ing effective treatment of the bulimia nervosa. The lifetime prevalence of substance use, particularly alcohol or stimulant use, is at least 30% among individuals with bulimia nervosa. Stimulant use often begins in an attempt to control appetite and weight. A substantial percentage of individuals with bulimia nervosa also have personality features that meet criteria for one or more personality disorders, most frequently borderline personality disorder.

Binge-Eating Disorder

Diagnostic Criteria **307.51 (F50.8)**

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:
   1. Eating much more rapidly than normal.
   2. Eating until feeling uncomfortably full.
   3. Eating large amounts of food when not feeling physically hungry.
   4. Eating alone because of feeling embarrassed by how much one is eating.
   5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Specify if:

In partial remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.

In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

Mild: 1–3 binge-eating episodes per week.

Moderate: 4–7 binge-eating episodes per week.

Severe: 8–13 binge-eating episodes per week.

Extreme: 14 or more binge-eating episodes per week.

Diagnostic Features

The essential feature of binge-eating disorder is recurrent episodes of binge eating that must occur, on average, at least once per week for 3 months (Criterion D). An "episode of binge eating" is defined as eating, in a discrete period of time, an amount of food that is defi-

nitely larger than most people would eat in a similar period of time under similar circumstances (Criterion A1). The context in which the eating occurs may affect the clinician's estimation of whether the intake is excessive. For example, a quantity of food that might be regarded as excessive for a typical meal might be considered normal during a celebration or holiday meal. A "discrete period of time" refers to a limited period, usually less than 2 hours. A single episode of binge eating need not be restricted to one setting. For example, an individual may begin a binge in a restaurant and then continue to eat on returning home. Continual snacking on small amounts of food throughout the day would not be considered an eating binge.

An occurrence of excessive food consumption must be accompanied by a sense of lack of control (Criterion A2) to be considered an episode of binge eating. An indicator of loss of control is the inability to refrain from eating or to stop eating once started. Some individuals describe a dissociative quality during, or following, the binge-eating episodes. The impairment in control associated with binge eating may not be absolute; for example, an individual may continue binge eating while the telephone is ringing but will cease if a roommate or spouse unexpectedly enters the room. Some individuals report that their binge-eating episodes are no longer characterized by an acute feeling of loss of control but rather by a more generalized pattern of uncontrolled eating. If individuals report that they have abandoned efforts to control their eating, loss of control may still be considered as present. Binge eating can also be planned in some instances.

The type of food consumed during binges varies both across individuals and for a given individual. Binge eating appears to be characterized more by an abnormality in the amount of food consumed than by a craving for a specific nutrient.

Binge eating must be characterized by marked distress (Criterion C) and at least three of the following features: eating much more rapidly than normal; eating until feeling uncomfortably full; eating large amounts of food when not feeling physically hungry; eating alone because of feeling embarrassed by how much one is eating; and feeling disgusted with oneself, depressed, or very guilty afterward (Criterion B).

Individuals with binge-eating disorder are typically ashamed of their eating problems and attempt to conceal their symptoms. Binge eating usually occurs in secrecy or as inconspicuously as possible. The most common antecedent of binge eating is negative affect. Other triggers include interpersonal stressors; dietary restraint; negative feelings related to body weight, body shape, and food; and boredom. Binge eating may minimize or mitigate factors that precipitated the episode in the short-term, but negative self-evaluation and dysphoria often are the delayed consequences.

Associated Features Supporting Diagnosis

Binge-eating disorder occurs in normal-weight/overweight and obese individuals. It is reliably associated with overweight and obesity in treatment-seeking individuals. Nevertheless, binge-eating disorder is distinct from obesity. Most obese individuals do not engage in recurrent binge eating. In addition, compared with weight-matched obese individuals without binge-eating disorder, those with the disorder consume more calories in laboratory studies of eating behavior and have greater functional impairment, lower quality of life, more subjective distress, and greater psychiatric comorbidity.

Prevalence

Twelve-month prevalence of binge-eating disorder among U.S. adult (age 18 or older) females and males is 1.6% and 0.8%, respectively. The gender ratio is far less skewed in binge-eating disorder than in bulimia nervosa. Binge-eating disorder is as prevalent among females from racial or ethnic minority groups as has been reported for white females. The disorder is more prevalent among individuals seeking weight-loss treatment than in the general population.

Development and Course

Little is known about the development of binge-eating disorder. Both binge eating and loss-of-control eating without objectively excessive consumption occur in children and are associated with increased body fat, weight gain, and increases in psychological symptoms. Binge eating is common in adolescent and college-age samples. Loss-of-control eating or episodic binge eating may represent a prodromal phase of eating disorders for some individuals.

Dieting follows the development of binge eating in many individuals with binge-eating disorder. (This is in contrast to bulimia nervosa, in which dysfunctional dieting usually precedes the onset of binge eating.) Binge-eating disorder typically begins in adolescence or young adulthood but can begin in later adulthood. Individuals with binge-eating disorder who seek treatment usually are older than individuals with either bulimia nervosa or anorexia nervosa who seek treatment.

Remission rates in both natural course and treatment outcome studies are higher for binge-eating disorder than for bulimia nervosa or anorexia nervosa. Binge-eating disorder appears to be relatively persistent, and the course is comparable to that of bulimia nervosa in terms of severity and duration. Crossover from binge-eating disorder to other eating disorders is uncommon.

Risk and Prognostic Factors

Genetic and physiological. Binge-eating disorder appears to run in families, which may reflect additive genetic influences.

Culture-Related Diagnostic Issues

Binge-eating disorder occurs with roughly similar frequencies in most industrialized countries, including the United States, Canada, many European countries, Australia, and New Zealand. In the United States, the prevalence of binge-eating disorder appears comparable among non-Latino whites, Latinos, Asians, and African Americans.

Functional Consequences of Binge-Eating Disorder

Binge-eating disorder is associated with a range of functional consequences, including social role adjustment problems, impaired health-related quality of life and life satisfaction, increased medical morbidity and mortality, and associated increased health care utilization compared with body mass index (BMI)–matched control subjects. It may also be associated with an increased risk for weight gain and the development of obesity.

Differential Diagnosis

Bulimia nervosa. Binge-eating disorder has recurrent binge eating in common with bulimia nervosa but differs from the latter disorder in some fundamental respects. In terms of clinical presentation, the recurrent inappropriate compensatory behavior (e.g., purging, driven exercise) seen in bulimia nervosa is absent in binge-eating disorder. Unlike individuals with bulimia nervosa, individuals with binge-eating disorder typically do not show marked or sustained dietary restriction designed to influence body weight and shape between binge-eating episodes. They may, however, report frequent attempts at dieting. Binge-eating disorder also differs from bulimia nervosa in terms of response to treatment. Rates of improvement are consistently higher among individuals with binge-eating disorder than among those with bulimia nervosa.

Obesity. Binge-eating disorder is associated with overweight and obesity but has several key features that are distinct from obesity. First, levels of overvaluation of body

weight and shape are higher in obese individuals with the disorder than in those without the disorder. Second, rates of psychiatric comorbidity are significantly higher among obese individuals with the disorder compared with those without the disorder. Third, the long-term successful outcome of evidence-based psychological treatments for binge-eating disorder can be contrasted with the absence of effective long-term treatments for obesity.

Bipolar and depressive disorders. Increases in appetite and weight gain are included in the criteria for major depressive episode and in the atypical features specifiers for depressive and bipolar disorders. Increased eating in the context of a major depressive episode may or may not be associated with loss of control. If the full criteria for both disorders are met, both diagnoses can be given. Binge eating and other symptoms of disordered eating are seen in association with bipolar disorder. If the full criteria for both disorders are met, both diagnoses should be given.

Borderline personality disorder. Binge eating is included in the impulsive behavior criterion that is part of the definition of borderline personality disorder. If the full criteria for both disorders are met, both diagnoses should be given.

Comorbidity

Binge-eating disorder is associated with significant psychiatric comorbidity that is comparable to that of bulimia nervosa and anorexia nervosa. The most common comorbid disorders are bipolar disorders, depressive disorders, anxiety disorders, and, to a lesser degree, substance use disorders. The psychiatric comorbidity is linked to the severity of binge eating and not to the degree of obesity.

Other Specified Feeding or Eating Disorder

307.59 (F50.8)

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

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Atypical anorexia nervosa:** All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.
2. **Bulimia nervosa (of low frequency and/or limited duration):** All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.
3. **Binge-eating disorder (of low frequency and/or limited duration):** All of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.
4. **Purging disorder:** Recurrent purging behavior to influence weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.

5. **Night eating syndrome:** Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

Unspecified Feeding or Eating Disorder

307.50 (F50.9)

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

Elimination Disorders

Elimination disorders all involve the inappropriate elimination of urine or feces and are usually first diagnosed in childhood or adolescence. This group of disorders includes *enuresis,* the repeated voiding of urine into inappropriate places, and *encopresis,* the repeated passage of feces into inappropriate places. Subtypes are provided to differentiate nocturnal from diurnal (i.e., during waking hours) voiding for enuresis and the presence or absence of constipation and overflow incontinence for encopresis. Although there are minimum age requirements for diagnosis of both disorders, these are based on developmental age and not solely on chronological age. Both disorders may be voluntary or involuntary. Although these disorders typically occur separately, co-occurrence may also be observed.

Enuresis

Diagnostic Criteria **307.6 (F98.0)**

A. Repeated voiding of urine into bed or clothes, whether involuntary or intentional.
B. The behavior is clinically significant as manifested by either a frequency of at least twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
C. Chronological age is at least 5 years (or equivalent developmental level).
D. The behavior is not attributable to the physiological effects of a substance (e.g., a diuretic, an antipsychotic medication) or another medical condition (e.g., diabetes, spina bifida, a seizure disorder).

Specify whether:

Nocturnal only: Passage of urine only during nighttime sleep.
Diurnal only: Passage of urine during waking hours.
Nocturnal and diurnal: A combination of the two subtypes above.

Subtypes

The nocturnal-only subtype of enuresis, sometimes referred to as *monosymptomatic enuresis,* is the most common subtype and involves incontinence only during nighttime sleep, typically during the first one-third of the night. The diurnal-only subtype occurs in the absence of nocturnal enuresis and may be referred to simply as *urinary incontinence.* Individuals with this subtype can be divided into two groups. Individuals with "urge incontinence" have sudden urge symptoms and detrusor instability, whereas individuals with "voiding postponement" consciously defer micturition urges until incontinence results. The nocturnal-and-diurnal subtype is also known as *nonmonosymptomatic enuresis.*

Diagnostic Features

The essential feature of enuresis is repeated voiding of urine during the day or at night into bed or clothes (Criterion A). Most often the voiding is involuntary, but occasionally it may

be intentional. To qualify for a diagnosis of enuresis, the voiding of urine must occur at least twice a week for at least 3 consecutive months or must cause clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning (Criterion B). The individual must have reached an age at which continence is expected (i.e., a chronological age of at least 5 years or, for children with developmental delays, a mental age of at least 5 years) (Criterion C). The urinary incontinence is not attributable to the physiological effects of a substance (e.g., a diuretic, an antipsychotic medication) or another medical condition (e.g., diabetes, spina bifida, a seizure disorder) (Criterion D).

Associated Features Supporting Diagnosis

During nocturnal enuresis, occasionally the voiding takes place during rapid eye movement (REM) sleep, and the child may recall a dream that involved the act of urinating. During daytime (diurnal) enuresis, the child defers voiding until incontinence occurs, sometimes because of a reluctance to use the toilet as a result of social anxiety or a preoccupation with school or play activity. The enuretic event most commonly occurs in the early afternoon on school days and may be associated with symptoms of disruptive behavior. The enuresis commonly persists after appropriate treatment of an associated infection.

Prevalence

The prevalence of enuresis is 5%–10% among 5-year-olds, 3%–5% among 10-year-olds, and around 1% among individuals 15 years or older.

Development and Course

Two types of course of enuresis have been described: a "primary" type, in which the individual has never established urinary continence, and a "secondary" type, in which the disturbance develops after a period of established urinary continence. There are no differences in prevalence of comorbid mental disorders between the two types. By definition, primary enuresis begins at age 5 years. The most common time for the onset of secondary enuresis is between ages 5 and 8 years, but it may occur at any time. After age 5 years, the rate of spontaneous remission is 5%–10% per year. Most children with the disorder become continent by adolescence, but in approximately 1% of cases the disorder continues into adulthood. Diurnal enuresis is uncommon after age 9 years. While occasional diurnal incontinence is not uncommon in middle childhood, it is substantially more common in those who also have persistent nocturnal enuresis. When enuresis persists into late childhood or adolescence, the frequency of incontinence may increase, whereas continence in early childhood is usually associated with a declining frequency of wet nights.

Risk and Prognostic Factors

Environmental. A number of predisposing factors for enuresis have been suggested, including delayed or lax toilet training and psychosocial stress.

Genetic and physiological. Enuresis has been associated with delays in the development of normal circadian rhythms of urine production, with resulting nocturnal polyuria or abnormalities of central vasopressin receptor sensitivity, and reduced functional bladder capacities with bladder hyperreactivity (unstable bladder syndrome). Nocturnal enuresis is a genetically heterogeneous disorder. Heritability has been shown in family, twin, and segregation analyses. Risk for childhood nocturnal enuresis is approximately 3.6 times higher in offspring of enuretic mothers and 10.1 times higher in the presence of paternal urinary incontinence. The risk magnitudes for nocturnal enuresis and diurnal incontinence are similar.

Culture-Related Diagnostic Issues

Enuresis has been reported in a variety of European, African, and Asian countries as well as in the United States. At a national level, prevalence rates are remarkably similar, and there is great similarity in the developmental trajectories found in different countries. There are very high rates of enuresis in orphanages and other residential institutions, likely related to the mode and environment in which toilet training occurs.

Gender-Related Diagnostic Issues

Nocturnal enuresis is more common in males. Diurnal incontinence is more common in females. The relative risk of having a child who develops enuresis is greater for previously enuretic fathers than for previously enuretic mothers.

Functional Consequences of Enuresis

The amount of impairment associated with enuresis is a function of the limitation on the child's social activities (e.g., ineligibility for sleep-away camp) or its effect on the child's self-esteem, the degree of social ostracism by peers, and the anger, punishment, and rejection on the part of caregivers.

Differential Diagnosis

Neurogenic bladder or another medical condition. The diagnosis of enuresis is not made in the presence of a neurogenic bladder or another medical condition that causes polyuria or urgency (e.g., untreated diabetes mellitus or diabetes insipidus) or during an acute urinary tract infection. However, a diagnosis is compatible with such conditions if urinary incontinence was regularly present prior to the development of another medical condition or if it persists after the institution of appropriate treatment of the medical condition.

Medication side effects. Enuresis may occur during treatment with antipsychotic medications, diuretics, or other medications that may induce incontinence. In this case, the diagnosis should not be made in isolation but may be noted as a medication side effect. However, a diagnosis of enuresis may be made if urinary incontinence was regularly present prior to treatment with the medication.

Comorbidity

Although most children with enuresis do not have a comorbid mental disorder, the prevalence of comorbid behavioral symptoms is higher in children with enuresis than in children without enuresis. Developmental delays, including speech, language, learning, and motor skills delays, are also present in a portion of children with enuresis. Encopresis, sleepwalking, and sleep terror disorder may be present. Urinary tract infections are more common in children with enuresis, especially the diurnal subtype, than in those who are continent.

Encopresis

Diagnostic Criteria **307.7 (F98.1)**

A. Repeated passage of feces into inappropriate places (e.g., clothing, floor), whether involuntary or intentional.
B. At least one such event occurs each month for at least 3 months.
C. Chronological age is at least 4 years (or equivalent developmental level).
D. The behavior is not attributable to the physiological effects of a substance (e.g., laxatives) or another medical condition except through a mechanism involving constipation.

Specify whether:

With constipation and overflow incontinence: There is evidence of constipation on physical examination or by history.

Without constipation and overflow incontinence: There is no evidence of constipation on physical examination or by history.

Subtypes

Feces in the with constipation and overflow incontinence subtype are characteristically (but not invariably) poorly formed, and leakage can be infrequent to continuous, occurring mostly during the day and rarely during sleep. Only part of the feces is passed during toileting, and the incontinence resolves after treatment of the constipation.

In the without constipation and overflow incontinence subtype, feces are likely to be of normal form and consistency, and soiling is intermittent. Feces may be deposited in a prominent location. This is usually associated with the presence of oppositional defiant disorder or conduct disorder or may be the consequence of anal masturbation. Soiling without constipation appears to be less common than soiling with constipation.

Diagnostic Features

The essential feature of encopresis is repeated passage of feces into inappropriate places (e.g., clothing or floor) (Criterion A). Most often the passage is involuntary but occasionally may be intentional. The event must occur at least once a month for at least 3 months (Criterion B), and the chronological age of the child must be at least 4 years (or for children with developmental delays, the mental age must be at least 4 years) (Criterion C). The fecal incontinence must not be exclusively attributable to the physiological effects of a substance (e.g., laxatives) or another medical condition except through a mechanism involving constipation (Criterion D).

When the passage of feces is involuntary rather than intentional, it is often related to constipation, impaction, and retention with subsequent overflow. The constipation may develop for psychological reasons (e.g., anxiety about defecating in a particular place, a more general pattern of anxious or oppositional behavior), leading to avoidance of defecation. Physiological predispositions to constipation include ineffectual straining or paradoxical defecation dynamics, with contraction rather than relaxation of the external sphincter or pelvic floor during straining for defecation. Dehydration associated with a febrile illness, hypothyroidism, or a medication side effect can also induce constipation. Once constipation has developed, it may be complicated by an anal fissure, painful defecation, and further fecal retention. The consistency of the stool may vary. In some individuals the stool may be of normal or near-normal consistency. In other individuals—such as those with overflow incontinence secondary to fecal retention—it may be liquid.

Associated Features Supporting Diagnosis

The child with encopresis often feels ashamed and may wish to avoid situations (e.g., camp, school) that might lead to embarrassment. The amount of impairment is a function of the effect on the child's self-esteem, the degree of social ostracism by peers, and the anger, punishment, and rejection on the part of caregivers. Smearing feces may be deliberate or accidental, resulting from the child's attempt to clean or hide feces that were passed involuntarily. When the incontinence is clearly deliberate, features of oppositional defiant disorder or conduct disorder may also be present. Many children with encopresis and chronic constipation also have enuresis symptoms and may have associated urinary reflux in the bladder or ureters that may lead to chronic urinary infections, the symptoms of which may remit with treatment of the constipation.

Prevalence

It is estimated that approximately 1% of 5-year-olds have encopresis, and the disorder is more common in males than in females.

Development and Course

Encopresis is not diagnosed until a child has reached a chronological age of at least 4 years (or for children with developmental delays, a mental age of at least 4 years). Inadequate, inconsistent toilet training and psychosocial stress (e.g., entering school, the birth of a sibling) may be predisposing factors. Two types of course have been described: a "primary" type, in which the individual has never established fecal continence, and a "secondary" type, in which the disturbance develops after a period of established fecal continence. Encopresis can persist, with intermittent exacerbations, for years.

Risk and Prognostic Factors

Genetic and physiological. Painful defecation can lead to constipation and a cycle of withholding behaviors that make encopresis more likely. Use of some medications (e.g., anticonvulsants, cough suppressants) may increase constipation and make encopresis more likely.

Diagnostic Markers

In addition to physical examination, gastrointestinal imaging (e.g., abdominal radiograph) may be informative to assess retained stool and gas in the colon. Additional tests, such as barium enema and anorectal manography, may be used to help exclude other medical conditions, such as Hirschsprung's disease.

Differential Diagnosis

A diagnosis of encopresis in the presence of another medical condition is appropriate only if the mechanism involves constipation that cannot be explained by other medical conditions. Fecal incontinence related to other medical conditions (e.g., chronic diarrhea, spina bifida, anal stenosis) would not warrant a DSM-5 diagnosis of encopresis.

Comorbidity

Urinary tract infections can be comorbid with encopresis and are more common in females.

Other Specified Elimination Disorder

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

Coding note: Code **788.39 (N39.498)** for other specified elimination disorder with urinary symptoms; **787.60 (R15.9)** for other specified elimination disorder with fecal symptoms.

Unspecified Elimination Disorder

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

Coding note: Code **788.30 (R32)** for unspecified elimination disorder with urinary symptoms; **787.60 (R15.9)** for unspecified elimination disorder with fecal symptoms.

Sleep-Wake Disorders

The DSM-5 classification of sleep-wake disorders is intended for use by general mental health and medical clinicians (those caring for adult, geriatric, and pediatric patients). Sleep-wake disorders encompass 10 disorders or disorder groups: insomnia disorder, hypersomnolence disorder, narcolepsy, breathing-related sleep disorders, circadian rhythm sleep-wake disorders, non–rapid eye movement (NREM) sleep arousal disorders, nightmare disorder, rapid eye movement (REM) sleep behavior disorder, restless legs syndrome, and substance/medication-induced sleep disorder. Individuals with these disorders typically present with sleep-wake complaints of dissatisfaction regarding the quality, timing, and amount of sleep. Resulting daytime distress and impairment are core features shared by all of these sleep-wake disorders.

The organization of this chapter is designed to facilitate differential diagnosis of sleep-wake complaints and to clarify when referral to a sleep specialist is appropriate for further assessment and treatment planning. The DSM-5 sleep disorders nosology uses a simple, clinically useful approach, while also reflecting scientific advances in epidemiology, genetics, pathophysiology, assessment, and interventions research since DSM-IV. In some cases (e.g., insomnia disorder), a "lumping" approach has been adopted, whereas in others (e.g., narcolepsy), a "splitting" approach has been taken, reflecting the availability of validators derived from epidemiological, neurobiological, and interventions research.

Sleep disorders are often accompanied by depression, anxiety, and cognitive changes that must be addressed in treatment planning and management. Furthermore, persistent sleep disturbances (both insomnia and excessive sleepiness) are established risk factors for the subsequent development of mental illnesses and substance use disorders. They may also represent a prodromal expression of an episode of mental illness, allowing the possibility of early intervention to preempt or to attenuate a full-blown episode.

The differential diagnosis of sleep-wake complaints necessitates a multidimensional approach, with consideration of possibly coexisting medical and neurological conditions. Coexisting clinical conditions are the rule, not the exception. Sleep disturbances furnish a clinically useful indicator of medical and neurological conditions that often coexist with depression and other common mental disorders. Prominent among these comorbidities are breathing-related sleep disorders, disorders of the heart and lungs (e.g., congestive heart failure, chronic obstructive pulmonary disease), neurodegenerative disorders (e.g., Alzheimer's disease), and disorders of the musculoskeletal system (e.g., osteoarthritis). These disorders not only may disturb sleep but also may themselves be worsened during sleep (e.g., prolonged apneas or electrocardiographic arrhythmias during REM sleep; confusional arousals in patients with dementing illness; seizures in persons with complex partial seizures). REM sleep behavior disorder is often an early indicator of neurodegenerative disorders (alpha synucleinopathies) like Parkinson's disease. For all of these reasons—related to differential diagnosis, clinical comorbidity, and facilitation of treatment planning—sleep disorders are included in DSM-5.

The approach taken to the classification of sleep-wake disorders in DSM-5 can be understood within the context of "lumping versus splitting." DSM-IV represented an effort to simplify sleep-wake disorders classification and thus aggregated diagnoses under broader, less differentiated labels. At the other pole, the *International Classification of Sleep Disorders,*