Snippets from the DSM-5: Personality Disorders

Mason Garrison

Snippets from the DSM-5: Personality Disorders

The following documents are listed in order of appearance.

- The American Psychiatric Association (APA) Personality Disorders Fact Sheet. The Fact Sheet is on the following page.
- Preface and Introduction to the DSM-5 is on page 17. Note, the discussion on the dimensional approach to diagnosis on page 28.
- DSM-5/DSM-IV-TR Personality Disorder Chapter begins on page 33. This chapter uses categorical personality structure.
- DSM-5 "Alternative DSM-5 Model for Personality Disorders" is the dimensional diagnosistic model. It is located in the DSM-5 Section III: Emerging Measures and Models. In this PDF, those files are located on page 74.

Personality Disorder Fact Sheet

Personality Disorders

Personality disorders are associated with ways of thinking and feeling about oneself and others that significantly and adversely affect how an individual functions in many aspects of life. They fall within 10 distinct types: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, antisocial personality disorder, borderline personality disorder, histrionic personality, narcissistic personality disorder, avoidant personality disorder, dependent personality disorder and obsessive-compulsive personality disorder.

During the development process of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), several proposed revisions were drafted that would have significantly changed the method by which individuals with these disorders are diagnosed. Based on feedback from a multilevel review of proposed revisions, the American Psychiatric Association Board of Trustees ultimately decided to retain the DSM-IV categorical approach with the same 10 personality disorders.

The proposed revisions that were not accepted for the main body of the manual were approved as an alternative hybrid dimensional-categorical model that will be included in a separate chapter in Section III of DSM-5. This alternative model is included to encourage further study on how this new methodology could be used to assess personality and diagnose personality disorders in clinical practice.

DSM-5 moves from the multiaxial system to a new assessment that removes the arbitrary boundaries between personality disorders and other mental disorders.

Assessing on a Single Axis

Until now, DSM has organized clinical assessment into five areas, or axes, addressing the different aspects and impact of disorders. This multiaxial system was introduced in part to solve a problem that no longer exists: Certain disorders, like personality disorders, received inadequate clinical and research focus. As a consequence, these disorders were designated to Axis II to ensure they received greater attention. However, the axis system was seen by some clinicians as burdensome and time consuming. Given that there is no fundamental difference between disorders described on DSM-IV's Axis I and Axis II, DSM-5 has shifted to a single axis system.

This system combines the first three axes outlined in past editions of DSM into one axis with all mental and other medical diagnoses. Doing so removes artificial distinctions among conditions, benefitting both clinical practice and research use.

Evolving the Diagnosis of Personality Disorders

The Personality Disorders Work Group began its efforts on DSM-5 by reviewing recent research on these disorders and considering general feedback from the field about the categorical approach.

The Work Group's first revision represented a significantly different approach to diagnosis. It attempted to break down the concise models of personality disorders, which sometimes are too rigid to fit patients' symptoms, and replaced them with a trait-specific method. Using this model, clinicians would

have determined if their patients had a personality disorder by looking at the traits suggested by their symptoms and ranking each trait by severity.

As evidenced by the field's reaction, this new model was too complex for clinical practice. After considering that response and additional research, the Work Group evolved the diagnostic criteria for personality disorders to marry the most useful aspects of DSM-IV criteria with features from the first revision's trait-based approach.

The result was reflected in a second proposal, a hybrid model that included evaluation of impairments in personality functioning (how an individual typically experiences himself or herself as well as others) plus five broad areas of pathological personality traits.

Although this hybrid proposal was not accepted for DSM-5's main manual, it is included in Section III for further study. Using this alternate methodology, clinicians would assess personality and diagnose a personality disorder based on an individual's particular difficulties in personality functioning and on specific patterns of those pathological traits.

The hybrid methodology retains six personality disorder types:

- Borderline Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Avoidant Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Narcissistic Personality Disorder

Each type is defined by a specific pattern of impairments and traits. This approach also includes a diagnosis of Personality Disorder—Trait Specified (PD-TS) that could be made when a Personality Disorder is considered present, but the criteria for a specific personality disorder are not fully met. For this diagnosis, the clinician would note the severity of impairment in personality functioning and the problematic personality trait(s).

This hybrid dimensional-categorical model and its components seek to address existing issues with the categorical approach to personality disorders. APA hopes that inclusion of the new methodology in Section III of DSM-5 will encourage research that might support this model in the diagnosis and care of patients, as well as contribute to greater understanding of the causes and treatments of personality disorders.

DSM-5 Title Page, et cetera

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FIFTH EDITION

DSM-5™

American Psychiatric Association

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS,

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DSM-5™

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Section III
Emerging Measures and Models

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DSM-5 Preface and Intro

Preface

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders. With successive editions over the past 60 years, it has become a standard reference for clinical practice in the mental health field. Since a complete description of the underlying pathological processes is not possible for most mental disorders, it is important to emphasize that the current diagnostic criteria are the best available description of how mental disorders are expressed and can be recognized by trained clinicians. DSM is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders. It is a tool for clinicians, an essential educational resource for students and practitioners, and a reference for researchers in the field.

Although this edition of DSM was designed first and foremost to be a useful guide to clinical practice, as an official nomenclature it must be applicable in a wide diversity of contexts. DSM has been used by clinicians and researchers from different orientations (biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems), all of whom strive for a common language to communicate the essential characteristics of mental disorders presented by their patients. The information is of value to all professionals associated with various aspects of mental health care, including psychiatrists, other physicians, psychologists, social workers, nurses, counselors, forensic and legal specialists, occupational and rehabilitation therapists, and other health professionals. The criteria are concise and explicit and intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings—inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care—as well in general community epidemiological studies of mental disorders. DSM-5 is also a tool for collecting and communicating accurate public health statistics on mental disorder morbidity and mortality rates. Finally, the criteria and corresponding text serve as a textbook for students early in their profession who need a structured way to understand and diagnose mental disorders as well as for seasoned professionals encountering rare disorders for the first time. Fortunately, all of these uses are mutually compatible.

These diverse needs and interests were taken into consideration in planning DSM-5. The classification of disorders is harmonized with the World Health Organization's *International Classification of Diseases* (ICD), the official coding system used in the United States, so that the DSM criteria define disorders identified by ICD diagnostic names and code numbers. In DSM-5, both ICD-9-CM and ICD-10-CM codes (the latter scheduled for adoption in October 2014) are attached to the relevant disorders in the classification.

Although DSM-5 remains a categorical classification of separate disorders, we recognize that mental disorders do not always fit completely within the boundaries of a single disorder. Some symptom domains, such as depression and anxiety, involve multiple diagnostic categories and may reflect common underlying vulnerabilities for a larger group of disorders. In recognition of this reality, the disorders included in DSM-5 were reordered into a revised organizational structure meant to stimulate new clinical perspectives. This new structure corresponds with the organizational arrangement of disorders planned for ICD-11 scheduled for release in 2015. Other enhancements have been introduced to promote ease of use across all settings:

- **Representation of developmental issues related to diagnosis.** The change in chapter organization better reflects a lifespan approach, with disorders more frequently diagnosed in childhood (e.g., neurodevelopmental disorders) at the beginning of the manual and disorders more applicable to older adulthood (e.g., neurocognitive disorders) at the end of the manual. Also, within the text, subheadings on development and course provide descriptions of how disorder presentations may change across the lifespan. Age-related factors specific to diagnosis (e.g., symptom presentation and prevalence differences in certain age groups) are also included in the text. For added emphasis, these age-related factors have been added to the criteria themselves where applicable (e.g., in the criteria sets for insomnia disorder and posttraumatic stress disorder, specific criteria describe how symptoms might be expressed in children). Likewise, gender and cultural issues have been integrated into the disorders where applicable.
- **Integration of scientific findings from the latest research in genetics and neuroimaging.** The revised chapter structure was informed by recent research in neuroscience and by emerging genetic linkages between diagnostic groups. Genetic and physiological risk factors, prognostic indicators, and some putative diagnostic markers are highlighted in the text. This new structure should improve clinicians' ability to identify diagnoses in a disorder spectrum based on common neurocircuitry, genetic vulnerability, and environmental exposures.
- **Consolidation of autistic disorder, Asperger's disorder, and pervasive developmental disorder into autism spectrum disorder.** Symptoms of these disorders represent a single continuum of mild to severe impairments in the two domains of social communication and restrictive repetitive behaviors/interests rather than being distinct disorders. This change is designed to improve the sensitivity and specificity of the criteria for the diagnosis of autism spectrum disorder and to identify more focused treatment targets for the specific impairments identified.
- **Streamlined classification of bipolar and depressive disorders.** Bipolar and depressive disorders are the most commonly diagnosed conditions in psychiatry. It was therefore important to streamline the presentation of these disorders to enhance both clinical and educational use. Rather than separating the definition of manic, hypomanic, and major depressive episodes from the definition of bipolar I disorder, bipolar II disorder, and major depressive disorder as in the previous edition, we included all of the component criteria within the respective criteria for each disorder. This approach will facilitate bedside diagnosis and treatment of these important disorders. Likewise, the explanatory notes for differentiating bereavement and major depressive disorders will provide far greater clinical guidance than was previously provided in the simple bereavement exclusion criterion. The new specifiers of anxious distress and mixed features are now fully described in the narrative on specifier variations that accompanies the criteria for these disorders.
- **Restructuring of substance use disorders for consistency and clarity.** The categories of substance abuse and substance dependence have been eliminated and replaced with an overarching new category of substance use disorders—with the specific substance used defining the specific disorders. "Dependence" has been easily confused with the term "addiction" when, in fact, the tolerance and withdrawal that previously defined dependence are actually very normal responses to prescribed medications that affect the central nervous system and do not necessarily indicate the presence of an addiction. By revising and clarifying these criteria in DSM-5, we hope to alleviate some of the widespread misunderstanding about these issues.
- **Enhanced specificity for major and mild neurocognitive disorders.** Given the explosion in neuroscience, neuropsychology, and brain imaging over the past 20 years, it was critical to convey the current state-of-the-art in the diagnosis of specific types of disorders that were previously referred to as the "dementias" or organic brain diseases. Biological markers identified by imaging for vascular and traumatic brain disorders and

specific molecular genetic findings for rare variants of Alzheimer's disease and Huntington's disease have greatly advanced clinical diagnoses, and these disorders and others have now been separated into specific subtypes.

- **Transition in conceptualizing personality disorders.** Although the benefits of a more dimensional approach to personality disorders have been identified in previous editions, the transition from a categorical diagnostic system of individual disorders to one based on the relative distribution of personality traits has not been widely accepted. In DSM-5, the categorical personality disorders are virtually unchanged from the previous edition. However, an alternative "hybrid" model has been proposed in Section III to guide future research that separates interpersonal functioning assessments and the expression of pathological personality traits for six specific disorders. A more dimensional profile of personality trait expression is also proposed for a trait-specified approach.
- **Section III: new disorders and features.** A new section (Section III) has been added to highlight disorders that require further study but are not sufficiently well established to be a part of the official classification of mental disorders for routine clinical use. Dimensional measures of symptom severity in 13 symptom domains have also been incorporated to allow for the measurement of symptom levels of varying severity across all diagnostic groups. Likewise, the WHO Disability Assessment Schedule (WHODAS), a standard method for assessing global disability levels for mental disorders that is based on the International Classification of Functioning, Disability and Health (ICF) and is applicable in all of medicine, has been provided to replace the more limited Global Assessment of Functioning scale. It is our hope that as these measures are implemented over time, they will provide greater accuracy and flexibility in the clinical description of individual symptomatic presentations and associated disability during diagnostic assessments.
- **Online enhancements.** DSM-5 features online supplemental information. Additional cross-cutting and diagnostic severity measures are available online (www.psychiatry.org/dsm5), linked to the relevant disorders. In addition, the Cultural Formulation Interview, Cultural Formulation Interview—Informant Version, and supplementary modules to the core Cultural Formulation Interview are also included online at www.psychiatry.org/dsm5.

These innovations were designed by the leading authorities on mental disorders in the world and were implemented on the basis of their expert review, public commentary, and independent peer review. The 13 work groups, under the direction of the DSM-5 Task Force, in conjunction with other review bodies and, eventually, the APA Board of Trustees, collectively represent the global expertise of the specialty. This effort was supported by an extensive base of advisors and by the professional staff of the APA Division of Research; the names of everyone involved are too numerous to mention here but are listed in the Appendix. We owe tremendous thanks to those who devoted countless hours and invaluable expertise to this effort to improve the diagnosis of mental disorders.

We would especially like to acknowledge the chairs, text coordinators, and members of the 13 work groups, listed in the front of the manual, who spent many hours in this volunteer effort to improve the scientific basis of clinical practice over a sustained 6-year period. Susan K. Schultz, M.D., who served as text editor, worked tirelessly with Emily A. Kuhl, Ph.D., senior science writer and DSM-5 staff text editor, to coordinate the efforts of the work groups into a cohesive whole. William E. Narrow, M.D., M.P.H., led the research group that developed the overall research strategy for DSM-5, including the field trials, that greatly enhanced the evidence base for this revision. In addition, we are grateful to those who contributed so much time to the independent review of the revision proposals, including Kenneth S. Kendler, M.D., and Robert Freedman, M.D., co-chairs of the Scientific Review Committee; John S. McIntyre, M.D., and Joel Yager, M.D., co-chairs of the Clinical and Public Health Committee; and Glenn Martin, M.D., chair of the APA Assem-

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We especially wish to recognize the outstanding APA Division of Research staff—identified in the Task Force and Work Group listing at the front of this manual—who worked tirelessly to interact with the task force, work groups, advisors, and reviewers to resolve issues, serve as liaisons between the groups, direct and manage the academic and routine clinical practice field trials, and record decisions in this important process. In particular, we appreciate the support and guidance provided by James H. Scully Jr., M.D., Medical Director and CEO of the APA, through the years and travails of the development process. Finally, we thank the editorial and production staff of American Psychiatric Publishing—specifically, Rebecca Rinehart, Publisher; John McDuffie, Editorial Director; Ann Eng, Senior Editor; Greg Kuny, Managing Editor; and Tammy Cordova, Graphics Design Manager—for their guidance in bringing this all together and creating the final product. It is the culmination of efforts of many talented individuals who dedicated their time, expertise, and passion that made DSM-5 possible.

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December 19, 2012

Introduction

The creation of the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) was a massive undertaking that involved hundreds of people working toward a common goal over a 12-year process. Much thought and deliberation were involved in evaluating the diagnostic criteria, considering the organization of every aspect of the manual, and creating new features believed to be most useful to clinicians. All of these efforts were directed toward the goal of enhancing the clinical usefulness of DSM-5 as a guide in the diagnosis of mental disorders.

Reliable diagnoses are essential for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information such as morbidity and mortality rates. As the understanding of mental disorders and their treatments has evolved, medical, scientific, and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research.

While DSM has been the cornerstone of substantial progress in reliability, it has been well recognized by both the American Psychiatric Association (APA) and the broad scientific community working on mental disorders that past science was not mature enough to yield fully validated diagnoses—that is, to provide consistent, strong, and objective scientific validators of individual DSM disorders. The science of mental disorders continues to evolve. However, the last two decades since DSM-IV was released have seen real and durable progress in such areas as cognitive neuroscience, brain imaging, epidemiology, and genetics. The DSM-5 Task Force overseeing the new edition recognized that research advances will require careful, iterative changes if DSM is to maintain its place as the touchstone classification of mental disorders. Finding the right balance is critical. Speculative results do not belong in an official nosology, but at the same time, DSM must evolve in the context of other clinical research initiatives in the field. One important aspect of this transition derives from the broad recognition that a too-rigid categorical system does not capture clinical experience or important scientific observations. The results of numerous studies of comorbidity and disease transmission in families, including twin studies and molecular genetic studies, make strong arguments for what many astute clinicians have long observed: the boundaries between many disorder "categories" are more fluid over the life course than DSM-IV recognized, and many symptoms assigned to a single disorder may occur, at varying levels of severity, in many other disorders. These findings mean that DSM, like other medical disease classifications, should accommodate ways to introduce dimensional approaches to mental disorders, including dimensions that cut across current categories. Such an approach should permit a more accurate description of patient presentations and increase the validity of a diagnosis (i.e., the degree to which diagnostic criteria reflect the comprehensive manifestation of an underlying psychopathological disorder). DSM-5 is designed to better fill the need of clinicians, patients, families, and researchers for a clear and concise description of each mental disorder organized by explicit diagnostic criteria, supplemented, when appropriate, by dimensional measures that cross diagnostic boundaries, and a brief digest of information about the diagnosis, risk factors, associated features, research advances, and various expressions of the disorder.

Clinical training and experience are needed to use DSM for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs, syndrome combinations, and durations that require clinical expertise to differentiate from normal life variation and transient responses to stress. To facilitate a thorough

examination of the range of symptoms present, DSM can serve clinicians as a guide to identify the most prominent symptoms that should be assessed when diagnosing a disorder. Although some mental disorders may have well-defined boundaries around symptom clusters, scientific evidence now places many, if not most, disorders on a spectrum with closely related disorders that have shared symptoms, shared genetic and environmental risk factors, and possibly shared neural substrates (perhaps most strongly established for a subset of anxiety disorders by neuroimaging and animal models). In short, we have come to recognize that the boundaries between disorders are more porous than originally perceived.

Many health profession and educational groups have been involved in the development and testing of DSM-5, including physicians, psychologists, social workers, nurses, counselors, epidemiologists, statisticians, neuroscientists, and neuropsychologists. Finally, patients, families, lawyers, consumer organizations, and advocacy groups have all participated in revising DSM-5 by providing feedback on the mental disorders described in this volume. Their monitoring of the descriptions and explanatory text is essential to improve understanding, reduce stigma, and advance the treatment and eventual cures for these conditions.

A Brief History

The APA first published a predecessor of DSM in 1844, as a statistical classification of institutionalized mental patients. It was designed to improve communication about the types of patients cared for in these hospitals. This forerunner to DSM also was used as a component of the full U.S. census. After World War II, DSM evolved through four major editions into a diagnostic classification system for psychiatrists, other physicians, and other mental health professionals that described the essential features of the full range of mental disorders. The current edition, DSM-5, builds on the goal of its predecessors (most recently, DSM-IV-TR, or Text Revision, published in 2000) of providing guidelines for diagnoses that can inform treatment and management decisions.

DSM-5 Revision Process

In 1999, the APA launched an evaluation of the strengths and weaknesses of DSM based on emerging research that did not support the boundaries established for some mental disorders. This effort was coordinated with the World Health Organization (WHO) Division of Mental Health, the World Psychiatric Association, and the National Institute of Mental Health (NIMH) in the form of several conferences, the proceedings of which were published in 2002 in a monograph entitled *A Research Agenda for DSM-V*. Thereafter, from 2003 to 2008, a cooperative agreement with the APA and the WHO was supported by the NIMH, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcoholism and Alcohol Abuse (NIAAA) to convene 13 international DSM-5 research planning conferences, involving 400 participants from 39 countries, to review the world literature in specific diagnostic areas to prepare for revisions in developing both DSM-5 and the *International Classification of Diseases*, 11th Revision (ICD-11). Reports from these conferences formed the basis for future DSM-5 Task Force reviews and set the stage for the new edition of DSM.

In 2006, the APA named David J. Kupfer, M.D., as Chair and Darrel A. Regier, M.D., M.P.H., as Vice-Chair of the DSM-5 Task Force. They were charged with recommending chairs for the 13 diagnostic work groups and additional task force members with a multidisciplinary range of expertise who would oversee the development of DSM-5. An additional vetting process was initiated by the APA Board of Trustees to disclose sources of income and thus avoid conflicts of interest by task force and work group members. The full disclosure of all income and research grants from commercial sources, including the pharmaceutical industry, in the previous 3 years, the imposition of an income cap from all commercial sources, and the publication of disclosures on a Web site set a new standard for the

field. Thereafter, the task force of 28 members was approved in 2007, and appointments of more than 130 work group members were approved in 2008. More than 400 additional work group advisors with no voting authority were also approved to participate in the process. A clear concept of the next evolutionary stage for the classification of mental disorders was central to the efforts of the task force and the work groups. This vision emerged as the task force and work groups recounted the history of DSM-IV's classification, its current strengths and limitations, and strategic directions for its revision. An intensive 6-year process involved conducting literature reviews and secondary analyses, publishing research reports in scientific journals, developing draft diagnostic criteria, posting preliminary drafts on the DSM-5 Web site for public comment, presenting preliminary findings at professional meetings, performing field trials, and revising criteria and text.

Proposals for Revisions

Proposals for the revision of DSM-5 diagnostic criteria were developed by members of the work groups on the basis of rationale, scope of change, expected impact on clinical management and public health, strength of the supporting research evidence, overall clarity, and clinical utility. Proposals encompassed changes to diagnostic criteria; the addition of new disorders, subtypes, and specifiers; and the deletion of existing disorders.

In the proposals for revisions, strengths and weaknesses in the current criteria and nosology were first identified. Novel scientific findings over the previous two decades were considered, leading to the creation of a research plan to assess potential changes through literature reviews and secondary data analyses. Four principles guided the draft revisions: 1) DSM-5 is primarily intended to be a manual to be used by clinicians, and revisions must be feasible for routine clinical practice; 2) recommendations for revisions should be guided by research evidence; 3) where possible, continuity should be maintained with previous editions of DSM; and 4) no a priori constraints should be placed on the degree of change between DSM-IV and DSM-5.

Building on the initial literature reviews, work groups identified key issues within their diagnostic areas. Work groups also examined broader methodological concerns, such as the presence of contradictory findings within the literature; development of a refined definition of mental disorder; cross-cutting issues relevant to all disorders; and the revision of disorders categorized in DSM-IV as "not otherwise specified." Inclusion of a proposal for revision in Section II was informed by consideration of its advantages and disadvantages for public health and clinical utility, the strength of the evidence, and the magnitude of the change. New diagnoses and disorder subtypes and specifiers were subject to additional stipulations, such as demonstration of reliability (i.e., the degree to which two clinicians could independently arrive at the same diagnosis for a given patient). Disorders with low clinical utility and weak validity were considered for deletion. Placement of conditions in "Conditions for Further Study" in Section III was contingent on the amount of empirical evidence generated on the diagnosis, diagnostic reliability or validity, presence of clear clinical need, and potential benefit in advancing research.

DSM-5 Field Trials

The use of field trials to empirically demonstrate reliability was a noteworthy improvement introduced in DSM-III. The design and implementation strategy of the DSM-5 Field Trials represent several changes over approaches used for DSM-III and DSM-IV, particularly in obtaining data on the precision of kappa reliability estimates (a statistical measure that assesses level of agreement between raters that corrects for chance agreement due to prevalence rates) in the context of clinical settings with high levels of diagnostic comorbidity. For DSM-5, field trials were extended by using two distinctive designs: one in large, diverse medical-academic settings, and the other in routine clinical practices. The former capitalized on the need for large sample sizes to test hypotheses on reliability and clinical utility of a range of diagnoses in a

variety of patient populations; the latter supplied valuable information about how proposed revisions performed in everyday clinical settings among a diverse sample of DSM users. It is anticipated that future clinical and basic research studies will focus on the validity of the revised categorical diagnostic criteria and the underlying dimensional features of these disorders (including those now being explored by the NIMH Research Domain Criteria initiative).

The medical-academic field trials were conducted at 11 North American medical-academic sites and assessed the reliability, feasibility, and clinical utility of select revisions, with priority given to those that represented the greatest degree of change from DSM-IV or those potentially having the greatest public health impact. The full clinical patient populations coming to each site were screened for DSM-IV diagnoses or qualifying symptoms likely to predict several specific DSM-5 disorders of interest. Stratified samples of four to seven specific disorders, plus a stratum containing a representative sample of all other diagnoses, were identified for each site. Patients consented to the study and were randomly assigned for a clinical interview by a clinician blind to the diagnosis, followed by a second interview with a clinician blind to previous diagnoses. Patients first filled out a computer-assisted inventory of cross-cutting symptoms in more than a dozen psychological domains. These inventories were scored by a central server, and results were provided to clinicians before they conducted a typical clinical interview (with no structured protocol). Clinicians were required to score the presence of qualifying criteria on a computer-assisted DSM-5 diagnostic checklist, determine diagnoses, score the severity of the diagnosis, and submit all data to the central Web-based server. This study design allowed the calculation of the degree to which two independent clinicians could agree on a diagnosis (using the intraclass kappa statistic) and the agreement of a single patient or two different clinicians on two separate ratings of cross-cutting symptoms, personality traits, disability, and diagnostic severity measures (using intraclass correlation coefficients) along with information on the precision of these estimates of reliability. It was also possible to assess the prevalence rates of both DSM-IV and DSM-5 conditions in the respective clinical populations.

The routine clinical practice field trials involved recruitment of individual psychiatrists and other mental health clinicians. A volunteer sample was recruited that included generalist and specialty psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice psychiatric mental health nurses. The field trials provided exposure of the proposed DSM-5 diagnoses and dimensional measures to a wide range of clinicians to assess their feasibility and clinical utility.

Public and Professional Review

In 2010, the APA launched a unique Web site to facilitate public and professional input into DSM-5. All draft diagnostic criteria and proposed changes in organization were posted on www.dsm5.org for a 2-month comment period. Feedback totaled more than 8,000 submissions, which were systematically reviewed by each of the 13 work groups, whose members, where appropriate, integrated questions and comments into discussions of draft revisions and plans for field trial testing. After revisions to the initial draft criteria and proposed chapter organization, a second posting occurred in 2011. Work groups considered feedback from both Web postings and the results of the DSM-5 Field Trials when drafting proposed final criteria, which were posted on the Web site for a third and final time in 2012. These three iterations of external review produced more than 13,000 individually signed comments on the Web site that were received and reviewed by the work groups, plus thousands of organized petition signers for and against some proposed revisions, all of which allowed the task force to actively address concerns of DSM users, as well as patients and advocacy groups, and ensure that clinical utility remained a high priority.

Expert Review

The members of the 13 work groups, representing expertise in their respective areas, collaborated with advisors and reviewers under the overall direction of the DSM-5 Task

Force to draft the diagnostic criteria and accompanying text. This effort was supported by a team of APA Division of Research staff and developed through a network of text coordinators from each work group. The preparation of the text was coordinated by the text editor, working in close collaboration with the work groups and under the direction of the task force chairs. The Scientific Review Committee (SRC) was established to provide a scientific peer review process that was external to that of the work groups. The SRC chair, vice-chair, and six committee members were charged with reviewing the degree to which the proposed changes from DSM-IV could be supported with scientific evidence. Each proposal for diagnostic revision required a memorandum of evidence for change prepared by the work group and accompanied by a summary of supportive data organized around validators for the proposed diagnostic criteria (i.e., antecedent validators such as familial aggregation, concurrent validators such as biological markers, and prospective validators such as response to treatment or course of illness). The submissions were reviewed by the SRC and scored according to the strength of the supportive scientific data. Other justifications for change, such as those arising from clinical experience or need or from a conceptual reframing of diagnostic categories, were generally seen as outside the purview of the SRC. The reviewers' scores, which varied substantially across the different proposals, and an accompanying brief commentary were then returned to the APA Board of Trustees and the work groups for consideration and response.

The Clinical and Public Health Committee (CPHC), composed of a chair, vice-chair, and six members, was appointed to consider additional clinical utility, public health, and logical clarification issues for criteria that had not yet accumulated the type or level of evidence deemed sufficient for change by the SRC. This review process was particularly important for DSM-IV disorders with known deficiencies for which proposed remedies had neither been previously considered in the DSM revision process nor been subjected to replicated research studies. These selected disorders were evaluated by four to five external reviewers, and the blinded results were reviewed by CPHC members, who in turn made recommendations to the APA Board of Trustees and the work groups.

Forensic reviews by the members of the APA Council on Psychiatry and Law were conducted for disorders frequently appearing in forensic environments and ones with high potential for influencing civil and criminal judgments in courtroom settings. Work groups also added forensic experts as advisors in pertinent areas to complement expertise provided by the Council on Psychiatry and Law.

The work groups themselves were charged with the responsibility to review the entire research literature surrounding a diagnostic area, including old, revised, and new diagnostic criteria, in an intensive 6-year review process to assess the pros and cons of making either small iterative changes or major conceptual changes to address the inevitable reification that occurs with diagnostic conceptual approaches that persist over several decades. Such changes included the merger of previously separate diagnostic areas into more dimensional spectra, such as that which occurred with autism spectrum disorder, substance use disorders, sexual dysfunctions, and somatic symptom and related disorders. Other changes included correcting flaws that had become apparent over time in the choice of operational criteria for some disorders. These types of changes posed particular challenges to the SRC and CPHC review processes, which were not constructed to evaluate the validity of DSM-IV diagnostic criteria. However, the DSM-5 Task Force, which had reviewed proposed changes and had responsibility for reviewing the text describing each disorder contemporaneously with the work groups during this period, was in a unique position to render an informed judgment on the scientific merits of such revisions. Furthermore, many of these major changes were subject to field trial testing, although comprehensive testing of all proposed changes could not be accommodated by such testing because of time limitations and availability of resources.

A final recommendation from the task force was then provided to the APA Board of Trustees and the APA Assembly's Committee on DSM-5 to consider some of the clinical utility and feasibility features of the proposed revisions. The assembly is a deliberative

body of the APA representing the district branches and wider membership that is composed of psychiatrists from throughout the United States who provide geographic, practice size, and interest-based diversity. The Committee on DSM-5 is a committee made up of a diverse group of assembly leaders.

Following all of the preceding review steps, an executive "summit committee" session was held to consolidate input from review and assembly committee chairs, task force chairs, a forensic advisor, and a statistical advisor, for a preliminary review of each disorder by the assembly and APA Board of Trustees executive committees. This preceded a preliminary review by the full APA Board of Trustees. The assembly voted, in November 2012, to recommend that the board approve the publication of DSM-5, and the APA Board of Trustees approved its publication in December 2012. The many experts, reviewers, and advisors who contributed to this process are listed in the Appendix.

Organizational Structure

The individual disorder definitions that constitute the operationalized sets of diagnostic criteria provide the core of DSM-5 for clinical and research purposes. These criteria have been subjected to scientific review, albeit to varying degrees, and many disorders have undergone field testing for interrater reliability. In contrast, the classification of disorders (the way in which disorders are grouped, which provides a high-level organization for the manual) has not generally been thought of as scientifically significant, despite the fact that judgments had to be made when disorders were initially divided into chapters for DSM-III.

DSM is a medical classification of disorders and as such serves as a historically determined cognitive schema imposed on clinical and scientific information to increase its comprehensibility and utility. Not surprisingly, as the foundational science that ultimately led to DSM-III has approached a half-century in age, challenges have begun to emerge for clinicians and scientists alike that are inherent in the DSM structure rather than in the description of any single disorder. These challenges include high rates of comorbidity within and across DSM chapters, an excessive use of and need to rely on "not otherwise specified" (NOS) criteria, and a growing inability to integrate DSM disorders with the results of genetic studies and other scientific findings.

As the APA and the WHO began to plan their respective revisions of the DSM and the *International Classification of Disorders* (ICD), both considered the possibility of improving clinical utility (e.g., by helping to explain apparent comorbidity) and facilitating scientific investigation by rethinking the organizational structures of both publications in a linear system designated by alphanumeric codes that sequence chapters according to some rational and relational structure. It was critical to both the DSM-5 Task Force and the WHO International Advisory Group on the revision of the ICD-10 Section on Mental and Behavioral Disorders that the revisions to the organization enhance clinical utility and remain within the bounds of well-replicated scientific information. Although the need for reform seemed apparent, it was important to respect the state of the science as well as the challenge that overly rapid change would pose for the clinical and research communities. In that spirit, revision of the organization was approached as a conservative, evolutionary diagnostic reform that would be guided by emerging scientific evidence on the relationships between disorder groups. By reordering and regrouping the existing disorders, the revised structure is meant to stimulate new clinical perspectives and to encourage researchers to identify the psychological and physiological cross-cutting factors that are not bound by strict categorical designations.

The use of DSM criteria has the clear virtue of creating a common language for communication between clinicians about the diagnosis of disorders. The official criteria and disorders that were determined to have accepted clinical applicability are located in Section II of the manual. However, it should be noted that these diagnostic criteria and their

relationships within the classification are based on current research and may need to be modified as new evidence is gathered by future research both within and across the domains of proposed disorders. "Conditions for Further Study," described in Section III, are those for which we determined that the scientific evidence is not yet available to support widespread clinical use. These diagnostic criteria are included to highlight the evolution and direction of scientific advances in these areas to stimulate further research.

With any ongoing review process, especially one of this complexity, different viewpoints emerge, and an effort was made to consider various viewpoints and, when warranted, accommodate them. For example, personality disorders are included in both Sections II and III. Section II represents an update of the text associated with the same criteria found in DSM-IV-TR, whereas Section III includes the proposed research model for personality disorder diagnosis and conceptualization developed by the DSM-5 Personality and Personality Disorders Work Group. As this field evolves, it is hoped that both versions will serve clinical practice and research initiatives.

Harmonization With ICD-11

The groups tasked with revising the DSM and ICD systems shared the overarching goal of harmonizing the two classifications as much as possible, for the following reasons:

- The existence of two major classifications of mental disorders hinders the collection and use of national health statistics, the design of clinical trials aimed at developing new treatments, and the consideration of global applicability of the results by international regulatory agencies.
- More broadly, the existence of two classifications complicates attempts to replicate scientific results across national boundaries.
- Even when the intention was to identify identical patient populations, DSM-IV and ICD-10 diagnoses did not always agree.

Early in the course of the revisions, it became apparent that a shared organizational structure would help harmonize the classifications. In fact, the use of a shared framework helped to integrate the work of DSM and ICD work groups and to focus on scientific issues. The DSM-5 organization and the proposed linear structure of the ICD-11 have been endorsed by the leadership of the NIMH Research Domain Criteria (RDoC) project as consistent with the initial overall structure of that project.

Of course, principled disagreements on the classification of psychopathology and on specific criteria for certain disorders were expected given the current state of scientific knowledge. However, most of the salient differences between the DSM and the ICD classifications do not reflect real scientific differences, but rather represent historical by-products of independent committee processes.

To the surprise of participants in both revision processes, large sections of the content fell relatively easily into place, reflecting real strengths in some areas of the scientific literature, such as epidemiology, analyses of comorbidity, twin studies, and certain other genetically informed designs. When disparities emerged, they almost always reflected the need to make a judgment about where to place a disorder in the face of incomplete—or, more often, conflicting—data. Thus, for example, on the basis of patterns of symptoms, comorbidity, and shared risk factors, attention-deficit/hyperactivity disorder (ADHD) was placed with neurodevelopmental disorders, but the same data also supported strong arguments to place ADHD within disruptive, impulse-control, and conduct disorders. These issues were settled with the preponderance of evidence (most notably validators approved by the DSM-5 Task Force). The work groups recognize, however, that future discoveries might change the placement as well as the contours of individual disorders and, furthermore, that the simple and linear organization that best supports clinical practice

may not fully capture the complexity and heterogeneity of mental disorders. The revised organization is coordinated with the mental and behavioral disorders chapter (Chapter V) of ICD-11, which will utilize an expanded numeric–alphanumeric coding system. However, the official coding system in use in the United States at the time of publication of this manual is that of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM)—the U.S. adaptation of ICD-9. *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM), adapted from ICD-10, is scheduled for implementation in the United States in October 2014. Given the impending release of ICD-11, it was decided that this iteration, and not ICD-10, would be the most relevant on which to focus harmonization. However, given that adoption of the ICD-9-CM coding system will remain at the time of the DSM-5 release, it will be necessary to use the ICD-9-CM codes. Furthermore, given that DSM-5's organizational structure reflects the anticipated structure of ICD-11, the eventual ICD-11 codes will follow the sequential order of diagnoses in the DSM-5 chapter structure more closely. At present, both the ICD-9-CM and the ICD-10-CM codes have been indicated for each disorder. These codes will not be in sequential order throughout the manual because they were assigned to complement earlier organizational structures.

Dimensional Approach to Diagnosis

Structural problems rooted in the basic design of the previous DSM classification, constructed of a large number of narrow diagnostic categories, have emerged in both clinical practice and research. Relevant evidence comes from diverse sources, including studies of comorbidity and the substantial need for not otherwise specified diagnoses, which represent the majority of diagnoses in areas such as eating disorders, personality disorders, and autism spectrum disorder. Studies of both genetic and environmental risk factors, whether based on twin designs, familial transmission, or molecular analyses, also raise concerns about the categorical structure of the DSM system. Because the previous DSM approach considered each diagnosis as categorically separate from health and from other diagnoses, it did not capture the widespread sharing of symptoms and risk factors across many disorders that is apparent in studies of comorbidity. Earlier editions of DSM focused on excluding false-positive results from diagnoses; thus, its categories were overly narrow, as is apparent from the widespread need to use NOS diagnoses. Indeed, the once plausible goal of identifying homogeneous populations for treatment and research resulted in narrow diagnostic categories that did not capture clinical reality, symptom heterogeneity within disorders, and significant sharing of symptoms across multiple disorders. The historical aspiration of achieving diagnostic homogeneity by progressive subtyping within disorder categories no longer is sensible; like most common human ills, mental disorders are heterogeneous at many levels, ranging from genetic risk factors to symptoms.

Related to recommendations about alterations in the chapter structure of DSM-5, members of the diagnostic spectra study group examined whether scientific validators could inform possible new groupings of related disorders within the existing categorical framework. Eleven such indicators were recommended for this purpose: shared neural substrates, family traits, genetic risk factors, specific environmental risk factors, biomarkers, temperamental antecedents, abnormalities of emotional or cognitive processing, symptom similarity, course of illness, high comorbidity, and shared treatment response. These indicators served as empirical guidelines to inform decision making by the work groups and the task force about how to cluster disorders to maximize their validity and clinical utility.

A series of papers was developed and published in a prominent international journal (*Psychological Medicine*, Vol. 39, 2009) as part of both the DSM-5 and the ICD-11 developmental processes to document that such validators were most useful for suggesting large groupings of disorders rather than for "validating" individual disorder diagnostic criteria. The regrouping of mental disorders in DSM-5 is intended to enable future research to en-

hance understanding of disease origins and pathophysiological commonalities between disorders and provide a base for future replication wherein data can be reanalyzed over time to continually assess validity. Ongoing revisions of DSM-5 will make it a "living document," adaptable to future discoveries in neurobiology, genetics, and epidemiology.

On the basis of the published findings of this common DSM-5 and ICD-11 analysis, it was demonstrated that clustering of disorders according to what has been termed *internalizing* and *externalizing* factors represents an empirically supported framework. Within both the internalizing group (representing disorders with prominent anxiety, depressive, and somatic symptoms) and the externalizing group (representing disorders with prominent impulsive, disruptive conduct, and substance use symptoms), the sharing of genetic and environmental risk factors, as shown by twin studies, likely explains much of the systematic comorbidities seen in both clinical and community samples. The adjacent placement of "internalizing disorders," characterized by depressed mood, anxiety, and related physiological and cognitive symptoms, should aid in developing new diagnostic approaches, including dimensional approaches, while facilitating the identification of biological markers. Similarly, adjacencies of the "externalizing group," including disorders exhibiting antisocial behaviors, conduct disturbances, addictions, and impulse-control disorders, should encourage advances in identifying diagnoses, markers, and underlying mechanisms.

Despite the problem posed by categorical diagnoses, the DSM-5 Task Force recognized that it is premature scientifically to propose alternative definitions for most disorders. The organizational structure is meant to serve as a bridge to new diagnostic approaches without disrupting current clinical practice or research. With support from DSM-associated training materials, the National Institutes of Health other funding agencies, and scientific publications, the more dimensional DSM-5 approach and organizational structure can facilitate research across current diagnostic categories by encouraging broad investigations within the proposed chapters and across adjacent chapters. Such a reformulation of research goals should also keep DSM-5 central to the development of dimensional approaches to diagnosis that will likely supplement or supersede current categorical approaches in coming years.

Developmental and Lifespan Considerations

To improve clinical utility, DSM-5 is organized on developmental and lifespan considerations. It begins with diagnoses thought to reflect developmental processes that manifest early in life (e.g., neurodevelopmental and schizophrenia spectrum and other psychotic disorders), followed by diagnoses that more commonly manifest in adolescence and young adulthood (e.g., bipolar, depressive, and anxiety disorders), and ends with diagnoses relevant to adulthood and later life (e.g., neurocognitive disorders). A similar approach has been taken, where possible, within each chapter. This organizational structure facilitates the comprehensive use of lifespan information as a way to assist in diagnostic decision making.

The proposed organization of chapters of DSM-5, after the neurodevelopmental disorders, is based on groups of internalizing (emotional and somatic) disorders, externalizing disorders, neurocognitive disorders, and other disorders. It is hoped that this organization will encourage further study of underlying pathophysiological processes that give rise to diagnostic comorbidity and symptom heterogeneity. Furthermore, by arranging disorder clusters to mirror clinical reality, DSM-5 should facilitate identification of potential diagnoses by non–mental health specialists, such as primary care physicians.

The organizational structure of DSM-5, along with ICD harmonization, is designed to provide better and more flexible diagnostic concepts for the next epoch of research and to serve as a useful guide to clinicians in explaining to patients why they might have received multiple diagnoses or why they might have received additional or altered diagnoses over their lifespan.

Cultural Issues

Mental disorders are defined in relation to cultural, social, and familial norms and values. Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis. Culture is transmitted, revised, and recreated within the family and other social systems and institutions. Diagnostic assessment must therefore consider whether an individual's experiences, symptoms, and behaviors differ from sociocultural norms and lead to difficulties in adaptation in the cultures of origin and in specific social or familial contexts. Key aspects of culture relevant to diagnostic classification and assessment have been considered in the development of DSM-5.

In Section III, the "Cultural Formulation" contains a detailed discussion of culture and diagnosis in DSM-5, including tools for in-depth cultural assessment. In the Appendix, the "Glossary of Cultural Concepts of Distress" provides a description of some common cultural syndromes, idioms of distress, and causal explanations relevant to clinical practice.

The boundaries between normality and pathology vary across cultures for specific types of behaviors. Thresholds of tolerance for specific symptoms or behaviors differ across cultures, social settings, and families. Hence, the level at which an experience becomes problematic or pathological will differ. The judgment that a given behavior is abnormal and requires clinical attention depends on cultural norms that are internalized by the individual and applied by others around them, including family members and clinicians. Awareness of the significance of culture may correct mistaken interpretations of psychopathology, but culture may also contribute to vulnerability and suffering (e.g., by amplifying fears that maintain panic disorder or health anxiety). Cultural meanings, habits, and traditions can also contribute to either stigma or support in the social and familial response to mental illness. Culture may provide coping strategies that enhance resilience in response to illness, or suggest help seeking and options for accessing health care of various types, including alternative and complementary health systems. Culture may influence acceptance or rejection of a diagnosis and adherence to treatments, affecting the course of illness and recovery. Culture also affects the conduct of the clinical encounter; as a result, cultural differences between the clinician and the patient have implications for the accuracy and acceptance of diagnosis as well as for treatment decisions, prognostic considerations, and clinical outcomes.

Historically, the construct of the culture-bound syndrome has been a key interest of cultural psychiatry. In DSM-5, this construct has been replaced by three concepts that offer greater clinical utility:

1. *Cultural syndrome* is a cluster or group of co-occurring, relatively invariant symptoms found in a specific cultural group, community, or context (e.g., *ataque de nervios*). The syndrome may or may not be recognized as an illness within the culture (e.g., it might be labeled in various ways), but such cultural patterns of distress and features of illness may nevertheless be recognizable by an outside observer.
2. *Cultural idiom of distress* is a linguistic term, phrase, or way of talking about suffering among individuals of a cultural group (e.g., similar ethnicity and religion) referring to shared concepts of pathology and ways of expressing, communicating, or naming essential features of distress (e.g., *kufungisisa*). An idiom of distress need not be associated with specific symptoms, syndromes, or perceived causes. It may be used to convey a wide range of discomfort, including everyday experiences, subclinical conditions, or suffering due to social circumstances rather than mental disorders. For example, most cultures have common bodily idioms of distress used to express a wide range of suffering and concerns.
3. *Cultural explanation or perceived cause* is a label, attribution, or feature of an explanatory model that provides a culturally conceived etiology or cause for symptoms, illness, or distress (e.g., *maladi moun*). Causal explanations may be salient features of folk classifications of disease used by laypersons or healers.

These three concepts (for which discussion and examples are provided in Section III and the Appendix) suggest cultural ways of understanding and describing illness experiences that can be elicited in the clinical encounter. They influence symptomatology, help seeking, clinical presentations, expectations of treatment, illness adaptation, and treatment response. The same cultural term often serves more than one of these functions.

Gender Differences

Sex and gender differences as they relate to the causes and expression of medical conditions are established for a number of diseases, including selected mental disorders. Revisions to DSM-5 included review of potential differences between men and women in the expression of mental illness. In terms of nomenclature, *sex differences* are variations attributable to an individual's reproductive organs and XX or XY chromosomal complement. *Gender differences* are variations that result from biological sex as well as an individual's self-representation that includes the psychological, behavioral, and social consequences of one's perceived gender. The term *gender differences* is used in DSM-5 because, more commonly, the differences between men and women are a result of both biological sex and individual self-representation. However, some of the differences are based on only biological sex.

Gender can influence illness in a variety of ways. First, it may exclusively determine whether an individual is at risk for a disorder (e.g., as in premenstrual dysphoric disorder). Second, gender may moderate the overall risk for development of a disorder as shown by marked gender differences in the prevalence and incidence rates for selected mental disorders. Third, gender may influence the likelihood that particular symptoms of a disorder are experienced by an individual. Attention-deficit/hyperactivity disorder is an example of a disorder with differences in presentation that are most commonly experienced by boys or girls. Gender likely has other effects on the experience of a disorder that are indirectly relevant to psychiatric diagnosis. It may be that certain symptoms are more readily endorsed by men or women, and that this contributes to differences in service provision (e.g., women may be more likely to recognize a depressive, bipolar, or anxiety disorder and endorse a more comprehensive list of symptoms than men).

Reproductive life cycle events, including estrogen variations, also contribute to gender differences in risk and expression of illness. Thus, a specifier for postpartum onset of mania or major depressive episode denotes a time frame wherein women may be at increased risk for the onset of an illness episode. In the case of sleep and energy, alterations are often normative postpartum and thus may have lower diagnostic reliability in postpartum women.

The manual is configured to include information on gender at multiple levels. If there are gender-specific symptoms, they have been added to the diagnostic criteria. A gender-related specifier, such as perinatal onset of a mood episode, provides additional information on gender and diagnosis. Finally, other issues that are pertinent to diagnosis and gender considerations can be found in the section "Gender-Related Diagnostic Issues."

Use of Other Specified and Unspecified Disorders

To enhance diagnostic specificity, DSM-5 replaces the previous NOS designation with two options for clinical use: *other specified disorder* and *unspecified disorder*. The other specified disorder category is provided to allow the clinician to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class. This is done by recording the name of the category, followed by the specific reason. For example, for an individual with clinically significant depressive symptoms lasting 4 weeks but whose symptomatology falls short of the diagnostic threshold for a major depressive episode, the clinician would record "other specified depressive disorder, depressive episode with insufficient symptoms." If the clinician chooses not to specify the

reason that the criteria are not met for a specific disorder, then "unspecified depressive disorder" would be diagnosed. Note that the differentiation between other specified and unspecified disorders is based on the clinician's decision, providing maximum flexibility for diagnosis. Clinicians do not have to differentiate between other specified and unspecified disorders based on some feature of the presentation itself. When the clinician determines that there is evidence to specify the nature of the clinical presentation, the other specified diagnosis can be given. When the clinician is not able to further specify and describe the clinical presentation, the unspecified diagnosis can be given. This is left entirely up to clinical judgment.

For a more detailed discussion of how to use other specified and unspecified designations, see "Use of the Manual" in Section I.

The Multiaxial System

Despite widespread use and its adoption by certain insurance and governmental agencies, the multiaxial system in DSM-IV was not required to make a mental disorder diagnosis. A nonaxial assessment system was also included that simply listed the appropriate Axis I, II, and III disorders and conditions without axial designations. DSM-5 has moved to a nonaxial documentation of diagnosis (formerly Axes I, II, and III), with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V). This revision is consistent with the DSM-IV text that states, "The multiaxial distinction among Axis I, Axis II, and Axis III disorders does not imply that there are fundamental differences in their conceptualization, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes." The approach of separately noting diagnosis from psychosocial and contextual factors is also consistent with established WHO and ICD guidance to consider the individual's functional status separately from his or her diagnoses or symptom status. In DSM-5, Axis III has been combined with Axes I and II. Clinicians should continue to list medical conditions that are important to the understanding or management of an individual's mental disorder(s).

DSM-IV Axis IV covered psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders. Although this axis provided helpful information, even if it was not used as frequently as intended, the DSM-5 Task Force recommended that DSM-5 should not develop its own classification of psychosocial and environmental problems, but rather use a selected set of the ICD-9-CM V codes and the new Z codes contained in ICD-10-CM. The ICD-10 Z codes were examined to determine which are most relevant to mental disorders and also to identify gaps.

DSM-IV Axis V consisted of the Global Assessment of Functioning (GAF) scale, representing the clinician's judgment of the individual's overall level of "functioning on a hypothetical continuum of mental health–illness." It was recommended that the GAF be dropped from DSM-5 for several reasons, including its conceptual lack of clarity (i.e., including symptoms, suicide risk, and disabilities in its descriptors) and questionable psychometrics in routine practice. In order to provide a global measure of disability, the WHO Disability Assessment Schedule (WHODAS) is included, for further study, in Section III of DSM-5 (see the chapter "Assessment Measures"). The WHODAS is based on the International Classification of Functioning, Disability and Health (ICF) for use across all of medicine and health care. The WHODAS (version 2.0), and a modification developed for children/adolescents and their parents by the Impairment and Disability Study Group were included in the DSM-5 field trial.

DSM-5/DSM-IV-TR Personality Disorders

Personality Disorders

This chapter begins with a general definition of personality disorder that applies to each of the 10 specific personality disorders. A *personality disorder* is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

With any ongoing review process, especially one of this complexity, different viewpoints emerge, and an effort was made to accommodate them. Thus, personality disorders are included in both Sections II and III. The material in Section II represents an update of text associated with the same criteria found in DSM-IV-TR, whereas Section III includes the proposed research model for personality disorder diagnosis and conceptualization developed by the DSM-5 Personality and Personality Disorders Work Group. As this field evolves, it is hoped that both versions will serve clinical practice and research initiatives, respectively.

The following personality disorders are included in this chapter.

- **Paranoid personality disorder** is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.
- **Schizoid personality disorder** is a pattern of detachment from social relationships and a restricted range of emotional expression.
- **Schizotypal personality disorder** is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.
- **Antisocial personality disorder** is a pattern of disregard for, and violation of, the rights of others.
- **Borderline personality disorder** is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.
- **Histrionic personality disorder** is a pattern of excessive emotionality and attention seeking.
- **Narcissistic personality disorder** is a pattern of grandiosity, need for admiration, and lack of empathy.
- **Avoidant personality disorder** is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
- **Dependent personality disorder** is a pattern of submissive and clinging behavior related to an excessive need to be taken care of.
- **Obsessive-compulsive personality disorder** is a pattern of preoccupation with orderliness, perfectionism, and control.
- **Personality change due to another medical condition** is a persistent personality disturbance that is judged to be due to the direct physiological effects of a medical condition (e.g., frontal lobe lesion).
- **Other specified personality disorder and unspecified personality disorder** is a category provided for two situations: 1) the individual's personality pattern meets the general criteria for a personality disorder, and traits of several different personality disorders are present, but the criteria for any specific personality disorder are not met;

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or 2) the individual's personality pattern meets the general criteria for a personality disorder, but the individual is considered to have a personality disorder that is not included in the DSM-5 classification (e.g., passive-aggressive personality disorder).

The personality disorders are grouped into three clusters based on descriptive similarities. Cluster A includes paranoid, schizoid, and schizotypal personality disorders. Individuals with these disorders often appear odd or eccentric. Cluster B includes antisocial, borderline, histrionic, and narcissistic personality disorders. Individuals with these disorders often appear dramatic, emotional, or erratic. Cluster C includes avoidant, dependent, and obsessive-compulsive personality disorders. Individuals with these disorders often appear anxious or fearful. It should be noted that this clustering system, although useful in some research and educational situations, has serious limitations and has not been consistently validated.

Moreover, individuals frequently present with co-occurring personality disorders from different clusters. Prevalence estimates for the different clusters suggest 5.7% for disorders in Cluster A, 1.5% for disorders in Cluster B, 6.0% for disorders in Cluster C, and 9.1% for any personality disorder, indicating frequent co-occurrence of disorders from different clusters. Data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions suggest that approximately 15% of U.S. adults have at least one personality disorder.

Dimensional Models for Personality Disorders

The diagnostic approach used in this manual represents the categorical perspective that personality disorders are qualitatively distinct clinical syndromes. An alternative to the categorical approach is the dimensional perspective that personality disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another. See Section III for a full description of a dimensional model for personality disorders. The DSM-IV personality disorder clusters (i.e., odd-eccentric, dramatic-emotional, and anxious-fearful) may also be viewed as dimensions representing spectra of personality dysfunction on a continuum with other mental disorders. The alternative dimensional models have much in common and together appear to cover the important areas of personality dysfunction. Their integration, clinical utility, and relationship with the personality disorder diagnostic categories and various aspects of personality dysfunction are under active investigation.

General Personality Disorder

Criteria

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
   1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
   2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
   3. Interpersonal functioning.
   4. Impulse control.

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma).

Diagnostic Features

Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute personality disorders. The essential feature of a personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control (Criterion A). This enduring pattern is inflexible and pervasive across a broad range of personal and social situations (Criterion B) and leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood (Criterion D). The pattern is not better explained as a manifestation or consequence of another mental disorder (Criterion E) and is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, exposure to a toxin) or another medical condition (e.g., head trauma) (Criterion F). Specific diagnostic criteria are also provided for each of the personality disorders included in this chapter.

The diagnosis of personality disorders requires an evaluation of the individual's long-term patterns of functioning, and the particular personality features must be evident by early adulthood. The personality traits that define these disorders must also be distinguished from characteristics that emerge in response to specific situational stressors or more transient mental states (e.g., bipolar, depressive, or anxiety disorders; substance intoxication). The clinician should assess the stability of personality traits over time and across different situations. Although a single interview with the individual is sometimes sufficient for making the diagnosis, it is often necessary to conduct more than one interview and to space these over time. Assessment can also be complicated by the fact that the characteristics that define a personality disorder may not be considered problematic by the individual (i.e., the traits are often ego-syntonic). To help overcome this difficulty, supplementary information from other informants may be helpful.

Deveiopment and Course

The features of a personality disorder usually become recognizable during adolescence or early adult life. By definition, a personality disorder is an enduring pattern of thinking, feeling, and behaving that is relatively stable over time. Some types of personality disorder (notably, antisocial and borderline personality disorders) tend to become less evident or to remit with age, whereas this appears to be less true for some other types (e.g., obsessive-compulsive and schizotypal personality disorders).

Personality disorder categories may be applied with children or adolescents in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or another mental disorder. It should be recognized that the traits of a personality disorder that appear in childhood will often not persist unchanged into adult life. For a personality disorder to be diagnosed in an individual younger than 18 years, the features must have been present for at least 1 year. The one exception to this is antisocial per-

sonality disorder, which cannot be diagnosed in individuals younger than 18 years. Although, by definition, a personality disorder requires an onset no later than early adulthood, individuals may not come to clinical attention until relatively late in life. A personality disorder may be exacerbated following the loss of significant supporting persons (e.g., a spouse) or previously stabilizing social situations (e.g., a job). However, the development of a change in personality in middle adulthood or later life warrants a thorough evaluation to determine the possible presence of a personality change due to another medical condition or an unrecognized substance use disorder.

Culture-Related Diagnostic Issues

Judgments about personality functioning must take into account the individual's ethnic, cultural, and social background. Personality disorders should not be confused with problems associated with acculturation following immigration or with the expression of habits, customs, or religious and political values professed by the individual's culture of origin. It is useful for the clinician, especially when evaluating someone from a different background, to obtain additional information from informants who are familiar with the person's cultural background.

Gender-Related Diagnostic Issues

Certain personality disorders (e.g., antisocial personality disorder) are diagnosed more frequently in males. Others (e.g., borderline, histrionic, and dependent personality disorders) are diagnosed more frequently in females. Although these differences in prevalence probably reflect real gender differences in the presence of such patterns, clinicians must be cautious not to overdiagnose or underdiagnose certain personality disorders in females or in males because of social stereotypes about typical gender roles and behaviors.

Differential Diagnosis

Other mental disorders and personality traits. Many of the specific criteria for the personality disorders describe features (e.g., suspiciousness, dependency, insensitivity) that are also characteristic of episodes of other mental disorders. A personality disorder should be diagnosed only when the defining characteristics appeared before early adulthood, are typical of the individual's long-term functioning, and do not occur exclusively during an episode of another mental disorder. It may be particularly difficult (and not particularly useful) to distinguish personality disorders from persistent mental disorders such as persistent depressive disorder that have an early onset and an enduring, relatively stable course. Some personality disorders may have a "spectrum" relationship to other mental disorders (e.g., schizotypal personality disorder with schizophrenia; avoidant personality disorder with social anxiety disorder [social phobia]) based on phenomenological or biological similarities or familial aggregation.

Personality disorders must be distinguished from personality traits that do not reach the threshold for a personality disorder. Personality traits are diagnosed as a personality disorder only when they are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress.

Psychotic disorders. For the three personality disorders that may be related to the psychotic disorders (i.e., paranoid, schizoid, and schizotypal), there is an exclusion criterion stating that the pattern of behavior must not have occurred exclusively during the course of schizophrenia, a bipolar or depressive disorder with psychotic features, or another psychotic disorder. When an individual has a persistent mental disorder (e.g., schizophrenia) that was preceded by a preexisting personality disorder, the personality disorder should also be recorded, followed by "premorbid" in parentheses.

Anxiety and depressive disorders. The clinician must be cautious in diagnosing personality disorders during an episode of a depressive disorder or an anxiety disorder, be-

cause these conditions may have cross-sectional symptom features that mimic personality traits and may make it more difficult to evaluate retrospectively the individual's long-term patterns of functioning.

Posttraumatic stress disorder. When personality changes emerge and persist after an individual has been exposed to extreme stress, a diagnosis of posttraumatic stress disorder should be considered.

Substance use disorders. When an individual has a substance use disorder, it is important not to make a personality disorder diagnosis based solely on behaviors that are consequences of substance intoxication or withdrawal or that are associated with activities in the service of sustaining substance use (e.g., antisocial behavior).

Personality change due to another medical condition. When enduring changes in personality arise as a result of the physiological effects of another medical condition (e.g., brain tumor), a diagnosis of personality change due to another medical condition should be considered.

Cluster A Personality Disorders

Paranoid Personality Disorder

Diagnostic Criteria **301.0 (F60.0)**

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
   1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
   2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
   3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
   4. Reads hidden demeaning or threatening meanings into benign remarks or events.
   5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).
   6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.
   7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

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

Diagnostic Features

The essential feature of paranoid personality disorder is a pattern of pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with this disorder assume that other people will exploit, harm, or deceive them, even if no evidence exists to support this expectation (Criterion A1). They suspect on the basis of little or no evidence that others are plotting against them and may attack them suddenly, at any time and without reason. They often feel that they have been deeply and irreversibly injured by another person or persons even when there is no objective evidence for this. They are preoccupied with unjustified doubts about the loyalty or trustworthiness of their friends and associates, whose actions are minutely scrutinized for evidence of hostile intentions (Criterion A2). Any perceived deviation from trustworthiness or loyalty serves to support their underlying assumptions. They are so amazed when a friend or associate shows loyalty that they cannot trust or believe it. If they get into trouble, they expect that friends and associates will either attack or ignore them.

Individuals with paranoid personality disorder are reluctant to confide in or become close to others because they fear that the information they share will be used against them (Criterion A3). They may refuse to answer personal questions, saying that the information is "nobody's business." They read hidden meanings that are demeaning and threatening into benign remarks or events (Criterion A4). For example, an individual with this disorder may misinterpret an honest mistake by a store clerk as a deliberate attempt to short-change, or view a casual humorous remark by a co-worker as a serious character attack. Compliments are often misinterpreted (e.g., a compliment on a new acquisition is misinterpreted as a criticism for selfishness; a compliment on an accomplishment is misinterpreted as an attempt to coerce more and better performance). They may view an offer of help as a criticism that they are not doing well enough on their own.

Individuals with this disorder persistently bear grudges and are unwilling to forgive the insults, injuries, or slights that they think they have received (Criterion A5). Minor slights arouse major hostility, and the hostile feelings persist for a long time. Because they are constantly vigilant to the harmful intentions of others, they very often feel that their character or reputation has been attacked or that they have been slighted in some other way. They are quick to counterattack and react with anger to perceived insults (Criterion A6). Individuals with this disorder may be pathologically jealous, often suspecting that their spouse or sexual partner is unfaithful without any adequate justification (Criterion A7). They may gather trivial and circumstantial "evidence" to support their jealous beliefs. They want to maintain complete control of intimate relationships to avoid being betrayed and may constantly question and challenge the whereabouts, actions, intentions, and fidelity of their spouse or partner.

Paranoid personality disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder, or if it is attributable to the physiological effects of a neurological (e.g., temporal lobe epilepsy) or another medical condition (Criterion B).

Associated Features Supporting Diagnosis

Individuals with paranoid personality disorder are generally difficult to get along with and often have problems with close relationships. Their excessive suspiciousness and hostility may be expressed in overt argumentativeness, in recurrent complaining, or by quiet, apparently hostile aloofness. Because they are hypervigilant for potential threats, they may act in a guarded, secretive, or devious manner and appear to be "cold" and lacking in tender feelings. Although they may appear to be objective, rational, and unemotional, they more often display a labile range of affect, with hostile, stubborn, and sarcastic expressions predominating. Their combative and suspicious nature may elicit a hostile response in others, which then serves to confirm their original expectations.

Because individuals with paranoid personality disorder lack trust in others, they have an excessive need to be self-sufficient and a strong sense of autonomy. They also need to

have a high degree of control over those around them. They are often rigid, critical of others, and unable to collaborate, although they have great difficulty accepting criticism themselves. They may blame others for their own shortcomings. Because of their quickness to counterattack in response to the threats they perceive around them, they may be litigious and frequently become involved in legal disputes. Individuals with this disorder seek to confirm their preconceived negative notions regarding people or situations they encounter, attributing malevolent motivations to others that are projections of their own fears. They may exhibit thinly hidden, unrealistic grandiose fantasies, are often attuned to issues of power and rank, and tend to develop negative stereotypes of others, particularly those from population groups distinct from their own. Attracted by simplistic formulations of the world, they are often wary of ambiguous situations. They may be perceived as "fanatics" and form tightly knit "cults" or groups with others who share their paranoid belief systems.

Particularly in response to stress, individuals with this disorder may experience very brief psychotic episodes (lasting minutes to hours). In some instances, paranoid personality disorder may appear as the premorbid antecedent of delusional disorder or schizophrenia. Individuals with paranoid personality disorder may develop major depressive disorder and may be at increased risk for agoraphobia and obsessive-compulsive disorder. Alcohol and other substance use disorders frequently occur. The most common co-occurring personality disorders appear to be schizotypal, schizoid, narcissistic, avoidant, and borderline.

Prevalence

A prevalence estimate for paranoid personality based on a probability subsample from Part II of the National Comorbidity Survey Replication suggests a prevalence of 2.3%, while the National Epidemiologic Survey on Alcohol and Related Conditions data suggest a prevalence of paranoid personality disorder of 4.4%.

Development and Course

Paranoid personality disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, social anxiety, underachievement in school, hypersensitivity, peculiar thoughts and language, and idiosyncratic fantasies. These children may appear to be "odd" or "eccentric" and attract teasing. In clinical samples, this disorder appears to be more commonly diagnosed in males.

Risk and Prognostic Factors

Genetic and physiological. There is some evidence for an increased prevalence of paranoid personality disorder in relatives of probands with schizophrenia and for a more specific familial relationship with delusional disorder, persecutory type.

Culture-Related Diagnostic Issues

Some behaviors that are influenced by sociocultural contexts or specific life circumstances may be erroneously labeled paranoid and may even be reinforced by the process of clinical evaluation. Members of minority groups, immigrants, political and economic refugees, or individuals of different ethnic backgrounds may display guarded or defensive behaviors because of unfamiliarity (e.g., language barriers or lack of knowledge of rules and regulations) or in response to the perceived neglect or indifference of the majority society. These behaviors can, in turn, generate anger and frustration in those who deal with these individuals, thus setting up a vicious cycle of mutual mistrust, which should not be confused with paranoid personality disorder. Some ethnic groups also display culturally related behaviors that can be misinterpreted as paranoid.

Differential Diagnosis

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

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

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

Paranoid traits associated with physical handicaps. The disorder must also be distinguished from paranoid traits associated with the development of physical handicaps (e.g., a hearing impairment).

Other personality disorders and personality traits. Other personality disorders may be confused with paranoid personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to paranoid personality disorder, all can be diagnosed. Paranoid personality disorder and schizotypal personality disorder share the traits of suspiciousness, interpersonal aloofness, and paranoid ideation, but schizotypal personality disorder also includes symptoms such as magical thinking, unusual perceptual experiences, and odd thinking and speech. Individuals with behaviors that meet criteria for schizoid personality disorder are often perceived as strange, eccentric, cold, and aloof, but they do not usually have prominent paranoid ideation. The tendency of individuals with paranoid personality disorder to react to minor stimuli with anger is also seen in borderline and histrionic personality disorders. However, these disorders are not necessarily associated with pervasive suspiciousness. People with avoidant personality disorder may also be reluctant to confide in others, but more from fear of being embarrassed or found inadequate than from fear of others' malicious intent. Although antisocial behavior may be present in some individuals with paranoid personality disorder, it is not usually motivated by a desire for personal gain or to exploit others as in antisocial personality disorder, but rather is more often attributable to a desire for revenge. Individuals with narcissistic personality disorder may occasionally display suspiciousness, social withdrawal, or alienation, but this derives primarily from fears of having their imperfections or flaws revealed.

Paranoid traits may be adaptive, particularly in threatening environments. Paranoid personality disorder should be diagnosed only when these traits are inflexible, maladaptive, and persisting and cause significant functional impairment or subjective distress.

Schizoid Personality Disorder

Diagnostic Criteria **301.20 (F60.1)**

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Neither desires nor enjoys close relationships, including being part of a family.
2. Almost always chooses solitary activities.
3. Has little, if any, interest in having sexual experiences with another person.
4. Takes pleasure in few, if any, activities.
5. Lacks close friends or confidants other than first-degree relatives.
6. Appears indifferent to the praise or criticism of others.
7. Shows emotional coldness, detachment, or flattened affectivity.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder and is not attributable to the physiological effects of another medical condition.

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

Diagnostic Features

The essential feature of schizoid personality disorder is a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings. This pattern begins by early adulthood and is present in a variety of contexts.

Individuals with schizoid personality disorder appear to lack a desire for intimacy, seem indifferent to opportunities to develop close relationships, and do not seem to derive much satisfaction from being part of a family or other social group (Criterion A1). They prefer spending time by themselves, rather than being with other people. They often appear to be socially isolated or "loners" and almost always choose solitary activities or hobbies that do not include interaction with others (Criterion A2). They prefer mechanical or abstract tasks, such as computer or mathematical games. They may have very little interest in having sexual experiences with another person (Criterion A3) and take pleasure in few, if any, activities (Criterion A4). There is usually a reduced experience of pleasure from sensory, bodily, or interpersonal experiences, such as walking on a beach at sunset or having sex. These individuals have no close friends or confidants, except possibly a first-degree relative (Criterion A5).

Individuals with schizoid personality disorder often seem indifferent to the approval or criticism of others and do not appear to be bothered by what others may think of them (Criterion A6). They may be oblivious to the normal subtleties of social interaction and often do not respond appropriately to social cues so that they seem socially inept or superficial and self-absorbed. They usually display a "bland" exterior without visible emotional reactivity and rarely reciprocate gestures or facial expressions, such as smiles or nods (Criterion A7). They claim that they rarely experience strong emotions such as anger and joy. They often display a constricted affect and appear cold and aloof. However, in those very unusual circumstances in which these individuals become at least temporarily comfortable in revealing themselves, they may acknowledge having painful feelings, particularly related to social interactions.

Schizoid personality disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of schizophrenia, a bipolar or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder, or if it is attributable to the physiological effects of a neurological (e.g., temporal lobe epilepsy) or another medical condition (Criterion B).

Associated Features Supporting Diagnosis

Individuals with schizoid personality disorder may have particular difficulty expressing anger, even in response to direct provocation, which contributes to the impression that

they lack emotion. Their lives sometimes seem directionless, and they may appear to "drift" in their goals. Such individuals often react passively to adverse circumstances and have difficulty responding appropriately to important life events. Because of their lack of social skills and lack of desire for sexual experiences, individuals with this disorder have few friendships, date infrequently, and often do not marry. Occupational functioning may be impaired, particularly if interpersonal involvement is required, but individuals with this disorder may do well when they work under conditions of social isolation. Particularly in response to stress, individuals with this disorder may experience very brief psychotic episodes (lasting minutes to hours). In some instances, schizoid personality disorder may appear as the premorbid antecedent of delusional disorder or schizophrenia. Individuals with this disorder may sometimes develop major depressive disorder. Schizoid personality disorder most often co-occurs with schizotypal, paranoid, and avoidant personality disorders.

Prevalence

Schizoid personality disorder is uncommon in clinical settings. A prevalence estimate for schizoid personality based on a probability subsample from Part II of the National Comorbidity Survey Replication suggests a prevalence of 4.9%. Data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions suggest a prevalence of 3.1%.

Development and Course

Schizoid personality disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, and underachievement in school, which mark these children or adolescents as different and make them subject to teasing.

Risk and Prognostic Factors

Genetic and physiological. Schizoid personality disorder may have increased prevalence in the relatives of individuals with schizophrenia or schizotypal personality disorder.

Culture-Related Diagnostic Issues

Individuals from a variety of cultural backgrounds sometimes exhibit defensive behaviors and interpersonal styles that may be erroneously labeled as "schizoid." For example, those who have moved from rural to metropolitan environments may react with "emotional freezing" that may last for several months and manifest as solitary activities, constricted affect, and other deficits in communication. Immigrants from other countries are sometimes mistakenly perceived as cold, hostile, or indifferent.

Gender-Related Diagnostic Issues

Schizoid personality disorder is diagnosed slightly more often in males and may cause more impairment in them.

Differential Diagnosis

Other mental disorders with psychotic symptoms. Schizoid personality disorder can be distinguished from delusional disorder, schizophrenia, and a bipolar or depressive disorder with psychotic features because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). To give an additional diagnosis of schizoid personality disorder, the personality disorder must have been present before the onset of psychotic symptoms and must persist when the psychotic symptoms

are in remission. When an individual has a persistent psychotic disorder (e.g., schizophrenia) that was preceded by schizoid personality disorder, schizoid personality disorder should also be recorded, followed by "premorbid" in parentheses.

Autism spectrum disorder. There may be great difficulty differentiating individuals with schizoid personality disorder from those with milder forms of autism spectrum disorder, which may be differentiated by more severely impaired social interaction and stereotyped behaviors and interests.

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

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

Other personality disorders and personality traits. Other personality disorders may be confused with schizoid personality disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to schizoid personality disorder, all can be diagnosed. Although characteristics of social isolation and restricted affectivity are common to schizoid, schizotypal, and paranoid personality disorders, schizoid personality disorder can be distinguished from schizotypal personality disorder by the lack of cognitive and perceptual distortions and from paranoid personality disorder by the lack of suspiciousness and paranoid ideation. The social isolation of schizoid personality disorder can be distinguished from that of avoidant personality disorder, which is attributable to fear of being embarrassed or found inadequate and excessive anticipation of rejection. In contrast, people with schizoid personality disorder have a more pervasive detachment and limited desire for social intimacy. Individuals with obsessive-compulsive personality disorder may also show an apparent social detachment stemming from devotion to work and discomfort with emotions, but they do have an underlying capacity for intimacy.

Individuals who are "loners" may display personality traits that might be considered schizoid. Only when these traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute schizoid personality disorder.

Schizotypal Personality Disorder

Diagnostic Criteria **301.22 (F21)**

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Ideas of reference (excluding delusions of reference).
2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations).
3. Unusual perceptual experiences, including bodily illusions.
4. Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped).
5. Suspiciousness or paranoid ideation.

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

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

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

Diagnostic Features

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

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

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

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

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

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

Associated Features Supporting Diagnosis

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

Prevalence

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

Development and Course

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

Risk and Prognostic Factors

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

Cultural-Related Diagnostic Issues

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

Gender-Related Diagnostic Issues

Schizotypal personality disorder may be slightly more common in males.

Differential Diagnosis

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

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

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

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

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

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

Cluster B Personality Disorders

Antisocial Personality Disorder

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

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

B. The individual is at least age 18 years.

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

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

Diagnostic Features

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

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

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

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

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

Associated Features Supporting Diagnosis

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

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

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

Prevalence

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

Development and Course

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

Risk and Prognostic Factors

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

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

Culture-Related Diagnostic Issues

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

Gender-Related Diagnostic Issues

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

Differential Diagnosis

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

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

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

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

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

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

Borderline Personality Disorder

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

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

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

Diagnostic Features

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

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

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

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

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

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

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

Associated Features Supporting Diagnosis

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

Prevalence

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

Development and Course

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

Risk and Prognostic Factors

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

Culture-Related Diagnostic Issues

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

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

Gender-Related Diagnostic Issues

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

Differential Diagnosis

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

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

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

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

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

Histrionic Personality Disorder

Diagnostic Criteria 301.50 (F60.4)

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

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

Diagnostic Features

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

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

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

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

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

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

Associated Features Supporting Diagnosis

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

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

Prevalence

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

Culture-Related Diagnostic Issues

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

Gender-Related Diagnostic Issues

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

Differential Diagnosis

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

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

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

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

Narcissistic Personality Disorder

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

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

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

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

Diagnostic Features

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

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

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

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

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

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

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

Associated Features Supporting Diagnosis

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

Prevalence

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

Development and Course

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

Gender-Related Diagnostic Issues

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

Differential Diagnosis

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

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

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

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

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

Cluster C Personality Disorders

Avoidant Personality Disorder

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

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

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

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

Diagnostic Features

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

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

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

Associated Features Supporting Diagnosis

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

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

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

Prevalence

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

Development and Course

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

Culture-Related Diagnostic Issues

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

Gender-Related Diagnostic Issues

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

Differential Diagnosis

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

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

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

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

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

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

Dependent Personality Disorder

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

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

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

Diagnostic Features

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

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

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

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

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

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

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

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

Associated Features Supporting Diagnosis

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

Prevalence

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

Deveiopment and Course

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

Culture-Reiated Diagnostic Issues

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

Gender-Related Diagnostic Issues

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

Differential Diagnosis

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

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

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

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

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

Obsessive-Compulsive Personality Disorder

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

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

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

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

Diagnostic Features

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

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

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

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

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

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

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

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

Associated Features Supporting Diagnosis

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

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

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

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

Prevalence

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

Culture-Related Diagnostic Issues

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

Gender-Related Diagnostic Issues

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

Differential Diagnosis

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

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

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

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

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

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

Other Personality Disorders

Personality Change Due to Another Medical Condition

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

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

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

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

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

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

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

Specify whether:

Labile type: If the predominant feature is affective lability.

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

Aggressive type: If the predominant feature is aggressive behavior.

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

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

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

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

Unspecified type

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

Subtypes

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

Diagnostic Features

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

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

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

Associated Features Supporting Diagnosis

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

Differential Diagnosis

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

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

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

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

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

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

Other Specified Personality Disorder

301.89 (F60.89)

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

Unspecified Personality Disorder

301.9 (F60.9)

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

DSM-5 Alternative Model

SECTION III
Emerging Measures and Models

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.

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 Personaiity 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 Detachment]): 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.