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

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

Differential Diagnosis

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

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

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

Comorbidity

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

Transvestic Disorder

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

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

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

Specify if:

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

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

Specify if:

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

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

Specifiers

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

Diagnostic Features

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

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

Associated Features Supporting Diagnosis

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

Prevalence

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

Development and Course

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

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

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

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

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

Functional Consequences of Transvestic Disorder

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

Differential Diagnosis

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

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

Comorbidity

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

Other Specified Paraphilic Disorder

302.89 (F65.89)

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

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

Unspecified Paraphilic Disorder

302.9 (F65.9)

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

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Other Mental Disorders

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

Other Specified Mental Disorder Due to Another Medical Condition

294.8 (F06.8)

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

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

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

Unspecified Mental Disorder Due to Another Medical Condition

294.9 (F09)

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

Other Specified Mental Disorder

300.9 (F99)

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

Unspecified Mental Disorder

300.9 (F99)

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

Medication-Induced Movement Disorders and Other Adverse Effects of Medication

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

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

Neuroleptic-Induced Parkinsonism
Other Medication-Induced Parkinsonism

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

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

Neuroleptic Malignant Syndrome

333.92 (G21.0) Neuroleptic Malignant Syndrome

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

Diagnostic Features

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

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

Development and Course

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

Risk and Prognostic Factors

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

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

Differential Diagnosis

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

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

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

Medication-Induced Acute Dystonia

333.72 (G24.02) Medication-Induced Acute Dystonia

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

Medication-Induced Acute Akathisia

333.99 (G25.71) Medication-Induced Acute Akathisia

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

Tardive Dyskinesia

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

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

Tardive Dystonia
Tardive Akathisia

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

Medication-Induced Postural Tremor

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

Other Medication-Induced Movement Disorder

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

Antidepressant Discontinuation Syndrome

995.29 (T43.205A) Initial encounter

995.29 (T43.205D) Subsequent encounter

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

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

Diagnostic Features

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

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

Prevalence

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

Course and Development

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

Differential Diagnosis

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

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

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

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

Comorbidity

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

Other Adverse Effect of Medication

995.20 (T50.905A) Initial encounter

995.20 (T50.905D) Subsequent encounter

995.20 (T50.905S) Sequelae

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

Other Conditions That May Be a Focus of Clinical Attention

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

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

Relational Problems

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

Problems Related to Family Upbringing

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

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

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

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

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

Other Problems Related to Primary Support Group

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

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

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

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

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

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

Abuse and Neglect

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

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

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

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

Child Maltreatment and Neglect Problems

Child Physical Abuse

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

Child Physical Abuse, Confirmed

995.54 (T74.12XA) Initial encounter

995.54 (T74.12XD) Subsequent encounter

Child Physical Abuse, Suspected

995.54 (T76.12XA) Initial encounter

995.54 (T76.12XD) Subsequent encounter

Other Circumstances Related to Child Physical Abuse

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

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

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

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

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

Child Sexual Abuse

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

Child Sexual Abuse, Confirmed

995.53 (T74.22XA) Initial encounter

995.53 (T74.22XD) Subsequent encounter

Child Sexual Abuse, Suspected

995.53 (T76.22XA) Initial encounter

995.53 (T76.22XD) Subsequent encounter

Other Circumstances Related to Child Sexual Abuse

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

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

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

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

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

Child Neglect

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

Child Neglect, Confirmed

995.52 (T74.02XA) Initial encounter

995.52 (T74.02XD) Subsequent encounter

Child Neglect, Suspected

995.52 (T76.02XA) Initial encounter

995.52 (T76.02XD) Subsequent encounter

Other Circumstances Related to Child Neglect

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

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

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

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

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

Child Psychological Abuse

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

Child Psychological Abuse, Confirmed

995.51 (T74.32XA) Initial encounter

995.51 (T74.32XD) Subsequent encounter

Child Psychological Abuse, Suspected

995.51 (T76.32XA) Initial encounter

995.51 (T76.32XD) Subsequent encounter

Other Circumstances Related to Child Psychological Abuse

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

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

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

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

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

Adult Maltreatment and Neglect Problems

Spouse or Partner Violence, Physical

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

Spouse or Partner Violence, Physical, Confirmed

995.81 (T74.11XA) Initial encounter

995.81 (T74.11XD) Subsequent encounter

Spouse or Partner Violence, Physical, Suspected

995.81 (T76.11XA) Initial encounter

995.81 (T76.11XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Violence, Physical

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

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

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

Spouse or Partner Violence, Sexual

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

Spouse or Partner Violence, Sexual, Confirmed

995.83 (T74.21XA) Initial encounter

995.83 (T74.21XD) Subsequent encounter

Spouse or Partner Violence, Sexual, Suspected

995.83 (T76.21XA) Initial encounter

995.83 (T76.21XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Violence, Sexual

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

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

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

Spouse or Partner Neglect

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

Spouse or Partner Neglect, Confirmed

995.85 (T74.01XA) Initial encounter

995.85 (T74.01XD) Subsequent encounter

Spouse or Partner Neglect, Suspected

995.85 (T76.01XA) Initial encounter

995.85 (T76.01XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Neglect

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

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

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

Spouse or Partner Abuse, Psychological

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

Spouse or Partner Abuse, Psychological, Confirmed

995.82 (T74.31XA) Initial encounter

995.82 (T74.31XD) Subsequent encounter

Spouse or Partner Abuse, Psychological, Suspected

995.82 (T76.31XA) Initial encounter

995.82 (T76.31XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Abuse, Psychological

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

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

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

Adult Abuse by Nonspouse or Nonpartner

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

Adult Physical Abuse by Nonspouse or Nonpartner, Confirmed

995.81 (T74.11XA) Initial encounter

995.81 (T74.11XD) Subsequent encounter

Adult Physical Abuse by Nonspouse or Nonpartner, Suspected

995.81 (T76.11XA) Initial encounter

995.81 (T76.11XD) Subsequent encounter

Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed

995.83 (T74.21XA) Initial encounter

995.83 (T74.21XD) Subsequent encounter

Adult Sexual Abuse by Nonspouse or Nonpartner, Suspected

995.83 (T76.21XA) Initial encounter

995.83 (T76.21XD) Subsequent encounter

Adult Psychological Abuse by Nonspouse or Nonpartner, Confirmed

995.82 (T74.31XA) Initial encounter

995.82 (T74.31XD) Subsequent encounter

Adult Psychological Abuse by Nonspouse or Nonpartner, Suspected

995.82 (T76.31XA) Initial encounter

995.82 (T76.31XD) Subsequent encounter

Other Circumstances Related to Adult Abuse by Nonspouse or Nonpartner

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

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

Educational and Occupational Problems

Educational Problems

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

Occupational Problems

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

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

Housing and Economic Problems

Housing Problems

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

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

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

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

Economic Problems

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

V60.2 (Z59.5) Extreme Poverty

V60.2 (Z59.6) Low Income

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

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

Other Problems Related to the Social Environment

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

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

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

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

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

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

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

Problems Related to Crime or Interaction With the Legal System

V62.89 (Z65.4) Victim of Crime

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

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

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

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

Other Health Service Encounters for Counseling and Medical Advice

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

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

Problems Related to Other Psychosocial, Personal, and Environmental Circumstances

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

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

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

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

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

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

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

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

Other Circumstances of Personal History

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

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

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

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

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

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

V71.01 (Z72.811) Adult Antisocial Behavior

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

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

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

Problems Related to Access to Medical and Other Health Care

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

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

Nonadherence to Medical Treatment

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

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

278.00 (E66.9) Overweight or Obesity

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

V65.2 (Z76.5) Malingering

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

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

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

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

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

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

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

V62.89 (R41.83) Borderline Intellectual Functioning

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

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SECTION III
Emerging Measures and Models

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

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

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

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Assessment Measures

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

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

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

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

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

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

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

Cross-Cutting Symptom Measures

Level 1 Cross-Cutting Symptom Measure

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

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

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

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

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

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

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

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

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

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

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

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

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

Level 2 Cross-Cutting Symptom Measures

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

Frequency of Use of the Cross-Cutting Symptom Measures

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

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

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

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

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

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

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

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

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

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

Relationship to the child: _____

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

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

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

Clinician-Rated Dimensions of Psychosis Symptom Severity

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

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

Scoring and Interpretation

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

Frequency of Use

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

Clinician-Rated Dimensions of Psychosis Symptom Severity

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

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

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

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

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

World Health Organization Disability Assessment Schedule 2.0

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

WHODAS 2.0 Scoring Instructions Provided by WHO

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

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

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

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

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

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

Additional Scoring and Interpretation Guidance for DSM-5 Users

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

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

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

WHODAS 2.0

World Health Organization Disability Assessment Schedule 2.0

36-item version, self-administered

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

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

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

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

Cultural Formulation

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

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

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

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

Outline for Cultural Formulation

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

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

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

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

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

Cultural Formulation Interview (CFI)

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

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

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

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

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

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

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

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

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

Cultural Formulation Interview (CFI)

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

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

CULTURAL DEFINITION OF THE PROBLEM

Cultural Definition of the Problem

(Explanatory Model, Level of Functioning)

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

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

Causes

(Explanatory Model, Social Network, Older Adults)

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

Cultural Formulation Interview (CFI) *(continued)*

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

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

STRESSORS AND SUPPORTS

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

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

ROLE OF CULTURAL IDENTITY

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

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

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

SELF-COPING

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

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

Cultural Formulation Interview (CFI) *(continued)*

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

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

PAST HELP SEEKING

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

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

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

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

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

    PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:

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

BARRIERS

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

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

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

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

    PROBE AS NEEDED:

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

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

PREFERENCES

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

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

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

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

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

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

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

CLINICIAN-PATIENT RELATIONSHIP

(Clinician-Patient Relationship, Older Adults)

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

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

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

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

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

Cultural Formulation Interview (CFI)—Informant Version

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

Cultural Formulation Interview (CFI)—Informant Version

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

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.