SECTION III Emerging Measures and Models

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

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

Proposed disorders for future study are provided, which include a new model for the diagnosis of personality disorders as an alternative to the established diagnostic criteria; the proposed model incorporates impairments in personality functioning as well as pathological personality traits. Also included are new conditions that are the focus of active research, such as attenuated psychosis syndrome and nonsuicidal self-injury. ―――――――732

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Assessment Measures

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

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

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

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

*Severity* *measures* are disorder-specific, corresponding closely to the criteria that constitute the disorder definition. They may be administered to individuals who have received a diagnosis or who have a clinically significant syndrome that falls short of meeting full criteria for a diagnosis. Some of the assessments are self-completed by the individual, while others require a clinician to complete. As with the cross-cutting symptom measures, these measures were developed to be administered both at initial interview and over time to track the severity of the individual's disorder and response to treatment. ―――――――734

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

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

Cross-Cutting Symptom Measures

Level 1 Cross-Cutting Symptom Measure

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

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

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

*Scoring* *and* *interpretation.* On the adult self-rated version of the measure, each item is rated on a 5-point scale (0.knone or not at all; l*kslight* or rare, less than a day or two; 2.kmild or several days; 3.kmoderate or more than half the days; and 4.ksevere or nearly every day). The score on each item within a domain should be reviewed. However, a rating of mild (i.e., 2) or greater on any item within a domain, except for substance use, suicidal ideation, and psychosis, may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment is necessary, which may include the Level 2 cross-cutting symptom assessment for the domain (see Table 2). For substance use, suicidal ideation, and psychosis, a ―――――――735

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

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

The following table is in

list format. Headings and columns

are separated by a colon and one

blank cell. Blank cells

contain two dashes.

*Domain* @: *Domain* *name* @: *Threshold to guide further inquiry* @: *DSM-5 Level 2 Cross-Cutting Symptom Measure* a

I. @: Depression @: Mild or greater @: Level 2—Depression—Adult (PROMIS Emotional Distress—Short Form)

II. @: Anger @: Mild or greater @: Level 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form)

III. @: Mania @: Mild or greater @: Level 2—Mania—Adult (Altman Self-Rating Mania Scale [ASRM])

IV. @: Anxiety @: Mild or greater @: Level 2—Anxiety—Adult (PROMIS Emotional Distress—Anxiety—Short Form)

V. @: Somatic symptoms @: Mild or greater @: Level 2—Somatic Symptom—Adult (Patient Health Questionnaire-15 [PHQ-15] Somatic Symptom Severity Scale)

VI. @: Suicidal ideation @: Slight or greater @: None

VII. @: Psychosis @: Slight or greater @: None

VIII. @: Sleep problems @: Mild or greater @: Level 2—Sleep Disturbance—Adult (PROMIS Sleep Disturbance—Short Form)

IX. @: Memory @: Mild or greater @: None

X. @: Repetitive thoughts and behaviors @: Mild or greater @: Level 2—Repetitive Thoughts and Behaviors—Adult (Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale)

XI. @: Dissociation @: Mild or greater @: None

XII. @: Personality functioning @: Mild or greater @: None

XIII. @: Substance use @: Slight or greater @: Level 2—Substance Use—Adult (adapted from the NIDA-Modified ASSIST)

*Note.* NIDA*KNational* Institute on Drug Abuse. a Available at www.psychiatry.org/dsm5.

On the parent/guardian-rated version of the measure (for children ages 6-17), 19 of the 25 items are each rated on a 5-point scale (0.knone or not at all; l*kslight* or rare, less than a day or two; 2.kmild or several days; 3.kmoderate or more than half the days; and 4.ksevere or nearly every day). The suicide ideation, suicide attempt, and substance abuse items are each rated on a "Yes, No, or Don't Know" scale. The score on each item within a domain should be reviewed. However, with the exception of inattention and psychosis, a rating of mild (i.e., 2) or greater on any item within a domain that is scored on the 5-point scale may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment is necessary, which may include the Level 2 cross-cutting symptom assessment for the domain (see Table 2). For inattention or psychosis, a rating of slight or greater (i.e., 1 or greater) may be ―――――――736

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

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

The following table is in

list format. Headings and columns

are separated by a colon and one

blank cell. Blank cells

contain two dashes.

*Domain* @: *Domain* *name* @: *Threshold to guide further inquiry* @: *DSM-5 Level 2 Cross-Cutting Symptom Measure* a

I. @: Somatic symptoms @: Mild or greater @: Level 2—Somatic Symptoms—Parent/Guardian of Child Age 6-17 (Patient Health Questionnaire-15 Somatic Symptom Severity Scale [PHQ-15])

II. @: Sleep problems @: Mild or greater @: Level 2—Sleep Disturbance—Parent/Guardian of Child Age 6-17 (PROMIS Sleep Disturbance—Short Form)

III. @: Inattention @: Slight or greater @: Level 2—Inattention—Parent/Guardian of Child Age 6-17 (Swanson, Nolan, and Pel-ham, Version IV [SNAP-IV])

IV. @: Depression @: Mild or greater @: Level 2—Depression—Parent/Guardian of Child Age 6-17 (PROMIS Emotional Distress—Depression—Parent Item Bank)

V. @: Anger @: Mild or greater @: Level 2—Anger—Parent/Guardian of Child (PROMIS Calibrated Anger Measure—Parent)

VI. @: Irritability @: Mild or greater @: Level 2—Irritability—Parent/Guardi- an of Child (Affective Reactivity Index [ARI])

VII. @: Mania @: Mild or greater @: Level 2—Mania—Parent/Guardian of Child Age 6-17 (Altman Self-Rating Mania Scale [ASRM])

VIII. @: Anxiety @: Mild or greater @: Level 2—Anxiety—Parent/Guardian of Child Age 6-17 (PROMIS Emotional Distress-Anxiety—Parent Item Bank)

IX. @: Psychosis @: Slight or greater @: None

X. @: Repetitive thoughts and behaviors @: Mild or greater @: None

XI. @: Substance use @: Yes @: Level 2—Substance Use—Parent/Guardian of Child (adapted from the NIDA-MODIFIED ASSIST)

—@: —@: Don't Know @: NIDA-MODIFIED ASSIST (adapted)— Child-Rated (age 11-17 years)

XII. @: Suicidal ideation/ suicide attempts @: Yes @: None

—@: —@: Don't Know @: None

*Note.* NIDA *knowledge* National Institute on Drug Abuse. a Available at www.psychiatry.org/dsm5. ―――――――737

Level 2 Cross-Cutting Symptom Measures

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

Frequency of Use of the Cross-Cutting Symptom Measures

To track change in the individual's symptom presentation over time, the Level 1 and relevant Level 2 cross-cutting symptom measures may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. For individuals with impaired capacity and for children ages 6-17 years, it is preferable for the measures to be completed at follow-up appointments by the same knowledgeable informant and by the same parent or guardian. Consistently high scores on a particular domain may indicate significant and problematic symptoms for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making. ―――――――738

[Table: *DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult* $7' ―――――――739

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[Table: *Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure—Child Age 6-.17. 7' ―――――――741*

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

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

*Scoring and Interpretation*

*Each item on the measure is rated on a 5-point scale (0.knone; lkequivocal;* 2.kpresent, but mild; 3.kpresent and moderate; and 4.kpresent and severe) with a symptom-specific definition of each rating level. The clinician may review all of the individual's available information and, based on clinical judgment, select (by circling) the level that most accurately describes the severity of the individual's condition. The clinician then indicates the score for each item in the "Score" column provided.

Frequency of Use

To track changes in the individual's symptom severity over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making. ―――――――743

*Note.* SD*KSTANDARD* deviation; SES*KSOCIOECONOMIC* status. ―――――――744

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World Health Organization Disability Assessment Schedule 2.0

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

WHODAS 2.0 Scoring Instructions Provided by WHO

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

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

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

\* Step 1—Summing of recoded item scores within each domain.

\* Step 2—Summing of all six domain scores.

\* Step 3—Converting the summary score into a metric ranging from 0 to 100 (where 0.kno disability; 100.kfull disability).

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

*WHODAS 2.0 population norms.* For the population norms for IRT-BASED scoring of the WHODAS 2.0 and for the population distribution of IRT-BASED scores for WHODAS 2.0, please see www.who.int/classifications/i- cf/popNormsDistribIrtScores- .pdf.

Additional Scoring and Interpretation Guidance for DSM-5 Users

The clinician is asked to review the individual's response on each item on the measure during the clinical interview and to indicate the self-reported score for each item in the section provided for "Clinician Use Only." However, if the clinician determines that the score on an item should be different based on the clinical interview and other information available, ―――――――746

he or she may indicate a corrected score in the raw item score box. Based on findings from the DSM-5 Field Trials in adult patient samples across six sites in the United States and one in Canada, *DSM-5 recommends calculation and use of average scores for each domain and for general disability.* The average scores are comparable to the WHODAS 5-point scale, which allows the clinician to think of the individual's disability in terms of none (1), mild (2), moderate (3), severe (4), or extreme (5). The average domain and general disability scores were found to be reliable, easy to use, and clinically useful to the clinicians in the DSM-5 Field Trials. The *average* *domain* *score* is calculated by dividing the raw domain score by the number of items in the domain (e.g., if all the items within the "understanding and communicating" domain are rated as being moderate then the average domain score would be 18/6.k3, indicating moderate disability). The *average general disability score* is calculated by dividing the raw overall score by number of items in the measure (i.e., 36). The individual should be encouraged to complete all of the items on the WHODAS 2.0. If no response is given on 10 or more items of the measure (i.e., more than 25% of the 36 total items), calculation of the simple and average general disability scores may not be helpful. If 10 or more of the total items on the measure are missing but the items for some of the domains are 75%combleajj% complete, the simple or average domain scores may be used for those domains.

*Frequency* *of* *use.* To track change in the individual's level of disability over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the individual that might warrant further assessment and intervention. ―――――――747

[Table: *WHODAS* *2just*

*World Health Organization Disability Assessment Schedule 2just* $7' ―――――――748

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Cultural Formulation

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

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

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

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

Outline for Cultural Formulation

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

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

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

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

\* *Cultural conceptualizations of distress:* Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs may include cultural syndromes, idioms of distress, and explanatory models or perceived causes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.

\* *Psychosocial stressors and cultural features of vulnerability and resilience:* Identify key stressors and supports in the individual's social environment (which may include both local and distant events) and the role of religion, family, and other social networks (e.g., friends, neighbors, coworkers) in providing emotional, instrumental, and informational support. Social stressors and social supports vary with cultural interpretations of events, family structure, developmental tasks, and social context. Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural reference groups.

\* *Cultural features of the relationship between the individual and the clinician:* Identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance.

\* *Overall* *cultural* *assessment:* Summarize the implications of the components of the cultural formulation identified in earlier sections of the Outline for diagnosis and other clinically relevant issues or problems as well as appropriate management and treatment intervention.

Cultural Formulation Interview (CFI)

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

\* The values, orientations, knowledge, and practices that individuals derive from membership in diverse social groups (e.g., ethnic groups, faith communities, occupational groups, veterans groups).

\* Aspects of an individual's background, developmental experiences, and current social contexts that may affect his or her perspective, such as geographical origin, migration, language, religion, sexual orientation, or race/ethnicity.

\* The influence of family, friends, and other community members (the individual's *social* *network)* on the individual's illness experience. ―――――――751

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

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

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

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

\* Difficulty in diagnostic assessment owing to significant differences in the cultural, religious, or socioeconomic backgrounds of clinician and the individual.

\* Uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria.

\* Difficulty in judging illness severity or impairment.

\* Disagreement between the individual and clinician on the course of care.

\* Limited engagement in and adherence to treatment by the individual.

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

Supplementary modules have been developed that expand on each domain of the CFI and guide clinicians who wish to explore these domains in greater depth. Supplementary modules have also been developed for specific populations, such as children and adolescents, elderly individuals, and immigrants and refugees. These supplementary modules are referenced in the CFI under the pertinent subheadings and are available online at www.psychiatry.org/dsm5. ―――――――752

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The following table is in

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*Cultural Formulation Interview (CFI)*

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

*Cultural Formulation Interview (CFI)*

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

*Cultural Formulation Interview (CFI)*

@: *GUIDE* *TO* *INTERVIEWER*

*Cultural Formulation Interview (CFI)*

@: *INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

*Cultural Formulation Interview (CFI)*

@: *The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.*

*Cultural Formulation Interview (CFI)*

@: *INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about*'your-* experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

*Cultural Formulation Interview (CFI)*

@: *CULTURAL DEFINITION OF THE PROBLEM*

*Cultural Formulation Interview (CFI)*

@: *CULTURAL DEFINITION OF THE PROBLEM*

*Cultural Formulation Interview (CFI)*

@: (Explanatory Model, Level of Functioning)

*Cultural Formulation Interview (CFI)*

@: *1.* What brings you here today?

*Cultural Formulation Interview (CFI)*

@: *Ask how individual frames the problem for members of the social network.*

*Cultural Formulation Interview (CFI)*

@: *2.* Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?

*Cultural Formulation Interview (CFI)*

@: *Focus on the aspects of the problem that matter most to the individual.*

*Cultural Formulation Interview (CFI)*

@: *3.* What troubles you most about your problem?

*Cultural Formulation Interview (CFI)*

@: *CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT*

*Cultural Formulation Interview (CFI)*

@: *CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT*

*Cultural Formulation Interview (CFI)*

@: (Explanatory Model, Social Network, Older Adults)

*Cultural Formulation Interview (CFI)*

@: (Explanatory Model, Social Network, Older Adults)

*Cultural Formulation Interview (CFI)*

@: *This question indicates the meaning of the condition for the individual, which may be relevant for clinical care.*

*Cultural Formulation Interview (CFI)*

@: *4.* Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]TH*PROMPT* *FURTHER* *IF* *REQUIRED:* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.

*Cultural Formulation Interview (CFI)*

@: *Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.*

*Cultural Formulation Interview (CFI)*

@: *5.* What do others in your family, your ―――――――753

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@: *INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

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

@: Stressors and Supports

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

@: Stressors and Supports

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

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

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

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

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

@: *Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from coworkers, from participation in religion or spirituality).*

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

@: *6.* Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?

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

@: *Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.*

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

@: *7.* Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

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

@: Role of Cultural Identity

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

@: Role of Cultural Identity

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

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

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

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

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

@: —

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

@: Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By*'background-* or*'identityea-* I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.

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

@: *Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9-10 as needed.*

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

@: *8.* For you, what are the most important aspects of your background or identity?

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

@: *Elicit aspects of identity that make the problem better or worse.*

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

@: *9.* Are there any aspects of your background or identity that make a difference to your [PROBLEM]?

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

@: *Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).*

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

@: *10.* Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

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

@: CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

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

@: CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

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

@: (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers,

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

@: (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers,

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

@: Psychosocial Stressorsgg*Clarify self-coping for the problem.*

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

@: *11.* Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]? ―――――――754

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

@: *GUIDE* *TO* *INTERVIEWER*

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

@: *INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

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

@: Past Help Seeking

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

@: Past Help Seeking

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

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

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

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

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

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

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

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

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

@: Barriers

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

@: Barriers

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

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

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

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

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

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

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

@: 13. Has anything prevented you from getting the help you need? PROBE*'AS* NEEDEDCC*-* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?

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

@: *CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING*

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

@: *CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING*

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

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

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

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

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

@: *Clarify individual's current perceived needs and expectations of help, broadly defined. Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?"). Focus on the views of the social network regarding help seeking.*

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

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

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

@: *Clinician-Patient* *Relationship*

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

@: *Clinician-Patient* *Relationship*

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

@: (Clinician-Patient Relationship, Older Adults)

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

@: —

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

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

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

@: Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations, 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need? ―――――――755

Cultural Formulation Interview (CFI)—Informant Version

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

The following table is in

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*Cultural Formulation Interview (CFI)—Informant Version*

@: *GUIDE* *TO* *INTERVIEWER*

*Cultural Formulation Interview (CFI)—Informant Version*

@: *INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

*Cultural Formulation Interview (CFI)—Informant Version*

@: *The following questions aim to clarify key aspects of the presenting clinical problem from the informant's point of view. This includes the problem's meaning, potential sources of help, and expectations for services.*

*Cultural Formulation Interview (CFI)—Informant Version*

@: *INTRODUCTION FOR THE INFORMANT:* I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about*'your-* experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers.

*Cultural Formulation Interview (CFI)—Informant Version*

@: *RELATIONSHIP WITH THE PATIENT*

*Cultural Formulation Interview (CFI)—Informant Version*

@: *RELATIONSHIP WITH THE PATIENT*

*Cultural Formulation Interview (CFI)—Informant Version*

@: *Clarify the informant's relationship with the individual and/or the individual's family.*

*Cultural Formulation Interview (CFI)—Informant Version*

@: *1* $ Howwould you describe your relationship to [INDIVIDUAL OR TO FAMILY]TH*PROBE* *IF* *NOT* *CLEAR:* How often do you see [INDIVIDUAL]?

*Cultural Formulation Interview (CFI)—Informant Version*

@: *CULTURAL DEFINITION OF THE PROBLEM*

*Cultural Formulation Interview (CFI)—Informant Version*

@: *CULTURAL DEFINITION OF THE PROBLEM*

*Cultural Formulation Interview (CFI)—Informant Version*

@: *Elicit the informant's view of core problems and key*

*Cultural Formulation Interview (CFI)—Informant Version*

@: *2* $ What brings your family member/friend here today?

*Cultural Formulation Interview (CFI)—Informant Version*

@: *Ask how informant frames the problem for members of the social network.*

*Cultural Formulation Interview (CFI)—Informant Version*

@: *3* $ Sometimes people have different ways of describing the problem to family, friends, or others in their community. How would*'you-* describe [INDIVIDUAL's] problem to them?

*Cultural Formulation Interview (CFI)—Informant Version*

@: *Focus on the aspects of the problem that matter most to the informant.*

*Cultural Formulation Interview (CFI)—Informant Version*

@: 4. What troubles you most about [INDIVIDUAL's] problem? ―――――――756

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@: CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

*GUIDE* *TO* *INTERVIEWER*

@: *This question indicates the meaning of the condition for the informant, which may be relevant for clinical care.*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: *5* $ Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]TH*PROMPT* *FURTHER* *IF* *REQUIRED:* Some people may explain the problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.

*GUIDE* *TO* *INTERVIEWER*

@: *Focus on the views of members of the individual's social network. These may be diverse and vary from the informant's.*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: 6. What do others in [INDIVIDUAL's] family, his/her friends, or others in the community think is causing [INDIVIDUAL's] [PROBLEM]?

*GUIDE* *TO* *INTERVIEWER*

@: Stressors and Supports

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: Stressors and Supports

*GUIDE* *TO* *INTERVIEWER*

@: *Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from coworkers, from participation in religion or spirituality).*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: 7. Are there any kinds of supports that make his/her [PROBLEM] better, such as from family, friends, or others?

*GUIDE* *TO* *INTERVIEWER*

@: *Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

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

*GUIDE* *TO* *INTERVIEWER*

@: Role of Cultural Identity

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: Role of Cultural Identity

*GUIDE* *TO* *INTERVIEWER*

@: —

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: Sometimes, aspects of people's background or identity can make the [PROBLEM] better or worsedd*Bybackground* or*'identityea-* I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion.

*GUIDE* *TO* *INTERVIEWER*

@: Así@cc*the informant to reflect on the most salient elements of the individual's cultural identity. Use this information to tailor questions 10-11 as needed.*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: 9. For you, what are the most important

*GUIDE* *TO* *INTERVIEWER*

@: *Elicit aspects of identity that make the problem better or worse.*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: 10. Are there any aspects of [INDIVIDUAL's] background or identity that make a difference to his/her [PROBLEM]?

*GUIDE* *TO* *INTERVIEWER*

@: *Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: 11. Are there any aspects of [INDIVIDUAL's] background or identity that are causing other concerns or difficulties for him/her? ―――――――757

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*GUIDE* *TO* *INTERVIEWER*

@: CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

*GUIDE* *TO* *INTERVIEWER*

@: *Clarify individual's self-coping for the problem.*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

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

*GUIDE* *TO* *INTERVIEWER*

@: Past Help Seeking

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: Past Help Seeking

*GUIDE* *TO* *INTERVIEWER*

@: *Elicit various sources of help* (*e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other alternative healing* 7$

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: 13. Often, people also look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing has [INDIVIDUAL] sought for his/ her [PROBLEM]?

*GUIDE* *TO* *INTERVIEWER*

@: Barriers

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: Barriers

*GUIDE* *TO* *INTERVIEWER*

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

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

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

*GUIDE* *TO* *INTERVIEWER*

@: CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

*GUIDE* *TO* *INTERVIEWER*

@: Preferences

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: Preferences

*GUIDE* *TO* *INTERVIEWER*

@: *Clarify individual's current perceived needs and*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: Now let's talk about the help [INDIVIDUAL] needs. 15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]?

*GUIDE* *TO* *INTERVIEWER*

@: *Focus on the views of the social network regarding help seeking.*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

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

*GUIDE* *TO* *INTERVIEWER*

@: Clinician-Patient Relationship

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: Clinician-Patient Relationship

*GUIDE* *TO* *INTERVIEWER*

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

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

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

*GUIDE* *TO* *INTERVIEWER*

@: *delivery. Probe details as needed* (*eddg.,* "*In* *what* *way?"* 7*Address* possible barriers to care or concerns *about*

*INSTRUCTIONS TO THE INTERVIEWER AREITALICIZED.*

@: 17. Have you been concerned about this, and is there anything that we can do to provide [INDIVIDUAL] with the care he/she needs? ―――――――758

Cultural Concepts of Distress

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

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

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

\* There is seldom a one-to-one correspondence of any cultural concept with a DSM diagnostic entity; the correspondence is more likely to be one-to-many in either direction. Symptoms or behaviors that might be sorted by DSM-5 into several disorders may be included in a single folk concept, and diverse presentations that might be classified by DSM-5 as variants of a single disorder may be sorted into several distinct concepts by an indigenous diagnostic system.

\* Cultural concepts may apply to a wide range of severity, including presentations that do not meet DSM criteria for any mental disorder. For example, an individual with acute grief or a social predicament may use the same idiom of distress or display the same cultural syndrome as another individual with more severe psychopathology.

\* In common usage, the same cultural term frequently denotes more than one type of cultural concept. A familiar example may be the concept of "depression," which may be used to describe a syndrome (e.g., major depressive disorder), an idiom of distress (e.g., as in the common expression "I feel depressed"), or a perceived cause (similar to "stress").

\* Like culture and DSM itself, cultural concepts may change over time in response to both local and global influences.

Cultural concepts are important to psychiatric diagnosis for several reasons:

\* *To* *avoid* *misdiagnosis:* Cultural variation in symptoms and in explanatory models associated with these cultural concepts may lead clinicians to misjudge the severity of a ―――――――759

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

\* *To obtain useful clinical information:* Cultural variations in symptoms and attributions may be associated with particular features of risk, resilience, and outcome.

\* *To improve clinical rapport and engagement:* "Speaking the language of the patient," both linguistically and in terms of his or her dominant concepts and metaphors, can result in greater communication and satisfaction, facilitate treatment negotiation, and lead to higher retention and adherence.

\* *To improve therapeutic efficacy:* Culture influences the psychological mechanisms of disorder, which need to be understood and addressed to improve clinical efficacy. For example, culturally specific catastrophic cognitions can contribute to symptom escalation into panic attacks.

\* *To guide clinical research:* Locally perceived connections between cultural concepts may help identify patterns of comorbidity and underlying biological substrates.

\* *To clarify the cultural epidemiology:* Cultural concepts of distress are not endorsed uniformly by everyone in a given culture. Distinguishing syndromes, idioms, and explanations provides an approach for studying the distribution of cultural features of illness across settings and regions, and over time. It also suggests questions about cultural determinants of risk, course, and outcome in clinical and community settings to enhance the evidence base of cultural research.

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

\* *Data in DSM-5 criteria and text for specific disorders:* The text includes information on cultural variations in prevalence, symptomatology, associated cultural concepts, and other clinical aspects. It is important to emphasize that there is no one-to-one correspondence at the categorical level between DSM disorders and cultural concepts. Differential diagnosis for individuals must therefore incorporate information on cultural variation with information elicited by the CFI.

\* *Other Conditions That May Be a Focus of Clinical Attention:* Some of the clinical concerns identified by the CFI may correspond to V codes or Z codes—for example, acculturation problems, parent-child relational problems, or religious or spiritual problems.

\* *Glossary of Cultural Concepts of Distress:* Located in the Appendix, this glossary provides examples of well-studied cultural concepts of distress that illustrate the relevance of cultural information for clinical diagnosis and some of the interrelationships among cultural syndromes, idioms of distress, and causal explanations. ―――――――760

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Alternative DSM-5 Model for Personality Disorders

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

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

General Criteria for Personality Disorder

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.

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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 psy-chopathology 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 ―――――――763

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. ―――――――764

\* 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 Aand 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. ―――――――765

*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 Dsvchooathic 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; ―――――――766

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 possibilities; ―――――――767

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

*3.*  *Separation* *insecurity* (an aspect of *Negative* *Affectivity):* Fears of rejection by— and/or separation from—significant others, associated with fears of excessive dependency and complete loss of autonomy.

*4.*  *Depressivity* (an aspect of *Negative* *Affectivity):* Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.

*5.*  *Impulsivity* (an aspect of *Disinhibition):* Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.

*6.*  *Risk* *taking* (an aspect of *Disinhibition):* Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger.

*7.*  *Hostility* (an aspect of *Antagonism):* Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.

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

Narcissistic Personality Disorder

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

Proposed Diagnostic Criteria

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

*1.*  *Identity:* Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal inflated or deflated, or vacillating between extremes; emotional regulation mirrors fluctuations in self-esteem.

*2.*  *Self-direction:* Goal setting based on gaining approval from others; personal standards unreasonably high in order to see oneself as exceptional, or too low based on a sense of entitlement; often unaware of own motivations.

*3.*  *Empathy:* Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- or underestimate of own effect on others.

*4.*  *Intimacy:* Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain. ―――――――768

*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* 7@: 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* 7@: Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships. ―――――――769

*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., anxious-ness) 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. ―――――――770

*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. ―――――――771

*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. ―――――――772

*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 ―――――――773

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 ―――――――774

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. ―――――――775

TABLE 2 Level of Personality Functioning Scale

The following table is in

listed format. For each cell the

heading is shown followed by a

colon, space and the cell contents

*SELF*

@: *Level* *of* *impairment*

*SELF*

@: *Identity*

*SELF*

@: *Self-direction*

*INTERPERSONAL*

@: *Empathy*

*INTERPERSONAL*

@: *Intimacy*

*SELF*

@: 0—Little or no impairment

*SELF*

@: Has ongoing awareness of a unique self; maintains role-appropriate boundaries.

*SELF*

@: Sets and aspires to reasonable goals based on a realistic assessment of personal capacities.

*INTERPERSONAL*

@: Is capable of accurately understanding others' experiences and motivations in most situations.

*INTERPERSONAL*

@: Maintains multiple satisfying and enduring relationships in personal and community life.

*SELF*

@: 1—Some impairment

*SELF*

@: Has relatively intact sense of self, with some decrease in clarity of boundaries when strong emotions and mental distress are experienced.

*SELF*

@: Is excessively goal-directed, somewhat goal-inhibited, or conflicted about goals.

*INTERPERSONAL*

@: 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.

*INTERPERSONAL*

@: Is able to establish enduring relationships in personal and community life, with some limitations on degree of depth and satisfaction. ―――――――776

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The following table is in

listed format. For each cell the

heading is shown followed by a

colon, space and the cell contents

@: *Level* *of* *impairment*

*SELF*

@: *Identity*

*SELF*

@: *Self-direction*

*INTERPERSONAL*

@: *Empathy*

*INTERPERSONAL*

@: *Intimacy*

@: 2—Moderate impairment

*SELF*

@: Depends excessively on others for identity definition, with compromised boundary delineation.

*SELF*

@: Goals are more often a means of gaining external approval than self-generated, and thus may lack coherence and/or stability.

*INTERPERSONAL*

@: Is hyperattuned to the experience of others, but only with respect to perceived relevance to self.

*INTERPERSONAL*

@: Is capable of forming and desires to form relationships in personal and community life, but connections may be largely superficial. ―――――――777

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The following table is in

listed format. For each cell the

heading is shown followed by a

colon, space and the cell contents

*SELF*

@: *Level* *of* *impairment*

*SELF*

@: *Identity*

*SELF*

@: *Self-direction*

*INTERPERSONAL*

@: *Empathy*

*INTERPERSONAL*

@: *Intimacy*

*SELF*

@: 3—Severe impairment

*SELF*

@: Has a weak sense of autonomy/ agency; experience of a lack of identity, or emptiness. Boundary definition is poor or rigid: may show overídentification with others, overemphasis on independence from others, or vacillation between these.

*SELF*

@: Has difficulty establishing and /or achieving personal goals.

*INTERPERSONAL*

@: 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.

*INTERPERSONAL*

@: Has some desire to form relationships in community and personal life is present, but capacity for positive and enduring connections is significantly impaired. ―――――――778

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The following table is in

listed format. For each cell the

heading is shown followed by a

colon, space and the cell contents

*SELF*

@: *Level* *of* *impairment*

*SELF*

@: *Identity*

*SELF*

@: *Self-direction*

*INTERPERSONAL*

@: *Empathy*

*INTERPERSONAL*

@: *Intimacy*

*SELF*

@: 4—Extreme impairment

*SELF*

@: 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.

*SELF*

@: Has poor differentiation of thoughts from actions, so goal-setting ability is severely compromised, with unrealistic or incoherent goals.

*INTERPERSONAL*

@: Has pronounced inability to consider and understand others' experience and motivation.

*INTERPERSONAL*

@: Desire for affiliation is limited because of profound disinterest or expectation of harm. Engagement with others is detached, disorganized, or consistently negative. ―――――――779

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

The following table is in

list format. Headings and columns

are separated by a colon and one

blank cell. Blank cells

contain two dashes.

*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 Suspiciousness Restricted affectivity (lack of) @: *See* Detachment.  *See* Detachment.

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 nor-matively 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. ―――――――780

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The following table is in

list format. Headings and columns

are separated by a colon and one

blank cell. Blank cells

contain two dashes.

*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 @: 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. ―――――――781

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The following table is in

listed format. For each cell the

heading is shown followed by a

colon, space and the cell contents

*DOMAINS* (*Polar* *Opposites)*

@: *and* *Facets*

*DOMAINS* (*Polar* *Opposites)*

@: *Definitions*

*DOMAINS* (*Polar* *Opposites)*

@: PSYCHOTICISM (vs. Lucidity)

*DOMAINS* (*Polar* *Opposites)*

@: 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).

*DOMAINS* (*Polar* *Opposites)*

@: Unusual beliefs and experiences

*DOMAINS* (*Polar* *Opposites)*

@: Belief that one has unusual abilities, such as mind reading, telekinesis, thought-action fusion, unusual experiences of reality, including hallucination-like experiences.

*DOMAINS* (*Polar* *Opposites)*

@: Eccentricity

*DOMAINS* (*Polar* *Opposites)*

@: Odd, unusual, or bizarre behavior, appearance, and/or speech; having strange and unpredictable thoughts; saying unusual or inappropriate things.

*DOMAINS* (*Polar* *Opposites)*

@: Cognitive and perceptual dysregulation

*DOMAINS* (*Polar* *Opposites)*

@: Odd or unusual thought processes and experiences, including depersonalization, derealization, and dissociative experiences; mixed sleep-wake state experiences; thought-control experiences. ―――――――782

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Conditions for Further Study

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

Attenuated Psychosis Syndrome

Proposed Criteria

*A.* At least one of the following symptoms is present in attenuated form, with relatively intact reality testing, and is of sufficient severity or frequency to warrant clinical attention:

*1.* Delusions.

*2.* Hallucinations.

*3.* Disorganized speech.

*B.* Symptomggness) must have been present at least once per week for the past month.

*C.* Symptomggness) must have begun or worsened in the past year.

*D.* Symptomggness) is sufficiently distressing and disabling to the individual to warrant clinical attention.

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

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

Diagnostic Features

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

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

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

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

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

Associated Features Supporting Diagnosis

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

Prevalence

The prevalence of attenuated psychosis syndrome is unknown. Symptoms in Criterion A are not uncommon in the non-help-seeking population, ranging from 8%combleac% for hallucinatory ―――――――785

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

Development and Course

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

Risk and Prognostic Factors

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

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

Functional Consequences of Attenuated Psychosis Syndrome

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

Differential Diagnosis

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

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

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

*Anxiety* *disorders.* Reality distortions that are temporally limited to an episode of an anxiety disorder and are descriptively more characteristic of an anxiety disorder do not ―――――――786

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

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

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

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

Extreme end of perceptual aberration and magical thinking in the non-ill population.

This diagnostic possibility should be strongly entertained when reality distortions are not associated with distress and functional impairment and need for care.

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

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

Comorbidity

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

Depressive Episodes With Short-Duration Hypomania

Proposed Criteria

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

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

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

*2.* Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation). ―――――――787

*3.* Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (*Note:* In children, consider failure to make expected weight gain.)

*4.* Insomnia or hypersomnia nearly every day.

*5.* Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

*6.* Fatigue or loss of energy nearly every day.

*7.* Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

*8.* Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

*9.* Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

*B.* The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*C.* The disturbance is not attributable to the physiological effects of a substance or another medical condition.

*D.* The disturbance is not better explained by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

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

*A.* A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy.

*B.* During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:

*1.* Inflated self-esteem or grandiosity.

*2.* Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).

*3.* More talkative than usual or pressured to keep talking.

*4.* Flight of ideas or subjective experience that thoughts are racing.

*5.* Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.

*6.* Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.

*7.* Excessive involvement in activities that have a high potential for painful consequences (e.g., the individual engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

*C.* The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

*D.* The disturbance in mood and the change in functioning are observable by others.

*E.* The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

*F.* The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment). ―――――――788

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

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

Associated Features Supporting Diagnosis

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

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

Prevalence

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

Risk and Prognostic Factors

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

Suicide Risk

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

Functional Consequences of Short-Duration Hypomania

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

Differential Diagnosis

*Bipolar* *II* *disorder.* Bipolar II disorder is characterized by a period of at least 4 days of hypomanic symptoms, whereas short-duration hypomania is characterized by periods of ―――――――789

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

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

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

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

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

Comorbidity

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

Persistent Complex Bereavement Disorder

Proposed Criteria

*A.* The individual experienced the death of someone with whom he or she had a close relationship.

*B.* Since the death, at least one of the following symptoms is experienced on more days than not and to a clinically significant degree and has persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:

*1.* Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behavior, including behaviors that reflect being separated from, and also reuniting with, a caregiver or other attachment figure.

*2.* Intense sorrow and emotional pain in response to the death.

*3.* Preoccupation with the deceased.

*4.* Preoccupation with the circumstances of the death. In children, this preoccupation with the deceased may be expressed through the themes of play and behavior and may extend to preoccupation with possible death of others close to them.

*C.* Since the death, at least six of the following symptoms are experienced on more days than not and to a clinically significant degree, and have persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children: ―――――――790

Reactive distress to the death

*1.* Marked difficulty accepting the death. In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.

*2.* Experiencing disbelief or emotional numbness over the loss.

*3.* Difficulty with positive reminiscing about the deceased.

*4.* Bitterness or anger related to the loss.

*5.* Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame).

*6.* Excessive avoidance of reminders of the loss (e.g., avoidance of individuals, places, or situations associated with the deceased; in children, this may include avoidance of thoughts and feelings regarding the deceased).

Social/identity disruption

*7.* A desire to die in order to be with the deceased.

*8.* Difficulty trusting other individuals since the death.

*9.* Feeling alone or detached from other individuals since the death.

*10.* Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased.

*11.* Confusion about one's role in life, or a diminished sense of one's identity (e.g., feeling that a part of oneself died with the deceased).

*12.* Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities).

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

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

*Specify* if:

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

Diagnostic Features

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

Six additional symptoms are required, including marked difficulty accepting that the individual has died (Criterion C1) (e.g. preparing meals for them), disbelief that the individual is dead (Criterion C2), distressing memories of the deceased (Criterion C3), anger over the loss (Criterion Cbled), maladaptive appraisals about oneself in relation to the deceased or the death (Criterion C5), and excessive avoidance of reminders of the loss (Criterion C6). Individuals may also report a desire to die because they wish to be with the deceased (Criterion C7); be distrustful of others (Criterion C8); feel isolated (Criterion C9); believe that life has no meaning or purpose without the deceased (Criterion C10); experience a diminished sense of identity in which they feel a part of themselves has died or been lost (Criterion C11); or have difficulty engaging in activities, pursuing relationships, or planning for the future (Criterion C12). ―――――――791

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

Associated Features Supporting Diagnosis

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

Prevalence

The prevalence of persistent complex bereavement disorder is approximately 2.4%combled*h%.* The disorder is more prevalent in females than in males.

Development and Course

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

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

Risk and Prognostic Factors

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

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

Culture-Related Diagnostic Issues

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

Suicide Risk

Individuals with persistent complex bereavement disorder frequently report suicidal ideation. ―――――――792

Functional Consequences of Persistent Complex Bereavement Disorder

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

Differential Diagnosis

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

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

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

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

Comorbidity

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

Caffeine Use Disorder

Proposed Criteria

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

*1.* A persistent desire or unsuccessful efforts to cut down or control caffeine use.

*2.* Continued caffeine use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by caffeine. ―――――――793

*3.* Withdrawal, as manifested by either of the following:

*a.* The characteristic withdrawal syndrome for caffeine.

*but.* Caffeine (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

*4.* Caffeine is often taken in larger amounts or over a longer period than was intended.

*5.* Recurrent caffeine use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated tardiness or absences from work or school related to caffeine use or withdrawal).

*6.* Continued caffeine use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of caffeine (e.g., arguments with spouse about consequences of use, medical problems, cost).

*7.* Tolerance, as defined by either of the following:

*a.* A need for markedly increased amounts of caffeine to achieve desired effect.

*but.* Markedly diminished effect with continued use of the same amount of caffeine.

*8.* A great deal of time is spent in activities necessary to obtain caffeine, use caffeine, or recover from its effects.

*9.* Craving or a strong desire or urge to use caffeine.

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

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

Diagnostic Features

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

Among those seeking treatment for quitting problematic caffeine use, 88% reported having made prior serious attempts to modify caffeine use, and 43% reported having been advised by a medical professional to reduce or eliminate caffeine. Ninety-three percent endorsed signs and symptoms meeting DSM-IV criteria for caffeine dependence, with the ―――――――794

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

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

Prevalence

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

Development and Course

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

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

Risk and Prognostic Factors

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

Functional Consequences of Caffeine Use Disorder

Caffeine use disorder may predict greater use of caffeine during pregnancy. Caffeine withdrawal, a key feature of caffeine use disorder, has been shown to produce functional impairment ―――――――795

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

Differential Diagnosis

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

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

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

Comorbidity

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

Internet Gaming Disorder

Proposed Criteria

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

*1.* Preoccupation with Internet games. (The individual thinks about previous gaming activity or anticipates playing the next game; Internet gaming becomes the dominant activity in daily life).

*Note:* This disorder is distinct from Internet gambling, which is included under gambling disorder.

*2.* Withdrawal symptoms when Internet gaming is taken away. (These symptoms are typically described as irritability, anxiety, or sadness, but there are no physical signs of pharmacological withdrawal.)

*3.* Tolerance—the need to spend increasing amounts of time engaged in Internet games.

*4.* Unsuccessful attempts to control the participation in Internet games.

*5.* Loss of interests in previous hobbies and entertainment as a result of, and with the exception of, Internet games.

*6.* Continued excessive use of Internet games despite knowledge of psychosocial problems.

*7.* Has deceived family members, therapists, or others regarding the amount of Internet gaming.

*8.* Use of Internet games to escape or relieve a negative mood (e.g., feelings of helplessness, guilt, anxiety).

*9.* Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of participation in Internet games. ―――――――796

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

Specify current severity:

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

Subtypes

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

Diagnostic Features

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

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

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

Internet gaming disorder is a pattern of excessive and prolonged Internet gaming that results in a cluster of cognitive and behavioral symptoms, including progressive loss of control over gaming, tolerance, and withdrawal symptoms, analogous to the symptoms of substance use disorders. As with substance-related disorders, individuals with Internet gaming disorder continue to sit at a computer and engage in gaming activities despite neglect of other activities. They typically devote 8-10 hours or more per day to this activity and at least 30 hours per week. If they are prevented from using a computer and returning to the game, they become agitated and angry. They often go for long periods without food or sleep. Normal ―――――――797

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

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

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

Associated Features Supporting Diagnosis

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

Prevalence

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

Risk and Prognostic Factors

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

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

Functional Consequences of Internet Gaming Disorder

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

Differential Diagnosis

Excessive use of the Internet not involving playing of online games (e.g., excessive use of social media, such as Facebook; viewing pornography online) is not considered analogous ―――――――798

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

Comorbidity

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

Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure

Proposed Criteria

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

B. Impaired neurocognitive functioning as manifested by one or more of the following:

*1.* Impairment in global intellectual performance (i.e., IQ of 70 or below, or a standard score of 70 or below on a comprehensive developmental assessment).

*2.* Impairment in executive functioning (e.g., poor planning and organization; inflexibility; difficulty with behavioral inhibition).

*3.* Impairment in learning (e.g., lower academic achievement than expected for intellectual level; specific learning disability).

*4.* Memory impairment (e.g., problems remembering information learned recently; repeatedly making the same mistakes; difficulty remembering lengthy verbal instructions).

*5.* Impairment in visual-spatial reasoning (e.g., disorganized or poorly planned drawings or constructions; problems differentiating left from right).

*C.* Impaired self-regulation as manifested by one or more of the following:

*1.* Impairment in mood or behavioral regulation (e.g., mood lability; negative affect or irritability; frequent behavioral outbursts).

*2.* Attention deficit (e.g., difficulty shifting attention; difficulty sustaining mental effort).

*3.* Impairment in impulse control (e.g., difficulty waiting turn; difficulty complying with rules).

*D.* Impairment in adaptive functioning as manifested by two or more of the following, one of which must be (1) or (2):

*1.* Communication deficit (e.g., delayed acquisition of language; difficulty understanding spoken language).

*2.* Impairment in social communication and interaction (e.g., overly friendly with strangers; difficulty reading social cues; difficulty understanding social consequences).

*3.* Impairment in daily living skills (e.g., delayed toileting, feeding, or bathing; difficulty managing daily schedule).

*4.* Impairment in motor skills (e.g., poor fine motor development; delayed attainment of gross motor milestones or ongoing deficits in gross motor function; deficits in coordination and balance).

*E.* Onset of the disorder (symptoms in Criteria B, C, and D) occurs in childhood. ―――――――799

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

*G.* The disorder is not better explained by the direct physiological effects associated with postnatal use of a substance (e.g., a medication, alcohol or other drugs), a general medical condition (e.g., traumatic brain injury, delirium, dementia), another known teratogen (e.g., fetal hydantoin syndrome), a genetic condition (e.g., Williams syndrome, Down syndrome, Cornelia de Lange syndrome), or environmental neglect.

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

Diagnostic Features

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

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

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

Associated Features Supporting Diagnosis

Associated features vary depending on age, degree of alcohol exposure, and the individual's environment. An individual can be diagnosed with this disorder regardless of socioeconomic or cultural background. However, ongoing parental alcohol/substance misuse, parental mental illness, exposure to domestic or community violence, neglect or abuse, disrupted caregiving relationships, multiple out-of-home placements, and lack of continuity in medical or mental health care are often present. ―――――――800

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

Development and Course

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

Suicide Risk

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

Functional Consequences of Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure

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

Differential Diagnosis

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

*Genetic and teratogenic conditions.* Genetic conditions such as Williams syndrome, Down syndrome, or Cornelia de Lange syndrome and other teratogenic conditions such as fetal hydantoin syndrome and maternal phenylketonuria may have similar physical and behavioral characteristics. A careful review of prenatal exposure history is needed to clarify the teratogenic agent, and an evaluation by a clinical geneticist may be needed to distinguish physical characteristics associated with these and other genetic conditions. ―――――――801

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

Suicidal Behavior Disorder

Proposed Criteria

*A.* Within the last 24 months, the individual has made a suicide attempt.

*Note:* A suicide attempt is a self-initiated sequence of behaviors by an individual who, at the time of initiation, expected that the set of actions would lead to his or her own death. The "time of initiation" is the time when a behavior took place that involved applying the method.)

*B.* The act does not meet criteria for nonsuicidal self-injury—that is, it does not involve self-injury directed to the surface of the body undertaken to induce relief from a negative feeling/cognitive state or to achieve a positive mood state.

*C.* The diagnosis is not applied to suicidal ideation or to preparatory acts.

*D.* The act was not initiated during a state of delirium or confusion.

*E.* The act was not undertaken solely for a political or religious objective.

*Specify* if:

*Current:* Not more than 12 months since the last attempt.

*In* *early* *remission:* 12-24 months since the last attempt.

Specifiers

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

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

Diagnostic Features

The essential manifestation of suicidal behavior disorder is a suicide attempt. A *suicide* *attempt* is a behavior that the individual has undertaken with at least some intent to die. The behavior might or might not lead to injury or serious medical consequences. Several factors can influence the medical consequences of the suicide attempt, including poor planning, lack of knowledge about the lethality of the method chosen, low intentionality or ambivalence, or chance intervention by others after the behavior has been initiated. These should not be considered in assigning the diagnosis. ―――――――802

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

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

Development and Course

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

Culture-Related Diagnostic Issues

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

Diagnostic Markers

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

Functional Consequences of Suicidal Behavior Disorder

Medical conditions (e.g., lacerations or skeletal trauma, cardiopulmonary instability, inhalation of vomit and suffocation, hepatic failure consequent to use of paracetamol) can occur as a consequence of suicidal behavior. ―――――――803

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

Nonsuicidal Self-Injury

Proposed Criteria

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

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

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

*1.* To obtain relief from a negative feeling or cognitive state.

*2.* To resolve an interpersonal difficulty.

*3.* To induce a positive feeling state.

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

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

*1.* Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.

*2.* Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control.

*3.* Thinking about self-injury that occurs frequently, even when it is not acted upon.

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

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

*F.* The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental disorder or medical condition (e.g., psychotic disorder, autism spectrum disorder, intellectual disability, Lesch-Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania [hair-pulling disorder], excoriation [skin-picking] disorder). ―――――――804

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

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

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

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

Development and Course

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

Risk and Prognostic Factors

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

Two theories of psychopathology—based on functional behavioral analyses—have been proposed: In the first, based on learning theory, either positive or negative reinforcement sustains the behavior. Positive reinforcement might result from punishing oneself in a way that the individual feels is deserved, with the behavior inducing a pleasant and relaxed state or generating attention and help from a significant other, or as an expression of anger. Negative reinforcement results from affect regulation and the reduction of unpleasant emotions or avoiding distressing thoughts, including thinking about suicide. In the second theory, nonsuicidal self-injury is thought to be a form of self-punishment, in which self-punitive actions are engaged in to make up for acts that caused distress or harm to others. ―――――――805

Functional Consequences of Nonsuicidal Self-Injury

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

Differential Diagnosis

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

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

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

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

*Trichotillomania* (*hair-pulling* *disorder).* Trichotillomania is an injurious behavior confined to pulling out one's own hair, most commonly from the scalp, eyebrows, or eyelashes. The behavior occurs in "sessions" that can last for hours. It is most likely to occur during a period of relaxation or distraction. ―――――――806

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

*Excoriation* (*skin-picking)* *disorder.* Excoriation disorder occurs mainly in females and is usually directed to picking at an area of the skin that the individual feels is unsightly or a blemish, usually on the face or the scalp. As in nonsuicidal self-injury, the picking is often preceded by an urge and is experienced as pleasurable, even though the individual realizes that he or she is harming himself or herself. It is not associated with the use of any implement. ―――――――807