **agoraphobia** are unlinked in DSM-5. Thus, the former DSM-IV diagnoses of panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder are now replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria. The "generalized" specifier for **social anxiety disorder** has been deleted and replaced with a "performance only" specifier. **Separation anxiety disorder** and **selective mutism** are now classified as anxiety disorders. The wording of the criteria is modified to more adequately represent the expression of separation anxiety symptoms in adulthood. Also, in contrast to DSM-IV, the diagnostic criteria no longer specify that onset must be before age 18 years, and a duration statement—"typically lasting for 6 months or more"—has been added for adults to minimize overdiagnosis of transient fears.

Obsessive-Compulsive and Related Disorders

The chapter "Obsessive-Compulsive and Related Disorders" is new in DSM-5. New disorders include **hoarding disorder, excoriation (skin-picking) disorder, substance/medication-induced obsessive-compulsive and related disorder,** and **obsessive-compulsive and related disorder due to another medical condition.** The DSM-IV diagnosis of trichotillomania is now termed **trichotillomania (hair-pulling disorder)** and has been moved from a DSM-IV classification of impulse-control disorders not elsewhere classified to obsessive-compulsive and related disorders in DSM-5. The DSM-IV "with poor insight" specifier for **obsessive-compulsive disorder** has been refined to allow a distinction between individuals with good or fair insight, poor insight, and "absent insight/delusional" obsessive-compulsive disorder beliefs (i.e., complete conviction that obsessive-compulsive disorder beliefs are true). Analogous "insight" specifiers have been included for body dysmorphic disorder and hoarding disorder. A "tic-related" specifier for obsessive-compulsive disorder has also been added, because presence of a comorbid tic disorder may have important clinical implications. A "muscle dysmorphia" specifier for **body dysmorphic disorder** is added to reflect a growing literature on the diagnostic validity and clinical utility of making this

distinction in individuals with body dysmorphic disorder. The delusional variant of body dysmorphic disorder (which identifies individuals who are completely convinced that their perceived defects or flaws are truly abnormal appearing) is no longer coded as both delusional disorder, somatic type, and body dysmorphic disorder; in DSM-5, this presentation is designated only as body dysmorphic disorder with the absent insight/delusional specifier. Individuals can also be diagnosed with **other specified obsessive-compulsive and related disorder,** which can include conditions such as body-focused repetitive behavior disorder and obsessional jealousy, or **unspecified obsessive-compulsive and related disorder.**

Trauma- and Stressor-Related Disorders

For a diagnosis of **acute stress disorder,** qualifying traumatic events are now explicit as to whether they were experienced directly, witnessed, or experienced indirectly. Also, the DSM-IV Criterion A2 regarding the subjective reaction to the traumatic event (e.g., experiencing "fear, helplessness, or horror") has been eliminated. **Adjustment disorders** are reconceptualized as a heterogeneous array of stress-response syndromes that occur after exposure to a distressing (traumatic or nontraumatic) event, rather than as a residual category for individuals who exhibit clinically significant distress but whose symptoms do not meet criteria for a more discrete disorder (as in DSM-IV).

DSM-5 criteria for **PTSD** differ significantly from the DSM-IV criteria. The stressor criterion (Criterion A) is more explicit with regard to events that qualify as "traumatic" experiences. Also, DSM-IV Criterion A2 (subjective reaction) has been eliminated. Whereas there were three major symptom clusters in DSM-IV—reexperiencing, avoidance/numbing, and arousal—there are now four symptom clusters in DSM-5, because the avoidance/numbing cluster is divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood. This latter category, which retains most of the DSM-IV numbing symptoms, also includes new or reconceptualized symptoms, such as persistent negative emotional states. The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms. It also includes irritable behavior or angry outbursts and reckless or self-destructive behavior. PTSD is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents. Furthermore, separate criteria have been added for children age 6 years or younger with this disorder.

The DSM-IV childhood diagnosis reactive attachment disorder had two subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. In DSM-5, these subtypes are defined as distinct disorders: **reactive attachment disorder** and **disinhibited social engagement disorder.**

Dissociative Disorders

Major changes in dissociative disorders in DSM-5 include the following: 1) derealization is included in the name and symptom structure of what previously was called depersonalization disorder (**depersonalization/derealization disorder**); 2) dissociative fugue is now a specifier of **dissociative amnesia** rather than a separate diagnosis, and 3) the criteria for **dissociative identity disorder** have been changed to indicate that symptoms of disruption of identity may be reported as well as observed, and that gaps in the recall of events may occur for everyday and not just traumatic events. Also, experiences of pathological possession in some cultures are included in the description of identity disruption.

Somatic Symptom and Related Disorders

In DSM-5, somatoform disorders are now referred to as **somatic symptom and related disorders.** The DSM-5 classification reduces the number of these disorders and subcategories to avoid problematic overlap. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed. Individuals previ-

ously diagnosed with somatization disorder will usually have symptoms that meet DSM-5 criteria for **somatic symptom disorder,** but only if they have the maladaptive thoughts, feelings, and behaviors that define the disorder, in addition to their somatic symptoms. Because the distinction between somatization disorder and undifferentiated somatoform disorder was arbitrary, they are merged in DSM-5 under somatic symptom disorder. Individuals previously diagnosed with hypochondriasis who have high health anxiety but no somatic symptoms would receive a DSM-5 diagnosis of **illness anxiety disorder** (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder). Some individuals with chronic pain would be appropriately diagnosed as having somatic symptom disorder, with predominant pain. For others, psychological factors affecting other medical conditions or an adjustment disorder would be more appropriate.

Psychological factors affecting other medical conditions is a new mental disorder in DSM-5, having formerly been listed in the DSM-IV chapter "Other Conditions That May Be a Focus of Clinical Attention." This disorder and **factitious disorder** are placed among the somatic symptom and related disorders because somatic symptoms are predominant in both disorders, and both are most often encountered in medical settings. The variants of psychological factors affecting other medical conditions are removed in favor of the stem diagnosis. Criteria for **conversion disorder (functional neurological symptom disorder)** have been modified to emphasize the essential importance of the neurological examination, and in recognition that relevant psychological factors may not be demonstrable at the time of diagnosis. Other specified somatic symptom disorder, other specified illness anxiety disorder, and pseudocyesis are now the only exemplars of the **other specified somatic symptom and related disorder** classification.

Feeding and Eating Disorders

Because of the elimination of the DSM-IV-TR chapter "Disorders Usually First Diagnosed During Infancy, Childhood, or Adolescence," this chapter describes several disorders found in the DSM-IV section "Feeding and Eating Disorders of Infancy or Early Childhood," such as **pica** and **rumination disorder.** The DSM-IV category feeding disorder of infancy or early childhood has been renamed **avoidant/restrictive food intake disorder,** and the criteria are significantly expanded. The core diagnostic criteria for **anorexia nervosa** are conceptually unchanged from DSM-IV with one exception: the requirement for amenorrhea is eliminated. As in DSM-IV, individuals with this disorder are required by Criterion A to be at a significantly low body weight for their developmental stage. The wording of the criterion is changed for clarification, and guidance regarding how to judge whether an individual is at or below a significantly low weight is provided in the text. In DSM-5, Criterion B is expanded to include not only overtly expressed fear of weight gain but also persistent behavior that interferes with weight gain. The only change in the DSM-IV criteria for **bulimia nervosa** is a reduction in the required minimum average frequency of binge eating and inappropriate compensatory behavior frequency from twice to once weekly. The extensive research that followed the promulgation of preliminary criteria for **binge-eating disorder** in Appendix B of DSM-IV documented the clinical utility and validity of binge-eating disorder. The only significant difference from the preliminary criteria is that the minimum average frequency of binge eating required for diagnosis is once weekly over the last 3 months, identical to the frequency criterion for bulimia nervosa (rather than at least 2 days a week for 6 months in DSM-IV).

Elimination Disorders

There have been no significant changes in this diagnostic class from DSM-IV to DSM-5. The disorders in this chapter were previously classified under disorders usually first diagnosed in infancy, childhood, or adolescence in DSM-IV and exist now as an independent classification in DSM-5.

Sleep-Wake Disorders

In DSM-5, the DSM-IV diagnoses named sleep disorder related to another mental disorder and sleep disorder related to another medical condition have been removed, and instead greater specification of coexisting conditions is provided for each sleep-wake disorder. The diagnosis of primary insomnia has been renamed **insomnia disorder** to avoid the differentiation between primary and secondary insomnia. DSM-5 also distinguishes **narcolepsy**—now known to be associated with hypocretin deficiency—from other forms of hypersomnolence (hypersomnolence disorder). Finally, throughout the DSM-5 classification of sleep-wake disorders, pediatric and developmental criteria and text are integrated where existing science and considerations of clinical utility support such integration. **Breathing-related sleep disorders** are divided into three relatively distinct disorders: obstructive sleep apnea hypopnea, central sleep apnea, and sleep-related hypoventilation. The subtypes of **circadian rhythm sleep disorders** are expanded to include advanced sleep phase type and irregular sleep-wake type, whereas the jet lag type has been removed. The use of the former "not otherwise specified" diagnoses in DSM-IV have been reduced by elevating **rapid eye movement sleep behavior disorder** and **restless legs syndrome** to independent disorders.

Sexual Dysfunctions

In DSM-5, some gender-specific sexual dysfunctions have been added, and, for females, sexual desire and arousal disorders have been combined into one disorder: **female sexual interest/arousal disorder.** All of the sexual dysfunctions (except **substance/medication-induced sexual dysfunction**) now require a minimum duration of approximately 6 months and more precise severity criteria. **Genito-pelvic pain/penetration disorder** has been added to DSM-5 and represents a merging of vaginismus and dyspareunia, which were highly comorbid and difficult to distinguish. The diagnosis of sexual aversion disorder has been removed due to rare use and lack of supporting research.

There are now only two subtypes for sexual dysfunctions: **lifelong** versus **acquired** and **generalized** versus **situational.** To indicate the presence and degree of medical and other nonmedical correlates, the following **associated features** have been added to the text: partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, and medical factors.

Gender Dysphoria

Gender dysphoria is a new diagnostic class in DSM-5 and reflects a change in conceptualization of the disorder's defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification per se, as was the case in DSM-IV gender identity disorder. Gender dysphoria includes separate sets of criteria: for children and for adults and adolescents. For the adolescents and adults criteria, the previous Criterion A (cross-gender identification) and Criterion B (aversion toward one's gender) are merged. In the wording of the criteria, "the other sex" is replaced by "the other gender" (or "some alternative gender")." *Gender* instead of *sex* is used systematically because the concept "sex" is inadequate when referring to individuals with a disorder of sex development. In the child criteria, "strong desire to be of the other gender" replaces the previous "repeatedly stated desire to be…the other sex" to capture the situation of some children who, in a coercive environment, may not verbalize the desire to be of another gender. For children, Criterion A1 ("a strong desire to be of the other gender or an insistence that he or she is the other gender…)" is now necessary (but not sufficient), which makes the diagnosis more restrictive and conservative. The subtyping on the basis of sexual orientation is removed because the distinction is no longer considered clinically useful. A **posttransition specifier** has been added to identify

individuals who have undergone at least one medical procedure or treatment to support the new gender assignment (e.g., cross-sex hormone treatment). Although the concept of post-transition is modeled on the concept of full or partial remission, the term *remission* has implications in terms of symptom reduction that do not apply directly to gender dysphoria.

Disruptive, Impulse-Control, and Conduct Disorders

The chapter "Disruptive, Impulse-Control, and Conduct Disorders" is new to DSM-5 and combines disorders that were previously included in the chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" (i.e., oppositional defiant disorder; conduct disorder; and disruptive behavior disorder not otherwise specified, now categorized as other specified and unspecified disruptive, impulse-control, and conduct disorders) and the chapter "Impulse-Control Disorders Not Elsewhere Classified" (i.e., intermittent explosive disorder, pyromania, and kleptomania). These disorders are all characterized by problems in emotional and behavioral self-control. Notably, ADHD is frequently comorbid with the disorders in this chapter but is listed with the neurodevelopmental disorders. Because of its close association with conduct disorder, antisocial personality disorder is listed both in this chapter and in the chapter "Personality Disorders," where it is described in detail.

The criteria for **oppositional defiant disorder** are now grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness. Additionally, the exclusionary criterion for conduct disorder has been removed. The criteria for **conduct disorder** include a descriptive features specifier for individuals who meet full criteria for the disorder but also present with **limited prosocial emotions.** The primary change in **intermittent explosive disorder** is in the type of aggressive outbursts that should be considered: DSM-IV required physical aggression, whereas in DSM-5 verbal aggression and nondestructive/noninjurious physical aggression also meet criteria. DSM-5 also provides more specific criteria defining frequency needed to meet the criteria and specifies that the aggressive outbursts are impulsive and/or anger based in nature, and must cause marked distress, cause impairment in occupational or interpersonal functioning, or be associated with negative financial or legal consequences. Furthermore, a minimum age of 6 years (or equivalent developmental level) is now required.

Substance-Related and Addictive Disorders

An important departure from past diagnostic manuals is that the chapter on substance-related disorders has been expanded to include **gambling disorder**. Another key change is that DSM-5 does not separate the diagnoses of substance *abuse* and *dependence* as in DSM-IV. Rather criteria are provided for **substance use disorder,** accompanied by criteria for intoxication, withdrawal, substance-induced disorders, and unspecified substance-related disorders, where relevant. Within substance use disorders, the DSM-IV recurrent substance-related legal problems criterion has been deleted from DSM-5, and a new criterion—craving, or a strong desire or urge to use a substance—has been added. In addition, the threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria, in contrast to a threshold of one or more criteria for a diagnosis of DSM-IV substance abuse and three or more for DSM-IV dependence. **Cannabis withdrawal** and **caffeine withdrawal** are new disorders (the latter was in DSM-IV Appendix B, "Criteria Sets and Axes Provided for Further Study").

Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed. The DSM-IV specifier for a physiological subtype is eliminated in DSM-5, as is the DSM-IV diagnosis of polysubstance dependence. Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without meeting substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without meeting criteria (except craving). Additional new DSM-5 specifiers include **"in a controlled environment"** and **"on maintenance therapy"** as the situation warrants.

Neurocognitive Disorders

The DSM-IV diagnoses of dementia and amnestic disorder are subsumed under the newly named entity **major neurocognitive disorder** (NCD). The term *dementia* is not precluded from use in the etiological subtypes where that term is standard. Furthermore, DSM-5 now recognizes a less severe level of cognitive impairment, **mild NCD,** which is a new disorder that permits the diagnosis of less disabling syndromes that may nonetheless be the focus of concern and treatment. Diagnostic criteria are provided for both of these disorders, followed by diagnostic criteria for different **etiological subtypes.** In DSM-IV, individual diagnoses were designated for dementia of the Alzheimer's type, vascular dementia, and substance-induced dementia, whereas the other neurodegenerative disorders were classified as dementia due to another medical condition, with HIV, head trauma, Parkinson's disease, Huntington's disease, Pick's disease, Creutzfeldt-Jakob disease, and other medical conditions specified. In DSM-5, major or mild NCD due to Alzheimer's disease and major or mild vascular NCD have been retained, while new separate criteria are now presented for major or mild frontotemporal NCD, NCD with Lewy bodies, and NCDs due to traumatic brain injury, a substance/medication, HIV infection, prion disease, Parkinson's disease, Huntington's disease, another medical condition, and multiple etiologies, respectively. Unspecified NCD is also included as a diagnosis.

Personality Disorders

The criteria for personality disorders in Section II of DSM-5 have not changed from those in DSM-IV. An alternative approach to the diagnosis of personality disorders was developed for DSM-5 for further study and can be found in Section III (see "Alternative DSM-5 Model for Personality Disorders"). For the **general criteria for personality disorder,** presented in Section III, a revised personality functioning criterion (Criterion A) has been developed based on a literature review of reliable clinical measures of core impairments central to personality pathology. A diagnosis of **personality disorder—trait specified,** based on moderate or greater impairment in personality functioning and the presence of pathological personality traits, replaces personality disorder not otherwise specified and provides a much more informative diagnosis for individuals who are not optimally described as having a specific personality disorder. A greater emphasis on personality functioning and trait-based criteria increases the stability and empirical bases of the disorders. **Personality functioning** and **personality traits** also can be assessed whether or not the individual has a personality disorder—a feature that provides clinically useful information about all individuals.

Paraphilic Disorders

An overarching change from DSM-IV is the addition of the course specifiers **"in a controlled environment"** and **"in remission"** to the diagnostic criteria sets for all the paraphilic disorders. These specifiers are added to indicate important changes in an individual's status. In DSM-5, paraphilias are not *ipso facto* mental disorders. There is a distinction between paraphilias and paraphilic disorders. 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 automatically justify or require clinical intervention. The **distinction between paraphilias and paraphilic disorders** was implemented without making any changes to the basic structure of the diagnostic criteria as they had existed since DSM-III-R. The change proposed for DSM-5 is that individuals who meet both Criterion A and Criterion B would now be diagnosed as having a paraphilic disorder. A diagnosis would not be given to individuals whose symptoms meet Criterion A but not Criterion B—that is, to individuals who have a paraphilia but not a paraphilic disorder.

Glossary of Technical Terms

affect A pattern of observable behaviors that is the expression of a subjectively experienced feeling state (emotion). Examples of affect include sadness, elation, and anger. In contrast to *mood,* which refers to a pervasive and sustained emotional "climate," *affect* refers to more fluctuating changes in emotional "weather." What is considered the normal range of the expression of affect varies considerably, both within and among different cultures. Disturbances in affect include

- **blunted** Significant reduction in the intensity of emotional expression.
- **flat** Absence or near absence of any sign of affective expression.
- **inappropriate** Discordance between affective expression and the content of speech or ideation.
- **labile** Abnormal variability in affect with repeated, rapid, and abrupt shifts in affective expression.
- **restricted or constricted** Mild reduction in the range and intensity of emotional expression.

affective blunting *See* AFFECT.

agitation (psychomotor) *See* PSYCHOMOTOR AGITATION.

agnosia Loss of ability to recognize objects, persons, sounds, shapes, or smells that occurs in the absence of either impairment of the specific sense or significant memory loss.

alogia An impoverishment in thinking that is inferred from observing speech and language behavior. There may be brief and concrete replies to questions and restriction in the amount of spontaneous speech (termed *poverty of speech*). Sometimes the speech is adequate in amount but conveys little information because it is overconcrete, overabstract, repetitive, or stereotyped (termed *poverty of content*).

amnesia An inability to recall important autobiographical information that is inconsistent with ordinary forgetting.

anhedonia Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure and take interest in things. Anhedonia is a facet of the broad personality trait domain DETACHMENT.

anosognosia A condition in which a person with an illness seems unaware of the existence of his or her illness.

antagonism Behaviors that put an individual at odds with other people, such as an exaggerated sense of self-importance with a concomitant expectation of special treatment, as well as a callous antipathy toward others, encompassing both unawareness of others' needs and feelings, and a readiness to use others in the service of self-enhancement. Antagonism is one of the five broad PERSONALITY TRAIT DOMAINS defined in Section III "Alternative DSM-5 Model for Personality Disorders."

SMALL CAPS indicate term found elsewhere in this glossary. Glossary definitions were informed by DSM-5 Work Groups, publicly available Internet sources, and previously published glossaries for mental disorders (World Health Organization and American Psychiatric Association).

antidepressant discontinuation syndrome A set of symptoms that can occur after abrupt cessation, or marked reduction in dose, of an antidepressant medication that had been taken continuously for at least 1 month.

anxiety The apprehensive anticipation of future danger or misfortune accompanied by a feeling of worry, distress, and/or somatic symptoms of tension. The focus of anticipated danger may be internal or external.

anxiousness Feelings of nervousness or tenseness in reaction to diverse situations; frequent worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and apprehensive about uncertainty; expecting the worst to happen. Anxiousness is a facet of the broad personality trait domain NEGATIVE AFFECTIVITY.

arousal The physiological and psychological state of being awake or reactive to stimuli.

asociality A reduced initiative for interacting with other people.

attention The ability to focus in a sustained manner on a particular stimulus or activity. A disturbance in attention may be manifested by easy DISTRACTIBILITY or difficulty in finishing tasks or in concentrating on work.

attention seeking Engaging in behavior designed to attract notice and to make oneself the focus of others' attention and admiration. Attention seeking is a facet of the broad personality trait domain ANTAGONISM.

autogynephilia Sexual arousal of a natal male associated with the idea or image of being a woman.

avoidance The act of keeping away from stress-related circumstances; a tendency to circumvent cues, activities, and situations that remind the individual of a stressful event experienced.

avolition An inability to initiate and persist in goal-directed activities. When severe enough to be considered pathological, avolition is pervasive and prevents the person from completing many different types of activities (e.g., work, intellectual pursuits, self-care).

bereavement The state of having lost through death someone with whom one has had a close relationship. This state includes a range of grief and mourning responses.

biological rhythms See CIRCADIAN RHYTHMS.

callousness Lack of concern for the feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others. Callousness is a facet of the broad personality trait domain ANTAGONISM.

catalepsy Passive induction of a posture held against gravity. Compare with WAXY FLEXIBILITY.

cataplexy Episodes of sudden bilateral loss of muscle tone resulting in the individual collapsing, often occurring in association with intense emotions such as laughter, anger, fear, or surprise.

circadian rhythms Cyclical variations in physiological and biochemical function, level of sleep-wake activity, and emotional state. Circadian rhythms have a cycle of about 24 hours, *ultradian* rhythms have a cycle that is shorter than 1 day, and *infradian* rhythms have a cycle that may last weeks or months.

cognitive and perceptual dysregulation Odd or unusual thought processes and experiences, including DEPERSONALIZATION, DEREALIZATION, and DISSOCIATION; mixed sleep-wake state experiences; and thought-control experiences. Cognitive and perceptual dysregulation is a facet of the broad personality trait domain PSYCHOTICISM.

coma State of complete loss of consciousness.

compulsion Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession, or according to rules that must be applied rigidly. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

conversion symptom A loss of, or alteration in, voluntary motor or sensory functioning, with or without apparent impairment of consciousness. The symptom is not fully explained by a neurological or another medical condition or the direct effects of a substance and is not intentionally produced or feigned.

deceitfulness Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events. Deceitfulness is a facet of the broad personality trait domain ANTAGONISM.

defense mechanism Mechanisms that mediate the individual´s reaction to emotional conflicts and to external stressors. Some defense mechanisms (e.g., projection, splitting, acting out) are almost invariably maladaptive. Others (e.g., suppression, denial) may be either maladaptive or adaptive, depending on their severity, their inflexibility, and the context in which they occur.

delusion A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusional conviction can sometimes be inferred from an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion). Delusions are subdivided according to their content. Common types are listed below:

- **bizarre** A delusion that involves a phenomenon that the person's culture would regard as physically impossible.
- **delusional jealousy** A delusion that one's sexual partner is unfaithful.
- **erotomanic** A delusion that another person, usually of higher status, is in love with the individual.
- **grandiose** A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.
- **mixed type** Delusions of more than one type (e.g., EROTOMANIC, GRANDIOSE, PERSECUTORY, SOMATIC) in which no one theme predominates.
- **mood-congruent** *See* MOOD-CONGRUENT PSYCHOTIC FEATURES.
- **mood-incongruent** *See* MOOD-INCONGRUENT PSYCHOTIC FEATURES.
- **of being controlled** A delusion in which feelings, impulses, thoughts, or actions are experienced as being under the control of some external force rather than being under one's own control.
- **of reference** A delusion in which events, objects, or other persons in one's immediate environment are seen as having a particular and unusual significance. These delusions are usually of a negative or pejorative nature but also may be grandiose in content. A delusion of reference differs from an *idea of reference,* in which the false belief is not as firmly held nor as fully organized into a true belief.
- **persecutory** A delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against.

somatic A delusion whose main content pertains to the appearance or functioning of one's body.

thought broadcasting A delusion that one's thoughts are being broadcast out loud so that they can be perceived by others.

thought insertion A delusion that certain of one's thoughts are not one´s own, but rather are inserted into one's mind.

depersonalization The experience of feeling detached from, and as if one is an outside observer of, one's mental processes, body, or actions (e.g., feeling like one is in a dream; a sense of unreality of self, perceptual alterations; emotional and/or physical numbing; temporal distortions; sense of unreality).

depressivity Feelings of being intensely sad, miserable, and/or hopeless. Some patients describe an absence of feelings and/or dysphoria; difficulty recovering from such moods; pessimism about the future; pervasive shame and/or guilt; feelings of inferior self-worth; and thoughts of suicide and suicidal behavior. Depressivity is a facet of the broad personality trait domain DETACHMENT.

derealization The experience of feeling detached from, and as if one is an outside observer of, one's surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).

detachment Avoidance of socioemotional experience, including both WITHDRAWAL from interpersonal interactions (ranging from casual, daily interactions to friendships and intimate relationships [i.e., INTIMACY AVOIDANCE]) and RESTRICTED AFFECTIVITY, particularly limited hedonic capacity. Detachment is one of the five pathological PERSONALITY TRAIT DOMAINS defined in Section III "Alternative DSM-5 Model for Personality Disorders."

disinhibition Orientation toward immediate gratification, leading to impulsive behavior driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences. RIGID PERFECTIONISM, the opposite pole of this domain, reflects excessive constraint of impulses, risk avoidance, hyperresponsibility, hyperperfectionism, and rigid, rule-governed behavior. Disinhibition is one of the five pathological PERSONALITY TRAIT DOMAINS defined in Section III "Alternative DSM-5 Model for Personality Disorders."

disorder of sex development Condition of significant inborn somatic deviations of the reproductive tract from the norm and/or of discrepancies among the biological indicators of male and female.

disorientation Confusion about the time of day, date, or season (time); where one is (place); or who one is (person).

dissociation The splitting off of clusters of mental contents from conscious awareness. Dissociation is a mechanism central to dissociative disorders. The term is also used to describe the separation of an idea from its emotional significance and affect, as seen in the inappropriate affect in schizophrenia. Often a result of psychic trauma, dissociation may allow the individual to maintain allegiance to two contradictory truths while remaining unconscious of the contradiction. An extreme manifestation of dissociation is dissociative identity disorder, in which a person may exhibit several independent personalities, each unaware of the others.

distractibility Difficulty concentrating and focusing on tasks; attention is easily diverted by extraneous stimuli; difficulty maintaining goal-focused behavior, including both planning and completing tasks. Distractibility is a facet of the broad personality trait domain DISINHIBITION.

dysarthria A disorder of speech sound production due to structural or motor impairment affecting the articulatory apparatus. Such disorders include cleft palate, muscle

disorders, cranial nerve disorders, and cerebral palsy affecting bulbar structures (i.e., lower and upper motor neuron disorders).

dyskinesia Distortion of voluntary movements with involuntary muscle activity.

dysphoria (dysphoric mood) A condition in which a person experiences intense feelings of depression, discontent, and in some cases indifference to the world around them.

dyssomnias Primary disorders of sleep or wakefulness characterized by INSOMNIA or HYPERSOMNIA as the major presenting symptom. Dyssomnias are disorders of the amount, quality, or timing of sleep. Compare with PARASOMNIAS.

dysthymia Presence, while depressed, of two or more of the following: 1) poor appetite or overeating, 2) insomnia or hypersomnia, 3) low energy or fatigue, 4) low self-esteem, 5) poor concentration or difficulty making decisions, or 6) feelings of hopelessness.

dystonia Disordered tonicity of muscles.

eccentricity Odd, unusual, or bizarre behavior, appearance, and/or speech having strange and unpredictable thoughts; saying unusual or inappropriate things. Eccentricity is a facet of the broad personality trait domain PSYCHOTICISM.

echolalia The pathological, parrotlike, and apparently senseless repetition (echoing) of a word or phrase just spoken by another person.

echopraxia Mimicking the movements of another.

emotional lability Instability of emotional experiences and mood; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances. Emotional lability is a facet of the broad personality trait domain NEGATIVE AFFECTIVITY.

empathy Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding the effects of own behavior on others.

episode (episodic) A specified duration of time during which the patient has developed or experienced symptoms that meet the diagnostic criteria for a given mental disorder. Depending on the type of mental disorder, *episode* may denote a certain number of symptoms or a specified severity or frequency of symptoms. Episodes may be further differentiated as a single (first) episode or a recurrence or relapse of multiple episodes if appropriate.

euphoria A mental and emotional condition in which a person experiences intense feelings of well-being, elation, happiness, excitement, and joy.

fatigability Tendency to become easily fatigued. *See also* FATIGUE.

fatigue A state (also called exhaustion, tiredness, lethargy, languidness, languor, lassitude, and listlessness) usually associated with a weakening or depletion of one's physical and/or mental resources, ranging from a general state of lethargy to a specific, work-induced burning sensation within one's muscles. Physical fatigue leads to an inability to continue functioning at one's normal level of activity. Although widespread in everyday life, this state usually becomes particularly noticeable during heavy exercise. Mental fatigue, by contrast, most often manifests as SOMNOLENCE (sleepiness).

fear An emotional response to perceived imminent threat or danger associated with urges to flee or fight.

flashback A dissociative state during which aspects of a traumatic event are reexperienced as though they were occurring at that moment.

flight of ideas A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When the condition is severe, speech may be disorganized and incoherent.

gender The public (and usually legally recognized) lived role as boy or girl, man or woman. Biological factors are seen as contributing in interaction with social and psychological factors to gender development.

gender assignment The initial assignment as male or female, which usually occurs at birth and is subsequently referred to as the "natal gender."

gender dysphoria Distress that accompanies the incongruence between one's experienced and expressed gender and one's assigned or natal gender.

gender experience The unique and personal ways in which individuals experience their gender in the context of the gender roles provided by their societies.

gender expression The specific ways in which individuals enact gender roles provided in their societies.

gender identity A category of social identity that refers to an individual's identification as male, female or, occasionally, some category other than male or female.

gender reassignment A change of gender that can be either medical (hormones, surgery) or legal (government recognition), or both. In case of medical interventions, often referred to as *sex reassignment.*

geometric hallucination See HALLUCINATION.

grandiosity Believing that one is superior to others and deserves special treatment; self-centeredness; feelings of entitlement; condescension toward others. Grandiosity is a facet of the broad personality trait domain ANTAGONISM.

grimace (grimacing) Odd and inappropriate facial expressions unrelated to situation (as seen in individuals with CATATONIA).

hallucination A perception-like experience with the clarity and impact of a true perception but without the external stimulation of the relevant sensory organ. Hallucinations should be distinguished from ILLUSIONS, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the nonveridical nature of the hallucination. One hallucinating person may recognize the false sensory experience, whereas another may be convinced that the experience is grounded in reality. The term *hallucination* is not ordinarily applied to the false perceptions that occur during dreaming, while falling asleep (*hypnagogic*), or upon awakening (*hypnopompic*). Transient hallucinatory experiences may occur without a mental disorder.

- **auditory** A hallucination involving the perception of sound, most commonly of voice.
- **geometric** Visual hallucinations involving geometric shapes such as tunnels and funnels, spirals, lattices, or cobwebs.
- **gustatory** A hallucination involving the perception of taste (usually unpleasant).
- **mood-congruent** *See* MOOD-CONGRUENT PSYCHOTIC FEATURES.
- **mood-incongruent** *See* MOOD-INCONGRUENT PSYCHOTIC FEATURES.
- **olfactory** A hallucination involving the perception of odor, such as of burning rubber or decaying fish.
- **somatic** A hallucination involving the perception of physical experience localized within the body (e.g., a feeling of electricity). A somatic hallucination is to be distinguished from physical sensations arising from an as-yet-undiagnosed general medical condition, from hypochondriacal preoccupation with normal physical sensations, or from a tactile hallucination.
- **tactile** A hallucination involving the perception of being touched or of something being under one's skin. The most common tactile hallucinations are the sensation

of electric shocks and formication (the sensation of something creeping or crawling on or under the skin).

visual A hallucination involving sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light. Visual hallucinations should be distinguished from ILLUSIONS, which are misperceptions of real external stimuli.

hostility Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behavior. Hostility is a facet of the broad personality trait domain ANTAGONISM.

hyperacusis Increased auditory perception.

hyperorality A condition in which inappropriate objects are placed in the mouth.

hypersexuality A stronger than usual urge to have sexual activity.

hypersomnia Excessive sleepiness, as evidenced by prolonged nocturnal sleep, difficulty maintaining an alert awake state during the day, or undesired daytime sleep episodes. See also SOMNOLENCE.

hypervigilance An enhanced state of sensory sensitivity accompanied by an exaggerated intensity of behaviors whose purpose is to detect threats. Hypervigilance is also accompanied by a state of increased anxiety which can cause exhaustion. Other symptoms include abnormally increased arousal, a high responsiveness to stimuli, and a continual scanning of the environment for threats. In hypervigilance, there is a perpetual scanning of the environment to search for sights, sounds, people, behaviors, smells, or anything else that is reminiscent of threat or trauma. The individual is placed on high alert in order to be certain danger is not near. Hypervigilance can lead to a variety of obsessive behavior patterns, as well as producing difficulties with social interaction and relationships.

hypomania An abnormality of mood resembling mania but of lesser intensity. *See also* MANIA.

hypopnea Episodes of overly shallow breathing or an abnormally low respiratory rate.

ideas of reference The feeling that causal incidents and external events have a particular and unusual meaning that is specific to the person. An idea of reference is to be distinguished from a DELUSION OF REFERENCE, in which there is a belief that is held with delusional conviction.

identity Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience.

illusion A misperception or misinterpretation of a real external stimulus, such as hearing the rustling of leaves as the sound of voices. *See also* HALLUCINATION.

impulsivity Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans; a sense of urgency and self-harming behavior under emotional distress. Impulsivity is a facet of the broad personality trait domain DISINHIBITION.

incoherence Speech or thinking that is essentially incomprehensible to others because word or phrases are joined together without a logical or meaningful connection. This disturbance occurs *within* clauses, in contrast to derailment, in which the disturbance is *between* clauses. This has sometimes been referred to a "word salad" to convey the degree of linguistic disorganization. Mildly ungrammatical constructions or idiomatic usages characteristic of a particular regional or cultural backgrounds, lack of education, or low intelligence should not be considered incoherence. The term is generally not applied when there is evidence that the disturbance in speech is due to an aphasia.

insomnia A subjective complaint of difficulty falling or staying asleep or poor sleep quality.

intersex condition A condition in which individuals have conflicting or ambiguous biological indicators of sex.

intimacy Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior.

intimacy avoidance Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships. Intimacy avoidance is a facet of the broad personality trait domain DETACHMENT.

irresponsibility Disregard for—and failure to honor—financial and other obligations or commitments; lack of respect for—and lack of follow-through on—agreements and promises; carelessness with others' property. Irresponsibility is a facet of the broad personality trait domain DISINHIBITION.

language pragmatics The understanding and use of language in a given context. For example, the warning "Watch your hands" when issued to a child who is dirty is intended not only to prompt the child to look at his or her hands but also to communicate the admonition "Don't get anything dirty."

lethargy A state of decreased mental activity, characterized by sluggishness, drowsiness, inactivity, and reduced alertness.

macropsia The visual perception that objects are larger than they actually are. Compare with MICROPSIA.

magical thinking The erroneous belief that one's thoughts, words, or actions will cause or prevent a specific outcome in some way that defies commonly understood laws of cause and effect. Magical thinking may be a part of normal child development.

mania A mental state of elevated, expansive, or irritable mood and persistently increased level of activity or energy. *See also* HYPOMANIA.

manipulativeness Use of subterfuge to influence or control others; use of seduction, charm, glibness, or ingratiation to achieve one's ends. Manipulativeness is a facet of the broad personality trait domain ANTAGONISM.

mannerism A peculiar and characteristic individual style of movement, action, thought, or speech.

melancholia (melancholic) A mental state characterized by very severe depression.

micropsia The visual perception that objects are smaller than they actually are. Compare with MACROPSIA.

mixed symptoms The specifier "with mixed features" is applied to mood episodes during which subthreshold symptoms from the opposing pole are present. Whereas these concurrent "mixed" symptoms are relatively simultaneous, they may also occur closely juxtaposed in time as a waxing and waning of individual symptoms of the opposite pole (i.e., depressive symptoms during hypomanic or manic episodes, and vice versa).

mood A pervasive and sustained emotion that colors the perception of the world. Common examples of mood include depression, elation, anger, and anxiety. In contrast to *affect*, which refers to more fluctuating changes in emotional "weather," mood refers to a pervasive and sustained emotional "climate." Types of mood include

- **dysphoric** An unpleasant mood, such as sadness, anxiety, or irritability.
- **elevated** An exaggerated feeling of well-being, or euphoria or elation. A person with elevated mood may describe feeling "high," "ecstatic," "on top of the world," or "up in the clouds."
- **euthymic** Mood in the "normal" range, which implies the absence of depressed or elevated mood.

expansive Lack of restraint in expressing one's feelings, frequently with an overvaluation of one's significance or importance.

irritable Easily annoyed and provoked to anger.

mood-congruent psychotic features Delusions or hallucinations whose content is entirely consistent with the typical themes of a depressed or manic mood. If the mood is depressed, the content of the delusions or hallucinations would involve themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. The content of the delusion may include themes of persecution if these are based on self-derogatory concepts such as deserved punishment. If the mood is manic, the content of the delusions or hallucinations would involve themes of inflated worth, power, knowledge, or identity, or a special relationship to a deity or a famous person. The content of the delusion may include themes of persecution if these are based on concepts such as inflated worth or deserved punishment.

mood-incongruent psychotic features Delusions or hallucinations whose content is not consistent with the typical themes of a depressed or manic mood. In the case of depression, the delusions or hallucinations would not involve themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. In the case of mania, the delusions or hallucinations would not involve themes of inflated worth, power, knowledge, or identity, or a special relationship to a deity or a famous person.

multiple sleep latency test Polysomnographic assessment of the sleep-onset period, with several short sleep-wake cycles assessed during a single session. The test repeatedly measures the time to daytime sleep onset ("sleep latency") and occurrence of and time to onset of the rapid eye movement sleep phase.

mutism No, or very little, verbal response (in the absence of known aphasia).

narcolepsy Sleep disorder characterized by periods of extreme drowsiness and frequent daytime lapses into sleep (sleep attacks). These must have been occurring at least three times per week over the last 3 months (in the absence of treatment).

negative affectivity Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/shame, worry, anger), and their behavioral (e.g., self-harm) and interpersonal (e.g., dependency) manifestations. Negative Affectivity is one of the five pathological PERSONALITY TRAIT DOMAINS defined in Section III "Alternative DSM-5 Model for Personality Disorders."

negativism Opposition to suggestion or advice; behavior opposite to that appropriate to a specific situation or against the wishes of others, including direct resistance to efforts to be moved.

night eating syndrome Recurrent episodes of night eating, as manifested by eating after awakening from sleep or excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better accounted for by external influences such as changes in the individual's sleep-wake cycle or by local social norms.

nightmare disorder Repeated occurrences of extended, extremely dysphoric, and well-remembered dreams that usually involve efforts to avoid threats to survival, security or physical integrity and that generally occur during the second half of the major sleep episode. On awakening from the dysphoric dreams, the individual rapidly becomes oriented and alert.

nonsubstance addiction(s) Behavioral disorder (also called *behavioral addiction*) not related to any substance of abuse that shares some features with substance-induced addiction.

obsession Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted and that in most individuals cause marked anxiety or distress. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

overeating Eating too much food too quickly.

overvalued idea An unreasonable and sustained belief that is maintained with less than delusional intensity (i.e., the person is able to acknowledge the possibility that the belief may not be true). The belief is not one that is ordinarily accepted by other members of the person's culture or subculture.

panic attacks Discrete periods of sudden onset of intense fear or terror, often associated with feelings of impending doom. During these attacks there are symptoms such as shortness of breath or smothering sensations; palpitations, pounding heart, or accelerated heart rate; chest pain or discomfort; choking; and fear of going crazy or losing control. Panic attacks may be unexpected, in which the onset of the attack is not associated with an obvious trigger and instead occurs "out of the blue," or expected, in which the panic attack is associated with an obvious trigger, either internal or external.

paranoid ideation Ideation, of less than delusional proportions, involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.

parasomnias Disorders of sleep involving abnormal behaviors or physiological events occurring during sleep or sleep-wake transitions. Compare with DYSSOMNIAS.

perseveration Persistence at tasks or in particular way of doing things long after the behavior has ceased to be functional or effective; continuance of the same behavior despite repeated failures or clear reasons for stopping. Perseveration is a facet of the broad personality trait domain NEGATIVE AFFECTIVITY.

personality Enduring patterns of perceiving, relating to, and thinking about the environment and oneself. PERSONALITY TRAITS are prominent aspects of personality that are exhibited in relatively consistent ways across time and across situations. Personality traits influence self and interpersonal functioning. Depending on their severity, impairments in personality functioning and personality trait expression may reflect the presence of a personality disorder.

personality disorder—trait specified In Section III "Alternative DSM-5 Model for Personality Disorders," a proposed diagnostic category for use when a personality disorder is considered present but the criteria for a specific disorder are not met. Personality disorder—trait specified (PD-TS) is defined by significant impairment in personality functioning, as measured by the Level of Personality Functioning Scale and one or more pathological PERSONALITY TRAIT DOMAINS or PERSONALITY TRAIT FACETS. PD-TS is proposed in DSM-5 Section III for further study as a possible future replacement for other specified personality disorder and unspecified personality disorder.

personality functioning Cognitive models of self and others that shape patterns of emotional and affiliative engagement.

personality trait A tendency to behave, feel, perceive, and think in relatively consistent ways across time and across situations in which the trait may be manifest.

personality trait facets Specific personality components that make up the five broad personality trait domains in the dimensional taxonomy of Section III "Alternative DSM-5 Model for Personality Disorders." For example, the broad domain antagonism has the following component facets: MANIPULATIVENESS, DECEITFULNESS, GRANDIOSITY, ATTENTION SEEKING, CALLOUSNESS, and HOSTILITY.

personality trait domains In the dimensional taxonomy of Section III "Alternative DSM-5 Model for Personality Disorders," personality traits are organized into five broad domains: NEGATIVE AFFECTIVITY, DETACHMENT, ANTAGONISM, DISINHIBITION, and PSYCHOTICISM. Within these five broad trait domains are 25 specific personality trait facets (e.g., IMPULSIVITY, RIGID PERFECTIONISM).

phobia A persistent fear of a specific object, activity, or situation (i.e., the phobic stimulus) out of proportion to the actual danger posed by the specific object or situation that results in a compelling desire to avoid it. If it cannot be avoided, the phobic stimulus is endured with marked distress.

pica Persistent eating of nonnutritive nonfood substances over a period of at least 1 month. The eating of nonnutritive nonfood substances is inappropriate to the developmental level of the individual (a minimum age of 2 years is suggested for diagnosis). The eating behavior is not part of a culturally supported or socially normative practice.

polysomnography Polysomnography (PSG), also known as a sleep study, is a multiparametric test used in the study of sleep and as a diagnostic tool in sleep medicine. The test result is called a *polysomnogram,* also abbreviated PSG. PSG monitors many body functions, including brain (electroencephalography), eye movements (electro-oculography), muscle activity or skeletal muscle activation (electromyography), and heart rhythm (electrocardiography).

posturing Spontaneous and active maintenance of a posture against gravity (as seen in CATATONIA). Abnormal posturing may also be a sign of certain injuries to the brain or spinal cord, including the following:

- **decerebrate posture** The arms and legs are out straight and rigid, the toes point downward, and the head is arched backward.
- **decorticate posture** The body is rigid, the arms are stiff and bent, the fists are tight, and the legs are straight out.
- **opisthotonus** The back is rigid and arching, and the head is thrown backward.

An affected person may alternate between different postures as the condition changes.

pressured speech Speech that is increased in amount, accelerated, and difficult or impossible to interrupt. Usually it is also loud and emphatic. Frequently the person talks without any social stimulation and may continue to talk even though no one is listening.

prodrome An early or premonitory sign or symptom of a disorder.

pseudocyesis A false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy.

psychological distress A range of symptoms and experiences of a person's internal life that are commonly held to be troubling, confusing, or out of the ordinary.

psychometric measures Standardized instruments such as scales, questionnaires, tests, and assessments that are designed to measure human knowledge, abilities, attitudes, or personality traits.

psychomotor agitation Excessive motor activity associated with a feeling of inner tension. The activity is usually nonproductive and repetitious and consists of behaviors such as pacing, fidgeting, wringing of the hands, pulling of clothes, and inability to sit still.

psychomotor retardation Visible generalized slowing of movements and speech.

psychotic features Features characterized by delusions, hallucinations, and formal thought disorder.

psychoticism Exhibiting a wide range of culturally incongruent odd, eccentric, or unusual behaviors and cognitions, including both process (e.g., perception, dissociation)

and content (e.g., beliefs). Psychoticism is one of the five broad PERSONALITY TRAIT DOMAINS defined in Section III "Alternative DSM-5 Model for Personality Disorders."

purging disorder Eating disorder characterized by recurrent purging behavior to influence weight or shape, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, in the absence of binge eating.

racing thoughts A state in which the mind uncontrollably brings up random thoughts and memories and switches between them very quickly. Sometimes the thoughts are related, with one thought leading to another; other times they are completely random. A person experiencing an episode of racing thoughts has no control over them and is unable to focus on a single topic or to sleep.

rapid cycling Term referring to bipolar disorder characterized by the presence of at least four mood episodes in the previous 12 months that meet the criteria for a manic, hypomanic, or major depressive episode. Episodes are demarcated either by partial or full remissions of at least 2 months or by a switch to an episode of the opposite polarity (e.g., major depressive episode to manic episode). The rapid cycling specifier can be applied to bipolar I or bipolar II disorder.

rapid eye movement (REM) A behavioral sign of the phase of sleep during which the sleeper is likely to be experiencing dreamlike mental activity.

repetitive speech Morphologically heterogeneous iterations of speech.

residual phase Period after an episode of schizophrenia that has partly or completed remitted but in which some symptoms may remain, and symptoms such as listlessness, problems with concentrating, and withdrawal from social activities may predominate.

restless legs syndrome An urge to move the legs, usually accompanied or caused by uncomfortable and unpleasant sensations in the legs (for pediatric restless legs syndrome, the description of these symptoms should be in the child's own words). The symptoms begin or worsen during periods of rest or inactivity. Symptoms are partially or totally relieved by movement. Symptoms are worse in the evening or at night than during the day or occur only in the night/evening.

restricted affectivity Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference and aloofness in normatively engaging situations. Restricted affectivity is a facet of the broad personality trait domain DETACHMENT.

rigid perfectionism Rigid insistence on everything being flawless, perfect, and without errors or faults, including one's own and others' performance; sacrificing of timeliness to ensure correctness in every detail; believing that there is only one right way to do things; difficulty changing ideas and/or viewpoint; preoccupation with details, organization, and order. Lack of rigid perfectionism is a facet of the broad personality trait domain DISINHIBITION.

risk taking Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger; reckless pursuit of goals regardless of the level of risk involved. Risk taking is a facet of the broad personality trait domain DISINHIBITION.

rumination (rumination disorders) Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out. In rumination disorders, there is no evidence that an associated gastrointestinal or another medical condition (e.g., gastroesophageal reflux) is sufficient to account for the repeated regurgitation.

seasonal pattern A pattern of the occurrence of a specific mental disorder in selected seasons of the year.

self-directedness, self-direction Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively.

separation insecurity Fears of being alone due to rejection by and/or separation from significant others, based in a lack of confidence in one's ability to care for oneself, both physically and emotionally. Separation insecurity is a facet of the broad personality trait domain NEGATIVE AFFECTIVITY.

sex Biological indication of male and female (understood in the context of reproductive capacity), such as sex chromosomes, gonads, sex hormones, and nonambiguous internal and external genitalia.

sign An objective manifestation of a pathological condition. Signs are observed by the examiner rather than reported by the affected individual. Compare with SYMPTOM.

sleep-onset REM Occurrence of the rapid eye movement (REM) phase of sleep within minutes after falling asleep. Usually assessed by a polysomnographic MULTIPLE SLEEP LATENCY TEST.

sleep terrors Recurrent episodes of abrupt terror arousals from sleep, usually occurring during the first third of the major sleep episode and beginning with a panicky scream. There is intense fear and signs of autonomic arousal, such as mydriasis, tachycardia, rapid breathing, and sweating, during each episode.

sleepwalking Repeated episodes of rising from bed during sleep and walking about, usually occurring during the first third of the major sleep episode. While sleepwalking, the person has a blank, staring face, is relatively unresponsive to the efforts of others to communicate with him or her, and can be awakened only with great difficulty.

somnolence (or "drowsiness") A state of near-sleep, a strong desire for sleep, or sleeping for unusually long periods. It has two distinct meanings, referring both to the usual state preceding falling asleep and to the chronic condition that involves being in that state independent of a circadian rhythm. Compare with HYPERSOMNIA.

specific food cravings Irresistible desire for special types of food.

startle response (or "startle reaction") An involuntary (reflexive) reaction to a sudden unexpected stimulus, such as a loud noise or sharp movement.

stereotypies, stereotyped behaviors/movements Repetitive, abnormally frequent, nongoal-directed movements, seemingly driven, and nonfunctional motor behavior (e.g., hand shaking or waving, body rocking, head banging, self-biting).

stress The pattern of specific and nonspecific responses a person makes to stimulus events that disturb his or her equilibrium and tax or exceed his or her ability to cope.

stressor Any emotional, physical, social, economic, or other factor that disrupts the normal physiological, cognitive, emotional, or behavioral balance of an individual.

stressor, psychological Any life event or life change that may be associated temporally (and perhaps causally) with the onset, occurrence, or exacerbation of a mental disorder.

stupor Lack of psychomotor activity, which may range from not actively relating to the environment to complete immobility.

submissiveness Adaptation of one's behavior to the actual or perceived interests and desires of others even when doing so is antithetical to one's own interests, needs, or desires. Submissiveness is a facet of the broad personality trait domain NEGATIVE AFFECTIVITY.

subsyndromal Below a specified level or threshold required to qualify for a particular condition. Subsyndromal conditions (*formes frustes*) are medical conditions that do not meet full criteria for a diagnosis—for example, because the symptoms are fewer or less severe than a defined syndrome—but that nevertheless can be identified and related to the "full-blown" syndrome.

suicidal ideas (suicidal ideation) Thoughts about self-harm, with deliberate consideration or planning of possible techniques of causing one's own death.

suicide The act of intentionally causing one's own death.

suicide attempt An attempt to end one's own life, which may lead to one's death.

suspiciousness Expectations of—and sensitivity to—signs of interpersonal ill intent or harm; doubts about loyalty and fidelity of others; feelings of being mistreated, used, and/or persecuted by others. Suspiciousness is a facet of the broad personality trait domain DETACHMENT.

symptom A subjective manifestation of a pathological condition. Symptoms are reported by the affected individual rather than observed by the examiner. Compare with SIGN.

syndrome A grouping of signs and symptoms, based on their frequent co-occurrence that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection.

synesthesias A condition in which stimulation of one sensory or cognitive pathway leads to automatic, involuntary experiences in a second sensory or cognitive pathway.

temper outburst An emotional outburst (also called a "tantrum"), usually associated with children or those in emotional distress, and typically characterized by stubbornness, crying, screaming, defiance, angry ranting, a resistance to attempts at pacification, and in some cases hitting. Physical control may be lost, the person may be unable to remain still, and even if the "goal" of the person is met, he or she may not be calmed.

thought-action fusion The tendency to treat thoughts and actions as equivalent.

tic An involuntary, sudden, rapid, recurrent, nonrhythmic motor movement or vocalization.

tolerance A situation that occurs with continued use of a drug in which an individual requires greater dosages to achieve the same effect.

transgender The broad spectrum of individuals who transiently or permanently identify with a gender different from their natal gender.

transsexual An individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all cases may also involve a somatic transition by cross-sex hormone treatment and genital surgery ("sex reassignment surgery").

traumatic stressor Any event (or events) that may cause or threaten death, serious injury, or sexual violence to an individual, a close family member, or a close friend.

unusual beliefs and experiences Belief that one has unusual abilities, such as mind reading, telekinesis, or THOUGHT-ACTION FUSION; unusual experiences of reality, including hallucinatory experiences. In general, the unusual beliefs are not held at the same level of conviction as DELUSIONS. Unusual beliefs and experiences are a facet of the personality trait domain PSYCHOTICISM.

waxy flexibility Slight, even resistance to positioning by examiner. Compare with CATALEPSY.

withdrawal, social Preference for being alone to being with others; reticence in social situations; AVOIDANCE of social contacts and activity; lack of initiation of social contact. Social withdrawal is a facet of the broad personality trait domain DETACHMENT.

worry Unpleasant or uncomfortable thoughts that cannot be consciously controlled by trying to turn the attention to other subjects. The worrying is often persistent, repetitive, and out of proportion to the topic worried about (it can even be about a triviality).

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Glossary of Cultural Concepts of Distress

Ataque de nervios

Ataque de nervios ("attack of nerves") is a syndrome among individuals of Latino descent, characterized by symptoms of intense emotional upset, including acute anxiety, anger, or grief; screaming and shouting uncontrollably; attacks of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive. Dissociative experiences (e.g., depersonalization, derealization, amnesia), seizure-like or fainting episodes, and suicidal gestures are prominent in some *ataques* but absent in others. A general feature of an *ataque de nervios* is a sense of being out of control. Attacks frequently occur as a direct result of a stressful event relating to the family, such as news of the death of a close relative, conflicts with a spouse or children, or witnessing an accident involving a family member. For a minority of individuals, no particular social event triggers their *ataques;* instead, their vulnerability to losing control comes from the accumulated experience of suffering.

No one-to-one relationship has been found between *ataque* and any specific psychiatric disorder, although several disorders, including panic disorder, other specified or unspecified dissociative disorder, and conversion disorder, have symptomatic overlap with *ataque*.

In community samples, *ataque* is associated with suicidal ideation, disability, and outpatient psychiatric utilization, after adjustment for psychiatric diagnoses, traumatic exposure, and other covariates. However, some *ataques* represent normative expressions of acute distress (e.g., at a funeral) without clinical sequelae. The term *ataque de nervios* may also refer to an idiom of distress that includes any "fit"-like paroxysm of emotionality (e.g., hysterical laughing) and may be used to indicate an episode of loss of control in response to an intense stressor.

Related conditions in other cultural contexts: Indisposition in Haiti, blacking out in the Southern United States, and falling out in the West Indies.

Related conditions in DSM-5: Panic attack, panic disorder, other specified or unspecified dissociative disorder, conversion (functional neurologic symptom) disorder, intermittent explosive disorder, other specified or unspecified anxiety disorder, other specified or unspecified trauma and stressor-related disorder.

Dhat syndrome

Dhat syndrome is a term that was coined in South Asia little more than half a century ago to account for common clinical presentations of young male patients who attributed their various symptoms to semen loss. Despite the name, it is not a discrete syndrome but rather a cultural explanation of distress for patients who refer to diverse symptoms, such as anxiety, fatigue, weakness, weight loss, impotence, other multiple somatic complaints, and depressive mood. The cardinal feature is anxiety and distress about the loss of *dhat* in the absence of any identifiable physiological dysfunction. *Dhat* was identified by patients as a white discharge that was noted on defecation or urination. Ideas about this substance are related to the concept of *dhatu* (semen) described in the Hindu system of medicine, Ayurveda, as one of seven essential bodily fluids whose balance is necessary to maintain health.

Although *dhat syndrome* was formulated as a cultural guide to local clinical practice, related ideas about the harmful effects of semen loss have been shown to be widespread in the general population, suggesting a cultural disposition for explaining health problems and symptoms with reference to *dhat syndrome.* Research in health care settings has yielded diverse estimates of the syndrome's prevalence (e.g., 64% of men attending psychiatric clinics in India for sexual complaints; 30% of men attending general medical clinics in Pakistan). Although *dhat syndrome* is most commonly identified with young men from lower socioeconomic backgrounds, middle-aged men may also be affected. Comparable concerns about white vaginal discharge (leukorrhea) have been associated with a variant of the concept for women.

Related conditions in other cultural contexts: *koro* in Southeast Asia, particularly Singapore and *shen-k'uei* ("kidney deficiency") in China.

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, somatic symptom disorder, illness anxiety disorder, erectile disorder, early (premature) ejaculation, other specified or unspecified sexual dysfunction, academic problem.

Khyâl cap

"*Khyâl* attacks" (*khyâl cap*), or "wind attacks," is a syndrome found among Cambodians in the United States and Cambodia. Common symptoms include those of panic attacks, such as dizziness, palpitations, shortness of breath, and cold extremities, as well as other symptoms of anxiety and autonomic arousal (e.g., tinnitus and neck soreness). *Khyâl* attacks include catastrophic cognitions centered on the concern that *khyâl* (a windlike substance) may rise in the body—along with blood—and cause a range of serious effects (e.g., compressing the lungs to cause shortness of breath and asphyxia; entering the cranium to cause tinnitus, dizziness, blurry vision, and a fatal syncope). *Khyâl* attacks may occur without warning, but are frequently brought about by triggers such as worrisome thoughts, standing up (i.e., orthostasis), specific odors with negative associations, and agoraphobic-type cues like going to crowded spaces or riding in a car. *Khyâl* attacks usually meet panic attack criteria and may shape the experience of other anxiety and trauma- and stressor-related disorders. *Khyâl* attacks may be associated with considerable disability.

Related conditions in other cultural contexts: Laos (*pen lom*), Tibet (*srog rlung gi nad*), Sri Lanka (*vata*), and Korea (*hwa byung*).

Related conditions in DSM-5: Panic attack, panic disorder, generalized anxiety disorder, agoraphobia, posttraumatic stress disorder, illness anxiety disorder.

Kufungisisa

Kufungisisa ("thinking too much" in Shona) is an idiom of distress and a cultural explanation among the Shona of Zimbabwe. As an explanation, it is considered to be causative of anxiety, depression, and somatic problems (e.g., "my heart is painful because I think too much"). As an idiom of psychosocial distress, it is indicative of interpersonal and social difficulties (e.g., marital problems, having no money to take care of children). *Kufungisisa* involves ruminating on upsetting thoughts, particularly worries.

Kufungisisa is associated with a range of psychopathology, including anxiety symptoms, excessive worry, panic attacks, depressive symptoms, and irritability. In a study of a random community sample, two-thirds of the cases identified by a general psychopathology measure were of this complaint.

In many cultures, "thinking too much" is considered to be damaging to the mind and body and to cause specific symptoms like headache and dizziness. "Thinking too much" may also be a key component of cultural syndromes such as "brain fag" in Nigeria. In the case of brain fag, "thinking too much" is primarily attributed to excessive study, which is considered to damage the brain in particular, with symptoms including feelings of heat or crawling sensations in the head.

Related conditions in other cultural contexts: "Thinking too much" is a common idiom of distress and cultural explanation across many countries and ethnic groups. It has been described in Africa, the Caribbean and Latin America, and among East Asian and Native American groups.

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, posttraumatic stress disorder, obsessive-compulsive disorder, persistent complex bereavement disorder (see "Conditions for Further Study").

Maladi moun

Maladi moun (literally "humanly caused illness," also referred to as "sent sickness") is a cultural explanation in Haitian communities for diverse medical and psychiatric disorders. In this explanatory model, interpersonal envy and malice cause people to harm their enemies by sending illnesses such as psychosis, depression, social or academic failure, and inability to perform activities of daily living. The etiological model assumes that illness may be caused by others' envy and hatred, provoked by the victim's economic success as evidenced by a new job or expensive purchase. One person's gain is assumed to produce another person's loss, so visible success makes one vulnerable to attack. Assigning the label of sent sickness depends on mode of onset and social status more than presenting symptoms. The acute onset of new symptoms or an abrupt behavioral change raises suspicions of a spiritual attack. Someone who is attractive, intelligent, or wealthy is perceived as especially vulnerable, and even young healthy children are at risk.

Related conditions in other cultural contexts: Concerns about illness (typically, physical illness) caused by envy or social conflict are common across cultures and often expressed in the form of "evil eye" (e.g. in Spanish, *mal de ojo,* in Italian, *mal'occhiu*).

Related conditions in DSM-5: Delusional disorder, persecutory type; schizophrenia with paranoid features.

Nervios

Nervios ("nerves") is a common idiom of distress among Latinos in the United States and Latin America. *Nervios* refers to a general state of vulnerability to stressful life experiences and to difficult life circumstances. The term *nervios* includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. The most common symptoms attributed to *nervios* include headaches and "brain aches" (occipital neck tension), irritability, stomach disturbances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like exacerbations). *Nervios* is a broad idiom of distress that spans the range of severity from cases with no mental disorder to presentations resembling adjustment, anxiety, depressive, dissociative, somatic symptom, or psychotic disorders. "Being nervous since childhood" appears to be more of a trait and may precede social anxiety disorder, while "being ill with nerves" is more related than other forms of *nervios* to psychiatric problems, especially dissociation and depression.

Related conditions in other cultural contexts: *Nevra* among Greeks in North America, *nierbi* among Sicilians in North America, and *nerves* among whites in Appalachia and Newfoundland.

Related conditions in DSM-5: Major depressive disorder, peristent depressive disorder (dysthymia), generalized anxiety disorder, social anxiety disorder, other specified or unspecified dissociative disorder, somatic symptom disorder, schizophrenia.

Shenjing shuairuo

Shenjing shuairuo ("weakness of the nervous system" in Mandarin Chinese) is a cultural syndrome that integrates conceptual categories of traditional Chinese medicine with the

Western diagnosis of neurasthenia. In the second, revised edition of the *Chinese Classification of Mental Disorders* (CCMD-2-R), *shenjing shuairuo* is defined as a syndrome composed of three out of five nonhierarchical symptom clusters: weakness (e.g., mental fatigue), emotions (e.g., feeling vexed), excitement (e.g., increased recollections), nervous pain (e.g., headache), and sleep (e.g., insomnia). *Fan nao* (feeling vexed) is a form of irritability mixed with worry and distress over conflicting thoughts and unfulfilled desires. The third edition of the CCMD retains *shenjing shuairuo* as a somatoform diagnosis of exclusion. Salient precipitants of *shenjing shuairuo* include work- or family-related stressors, loss of face (*mianzi, lianzi*), and an acute sense of failure (e.g., in academic performance). *Shenjing shuairuo* is related to traditional concepts of weakness (*xu*) and health imbalances related to deficiencies of a vital essence (e.g., the depletion of *qi* [vital energy] following overstraining or stagnation of *qi* due to excessive worry). In the traditional interpretation, *shenjing shuairuo* results when bodily channels (*jing*) conveying vital forces (*shen*) become dysregulated as a result of various social and interpersonal stressors, such as the inability to change a chronically frustrating and distressing situation. Various psychiatric disorders are associated with *shenjing shuairuo,* notably mood, anxiety, and somatic symptom disorders. In medical clinics in China, however, up to 45% of patients with *shenjing shuairuo* do not meet criteria for any DSM-IV disorder.

Related conditions in other cultural contexts: Neurasthenia-spectrum idioms and syndromes are present in India (*ashaktapanna*) and Japan (*shinkei-suijaku*), among other settings. Other conditions, such as brain fag syndrome, burnout syndrome, and chronic fatigue syndrome, are also closely related.

Related conditions in DSM-5: Major depressive disorder, persistent depressive disorder (dysthymia), generalized anxiety disorder, somatic symptom disorder, social anxiety disorder, specific phobia, posttraumatic stress disorder.

Susto

Susto ("fright") is a cultural explanation for distress and misfortune prevalent among some Latinos in the United States and among people in Mexico, Central America, and South America. It is not recognized as an illness category among Latinos from the Caribbean. *Susto* is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness, as well as difficulties functioning in key social roles. Symptoms may appear any time from days to years after the fright is experienced. In extreme cases, *susto* may result in death. There are no specific defining symptoms for *susto*; however, symptoms that are often reported by people with *susto* include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feelings of sadness, low self-worth or dirtiness, interpersonal sensitivity, and lack of motivation to do anything. Somatic symptoms accompanying *susto* may include muscle aches and pains, cold in the extremities, pallor, headache, stomachache, and diarrhea. Precipitating events are diverse, and include natural phenomena, animals, interpersonal situations, and supernatural agents, among others.

Three syndromic types of *susto* (referred to as *cibih* in the local Zapotec language) have been identified, each having different relationships with psychiatric diagnoses. An interpersonal *susto* characterized by feelings of loss, abandonment, and not being loved by family, with accompanying symptoms of sadness, poor self-image, and suicidal ideation, seemed to be closely related to major depressive disorder. When *susto* resulted from a traumatic event that played a major role in shaping symptoms and in emotional processing of the experience, the diagnosis of posttraumatic stress disorder appeared more appropriate. *Susto* characterized by various recurrent somatic symptoms—for which the person sought health care from several practitioners—was thought to resemble a somatic symptom disorder.

Related conditions in other cultural contexts: Similar etiological concepts and symptom configurations are found globally. In the Andean region, *susto* is referred to as *espanto*.

Related conditions in DSM-5: Major depressive disorder, posttraumatic stress disorder, other specified or unspecified trauma and stressor-related disorder, somatic symptom disorders.

Taijin kyofusho

Taijin kyofusho ("interpersonal fear disorder" in Japanese) is a cultural syndrome characterized by anxiety about and avoidance of interpersonal situations due to the thought, feeling, or conviction that one's appearance and actions in social interactions are inadequate or offensive to others. In the United States, the variant involves having an offensive body odor and is termed *olfactory reference syndrome.* Individuals with *taijin kyofusho* tend to focus on the impact of their symptoms and behaviors on others. Variants include major concerns about facial blushing (erythrophobia), having an offensive body odor (olfactory reference syndrome), inappropriate gaze (too much or too little eye contact), stiff or awkward facial expression or bodily movements (e.g., stiffening, trembling), or body deformity.

Taijin kyofusho is a broader construct than social anxiety disorder in DSM-5. In addition to performance anxiety, *taijin kyofusho* includes two culture-related forms: a "sensitive type," with extreme social sensitivity and anxiety about interpersonal interactions, and an "offensive type," in which the major concern is offending others. As a category, *taijin kyofusho* thus includes syndromes with features of body dysmorphic disorder as well as delusional disorder. Concerns may have a delusional quality, responding poorly to simple reassurance or counterexample.

The distinctive symptoms of *taijin kyofusho* occur in specific cultural contexts and, to some extent, with more severe social anxiety across cultures. Similar syndromes are found in Korea and other societies that place a strong emphasis on the self-conscious maintenance of appropriate social behavior in hierarchical interpersonal relationships. *Taijin kyofusho*–like symptoms have also been described in other cultural contexts, including the United States, Australia, and New Zealand.

Related conditions in other cultural contexts: *Taein kong po* in Korea.

Related conditions in DSM-5: Social anxiety disorder, body dysmorphic disorder, delusional disorder, obsessive-compulsive disorder, olfactory reference syndrome (a type of other specified obsessive-compulsive and related disorder). Olfactory reference syndrome is related specifically to the *jikoshu-kyofu* variant of *taijin kyofusho,* whose core symptom is the concern that the person emits an offensive body odor. This presentation is seen in various cultures outside Japan.

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Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)

ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014.

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
V62.3	Z55.9	Academic or educational problem
V62.4	Z60.3	Acculturation difficulty
308.3	F43.0	Acute stress disorder
		Adjustment disorders
309.24	F43.22	With anxiety
309.0	F43.21	With depressed mood
309.3	F43.24	With disturbance of conduct
309.28	F43.23	With mixed anxiety and depressed mood
309.4	F43.25	With mixed disturbance of emotions and conduct
309.9	F43.20	Unspecified
V71.01	Z72.811	Adult antisocial behavior
307.0	F98.5	Adult-onset fluency disorder
		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 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
		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

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
300.22	F40.00	Agoraphobia
291.89		Alcohol-induced anxiety disorder
	F10.180	With mild use disorder
	F10.280	With moderate or severe use disorder
	F10.980	Without use disorder
291.89		Alcohol-induced bipolar and related disorder
	F10.14	With mild use disorder
	F10.24	With moderate or severe use disorder
	F10.94	Without use disorder
291.89		Alcohol-induced depressive disorder
	F10.14	With mild use disorder
	F10.24	With moderate or severe use disorder
	F10.94	Without use disorder
291.1		Alcohol-induced major neurocognitive disorder, Amnestic confabulatory type
	F10.26	With moderate or severe use disorder
	F10.96	Without use disorder
291.2		Alcohol-induced major neurocognitive disorder, Nonamnestic confabulatory type
	F10.27	With moderate or severe use disorder
	F10.97	Without use disorder
291.89		Alcohol-induced mild neurocognitive disorder
	F10.288	With moderate or severe use disorder
	F10.988	Without use disorder
291.9		Alcohol-induced psychotic disorder
	F10.159	With mild use disorder
	F10.259	With moderate or severe use disorder
	F10.959	Without use disorder
291.89		Alcohol-induced sexual dysfunction
	F10.181	With mild use disorder
	F10.281	With moderate or severe use disorder
	F10.981	Without use disorder
291.82		Alcohol-induced sleep disorder
	F10.182	With mild use disorder
	F10.282	With moderate or severe use disorder
	F10.982	Without use disorder
303.00		Alcohol intoxication
	F10.129	With mild use disorder
	F10.229	With moderate or severe use disorder
	F10.929	Without use disorder
291.0		Alcohol intoxication delirium
	F10.121	With mild use disorder
	F10.221	With moderate or severe use disorder
	F10.921	Without use disorder

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
		Alcohol use disorder
305.00	F10.10	Mild
303.90	F10.20	Moderate
303.90	F10.20	Severe
291.81		Alcohol withdrawal
	F10.232	With perceptual disturbances
	F10.239	Without perceptual disturbances
291.0	F10.231	Alcohol withdrawal delirium
292.89		Amphetamine (or other stimulant)–induced anxiety disorder
	F15.180	With mild use disorder
	F15.280	With moderate or severe use disorder
	F15.980	Without use disorder
292.84		Amphetamine (or other stimulant)–induced bipolar and related disorder
	F15.14	With mild use disorder
	F15.24	With moderate or severe use disorder
	F15.94	Without use disorder
	F15.921	Amphetamine (or other stimulant)–induced delirium
292.84		Amphetamine (or other stimulant)–induced depressive disorder
	F15.14	With mild use disorder
	F15.24	With moderate or severe use disorder
	F15.94	Without use disorder
292.89		Amphetamine (or other stimulant)–induced obsessive-compulsive and related disorder
	F15.188	With mild use disorder
	F15.288	With moderate or severe use disorder
	F15.988	Without use disorder
292.9		Amphetamine (or other stimulant)–induced psychotic disorder
	F15.159	With mild use disorder
	F15.259	With moderate or severe use disorder
	F15.959	Without use disorder
292.89		Amphetamine (or other stimulant)–induced sexual dysfunction
	F15.181	With mild use disorder
	F15.281	With moderate or severe use disorder
	F15.981	Without use disorder
292.85		Amphetamine (or other stimulant)–induced sleep disorder
	F15.182	With mild use disorder
	F15.282	With moderate or severe use disorder
	F15.982	Without use disorder
292.89		Amphetamine or other stimulant intoxication
		Amphetamine or other stimulant intoxication, With perceptual disturbances
	F15.122	With mild use disorder
	F15.222	With moderate or severe use disorder
	F15.922	Without use disorder

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
		Amphetamine or other stimulant intoxication, Without perceptual disturbances
	F15.129	With mild use disorder
	F15.229	With moderate or severe use disorder
	F15.929	Without use disorder
292.81		Amphetamine (or other stimulant) intoxication delirium
	F15.121	With mild use disorder
	F15.221	With moderate or severe use disorder
	F15.921	Without use disorder
292.0	F15.23	Amphetamine or other stimulant withdrawal
		Amphetamine-type substance use disorder
305.70	F15.10	Mild
304.40	F15.20	Moderate
304.40	F15.20	Severe
307.1		Anorexia nervosa
	F50.02	Binge-eating/purging type
	F50.01	Restricting type
		Antidepressant discontinuation syndrome
995.29	T43.205A	Initial encounter
995.29	T43.205S	Sequelae
995.29	T43.205D	Subsequent encounter
301.7	F60.2	Antisocial personality disorder
293.84	F06.4	Anxiety disorder due to another medical condition
		Attention-deficit/hyperactivity disorder
314.01	F90.2	Combined presentation
314.01	F90.1	Predominantly hyperactive/impulsive presentation
314.00	F90.0	Predominantly inattentive presentation
299.00	F84.0	Autism spectrum disorder
301.82	F60.6	Avoidant personality disorder
307.59	F50.8	Avoidant/restrictive food intake disorder
307.51	F50.8	Binge-eating disorder
		Bipolar I disorder, Current or most recent episode depressed
296.56	F31.76	In full remission
296.55	F31.75	In partial remission
296.51	F31.31	Mild
296.52	F31.32	Moderate
296.53	F31.4	Severe
296.54	F31.5	With psychotic features
296.50	F31.9	Unspecified
296.40	F31.0	Bipolar I disorder, Current or most recent episode hypomanic
296.46	F31.72	In full remission
296.45	F31.71	In partial remission
296.40	F31.9	Unspecified

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
		Bipolar I disorder, Current or most recent episode manic
296.46	F31.74	In full remission
296.45	F31.73	In partial remission
296.41	F31.11	Mild
296.42	F31.12	Moderate
296.43	F31.13	Severe
296.44	F31.2	With psychotic features
296.40	F31.9	Unspecified
296.7	F31.9	Bipolar I disorder, Current or most recent episode unspecified
296.89	F31.81	Bipolar II disorder
293.83		Bipolar and related disorder due to another medical condition
	F06.33	With manic features
	F06.33	With manic- or hypomanic-like episodes
	F06.34	With mixed features
300.7	F45.22	Body dysmorphic disorder
V62.89	R41.83	Borderline intellectual functioning
301.83	F60.3	Borderline personality disorder
298.8	F23	Brief psychotic disorder
307.51	F50.2	Bulimia nervosa
292.89		Caffeine-induced anxiety disorder
	F15.180	With mild use disorder
	F15.280	With moderate or severe use disorder
	F15.980	Without use disorder
292.85		Caffeine-induced sleep disorder
	F15.182	With mild use disorder
	F15.282	With moderate or severe use disorder
	F15.982	Without use disorder
305.90	F15.929	Caffeine intoxication
292.0	F15.93	Caffeine withdrawal
292.89		Cannabis-induced anxiety disorder
	F12.180	With mild use disorder
	F12.280	With moderate or severe use disorder
	F12.980	Without use disorder
292.9		Cannabis-induced psychotic disorder
	F12.159	With mild use disorder
	F12.259	With moderate or severe use disorder
	F12.959	Without use disorder
292.85		Cannabis-induced sleep disorder
	F12.188	With mild use disorder
	F12.288	With moderate or severe use disorder
	F12.988	Without use disorder
292.89		Cannabis intoxication

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
		Cannabis intoxication, With perceptual disturbances
	F12.122	With mild use disorder
	F12.222	With moderate or severe use disorder
	F12.922	Without use disorder
		Cannabis intoxication, Without perceptual disturbances
	F12.129	With mild use disorder
	F12.229	With moderate or severe use disorder
	F12.929	Without use disorder
292.81		Cannabis intoxication delirium
	F12.121	With mild use disorder
	F12.221	With moderate or severe use disorder
	F12.921	Without use disorder
		Cannabis use disorder
305.20	F12.10	Mild
304.30	F12.20	Moderate
304.30	F12.20	Severe
292.0	F12.288	Cannabis withdrawal
293.89	F06.1	Catatonia associated with another mental disorder (catatonia specifier)
293.89	F06.1	Catatonic disorder due to another medical condition
		Central sleep apnea
780.57	G47.37	Central sleep apnea comorbid with opioid use
786.04	R06.3	Cheyne-Stokes breathing
327.21	G47.31	Idiopathic central sleep apnea
V61.29	Z62.898	Child affected by parental relationship distress
		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
V71.02	Z72.810	Child or adolescent antisocial behavior
		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
		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

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
		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
315.35	F80.81	Childhood-onset fluency disorder (stuttering)
		Circadian rhythm sleep-wake disorders
307.45	G47.22	Advanced sleep phase type
307.45	G47.21	Delayed sleep phase type
307.45	G47.23	Irregular sleep-wake type
307.45	G47.24	Non-24-hour sleep-wake type
307.45	G47.26	Shift work type
307.45	G47.20	Unspecified type
292.89		Cocaine-induced anxiety disorder
	F14.180	With mild use disorder
	F14.280	With moderate or severe use disorder
	F14.980	Without use disorder
292.84		Cocaine-induced bipolar and related disorder
	F14.14	With mild use disorder
	F14.24	With moderate or severe use disorder
	F14.94	Without use disorder
292.84		Cocaine-induced depressive disorder
	F14.14	With mild use disorder
	F14.24	With moderate or severe use disorder
	F14.94	Without use disorder
292.89		Cocaine-induced obsessive-compulsive and related disorder
	F14.188	With mild use disorder
	F14.288	With moderate or severe use disorder
	F14.988	Without use disorder
292.9		Cocaine-induced psychotic disorder
	F14.159	With mild use disorder
	F14.259	With moderate or severe use disorder
	F14.959	Without use disorder
292.89		Cocaine-induced sexual dysfunction
	F14.181	With mild use disorder
	F14.281	With moderate or severe use disorder
	F14.981	Without use disorder
292.85		Cocaine-induced sleep disorder
	F14.182	With mild use disorder
	F14.282	With moderate or severe use disorder
	F14.982	Without use disorder

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
292.89		Cocaine intoxication
		Cocaine intoxication, With perceptual disturbances
	F14.122	With mild use disorder
	F14.222	With moderate or severe use disorder
	F14.922	Without use disorder
		Cocaine intoxication, Without perceptual disturbances
	F14.129	With mild use disorder
	F14.229	With moderate or severe use disorder
	F14.929	Without use disorder
292.81		Cocaine intoxication delirium
	F14.121	With mild use disorder
	F14.221	With moderate or severe use disorder
	F14.921	Without use disorder
		Cocaine use disorder
305.60	F14.10	Mild
304.20	F14.20	Moderate
304.20	F14.20	Severe
292.0	F14.23	Cocaine withdrawal
		Conduct disorder
312.82	F91.2	Adolescent-onset type
312.81	F91.1	Childhood-onset type
312.89	F91.9	Unspecified onset
300.11		Conversion disorder (functional neurological symptom disorder)
	F44.4	With abnormal movement
	F44.6	With anesthesia or sensory loss
	F44.5	With attacks or seizures
	F44.7	With mixed symptoms
	F44.6	With special sensory symptoms
	F44.4	With speech symptoms
	F44.4	With swallowing symptoms
	F44.4	With weakness/paralysis
V62.5	Z65.0	Conviction in civil or criminal proceedings without imprisonment
301.13	F34.0	Cyclothymic disorder
302.74	F52.32	Delayed ejaculation
		Delirium
293.0	F05	Delirium due to another medical condition
293.0	F05	Delirium due to multiple etiologies
292.81		Medication-induced delirium *(for ICD-10-CM codes, see specific substances)*
		Substance intoxication delirium *(see specific substances for codes)*
		Substance withdrawal delirium *(see specific substances for codes)*
297.1	F22	Delusional disorder
301.6	F60.7	Dependent personality disorder

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
300.6	F48.1	Depersonalization/derealization disorder
293.83		Depressive disorder due to another medical condition
	F06.31	With depressive features
	F06.32	With major depressive–like episode
	F06.34	With mixed features
315.4	F82	Developmental coordination disorder
V60.89	Z59.2	Discord with neighbor, lodger, or landlord
V62.89	Z64.4	Discord with social service provider, including probation officer, case manager, or social services worker
313.89	F94.2	Disinhibited social engagement disorder
V61.03	Z63.5	Disruption of family by separation or divorce
296.99	F34.8	Disruptive mood dysregulation disorder
300.12	F44.0	Dissociative amnesia
300.13	F44.1	Dissociative amnesia, with dissociative fugue
300.14	F44.81	Dissociative identity disorder
307.7	F98.1	Encopresis
307.6	F98.0	Enuresis
302.72	F52.21	Erectile disorder
698.4	L98.1	Excoriation (skin-picking) disorder
302.4	F65.2	Exhibitionistic disorder
V62.22	Z65.5	Exposure to disaster, war, or other hostilities
V60.2	Z59.5	Extreme poverty
300.19	F68.10	Factitious disorder
302.73	F52.31	Female orgasmic disorder
302.72	F52.22	Female sexual interest/arousal disorder
302.81	F65.0	Fetishistic disorder
302.89	F65.81	Frotteuristic disorder
312.31	F63.0	Gambling disorder
302.85	F64.1	Gender dysphoria in adolescents and adults
302.6	F64.2	Gender dysphoria in children
300.02	F41.1	Generalized anxiety disorder
302.76	F52.6	Genito-pelvic pain/penetration disorder
315.8	F88	Global developmental delay
292.89	F16.983	Hallucinogen persisting perception disorder
V61.8	Z63.8	High expressed emotion level within family
301.50	F60.4	Histrionic personality disorder
300.3	F42	Hoarding disorder
V60.0	Z59.0	Homelessness
307.44	F51.11	Hypersomnolence disorder
300.7	F45.21	Illness anxiety disorder
V62.5	Z65.1	Imprisonment or other incarceration
V60.1	Z59.1	Inadequate housing

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
292.89		Inhalant-induced anxiety disorder
	F18.180	With mild use disorder
	F18.280	With moderate or severe use disorder
	F18.980	Without use disorder
292.84		Inhalant-induced depressive disorder
	F18.14	With mild use disorder
	F18.24	With moderate or severe use disorder
	F18.94	Without use disorder
292.82		Inhalant-induced major neurocognitive disorder
	F18.17	With mild use disorder
	F18.27	With moderate or severe use disorder
	F18.97	Without use disorder
292.89		Inhalant-induced mild neurocognitive disorder
	F18.188	With mild use disorder
	F18.288	With moderate or severe use disorder
	F18.988	Without use disorder
292.9		Inhalant-induced psychotic disorder
	F18.159	With mild use disorder
	F18.259	With moderate or severe use disorder
	F18.959	Without use disorder
292.89		Inhalant intoxication
	F18.129	With mild use disorder
	F18.229	With moderate or severe use disorder
	F18.929	Without use disorder
292.81		Inhalant intoxication delirium
	F18.121	With mild use disorder
	F18.221	With moderate or severe use disorder
	F18.921	Without use disorder
		Inhalant use disorder
305.90	F18.10	Mild
304.60	F18.20	Moderate
304.60	F18.20	Severe
307.42	F51.01	Insomnia disorder
V60.2	Z59.7	Insufficient social insurance or welfare support
		Intellectual disability (intellectual developmental disorder)
317	F70	Mild
318.0	F71	Moderate
318.1	F72	Severe
318.2	F73	Profound
312.34	F63.81	Intermittent explosive disorder
312.32	F63.2	Kleptomania
V60.2	Z59.4	Lack of adequate food or safe drinking water
315.32	F80.2	Language disorder
V60.2	Z59.6	Low income

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
		Major depressive disorder, Recurrent episode
296.36	F33.42	In full remission
296.35	F33.41	In partial remission
296.31	F33.0	Mild
296.32	F33.1	Moderate
296.33	F33.2	Severe
296.34	F33.3	With psychotic features
296.30	F33.9	Unspecified
		Major depressive disorder, Single episode
296.26	F32.5	In full remission
296.25	F32.4	In partial remission
296.21	F32.0	Mild
296.22	F32.1	Moderate
296.23	F32.2	Severe
296.24	F32.3	With psychotic features
296.20	F32.9	Unspecifed
331.9	G31.9	Major frontotemporal neurocognitive disorder, Possible
		Major frontotemporal neurocognitive disorder, Probable (*code first* 331.19 [G31.09] frontotemporal disease)
294.11	F02.81	With behavioral disturbance
294.10	F02.80	Without behavioral disturbance
331.9	G31.9	Major neurocognitive disorder due to Alzheimer's disease, Possible
		Major neurocognitive disorder due to Alzheimer's disease, Probable (*code first* 331.0 [G30.9] Alzheimer's disease)
294.11	F02.81	With behavioral disturbance
294.10	F02.80	Without behavioral disturbance
		Major neurocognitive disorder due to another medical condition
294.11	F02.81	With behavioral disturbance
294.10	F02.80	Without behavioral disturbance
		Major neurocognitive disorder due to HIV infection (*code first* 042 [B20] HIV infection)
294.11	F02.81	With behavioral disturbance
294.10	F02.80	Without behavioral disturbance
		Major neurocognitive disorder due to Huntington's disease (*code first* 333.4 [G10] Huntington's disease)
294.11	F02.81	With behavioral disturbance
294.10	F02.80	Without behavioral disturbance
331.9	G31.9	Major neurocognitive disorder with Lewy bodies, Possible
		Major neurocognitive disorder with Lewy bodies, Probable (*code first* 331.82 [G31.83] Lewy body disease)
294.11	F02.81	With behavioral disturbance
294.10	F02.80	Without behavioral disturbance
		Major neurocognitive disorder due to multiple etiologies
294.11	F02.81	With behavioral disturbance
294.10	F02.80	Without behavioral disturbance

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
331.9	G31.9	Major neurocognitive disorder due to Parkinson's disease, Possible
		Major neurocognitive disorder due to Parkinson's disease, Probable (*code first* 332.0 [G20] Parkinson's disease)
294.11	F02.81	With behavioral disturbance
294.10	F02.80	Without behavioral disturbance
		Major neurocognitive disorder due to prion disease (*code first* 046.79 [A81.9] prion disease)
294.11	F02.81	With behavioral disturbance
294.10	F02.80	Without behavioral disturbance
		Major neurocognitive disorder due to traumatic brain injury (*code first* 907.0 late effect of intracranial injury without skull fracture [S06.2X9S diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela])
294.11	F02.81	With behavioral disturbance
294.10	F02.80	Without behavioral disturbance
331.9	G31.9	Major vascular neurocognitive disorder, Possible
		Major vascular neurocognitive disorder, Probable
290.40	F01.51	With behavioral disturbance
290.40	F01.50	Without behavioral disturbance
302.71	F52.0	Male hypoactive sexual desire disorder
V65.2	Z76.5	Malingering
333.99	G25.71	Medication-induced acute akathisia
333.72	G24.02	Medication-induced acute dystonia
292.81		Medication-induced delirium *(for ICD-10-CM codes, see specific substances)*
333.1	G25.1	Medication-induced postural tremor
331.83	G31.84	Mild frontotemporal neurocognitive disorder
331.83	G31.84	Mild neurocognitive disorder due to Alzheimer's disease
331.83	G31.84	Mild neurocognitive disorder due to another medical condition
331.83	G31.84	Mild neurocognitive disorder due to HIV infection
331.83	G31.84	Mild neurocognitive disorder due to Huntington's disease
331.83	G31.84	Mild neurocognitive disorder due to multiple etiologies
331.83	G31.84	Mild neurocognitive disorder due to Parkinson's disease
331.83	G31.84	Mild neurocognitive disorder due to prion disease
331.83	G31.84	Mild neurocognitive disorder due to traumatic brain injury
331.83	G31.84	Mild neurocognitive disorder with Lewy bodies
331.83	G31.84	Mild vascular neurocognitive disorder
301.81	F60.81	Narcissistic personality disorder
		Narcolepsy
347.00	G47.419	Autosomal dominant cerebellar ataxia, deafness, and narcolepsy
347.00	G47.419	Autosomal dominant narcolepsy, obesity, and type 2 diabetes
347.10	G47.429	Narcolepsy secondary to another medical condition
347.01	G47.411	Narcolepsy with cataplexy but without hypocretin deficiency
347.00	G47.419	Narcolepsy without cataplexy but with hypocretin deficiency
332.1	G21.11	Neuroleptic-induced parkinsonism

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
333.92	G21.0	Neuroleptic malignant syndrome
307.47	F51.5	Nightmare disorder
V15.81	Z91.19	Nonadherence to medical treatment
		Non–rapid eye movement sleep arousal disorders
307.46	F51.4	Sleep terror type
307.46	F51.3	Sleepwalking type
300.3	F42	Obsessive-compulsive disorder
301.4	F60.5	Obsessive-compulsive personality disorder
294.8	F06.8	Obsessive-compulsive and related disorder due to another medical condition
327.23	G47.33	Obstructive sleep apnea hypopnea
292.89		Opioid-induced anxiety disorder
	F11.188	With mild use disorder
	F11.288	With moderate or severe use disorder
	F11.988	Without use disorder
	F11.921	Opioid-induced delirium
292.84		Opioid-induced depressive disorder
	F11.14	With mild use disorder
	F11.24	With moderate or severe use disorder
	F11.94	Without use disorder
292.89		Opioid-induced sexual dysfunction
	F11.181	With mild use disorder
	F11.281	With moderate or severe use disorder
	F11.981	Without use disorder
292.85		Opioid-induced sleep disorder
	F11.182	With mild use disorder
	F11.282	With moderate or severe use disorder
	F11.982	Without use disorder
292.89		Opioid intoxication
		Opioid intoxication, With perceptual disturbances
	F11.122	With mild use disorder
	F11.222	With moderate or severe use disorder
	F11.922	Without use disorder
		Opioid intoxication, Without perceptual disturbances
	F11.129	With mild use disorder
	F11.229	With moderate or severe use disorder
	F11.929	Without use disorder
292.81		Opioid intoxication delirium
	F11.121	With mild use disorder
	F11.221	With moderate or severe use disorder
	F11.921	Without use disorder
		Opioid use disorder
305.50	F11.10	Mild
304.00	F11.20	Moderate
304.00	F11.20	Severe

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
292.0	F11.23	Opioid withdrawal
292.0	F11.23	Opioid withdrawal delirium
313.81	F91.3	Oppositional defiant disorder
		Other adverse effect of medication
995.20	T50.905A	Initial encounter
995.20	T50.905S	Sequelae
995.20	T50.905D	Subsequent encounter
		Other circumstances related to adult abuse by nonspouse or nonpartner
V62.83	Z69.82	Encounter for mental health services for perpetrator of nonspousal adult abuse
V65.49	Z69.81	Encounter for mental health services for victim of nonspousal adult abuse
		Other circumstances related to child neglect
V62.83	Z69.021	Encounter for mental health services for perpetrator of nonparental child neglect
V61.22	Z69.011	Encounter for mental health services for perpetrator of parental 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
		Other circumstances related to child physical abuse
V62.83	Z69.021	Encounter for mental health services for perpetrator of nonparental child abuse
V61.22	Z69.011	Encounter for mental health services for perpetrator of parental child 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
		Other circumstances related to child psychological abuse
V62.83	Z69.021	Encounter for mental health services for perpetrator of nonparental child psychological abuse
V61.22	Z69.011	Encounter for mental health services for perpetrator of parental 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
		Other circumstances related to child sexual abuse
V62.83	Z69.021	Encounter for mental health services for perpetrator of nonparental child sexual abuse
V61.22	Z69.011	Encounter for mental health services for perpetrator of parental child sexual abuse

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
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
		Other circumstances related to spouse or partner abuse, Psychological
V61.12	Z69.12	Encounter for mental health services for perpetrator of spouse or partner psychological abuse
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
		Other circumstances related to spouse or partner neglect
V61.12	Z69.12	Encounter for mental health services for perpetrator of 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
		Other circumstances related to spouse or partner violence, Physical
V61.12	Z69.12	Encounter for mental health services for perpetrator of 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
		Other circumstances related to spouse or partner violence, Sexual
V61.12	Z69.12	Encounter for mental health services for perpetrator of 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
V65.40	Z71.9	Other counseling or consultation
292.89		Other hallucinogen–induced anxiety disorder
	F16.180	With mild use disorder
	F16.280	With moderate or severe use disorder
	F16.980	Without use disorder
292.84		Other hallucinogen–induced bipolar and related disorder
	F16.14	With mild use disorder
	F16.24	With moderate or severe use disorder
	F16.94	Without use disorder
292.84		Other hallucinogen–induced depressive disorder
	F16.14	With mild use disorder
	F16.24	With moderate or severe use disorder
	F16.94	Without use disorder

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
292.9		Other hallucinogen–induced psychotic disorder
	F16.159	With mild use disorder
	F16.259	With moderate or severe use disorder
	F16.959	Without use disorder
292.89		Other hallucinogen intoxication
	F16.129	With mild use disorder
	F16.229	With moderate or severe use disorder
	F16.929	Without use disorder
292.81		Other hallucinogen intoxication delirium
	F16.121	With mild use disorder
	F16.221	With moderate or severe use disorder
	F16.921	Without use disorder
		Other hallucinogen use disorder
305.30	F16.10	Mild
304.50	F16.20	Moderate
304.50	F16.20	Severe
333.99	G25.79	Other medication-induced movement disorder
332.1	G21.19	Other medication-induced parkinsonism
V15.49	Z91.49	Other personal history of psychological trauma
V15.89	Z91.89	Other personal risk factors
V62.29	Z56.9	Other problem related to employment
V62.89	Z65.8	Other problem related to psychosocial circumstances
300.09	F41.8	Other specified anxiety disorder
314.01	F90.8	Other specified attention-deficit/hyperactivity disorder
296.89	F31.89	Other specified bipolar and related disorder
780.09	R41.0	Other specified delirium
311	F32.8	Other specified depressive disorder
312.89	F91.8	Other specified disruptive, impulse-control, and conduct disorder
300.15	F44.89	Other specified dissociative disorder
		Other specified elimination disorder
787.60	R15.9	With fecal symptoms
788.39	N39.498	With urinary symptoms
307.59	F50.8	Other specified feeding or eating disorder
302.6	F64.8	Other specified gender dysphoria
780.54	G47.19	Other specified hypersomnolence disorder
780.52	G47.09	Other specified insomnia disorder
300.9	F99	Other specified mental disorder
294.8	F06.8	Other specified mental disorder due to another medical condition
315.8	F88	Other specified neurodevelopmental disorder
300.3	F42	Other specified obsessive-compulsive and related disorder
302.89	F65.89	Other specified paraphilic disorder
301.89	F60.89	Other specified personality disorder
298.8	F28	Other specified schizophrenia spectrum and other psychotic disorder
302.79	F52.8	Other specified sexual dysfunction

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
780.59	G47.8	Other specified sleep-wake disorder
300.89	F45.8	Other specified somatic symptom and related disorder
307.20	F95.8	Other specified tic disorder
309.89	F43.8	Other specified trauma- and stressor-related disorder
292.89		Other (or unknown) substance–induced anxiety disorder
	F19.180	With mild use disorder
	F19.280	With moderate or severe use disorder
	F19.980	Without use disorder
292.84		Other (or unknown) substance–induced bipolar and related disorder
	F19.14	With mild use disorder
	F19.24	With moderate or severe use disorder
	F19.94	Without use disorder
	F19.921	Other (or unknown) substance–induced delirium
292.84		Other (or unknown) substance–induced depressive disorder
	F19.14	With mild use disorder
	F19.24	With moderate or severe use disorder
	F19.94	Without use disorder
292.82		Other (or unknown) substance–induced major neurocognitive disorder
	F19.17	With mild use disorder
	F19.27	With moderate or severe use disorder
	F19.97	Without use disorder
292.89		Other (or unknown) substance–induced mild neurocognitive disorder
	F19.188	With mild use disorder
	F19.288	With moderate or severe use disorder
	F19.988	Without use disorder
292.89		Other (or unknown) substance–induced obsessive-compulsive and related disorder
	F19.188	With mild use disorder
	F19.288	With moderate or severe use disorder
	F19.988	Without use disorder
292.9		Other (or unknown) substance–induced psychotic disorder
	F19.159	With mild use disorder
	F19.259	With moderate or severe use disorder
	F19.959	Without use disorder
292.89		Other (or unknown) substance–induced sexual dysfunction
	F19.181	With mild use disorder
	F19.281	With moderate or severe use disorder
	F19.981	Without use disorder
292.85		Other (or unknown) substance–induced sleep disorder
	F19.182	With mild use disorder
	F19.282	With moderate or severe use disorder
	F19.982	Without use disorder