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Assessment Measures

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Assessment Measures A growing body of scientific evidence favors dimensional concepts in the diagnosis of mental disorders. 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), need for intermediate categories like schizoaffective disorder, high rates of comorbidity, need for frequent use of other or unspecified diagnoses, relative lack of utility in furthering 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 to better capture the heterogeneity in the presentation of various mental and substance use disorders. Such an approach allows clinicians or others to better communicate particular variation of features that apply to presentations that meet criteria for a disorder. Such features include differential severity of individual symptoms (including symptoms that are part of the diagnostic features as well as those that are associated with the disorder) as measured by intensity, duration, and impact on functioning. This combined approach also allows clinicians or others to identify conditions that do not meet criteria for a disorder but are severe and disabling and in need of treatment. It is expected that as the understanding of basic disease mechanisms for mental and substance use disorders based on pathophysiology, neurocircuitry, and gene-environment interactions increases, more objective measures of psychopathology will be incorporated into the diagnostic criteria sets to enhance their accuracy. Until such time, a dimensional approach depending primarily on an individual's subjective reports of symptom experiences along with the clinician's interpretation is highlighted by current psychiatric evaluation guidelines as an important step in enhancing diagnostic practice. Cross-cutting symptom measures, modeled on general medicine's review of systems, can serve as an approach for reviewing critical psychopathological domains across age groups and diagnoses. The general medical review of systems—a list of questions arranged by organ systems—is crucial to detecting signs and symptoms of dysfunction and disease with which the individual may or may not present that can facilitate diagnosis and treatment. A similar review of various mental systems (or domains), which is the goal of the cross-cutting symptom measures, can aid in a more comprehensive mental status assessment of individuals at the initial evaluation. The review of mental systems can systematically draw attention to signs and symptoms of other domains of mental health and functioning that may be important to the individual's care. The cross-cutting measures have two levels of inquiry: Level 1 uses 1 to 3 questions for each of 13 symptom domains for adults (self-rated) and 12 domains for children (ages 6–17, parent rated) and adolescents (child rated, ages 11–17) to identify emerging signs and symptoms. Level 2 questions

provide a more in-depth assessment of certain domains (e.g., depression, anxiety, mania, anger, irritability, somatic symptoms). These measures are developed to be administered

both at initial interview and at follow-up visits. Thus, use of these measures can form key aspects of measurement-based care, the process by which standardized assessment tools are administered and results used to track individuals' progress over time to guide a more precise plan of care. Use of these measures ultimately aims to inform measurement-based care by identifying areas of emerging symptoms and concerns as well as supporting ongoing symptom monitoring, treatment adjustment, and outcomes critical to the provision of quality care for individuals with mental and substance use disorders. As a result, these cross-cutting symptom measures have been identified as important components of psychiatric diagnostic assessment in clinical practice guidelines. 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 (e.g., use of the Clinician-Rated Dimensions of Psychosis Symptom Severity in individuals whose symptoms meet criteria for schizophrenia). Some of the assessments are selfrated, while others are rated by the clinician based on observation of the individual. As with the cross-cutting symptom measures, these measures can be administered both at initial interview and over time to track the severity of the individual's disorder and response to treatment. These assessments help operationalize symptom frequency, intensity, or duration; overall symptom severity; or symptom type (e.g., depression, anxiety, sleep disturbance) for many, though not all, DSM-5 diagnoses (e.g., generalized anxiety disorder, social anxiety disorder, psychotic disorders, posttraumatic stress disorder, autism spectrum disorder, and social (pragmatic) communication disorder). Data obtained from use of these disorder-specific measures can assist with diagnosis and inform symptom monitoring and treatment planning. The World Health Organization Disability Assessment Schedule, Version 2.0 (WHODAS 2.0) was developed by the World Health Organization to assess an individual'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. This version of the scale is self-administered and was developed for individuals with any medical condition, not just mental disorders. 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 an individual's level of functioning. Assessment of functioning is a key aspect of psychiatric diagnostic assessment given that most DSM-5 criteria sets include a requirement that the disturbance causes clinically significant distress or impairment in functioning. Individuals with mental disorders are more likely to have severe impairment in functioning (i.e., communicating or understanding; getting along with others; carrying out daily activities at work, home, or school; participating in social activities) compared to individuals with chronic medical conditions. In addition, many individuals seek help for mental disorders because of the direct impact of their disorders on functional impairment across multiple domains and settings. Functional impairment may impact prognosis across diagnoses and, if residual functional impairment remains after symptoms subside, can lead to recurrence or relapse for conditions such as major depressive disorder and anxiety disorders. 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. Description of the child-rated version is not included in print given the overall similarity in items, scoring, and clinician instructions and guidelines with the parent/guardian-rated version. These measures, including the child-rated version, and additional dimensional assessments, such as 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 self- or informant-rated measure that assesses 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 major neurocognitive disorder), a knowledgeable adult informant may complete this measure. TABLE 1 Adult DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: 13 domains, thresholds for further inquiry, and associated DSM-5 Level 2 measures Domain Domain name Threshold to guide further inquiry DSM-5 Level 2 Cross-Cutting Symptom Measurea I. Depression Mild or greater Level 2—Depression—Adult (PROMIS Emotional Distress—Short Form) II. Anger Mild or greater Level 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form) III. Mania Mild or greater Level 2—Mania—Adult (Altman Self-Rating Mania Scale [ASRM]) IV. Anxiety Mild or greater Level 2—Anxiety—Adult (PROMIS Emotional Distress—Anxiety—Short Form) V. Somatic symptoms Mild or greater Level 2—Somatic Symptom—Adult (Patient Health Questionnaire–15 [PHQ-15] Somatic Symptom Severity Scale)

VI. Suicidal ideation Slight or greater None VII. Psychosis Slight or greater None VIII. Sleep problems Mild or greater Level 2—Sleep Disturbance—Adult (PROMIS Sleep Disturbance—Short Form) IX. Memory Mild or greater None X. Repetitive thoughts and behaviors Mild or greater Level 2—Repetitive Thoughts and Behaviors— Adult (Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale) XI. Dissociation Mild or greater None XII. Personality functioning Mild or greater None XIII. Substance use Slight or greater Level 2—Substance Use—Adult (adapted from the NIDA-Modified ASSIST) Note. NIDA = National Institute on Drug Abuse. aAvailable at www.psychiatry.org/dsm5. 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. In the DSM-5 Field Trials, in which the individual's symptom ratings were shared with the clinician before meeting, individuals reported that the results from the measure helped facilitate communication during the clinical encounter. Similarly, clinicians in both major academicmedical research institutions as well as routine clinical practice settings found the measures clinically useful and feasible for integration into everyday clinical care as well as specialty clinical settings. In addition to results from the DSM-5 Field Trials, several studies have evaluated the psychometric properties of the adult self-rated version of the cross-cutting symptom measure in a variety of populations. For example, findings from a large study of nontreatment-seeking college students across the United States demonstrated acceptable internal consistency and internal validity. 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. 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 Threshold to guide DSM-5 Level 2 Cross-Cutting Symptom

Scoring and interpretation. Domain Domain name further inquiry Measurea I. Somatic symptoms Mild or greater Level 2—Somatic Symptoms—Parent/Guardian of Child Age 6–17 (Patient Health Questionnaire–15 [PHQ-15] Somatic Symptom Severity Scale) II. Sleep problems Mild or greater Level 2—Sleep Disturbance—Parent/Guardian of Child Age 6–17 (PROMIS Sleep Disturbance— Short Form) III. Inattention Slight or greater Level 2—Inattention—Parent/Guardian of Child Age 6–17 (Swanson, Nolan, and Pelham, Version IV [SNAP-IV]) IV. Depression Mild or greater Level 2—Depression—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Depression—Parent Item Bank) V. Anger Mild or greater Level 2—Anger—Parent/Guardian of Child (PROMIS Calibrated Anger Measure—Parent) VI. Irritability Mild or greater Level 2—Irritability—Parent/Guardian of Child (Affective Reactivity Index [ARI]) VII. Mania Mild or greater Level 2—Mania—Parent/Guardian of Child Age 6–17 (Altman Self-Rating Mania Scale [ASRM]) VIII. Anxiety Mild or greater Level 2—Anxiety—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Anxiety —Parent Item Bank) IX. Psychosis Slight or greater None X. Repetitive thoughts and behaviors Mild or greater None XI. Substance use Yes Level 2—Substance Use—Parent/Guardian of Child Age 6–17 (adapted from the NIDAmodified ASSIST) Don't Know NIDA-modified ASSIST (adapted)—Child-Rated (age 11–17 years) XII. Suicidal ideation/suicide attempts Yes None Don't Know None Note. NIDA = National Institute on Drug Abuse. aAvailable at www.psychiatry.org/dsm5. On the adult self-rated version of the measure, each item is rated on a 5-point scale (0 = none or not at all; 1 = slight or rare, less than a day or two; 2 = mild or several days; 3 = moderate or more than half the days; and 4 = severe or nearly every day). The score on each item within a multi-item domain should be reviewed by the clinician, especially if a Level 2 cross-cutting symptom assessment is not indicated, to understand which specific symptom within a domain is most problematic (e.g., auditory hallucinations or thought broadcasting for the psychosis domain) to help guide further inquiry. However, a rating of mild (i.e., 2) or greater on any item within a domain, except for substance use, suicidal ideation, and psychosis, strongly suggests the need 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 1). For substance use, suicidal ideation, and psychosis, a 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, the rater should indicate the highest score within a domain in the "Highest domain score" column. Table 1 outlines threshold scores that may guide further inquiry for the remaining domains. On the parent/guardian-rated version of the measure (for children ages

6–17), 19 of the 25 items are each rated on a 5-point scale (0 = none or not at all; 1 = slight or rare, less than a day or two; 2 = mild or several days; 3 = moderate or more than half the days; and 4 = severe or nearly every day). The suicidal ideation, suicide attempt, and substance abuse items are each rated on a "Yes, No, or Don't Know" scale. The score on each item within a domain should be reviewed by the clinician to understand which specific symptom within a domain is most problematic (e.g., visual or auditory hallucination on the psychosis domain) to help guide further inquiry. 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 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. The clinician instructions and guidelines for the child-rated version are similar to those of the parent/guardian-rated version described above with the exception of the "Don't Know" response categories, which are not present in the child-rated version (see www.psychiatry.org/dsm5). 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 indepth 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. Frequency of Use of the Cross-Cutting Symptom Measures To track change in the individual's symptom presentation over time, the Level 1 and relevant Level 2 cross-cutting symptom measures may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. For individuals with impaired capacity and for children ages 6–17 years, it is preferable for the

measures to be completed at follow-up appointments by the same knowledgeable informant and by the same parent or guardian. Consistently high scores on a particular domain may indicate significant and problematic symptoms for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making. DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult Name:______________________________________ Age: __________ Date:_____________ If the measure is being completed by an informant, what is your relationship with the individual?: ________________ In a typical week, approximately how much time do you spend with the individual? _________________________ hours/week Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS. During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems? None Not at all Slight Rare, less than a day or two Mild Several

days Moderate More than half the days Severe Nearly every day Highest Domain Score (clinician) I.

1. Little interest or pleasure in doing things? 1 3
2. Feeling down, depressed, or hopeless? 1 3 II.
3. Feeling more irritated, grouchy, angry than usual? 1 3 III.
4. Sleeping less than usual, but still have a lot of energy? 1 3
5. Starting lots more projects than usual or doing more risky things than usual? 1 3 IV.
6. Feeling nervous, anxious, frightened, worried, or on edge? 1 3
7. Feeling panic or being frightened? 1 3
8. Avoiding situations that make you anxious? 1 3 V.
9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? 1 3
10. Feeling that your illnesses are not being taken seriously enough? 1 3 VI.
11. Thoughts of actually hurting yourself? 1 3 848 VII.
12. Hearing things other people couldn't hear, such as voices even when no one was around? 1 3
13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? 1 3 VIII.
14. Problems with sleep that affected your sleep quality overall? 1 3 IX.
15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? 1 3 X.
16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? 1 3
17. Feeling driven to perform certain behaviors or mental acts over and over again? 1 3 XI.
18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? 1 3 XII.
19. Not knowing who you really are or what you want out of life? 1 3
20. Not feeling close to other people or enjoying your relationships with them? 1 3 XIII.
21. Drink at least 4 drinks of any kind of alcohol in a single day? 1 3
22. Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco? 1 3
23. Use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? 1 3 849 Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name:________________ Age: __________ Date:_____________ Relationship to the child: ___________________________________ Instructions (to parent or guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past TWO (2) WEEKS. During the past TWO (2) WEEKS, how much (or how often) has your child… None Not at all Slight Rare, less than a day or two Mild Several days Moderate More than half the days Severe Nearly every day Highest Domain Score (clinician) I.

1. Complained of stomachaches, headaches, or other aches and pains? 1 3
2. Said he/she was worried about his/her health or about getting sick? 1 3 II.

3. Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early? 1 3 III.
4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game? 1 3 IV.
5. Had less fun doing things than he/she used to? 1 3
6. Seemed sad or depressed for several hours? 1 3 V. andVI.
7. Seemed more irritated or easily annoyed than usual? 1 3
8. Seemed angry or lost his/her temper? 1 3 VII.
9. Starting lots more projects than usual or doing more risky things than usual? 1 3
10. Sleeping less than usual for him/her but still has lots of energy? 1 3 VIII.
11. Said he/she felt nervous, anxious, or scared? 1 3
12. Not been able to stop worrying? 1 3
13. Said he/she couldn't do things he/she wanted to or should have done because they made him/her feel nervous? 1 3 850 IX.
14. Said that he/she heard voices— when there was no one there— speaking about him/her or telling him/her what to do or saying bad things to him/her? 1 3
15. Said that he/she had a vision when he/she was completely awake 1 3

—that is, saw something or someone that no one else could see? X. 16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else? 1 3 17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off? 1 3 18. Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned? 1 3 19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening? 1 3 In the past TWO (2) WEEKS, has your child … XI. 20. Had an alcoholic beverage (beer, wine, liquor, etc.)? ❑ Yes ❑ No ❑ Don't Know 21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? ❑ Yes ❑ No ❑ Don't Know 22. Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? ❑ Yes ❑ No ❑ Don't Know 23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? ❑ Yes ❑ No ❑ Don't Know XII. 24. In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide? ❑ Yes ❑ No ❑ Don't Know 25. Has he/she EVER tried to kill himself/herself? ❑ Yes ❑ No ❑ Don't Know Clinician-Rated Dimensions of Psychosis Symptom Severity As described in the chapter "Schizophrenia Spectrum and Other Psychotic Disorders," psychotic disorders are heterogeneous, and symptom severity can predict important aspects of the illness,

such as the degree of cognitive and/or neurobiological deficits. Dimensional assessments capture meaningful variation in the severity of symptoms, which may help with treatment planning, prognostic decision-making, and research on pathophysiological mechanisms. The ClinicianRated Dimensions of Psychosis Symptom Severity measure 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 and

prognosis. In addition, scales for dimensional assessment of depression and mania are provided, which may alert clinicians to co-occurring mood pathology. The severity of mood symptoms in psychosis has prognostic value and can guide 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 when it was at its most severe during the past 7 days. Scoring and Interpretation Each item on the measure is rated on a 5-point scale (0 = none; 1 = equivocal; 2 = present, but mild; 3 = present and moderate; and 4 = present and severe) with a symptom-specific definition of each rating level. The clinician reviews all of the individual's available information and, based on clinical judgment, selects (with checkmark) the level that most accurately describes the severity of the symptom domain. 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 always guide decision making. Clinician-Rated Dimensions of Psychosis Symptom Severity
Name:___________________________________ Age: _________ Date:_______________ Instructions: Based on all the information you have on the individual and using your clinical judgment, please rate (with checkmark) the presence and severity of the following symptoms as experienced by the individual, when each symptom was at its most severe, in the past seven (7) days. Domain 1 3 Score I. Hallucinations ❑ Not present ❑ Equivocal (severity or duration not sufficient to be considered psychosis) ❑ Present, but mild (little pressure to act upon voices or other types of hallucinations, not very ❑ Present and moderate (some pressure to respond to voices or other types of hallucinations, ❑ Present and severe (severe pressure to respond to voices or other types of hallucinations, or is very bothered

II. Delusions ❑ Not ❑ Equivocal (severity or present duration not sufficient to be considered psychosis) ❑ Not ❑ Equivocal (severity or III. Disorganized speech present duration not sufficient to be considered disorganization) ❑ Not ❑ Equivocal (severity or IV. Abnormal psychomotor behavior present duration not sufficient to be considered abnormal psychomotor behavior) ❑ Not ❑ Equivocal decrease in present facial expressivity, prosody, gestures, or selfinitiated behavior V. Negative symptoms (restricted emotional expression or avolition) ❑ Not ❑ Equivocal (cognitive VI. Impaired cognition present function not clearly outside the range expected for age or SES; i.e., within 0.5 SD of mean) VII. Depression ❑ Not ❑ Equivocal (occasionally present feels sad, down, depressed, or hopeless; concerned about having failed someone or at something but not preoccupied) VIII. Mania ❑ Not ❑ Equivocal (occasional present elevated, expansive, or irritable mood or some restlessness) bothered by hallucinations) or is somewhat bothered by hallucinations) by hallucinations) ❑ Present, but ❑ Present and ❑ Present and mild (little pressure to act upon delusional beliefs, not very bothered by such beliefs) moderate (some pressure to act upon delusional beliefs, or is somewhat bothered by such beliefs) severe (severe pressure to act upon delusional beliefs, or is very bothered by such beliefs) ❑ Present, but ❑ Present and ❑ Present and mild (some difficulty following speech) moderate (speech often difficult to follow) severe (speech almost impossible to follow) ❑ Present, but ❑ Present and ❑ Present and mild (occasional abnormal or bizarre motor behavior or catatonia) moderate (frequent abnormal or bizarre motor behavior or catatonia) severe (abnormal or bizarre motor behavior or catatonia almost constant) ❑

Present, but ❑ Present and ❑ Present and mild decrease in facial expressivity, prosody, gestures, or selfinitiated behavior moderate decrease in facial expressivity, prosody, gestures, or selfinitiated behavior severe decrease in facial expressivity, prosody, gestures, or self-initiated behavior ❑ Present, but ❑ Present and ❑ Present and mild (some reduction in cognitive function; below expected for age and SES, 0.5–1 SD from mean) moderate (clear reduction in cognitive function; below expected for age and SES, 1–2 SD from mean) severe (severe reduction in cognitive function; below expected for age and SES, > 2 SD from mean) ❑ Present, but ❑ Present and ❑ Present and mild (frequent periods of feeling very sad, down, moderately depressed, or hopeless; concerned about having failed someone or at something, with some preoccupation) moderate (frequent periods of deep depression or hopelessness; preoccupation with guilt, having done wrong) severe (deeply depressed or hopeless daily; delusional guilt or unreasonable selfreproach grossly out of proportion to circumstances) ❑ Present, but ❑ Present and ❑ Present and mild (frequent periods of somewhat elevated, expansive, or irritable mood or restlessness) moderate (frequent periods of extensively elevated, expansive, or irritable mood severe (daily and extensively elevated, expansive, or irritable mood or restlessness)

WHODAS 2.0 summary scores. WHODAS 2.0 domain scores. or restlessness) Note. SD = standard deviation; SES = socioeconomic status. World Health Organization Disability Assessment Schedule 2.0 The adult self-administered version of the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) is a 36-item measure that assesses disability in adults age 18 years and older. It has been validated across numerous cultures worldwide and demonstrated sensitivity to change. 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 major neurocognitive disorder), 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 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 for a maximum total raw score of 180. 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 requires 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 (i.e., for each item, the response options 1–5 are converted to a rate of 0–4, leading to a total raw score of 144). Step 2—Summing of all six domain scores. Step 3—Converting the summary score into a metric ranging from 0 to 100 (where 0 = no disability; 100 = full disability).

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

WHODAS 2.0 population norms. work/school), and participation. For the population norms for IRT-based scoring of the WHODAS 2.0 and for the population distribution of IRT-based scores for WHODAS 2.0, please see www.who.int/classifications/icf/Pop_norms_distrib_IRT_scores.pdf. Additional Scoring and Interpretation Guidance for DSM-5-TR 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, 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-TR recommends calculation and use of average scores for each domain and for general disability. The average scores are comparable to the WHODAS 5-point scale, which allows the clinician to think of the individual’s disability in terms of none (1), mild (2), moderate (3), severe (4), or extreme (5). The average domain and general disability scores were found to be reliable, easy to use, and clinically useful to the clinicians in the DSM-5 Field Trials. The average domain score is calculated by dividing the raw domain score by the number of items in the domain (e.g., if all the items within the “understanding and communicating” domain are rated as being moderate, then the average domain score would be 18/6 = 3, indicating moderate disability). The average general disability score is calculated by dividing the raw overall score by number of items in the measure (i.e., 36). The individual should be encouraged to complete all of the items on the WHODAS 2.0. If no response is given on 10 or more items of the measure (i.e., more than 25% of the 36 total items), calculation of the simple and average general disability scores may not be helpful. If 10 or more of the total items on the measure are missing but the items for some of the domains are 75%–100% complete, the simple or average domain scores may be used for those domains. Frequency of Use To track change in the individual’s level of disability over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual’s symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the individual that might warrant further assessment and intervention.

02 - Culture and Psychiatric Diagnosis

Culture and Psychiatric Diagnosis

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Culture and Psychiatric Diagnosis This chapter provides basic information on integrating culture and social context in clinical diagnoses, with sections on key terms, cultural formulation, and cultural concepts of distress. The first section defines terms that are essential to the rest of the chapter: culture, race, and ethnicity. The Cultural Formulation section presents an outline for a systematic person-centered cultural assessment that is designed to be used by any clinician providing services to any individual in any care setting. This section also includes an interview protocol, the Cultural Formulation Interview, that operationalizes these components. Symptom presentations, interpretations of the illness or predicament that precipitates care, and help-seeking expectations are always influenced by individuals' cultural backgrounds and sociocultural contexts. A person-centered cultural assessment can help improve the care of every individual, regardless of his or her background. Cultural formulation may be especially helpful for individuals who are affected by healthcare disparities driven by systemic disadvantage and discrimination. The Cultural Concepts of Distress section describes the ways individuals express, report, and interpret experiences of illness and distress. Cultural concepts of distress include idioms, explanations or perceived causes, and syndromes. Symptoms are expressed and communicated using cultural idioms of distress—behaviors or linguistic terms, metaphors, phrases, or ways of talking about symptoms, problems, or suffering that are commonly used by individuals with similar cultural backgrounds to convey a wide range of concerns. Such idioms may be used for a broad spectrum of distress and may not indicate a psychiatric disorder. Common contemporary idioms in the United States include "burnout," "feeling stressed," "nervous breakdown," and "feeling depressed," in the sense of experiencing dissatisfaction or discouragement that does not meet criteria for any psychiatric disorder. Culturally specific explanations and syndromes are also common and distributed widely across populations. This section also provides some illustrative examples of idioms, explanations, and syndromes from diverse geographic regions. The examples were chosen because they have been well studied and their lack of familiarity to many U.S. clinicians highlights their specific verbal and behavioral expressions and communicative functions. Key Terms Understanding the cultural context of illness experience is essential for effective diagnostic

assessment and clinical management. Culture refers to systems of knowledge, concepts, values, norms, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, customs, and ways of understanding health and illness, as well as moral, political, economic, 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 cultural contexts, which they use to fashion their own identities and make sense of experience. This process of meaning-making derives from developmental and everyday social experiences in specific contexts, including health care, which may vary for each individual. Much of culture involves background knowledge, values, and assumptions that remain implicit or presumed and so may be difficult for individuals to describe. These features of culture make it crucial not to overgeneralize cultural information or stereotype groups in terms of fixed cultural traits. In relation to diagnosis, it is essential to recognize that all forms of illness and distress, including the DSM disorders, are shaped by cultural contexts. Culture influences how individuals fashion their identities, as well as how they interpret and respond to symptoms and illness. Race is a social, not a biological, construct that divides humanity into groups based on a variety of superficial physical traits such as skin color that have been falsely viewed as indicating attributes and capacities assumed to be inherent to the group. Racial categories and constructs have varied over history and across societies and have been used to justify systems of oppression, slavery, and genocide. The construct of race is important for psychiatry because it can lead to racial ideologies, racism, discrimination, and social oppression and exclusion, which 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, ancestry, geography, language, religion, or other shared characteristics of a group, which distinguish that group from others. Ethnicity may be selfassigned or attributed by outsiders. Increasing mobility, intermarriage, and intermixing of cultural groups have defined new mixed, multiple, or hybrid ethnic identities. These processes may also lead to the dilution of ethnic identification. Culture, race, and ethnicity may be related to political, economic, and social structural inequities associated with racism and discrimination resulting in health disparities. Cultural, ethnic, and racialized identities can be sources of strength and group support that enhance resilience. They may also lead to psychological, interpersonal, and intergenerational conflict or difficulties in adaptation that require socially and culturally informed diagnosis and clinical assessment. Additional key terms related to racialization and racism are defined in the DSM-5TR Section I Introduction, under “Cultural and Social Structural Issues,” in the subsection “Impact of Racism and Discrimination on Psychiatric Diagnosis.” Cultural Formulation 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. This assessment provides useful information on social context and illness experience relevant to the assessment of every individual, not only those whose cultural background may be unfamiliar to the clinician.

861 Updated from DSM-5, DSM-5-TR includes an expanded version of the Outline and an approach to assessment using the Cultural Formulation Interview (CFI), which has been field-tested among clinicians, patients, and accompanying relatives and found to be a feasible, acceptable, and useful

cultural assessment tool. The Outline for Cultural Formulation calls for systematic assessment of the following categories: Cultural identity of the individual: Describe the individual's demographic (e.g., age, gender, ethnoracial background) or other socially and culturally defined characteristics that may influence interpersonal relationships, access to resources, and developmental and current challenges, conflicts, or predicaments. Other clinically relevant aspects of identity may include religious affiliation and spirituality, socioeconomic class, caste, personal and family places of birth and growing up, migrant status, occupation, and sexual orientation, among others. Note which aspects of identity are prioritized by the individual and how they interact (intersectionality), which may reflect the influence of clinical setting and health concerns. For migrants, the degree and kinds of involvement with both the cultural contexts of origin and the new cultural contexts should be noted. Similarly, for individuals who identify with racialized and ethnic groups, the degree of interaction and identification with their own group and other segments of society should be noted. Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and clinical communication or the need for an interpreter. Cultural concepts 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 include cultural idioms of distress, cultural explanations or perceived causes, and cultural syndromes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural background. Priority symptoms, perceived seriousness of the illness, the level of associated stigma, and anticipated outcomes are all relevant. Elicit the individual's and family's or friends' help-seeking expectations and plans, as well as patterns of self-coping and their connection to the individual's cultural concepts of distress, including past help-seeking experiences. 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, challenges, and supports in the individual's social environment (which may include both local and distant events). These include social determinants of the individual's mental health such as access to resources (e.g., housing, transportation) and opportunities (e.g., education, employment); exposure to racism, discrimination, and systemic institutional stigmatization; and social marginalization or exclusion (structural violence). Also assess the role of religion, family, and other interpersonal relationships and social networks (e.g., friends, neighbors, coworkers, online forums or groups) in causing stress or providing emotional, instrumental, and informational support. Social stressors and social supports vary with social context, family structure, developmental tasks, and the cultural meaning of events. Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural background. Cultural features of the relationship between the individual and the clinician, treatment team, and institution: Identify differences in cultural background, language, education, and social status among other aspects of identity between an individual and clinician (or the treatment team and institution) that may cause difficulties in communication and may influence diagnosis and treatment. Considering the ways that individuals and clinicians are positioned socially and perceive each other in terms of social categories may influence the assessment

process. 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 accurate assessment and 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 the differential diagnosis of mental disorders 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 protocols 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. The CFI consists of three components: the core CFI, a set of 16 questions that can be used to obtain an initial assessment from any individual; an Informant version of the core CFI to obtain collateral information; and a set of Supplementary modules to expand the evaluation as needed. In the CFI, the term culture includes: The processes through which individuals assign meaning to experience, drawing from the values, orientations, knowledge, and practices of the diverse social groups (e.g., ethnic groups, faith groups, occupational groups, veterans' groups) and communities in which they participate. Aspects of individuals' background, developmental experiences, and current social contexts and position that affect their perspective, such as age, gender, social class, geographic origin, migration, language, religion, sexual orientation, disability, or ethnic or racialized background. The influence of family, friends, and other community members (particularly, the individual's social network) on the individual's illness experience. The cultural background of the health care providers and the values and assumptions embedded in the organization and practices of health care systems and institutions that may affect the clinical interaction. Cultural processes involve interactions of the individual with local and larger social contexts. A cultural assessment thus evaluates processes both within the individual and in the social world, assessing the context as much as the person. The CFI is a brief semistructured interview for systematically assessing cultural factors relevant to the care of any individual. The CFI focuses on the individual's experience and the social contexts of the clinical problem, symptoms, or concerns. The CFI follows a personcentered 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 core CFI (and informant version) is included later in this chapter and is available online at www.psychiatry.org/dsm5; the Supplementary modules are also available online. The core CFI (and informant version) 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 before 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, ethnic or racialized background, 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 at any age, in any clinical setting, 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 in clinical practice when any of the following occur: 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. Divergent views of symptoms or expectations of care based on previous experience with other cultural systems of healing and health care. Disagreement between the individual and clinician on the course of care. Potential mistrust of mainstream services and institutions by individuals with collective histories of trauma and oppression. Limited engagement in and adherence to treatment by the individual. The core 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 clinician should integrate the information obtained from the CFI 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 core 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, caregivers, and immigrants and refugees. These supplementary modules are

referenced in the core CFI under the pertinent subheadings and are available online at www.psychiatry.org/dsm5. Core Cultural Formulation Interview (CFI) Supplementary modules used to expand each CFI subtopic are noted in parentheses. GUIDE TO INTERVIEWER INSTRUCTIONS TO THE INTERVIEWER ARE ITALICIZED. The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual’s social network (i.e., family, friends, or others involved in current problem). This includes the problem’s meaning, potential sources of help, and expectations for services. INTRODUCTION FOR THE INDIVIDUAL: I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers. CULTURAL DEFINITION OF THE PROBLEM CULTURAL DEFINITION OF THE PROBLEM (Explanatory Model, Level of Functioning) Elicit the individual’s view of core problems and key concerns. Focus on the individual’s own way of understanding the problem. Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., “your conflict with your son”).

1. What brings you here today? IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE: People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem? Ask how individual frames the problem for members of the social network.

2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them? Focus on the aspects of the problem that matter most to the individual.
3. What troubles you most about your problem? CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT CAUSES (Explanatory Model, Social Network, Older Adults) This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.
4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? PROMPT FURTHER IF REQUIRED: Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes. Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.
5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]? STRESSORS AND SUPPORTS (Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking) Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe 6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?

other supports (e.g., from co-workers, from participation in religion or spirituality). Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination. 7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems? ROLE OF CULTURAL IDENTITY (Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents) Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion. Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed. 8. For you, what are the most important aspects of your background or identity? Elicit aspects of identity that make the problem better or worse. 9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]? Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation). Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles). 10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you? CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING SELF-COPING (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors) Clarify self-coping for the problem. 11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]? PAST HELP SEEKING (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship) Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing). 12. Often, people

look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]? Probe as needed (e.g., "What other sources of help have you used?"). PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED: Clarify the individual's experience and regard for previous help. What types of help or treatment were most useful? Not useful? BARRIERS (Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship) Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. Probe details as needed (e.g., "What got in the way?"). 13. Has anything prevented you from getting the help you need? PROBE AS NEEDED: For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your

language or background? CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING PREFERENCES (Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking) Clarify individual's current perceived needs and expectations of help, broadly defined. Now let's talk some more about the help you need. Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?"). 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]? Focus on the views of the social network regarding help seeking. 15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now? CLINICIAN-PATIENT RELATIONSHIP (Clinician-Patient Relationship, Older Adults) Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Probe details as needed (e.g., "In what way?"). Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously. 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need? Cultural Formulation Interview (CFI)—Informant Version The CFI Informant Version collects collateral information from an informant who is knowledgeable about the clinical problems and life circumstances of the identified individual. This version can be used to supplement information obtained from the core CFI or can be used instead of the core CFI when the individual is unable to provide information (e.g., children or adolescents, individuals with florid psychosis, individuals with cognitive impairment). Cultural Formulation Interview (CFI)—Informant Version GUIDE TO INTERVIEWER INSTRUCTIONS TO THE INTERVIEWER ARE ITALICIZED. The following questions aim to clarify key aspects of the presenting clinical problem from the informant's point of view. This includes the problem's meaning, potential sources of help, and expectations for services. INTRODUCTION FOR THE INFORMANT: I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers. RELATIONSHIP WITH THE PATIENT Clarify the informant's relationship with the individual and/or the individual's family.

1. How would you describe your relationship to [INDIVIDUAL OR TO FAMILY]? PROBE IF NOT CLEAR: How often do you see [INDIVIDUAL]?

Elicit the informant's view of core problems and key concerns. Focus on the informant's way of understanding the individual's problem. Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "her conflict with her son"). Ask how informant frames the problem for members of the social network. Focus on the aspects of the problem that matter most to the informant. This question indicates the meaning of the condition for the informant, which may be relevant for clinical care. Note that informants may identify multiple causes depending on the facet of the problem they are considering. Focus on the views of members of the individual's social network. These may be diverse and vary from the informant's. Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality). Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination. Ask the informant to reflect on the most salient elements of the individual's cultural identity. Use this information to tailor questions 10–11 as needed. Elicit aspects of identity that make the problem better or worse. Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation). Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles). CULTURAL DEFINITION OF THE PROBLEM 2. What brings your family member/friend here today? IF INFORMANT GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE: People often understand problems in their own way, which may be similar or different from how doctors describe the problem. How would you describe [INDIVIDUAL'S] problem? 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? 4. What troubles you most about [INDIVIDUAL'S] problem? CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT CAUSES 5. Why do you think this is happening to [INDIVIDUAL]? What do you think are the causes of his/her [PROBLEM]? 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. 6. What do others in [INDIVIDUAL'S] family, his/her friends, or others in the community think is causing [INDIVIDUAL'S] [PROBLEM]? STRESSORS AND SUPPORTS 7. Are there any kinds of supports that make his/her [PROBLEM] better, such as from family, friends, or others? 8. Are there any kinds of stresses that make his/her [PROBLEM] worse, such as difficulties with money, or family problems? ROLE OF CULTURAL IDENTITY Sometimes, aspects of people's background or identity can make the [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion. 9. For you, what are the most important aspects of [INDIVIDUAL'S] background or identity? 10. Are there any aspects of [INDIVIDUAL'S] background or identity that make a difference to his/her [PROBLEM]? 11. Are there any aspects of [INDIVIDUAL'S] background or identity that are causing other concerns or difficulties for

him/her? CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING SELF-COPING Clarify individual's self-coping for the problem. 12. Sometimes people have various ways of dealing with problems like [PROBLEM]. What has [INDIVIDUAL] done on his/her own to cope with his/her [PROBLEM]? PAST HELP SEEKING Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other alternative healing). Probe as needed (e.g., "What other sources of help has he/she used?").

Clarify the individual's experience and regard for previous help. 13. Often, people also look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing has [INDIVIDUAL] sought for his/her [PROBLEM]? PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED: What types of help or treatment were most useful? Not useful? BARRIERS Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. 14. Has anything prevented [INDIVIDUAL] from getting the help he/she needs? Probe details as needed (e.g., "What got in the way?"). PROBE AS NEEDED: For example, money, work or family commitments, stigma or discrimination, or lack of services that understand his/her language or background? CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING PREFERENCES Clarify individual's current perceived needs and expectations of help, broadly defined, from the point of view of the informant. Now let's talk about the help [INDIVIDUAL] needs. Probe if informant lists only one source of help (e.g., "What other kinds of help would be useful to [INDIVIDUAL] at this time?"). 15. What kinds of help would be most useful to him/her at this time for his/her [PROBLEM]? Focus on the views of the social network regarding help seeking. 16. Are there other kinds of help that [INDIVIDUAL'S] family, friends, or other people have suggested would be helpful for him/her now? CLINICIAN-PATIENT RELATIONSHIP Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Probe details as needed (e.g., "In what way?"). Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously. 17. Have you been concerned about this, and is there anything that we can do to provide [INDIVIDUAL] with the care he/she needs?

Cultural Concepts of Distress Relevance for Diagnostic Assessment The term cultural concepts of distress refers to ways that individuals experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions. Three main types of cultural concepts of distress may be distinguished. 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. 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. These three cultural concepts of distress—cultural idioms of distress, cultural explanations, and cultural syndromes—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 extent to which cultural concepts of distress are characterized by highly idiosyncratic experiences that are restricted to specific geographic regions. 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 in turn are associated with coping strategies and patterns of help seeking. Cultural concepts of distress 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 of distress have four key features in relation to the DSM-5 nosology: There is seldom a one-to-one correspondence of any cultural concept of distress 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 cultural concept of distress, 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 of distress may apply to a wide range of symptom and functional 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 of distress. 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 an explanation or perceived cause (e.g., “the baby was born with emotional problems because his mother suffered from depression during her pregnancy”). Like culture and DSM itself, cultural concepts of distress may change over time in response to both local and global influences. Cultural concepts of distress are important to psychiatric diagnosis for several reasons: To enhance identification of individuals’ concerns and detection of psychopathology: Referring to cultural concepts of distress in screening instruments or in reviews of systems may facilitate identification of individuals’ concerns and enhance detection of psychopathology, as individuals may be more familiar with these cultural concepts of distress than with professional terminology. To avoid misdiagnosis: Cultural variation in symptoms and in explanatory models associated with these cultural concepts of distress may lead clinicians to misjudge the severity of a problem or assign the wrong diagnosis (e.g., socially warranted suspicion may be misunderstood as paranoia; unfamiliar symptom presentations may be misdiagnosed as psychosis). To obtain useful clinical information: Cultural variations in symptoms and attributions may be associated with particular features of risk, resilience, and outcome. Clinical exploration of cultural concepts of distress can elicit information on the role that specific contexts play in symptom development and course and in their response to coping strategies. To improve clinical rapport and engagement: “Speaking the language of the patient,” both linguistically and in terms of his or her dominant cultural concepts of distress 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 a 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 of distress may help identify patterns of comorbidity and underlying biological substrates. Cultural concepts of distress, particularly cultural syndromes, may also point to previously unrecognized disorders or variants that could be included in future nosological revisions (e.g., in a change from DSM-IV, the concept of possession was added to the DSM-5 criteria for dissociative identity disorder). To clarify cultural epidemiology: Cultural concepts of distress are not endorsed uniformly by everyone in a

given cultural context. Distinguishing cultural idioms of distress, cultural explanations, and cultural syndromes 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 of distress in order to improve the accuracy of diagnosis and the comprehensiveness of clinical assessment. Clinical assessment of individuals presenting with these cultural concepts of distress should determine whether their presentation meets DSM-5 criteria for a specified disorder or instead is best classified as an other

specified 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 caseby-case basis. In addition to the CFI and its informant and supplementary modules, DSM-5-TR contains the following information and tools that may be useful when integrating cultural information in clinical practice: Data in updated DSM-5-TR text for specific disorders: The text includes information on cultural variations in symptom expression; attributions for disorder causes or precipitants; factors associated with differential prevalence across demographic groups; cultural norms that may affect the threshold for pathology and the perceived severity of the condition; risk for misdiagnosis when evaluating individuals from socially oppressed ethnoracial or marginalized groups; associated cultural concepts of distress; and other material relevant to culturally informed diagnosis. It is important to emphasize that there is no one-to-one correspondence at the categorical level between DSM disorders and cultural concepts of distress. 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 one of the conditions or problems listed in the Section II chapter “Other Conditions That May Be a Focus of Clinical Attention” (e.g., acculturation problems, parent-child relational problems, religious or spiritual problems), along with the associated ICD-10-CM code. Examples of Cultural Concepts of Distress Clinicians need to familiarize themselves with individuals’ cultural concepts of distress to understand individuals’ concerns and facilitate accurate diagnostic assessment; use of the Cultural Formulation Interview may help in this regard. The following ten examples were selected to illustrate some of the ways in which cultural concepts of distress may affect the process of diagnosis. The principles illustrated with these examples can be applied to the myriad other cultural concepts of distress found in specific cultural contexts. The same term may be used for multiple types of cultural concepts of distress and clinical presentations, depending on context. Potentially, cultural concepts of distress can occur on their own or coexist with any psychiatric disorder and influence clinical presentation, course, and outcome. For example, in U.S. Latinx communities, ataque de nervios can be comorbid with nearly all psychiatric disorders. Each of the following examples of cultural concepts of distress includes a description of “Related conditions in DSM-5-TR” to highlight 1) the DSM-5 disorders that overlap phenomenologically with the cultural concept of distress (e.g., panic disorder and ataque de nervios, due to their paroxysmic nature and symptom similarity) and 2) the DSM-5 disorders that are frequently attributed to the causal explanation or idiom (e.g., PTSD and kufungisisa). Ataque de nervios Ataque de nervios (“attack of nerves”) is a syndrome found in Latinx cultural contexts,

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. characterized by symptoms of intense emotional upset, including acute anxiety, anger, or grief; screaming and shouting uncontrollably; attacks of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive. Dissociative experiences (e.g., depersonalization, derealization, amnesia), seizure-like or fainting episodes, and suicidal behavior are prominent in some ataques but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Attacks frequently occur as a direct result of a stressful event relating to the family, such as news of the death of a close relative, conflicts with a spouse or children, or witnessing an accident involving a family member. For a minority of individuals, no particular social or interpersonal event triggers their ataques; instead, their vulnerability to losing control comes from the accumulated experience of suffering. No one-to-one relationship has been found between ataque and any specific psychiatric disorder, although several disorders, including panic disorder, other specified or unspecified dissociative disorder, and functional neurological symptom disorder (conversion disorder), have symptomatic overlap with ataque. In community samples, ataque is reported among U.S. Latinx by 7%–15% of adults and 4%– 9% of youth, depending on region and Latinx subgroup. It is associated with suicidal thoughts, disability, and outpatient psychiatric utilization, after adjustment for psychiatric diagnoses, traumatic exposure, and other covariates. However, some ataques represent normative expressions of acute distress (e.g., at a funeral) without clinical sequelae. The term ataque de nervios may also refer to an idiom of distress that includes any “fit”-like paroxysm of emotionality (e.g., hysterical laughing) and may be used to indicate an episode of loss of control in response to an intense stressor. Indisposition in Haiti, blacking out in several West Indies and Caribbean countries, and falling out in the Southern United States. This use of the terms blacking out or falling out should not be confused with alcohol- or other substance-induced blackouts or amnesia. Panic attack, panic disorder, other specified or unspecified dissociative disorder, functional neurological symptom disorder, intermittent explosive disorder, other specified or unspecified anxiety disorder, other specified or unspecified trauma- and stressor-related disorder. Dhat syndrome Dhat syndrome is a term that was coined in South Asia little more than half a century ago to account for common clinical presentations of young men who attributed their various symptoms to semen loss. Despite the name, it is not a discrete syndrome but rather a cultural explanation of distress for individuals who refer to diverse symptoms, such as anxiety, fatigue, weakness, weight loss, erectile dysfunction, other multiple somatic complaints, and depressed mood. The cardinal feature is anxiety and distress about the loss of dhat in the absence of any identifiable physiological dysfunction. Dhat was identified by individuals as a white discharge that was noted on defecation or urination. Ideas about this substance are related to the concept of dhatu (semen) described in the Hindu system of medicine, Ayurveda, as one of seven essential bodily fluids whose balance is necessary to maintain health.

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Although dhat syndrome was formulated as a clinical category to help inform local clinical practice, related ideas about the harmful effects of semen loss have been shown to be widespread in the general population, suggesting a cultural disposition for explaining health problems and symptoms with reference to dhat-related concepts. Research in health care settings has yielded diverse estimates of the prevalence of dhat syndrome (e.g., 64% of men attending psychiatric clinics in India for sexual complaints; 30% of men attending general medical clinics in Pakistan). Although dhat syndrome is most commonly identified with young men from lower socioeconomic backgrounds, middle-age men may also be affected.

Comparable concerns about white vaginal discharge (leukorrhea) have been associated with a variant of the concept for women. The term dhat may also be used as an idiom and causal explanation for sexually transmitted infections (e.g., gonorrhea, chlamydia), in the absence of psychological distress. Koro in Southeast Asia, particularly Singapore, and shen-k'uei ("kidney deficiency") in China. Major depressive disorder, persistent depressive disorder, generalized anxiety disorder, somatic symptom disorder, illness anxiety disorder, erectile disorder, early (premature) ejaculation, other specified or unspecified sexual dysfunction, educational problems. Hikikomori Hikikomori (a Japanese term composed of hiku [to pull back] and moru [to seclude oneself]) is a syndrome of protracted and severe social withdrawal observed in Japan that may result in complete cessation of in-person interactions with others. The typical picture in hikikomori is an adolescent or young adult male who does not leave his room within his parents' home and has no in-person social interactions. This behavior may initially be ego-syntonic but usually leads to distress over time; it is often associated with high intensity of Internet use and virtual social exchanges. Other features include no interest or willingness to attend school or work. The 2010 guideline of the Japan Ministry of Health, Labor, and Welfare requires 6 months of social withdrawal for a diagnosis of hikikomori. The extreme social withdrawal seen in hikikomori may occur in the context of an established DSM-5 disorder ("secondary") or manifest independently ("primary"). Protracted social withdrawal among adolescents and young adults has been reported in many settings, including Australia, Bangladesh, Brazil, China, France, India, Iran, Italy, Oman, South Korea, Spain, Taiwan, Thailand, and the United States. Individuals with hikikomori-type behaviors in Japan, India, South Korea, and the United States tend to display high levels of loneliness, limited social networks, and moderate functional impairment. Social anxiety disorder, major depressive disorder, generalized anxiety disorder, posttraumatic stress disorder, autism spectrum disorder, schizoid personality disorder, avoidant personality disorder, schizophrenia or other psychotic disorder. The condition may also be associated with Internet gaming disorder and, in adolescents, with school refusal. Khyâl cap "Khyâl attacks" (khyâl cap), or "wind attacks," is a syndrome found in Cambodian cultural

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Related conditions in other cultural contexts. contexts. Common symptoms include those of panic attacks, such as dizziness, palpitations, shortness of breath, and cold extremities, as well as other symptoms of anxiety and autonomic arousal (e.g., tinnitus and neck soreness). Khyâl attacks include catastrophic cognitions centered on the concern that khyâl (a windlike substance) may rise in the body—along with blood—and cause a range of serious effects (e.g., compressing the lungs to cause shortness of breath and asphyxia; entering the cranium to cause tinnitus, dizziness, blurry vision, and a fatal syncope). Khyâl attacks may occur without warning but are frequently brought about by triggers such as worrisome thoughts, standing up (i.e., orthostasis), specific odors with negative associations, and agoraphobic-type cues like going to crowded spaces or riding in a car. Khyâl attacks usually meet panic attack criteria and may shape the experience of other anxiety and trauma- and stressor-related disorders. Khyâl attacks may be associated with considerable disability. Pen lom in Laos, srog rlung gi nad in Tibet, vata in Sri Lanka, and hwa byung in Korea. Panic attack, panic disorder, generalized anxiety disorder, agoraphobia, posttraumatic stress disorder, illness anxiety disorder. Kufungisisa Kufungisisa ("thinking too much" in Shona) is an idiom of distress and a cultural explanation among the Shona of Zimbabwe. As an explanation, it is considered to be causative of anxiety, depression, and somatic problems (e.g., "My heart is painful because I think too much"). As an idiom of psychosocial distress, it is indicative of interpersonal

and social difficulties (e.g., marital problems, having no money to take care of children, unemployment). Kufungisisa involves ruminating on upsetting thoughts, particularly worries, including concerns about chronic physical illness, such as HIV-related disorders. Kufungisisa is associated with a range of psychopathology, including anxiety symptoms, excessive worry, panic attacks, depressive symptoms, irritability, and posttraumatic stress disorder. In a study of a random community sample, two-thirds of the cases identified by a general psychopathology measure included this complaint. “Thinking too much” is a common idiom of distress and cultural explanation across many countries and ethnic groups; despite some commonalities across global regions, “thinking too much” shows important heterogeneity across and within cultural contexts. It has been described in Africa, Asia, the Caribbean and Latin America, the Middle East, and among indigenous groups. “Thinking too much” may also be a key component of cultural syndromes such as “brain fag” in Nigeria. In the case of “brain fag,” “thinking too much” is primarily attributed to excessive study, which is considered to damage the brain in particular, with symptoms including feelings of heat or crawling sensations in the head. Cross-culturally, “thinking too much” typically references ruminative, intrusive, and/or anxious thoughts—sometimes focused on a singular concern or past trauma and other times based on numerous current worries. In some contexts, it is thought to lead to more severe disorder-like psychosis, suicidal thoughts, or even death.

Related conditions in DSM-5-TR. Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Major depressive disorder, persistent depressive disorder, generalized anxiety disorder, posttraumatic stress disorder, obsessive-compulsive disorder, prolonged grief disorder. Maladi dyab Maladi dyab or maladi satan (literally “devil/Satan illness,” also referred to as “sent sickness”) is a cultural explanation in Haitian communities for diverse medical and psychiatric disorders, or other negative experiences and problems in functioning. In this explanatory model, interpersonal envy and malice cause people to harm their enemies by having sorcerers send illnesses such as psychosis, depression, social or academic failure, and inability to perform activities of daily living. These sicknesses have various names (e.g., ekspedisyon, mòvè zespri, kout poud) based on how they are “sent”. This etiological explanation assumes that illness may be caused by others’ envy and hatred, provoked by the victim’s economic success as evidenced by a new job or expensive purchase. One person’s gain is assumed to produce another person’s loss, so visible success makes an individual vulnerable to attack. Assigning the label of “sent sickness” depends more on mode of onset, social status, and form of treatment that proves successful than on presenting symptoms. A wide range of psychiatric disorders can be attributed to this cultural explanation. The acute onset of new symptoms or an abrupt behavioral change raises suspicions of a spiritual attack. An individual who is attractive, intelligent, or wealthy is perceived as especially vulnerable, and even young healthy children are at risk. Concerns about illness (typically, physical illness) caused by envy or social conflict are common across cultural contexts and often expressed in the form of “evil eye” (e.g., in Spanish, mal de ojo; in Italian, mal’occhiu). Subsyndromal affliction (e.g., problems related to the social environment, educational problems), in addition to a wide range of psychiatric disorders; the cultural explanation of supernatural forces may lead to misdiagnosis of delusional disorder, persecutory type; or schizophrenia. Nervios Nervios (“nerves”) is a common cultural idiom of distress and causal explanation in Latinx cultural contexts in the United States and Latin America. Nervios refers to a general state of vulnerability to stressful life experiences and to difficult life circumstances. The term nervios includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. The most common symptoms attributed to nervios include headaches and “brain aches” (occipital neck tension), irritability, gastrointestinal

disturbances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and mareos (dizziness with occasional vertigo-like exacerbations). Nervios is a broad cultural idiom of distress that spans the range of severity from cases with no mental disorder to presentations resembling adjustment, anxiety, depressive, dissociative, somatic symptom, or psychotic disorders. The term can also refer to a cultural explanation for multiple forms of psychological distress, especially

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. those involving weakness, enervation, and anxiety. Nervios may indicate a range of conditions, which show regional variation, related to the nervous system (literally, the anatomical nerves). In Puerto Rican communities, for example, nervios includes conditions such as “being nervous since childhood,” which appears to be more of a trait and may precede social anxiety disorder, and “being ill with nerves,” which is more related than other forms of nervios to psychiatric problems, especially dissociation and depression. Nevra among Greeks in North America, nierbi among Sicilians in North America, and “nerves” among Whites in Appalachia and Newfoundland. “Tension” is a related idiom and causal explanation among South Asian popul ations. Major depressive disorder, persistent depressive disorder, generalized anxiety disorder, social anxiety disorder, other specified or unspecified dissociative disorder, somatic symptom disorder, schizophrenia. Shenjing shuairuo Shenjing shuairuo (“weakness of the nervous system” in Mandarin Chinese) is a cultural syndrome that integrates conceptual categories of Traditional Chinese Medicine with the Western construct of neurasthenia. In the second, revised edition of the Chinese Classification of Mental Disorders (CCMD-2-R), shenjing shuairuo was defined as a syndrome composed of three out of five symptom clusters: weakness (e.g., mental fatigue), emotions (e.g., feeling vexed), excitement (e.g., increased recollections), nervous pain (e.g., headache), and sleep (e.g., insomnia). Fan nao (feeling vexed) is a form of irritability mixed with worry and distress over conflicting thoughts and unfulfilled desires. The third edition of the CCMD retained shenjing shuairuo as a somatoform diagnosis of exclusion. However, China adopted the ICD-10 as its official classification system in 2011, displacing the CCMD; although ICD-10 included neurasthenia as a diagnostic category, ICD-11 does not. The use of shenjing shuairuo has decreased substantially in recent years and appears to have been replaced by idioms of depression and anxiety, at least in urban areas; among mental health clinicians, shenjing shuairuo may largely be invoked in interactions with traditional patients to facilitate communication and limit the stigma associated with psychiatric diagnoses. Salient precipitants of shenjing shuairuo include work or family-related stressors, loss of face (mianzi, lianzi), and an acute sense of failure (e.g., in academic performance). Shenjing shuairuo is related to traditional concepts of weakness (xu) and health imbalances related to deficiencies of a vital essence (e.g., the depletion of qi [vital energy] following overstraining or stagnation of qi due to excessive worry). In the traditional interpretation, shenjing shuairuo results when bodily channels (jing) conveying vital forces (shen) become dysregulated as a result of various social and interpersonal stressors, such as the inability to change a chronically frustrating and distressing situation. Various psychiatric disorders are associated with shenjing shuairuo, notably mood, anxiety, and somatic symptom disorders. In medical clinics in China, however, up to 45% of patients with shenjing shuairuo do not have symptoms that meet criteria for any DSM-IV disorder.

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Neurasthenia-spectrum idioms and syndromes are present in many cultural contexts, including India (ashaktapanna), Mongolia

(yadargaa), and Japan (shinkei-suijaku), among other settings. Other conditions, such as brain fag syndrome, burnout syndrome, and chronic fatigue syndrome, are also closely related. Major depressive disorder, persistent depressive disorder, generalized anxiety disorder, somatic symptom disorder, social anxiety disorder, specific phobia, posttraumatic stress disorder. Susto Susto ("fright") is a cultural explanation for distress and misfortune prevalent in some Latinx cultural contexts in North, Central, and South America. It is not recognized as an illness category among Latinx from the Caribbean. Susto is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness, as well as difficulties functioning in key social roles. Symptoms may appear any time from days to years after the fright is experienced. In extreme cases, susto may result in death. There are no specific defining symptoms for susto; however, symptoms that are often reported by individuals with susto include appetite disturbances; inadequate or excessive sleep; troubled sleep or dreams; feelings of sadness, low self-worth, or dirtiness; interpersonal sensitivity; and lack of motivation to do anything. Somatic symptoms accompanying susto may include muscle aches and pains, cold in the extremities, pallor, headache, stomachache, and diarrhea. Precipitating events are diverse and include natural phenomena, animals, interpersonal situations, and supernatural agents, among others. Three syndromic types of susto (referred to as cibih in the Zapotec language) have been identified, each having different relationships with psychiatric diagnoses. An interpersonal susto characterized by feelings of loss, abandonment, and not being loved by family, with accompanying symptoms of sadness, poor self-image, and suicidal thoughts, seems to be closely related to major depressive disorder. When susto results from a traumatic event that plays a major role in shaping symptoms and in emotional processing of the experience, the diagnosis of posttraumatic stress disorder appears more appropriate. Susto characterized by various recurrent somatic symptoms—for which the individual seeks health care from several practitioners—is thought to resemble a somatic symptom disorder. Similar etiological concepts and symptom configurations are found globally. In the Andean region, susto is referred to as espanto. Soul loss conditions in South Asia and Southeast Asia also share features with susto. In soul loss, individuals experiencing a fright are thought to temporarily lose their soul, a piece of their soul, or one of many souls. This makes the individual vulnerable to other physical and psychological forms of distress. Major depressive disorder, posttraumatic stress disorder, other specified or unspecified trauma and stressor-related disorder, somatic symptom disorder. Taijin kyofusho

Related conditions in other cultural contexts. Related conditions in DSM-5-TR. Taijin kyofusho ("interpersonal fear disorder" in Japanese) is a syndrome found in Japanese cultural contexts characterized by anxiety about and avoidance of interpersonal situations due to the thought, feeling, or conviction that the individual's appearance and actions in social interactions are inadequate or offensive to others. Taijin kyofusho includes two culture-related forms: a "sensitive type," with extreme social sensitivity and anxiety about interpersonal interactions, and an "offensive type," in which the major concern is offending others. Variants include major concerns about facial blushing (sekimen-kyofu), having an offensive body odor (jiko-shu-kyofu), inappropriate gaze (too much or too little eye contact, jiko-shisen-kyofu), and stiff or awkward facial expression or bodily movements (e.g., stiffening, trembling) or body deformity (shubo-kyofu). Taijin kyofusho is a broader construct than social anxiety disorder in DSM-5. Taijin kyofusho also includes syndromes with features of body dysmorphic disorder, olfactory reference syndrome, and delusional disorder; delusional disorder should be considered when concerns have a delusional quality, responding poorly to simple reassurance or counterexample. The distinctive symptoms of

taijin kyofusho occur in specific cultural contexts and, to some extent, with more severe social anxiety cross-culturally. Similar syndromes are found in Korea (taein kong po) and other societies that place a strong emphasis on the self-conscious maintenance of appropriate social behavior in hierarchical interpersonal relationships. An interdependent self-construal, which emphasizes the relatedness of self to a collective and the identification of self in terms of social roles and relationships, may be a risk factor for taijin kyofusho symptoms across diverse cultures. The concern with offending others through inappropriate social behavior, characteristic of offensive-type taijin kyofusho, has also been described in several societies, including the United States, Australia, Indonesia, and New Zealand. Social anxiety disorder, body dysmorphic disorder, delusional disorder, obsessive-compulsive disorder, olfactory reference syndrome (a type of other specified obsessive-compulsive and related disorder). Olfactory reference syndrome is related specifically to the jikoshu-kyofu variant of taijin kyofusho; this presentation is seen in various cultures outside Japan.

03 - Alternative DSM 5 Model for Personality Disor

Alternative DSM-5 Model for Personality Disorders

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Alternative DSM-5 Model for Personality Disorders Provided as an alternative to the extant personality disorders classification in Section II, this hybrid dimensional-categorical model in Section III defines personality disorder in terms of impairments in personality functioning and pathological personality traits. The inclusion of both models of personality disorder diagnosis in DSM-5 reflects the decision of the APA Board of Trustees to preserve continuity with current clinical practice, while also introducing an alternative approach that aims to address numerous shortcomings of the approach in Section II to personality disorders. For example, in the approach in Section II, symptoms meeting criteria for a specific personality disorder frequently also meet criteria for other personality disorders, and other specified or unspecified personality disorder is often the correct (but mostly uninformative) diagnosis, in the sense that individuals do not tend to present with patterns of symptoms that correspond with one and only one personality disorder. In the following alternative DSM-5 model, personality disorders are characterized by impairments in personality functioning and pathological personality traits. The specific personality disorder diagnoses that may be derived from this model include antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders. This approach also includes a diagnosis of personality disorder—trait specified (PD-TS) that can be made when a personality disorder is considered present but the criteria for a specific disorder are not met. General Criteria for Personality Disorder General Criteria for Personality Disorder The essential features of a personality disorder are A. Moderate or greater impairment in personality (self/interpersonal) functioning. B. One or more pathological personality traits. C. The impairments in personality functioning and the individual’s personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations. D. The impairments in personality functioning and the individual’s personality trait expression are relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood. E. The impairments in personality functioning and the individual’s personality trait

expression are not better explained by another mental disorder. F. The impairments in personality functioning and the individual's personality trait expression are not solely attributable to the physiological effects of a substance or another medical condition (e.g., severe head trauma). G. The impairments in personality functioning and the individual's personality trait expression are not better understood as normal for an individual's developmental stage or sociocultural environment. A diagnosis of a personality disorder requires two determinations: 1) an assessment of the level of impairment in personality functioning, which is needed for Criterion A, and 2) an evaluation of pathological personality traits, which is required for Criterion B. The impairments in personality functioning and personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations (Criterion C); relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood (Criterion D); not better explained by another mental disorder (Criterion E); not attributable to the physiological effects of a substance or another medical condition (Criterion F); and not better understood as normal for an individual's developmental stage or sociocultural environment (Criterion G). All Section III personality disorders described by criteria sets, as well as PD-TS, meet these general criteria, by definition. Criterion A: Level of Personality Functioning Disturbances in self and interpersonal functioning constitute the core of personality psychopathology, and in this alternative diagnostic model they are evaluated on a continuum. Self functioning involves identity and self-direction; interpersonal functioning involves empathy and intimacy (see Table 1). The Level of Personality Functioning Scale (LPFS; see Table 2, pp. 895–898) 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. 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. 899–901). The B criteria for the

specific personality disorders comprise subsets of the 25 trait facets, based on meta-analytic reviews and empirical data on the relationships of the traits to DSM-IV personality disorder diagnoses. Criteria C and D: Pervasiveness and Stability Impairments in personality functioning and pathological personality traits are relatively pervasive across a range of personal and social contexts, as personality is defined as a pattern of perceiving, relating to, and thinking about the environment and oneself. The term relatively reflects the fact that all except the most extremely pathological personalities show some degree of adaptability. The pattern in personality disorders is maladaptive and relatively inflexible, which leads to disabilities in social, occupational, or other important pursuits, as individuals are unable to modify their thinking or behavior, even in the face of evidence that their approach is not working. The impairments in functioning and personality traits are also relatively stable. Personality traits—the dispositions to behave or feel in certain ways—are more stable than the symptomatic expressions of these dispositions, but personality

traits can also change. Impairments in personality functioning are more stable than symptoms. 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:
3. Empathy: Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding of the effects of one's own behavior on others.
4. Intimacy: Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior. 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 physiological 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, obsessivecompulsive, and schizotypal personality disorders. Each personality disorder is defined by typical impairments in personality functioning (Criterion A) and characteristic pathological personality traits (Criterion B): Typical features of antisocial personality disorder are a failure to conform to lawful and ethical behavior, and an egocentric, callous lack of concern for others, accompanied by deceitfulness, irresponsibility, manipulativeness, and/or risk taking. Typical features of avoidant personality disorder are avoidance of social situations and inhibition in interpersonal relationships related to feelings of ineptitude and inadequacy, anxious preoccupation with negative evaluation and rejection, and fears of ridicule or embarrassment. Typical features of borderline personality disorder are instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking, and/or hostility. Typical features of narcissistic personality disorder are variable and vulnerable self-esteem, with attempts at regulation through attention and approval seeking, and either overt or covert grandiosity. Typical features of obsessive-compulsive personality disorder are difficulties in establishing and sustaining close relationships, associated with rigid perfectionism, inflexibility, and restricted emotional expression. Typical features of schizotypal personality disorder are impairments in the capacity for social and close relationships, and eccentricities in cognition, perception, and behavior that are associated with distorted self-image and incoherent personal

goals and accompanied by suspiciousness and restricted emotional expression. The A and B criteria for the six specific personality disorders and for PD-TS follow. All personality disorders also meet criteria C through G of the General Criteria for Personality Disorder. Antisocial Personality Disorder Typical features of antisocial personality disorder are a failure to conform to lawful and ethical behavior, and an egocentric, callous lack of concern for others, accompanied by deceitfulness, irresponsibility, manipulativeness, and/or risk taking. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domains of Antagonism and Disinhibition. Proposed Diagnostic Criteria A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:

Specifiers.

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:
5. 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.
6. 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.
7. Deceitfulness (an aspect of Antagonism): Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events.
8. 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.
9. 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.
10. 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.
11. Irresponsibility (an aspect of Disinhibition): Disregard for—and failure to honor—financial and other obligations or commitments; lack of respect for— and lack of follow-through on—agreements and promises. Note. The individual is at least 18 years of age. Specify if: With psychopathic features 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, manifested 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:
5. Anxiousness (an aspect of Negative Affectivity): Intense feelings of nervousness, tenseness, or panic, often in reaction to social situations; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of embarrassment.

Specifiers. 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. 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

Specifiers. 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; 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. 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

Specifiers. 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 underestimation of own effect on others.
4. Intimacy: Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain. B. Both of the following pathological personality traits:
5. 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.
6. Attention seeking (an aspect of Antagonism): Excessive attempts to attract and be the focus of the attention of others; admiration seeking. 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.

Specifiers. 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:
5. Rigid perfectionism (an aspect of extreme Conscientiousness [the opposite pole of Disinhibition]): Rigid insistence on everything being flawless, perfect, and without errors or faults, including one’s own and others’ performance; sacrificing of timeliness to ensure correctness in every detail; believing that there is only one right way to do things; difficulty changing ideas and/or viewpoint; preoccupation with details, organization, and order.
6. Perseveration (an aspect of Negative Affectivity): Persistence at tasks long after the behavior has ceased to be functional or effective; continuance of the same behavior despite repeated failures.
7. Intimacy avoidance (an aspect of Detachment): Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships.
8. Restricted affectivity (an aspect of Detachment): Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference or coldness. Trait and personality functioning specifiers may be used to record additional

personality features that may be present in obsessive-compulsive personality disorder but are not required for the diagnosis. For example, other traits of Negative Affectivity (e.g., anxiousness) are not diagnostic criteria for obsessive-compulsive personality disorder (see Criterion B) but can be specified when appropriate. Furthermore, although moderate or greater impairment in personality functioning is required for the diagnosis of obsessive-compulsive personality disorder (Criterion A), the level of personality functioning can also be specified. Schizotypal Personality Disorder Typical features of schizotypal personality disorder are impairments in the capacity for social and close relationships and eccentricities in cognition, perception, and behavior that are associated with distorted self-image and incoherent personal goals and accompanied by suspiciousness and restricted emotional expression. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, along with specific maladaptive traits in the domains of Psychoticism and Detachment. Proposed Diagnostic Criteria A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:

1. Identity: Confused boundaries between self and others; distorted selfconcept; 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:
5. 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.
6. 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.
7. Eccentricity (an aspect of Psychoticism): Odd, unusual, or bizarre behavior or appearance; saying unusual or inappropriate things.
8. Restricted affectivity (an aspect of Detachment): Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference or coldness.

Specifiers. 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. 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:
5. 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.
6. 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.

7. Antagonism (vs. Agreeableness): Behaviors that put the individual at odds with other people, including an exaggerated sense of self-importance and a

Subtypes. Specifiers. 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). 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. 899–901). 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. The specific personality features of individuals are always recorded in evaluating Criterion B, so the combination of personality features characterizing an individual directly constitutes the specifiers in each case. For example, two individuals who are both characterized by emotional lability, hostility, and depressivity may differ such that the first individual is characterized additionally by callousness, whereas the second is not. Personality Disorder Scoring Algorithms The requirement for any two of the four A criteria for each of the six personality disorders was based on maximizing the relationship of these criteria to their corresponding personality disorder. Diagnostic thresholds for the B criteria were also set empirically to minimize change in prevalence of the disorders from DSM-IV and overlap with other personality disorders, and to maximize relationships with functional impairment. The resulting diagnostic criteria sets represent clinically useful personality disorders with high fidelity, in terms of core impairments in personality functioning of varying degrees of severity and constellations of pathological personality traits. Personality Disorder Diagnosis Individuals who have a pattern of impairment in personality functioning and maladaptive traits that matches one of the six defined personality disorders should be diagnosed with that personality disorder. If an individual also has one or even several prominent traits that may have clinical relevance in addition to those required for the diagnosis (e.g., see narcissistic personality

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

and can be specified by the relevant pathological personality trait combinations. Level of Personality Functioning Like most human tendencies, personality functioning is distributed on a continuum. Central to functioning and adaptation are individuals' characteristic ways of thinking about and understanding themselves and their interactions with others. An optimally functioning individual has a complex, fully elaborated, and well-integrated psychological world that includes a mostly positive, volitional, and adaptive self-concept; a rich, broad, and appropriately regulated emotional life; and the capacity to behave as a productive member of society with reciprocal and fulfilling interpersonal relationships. At the opposite end of the continuum, an individual with severe personality pathology has an impoverished, disorganized, and/or conflicted psychological world that includes a weak, unclear, and maladaptive self-concept; a propensity to negative, dysregulated emotions; and a deficient capacity for adaptive interpersonal functioning and social behavior. Self and Interpersonal Functioning Dimensional Definition Generalized severity may be the most important single predictor of concurrent and prospective dysfunction in assessing personality psychopathology. Personality disorders are optimally characterized by a generalized personality severity continuum with additional specification of stylistic elements, derived from personality disorder symptom constellations and personality traits. At the same time, the core of personality psychopathology is impairment in ideas and feelings regarding self and interpersonal relationships; this notion is consistent with multiple theories of personality disorder and their research bases. The components of the Level of Personality Functioning Scale—identity, self-direction, empathy, and intimacy (see Table 1) —are particularly central in describing a personality functioning continuum. Mental representations of the self and interpersonal relationships are reciprocally influential and inextricably tied, affect the nature of interaction with mental health professionals, and can have a significant impact on both treatment efficacy and outcome, underscoring the importance of assessing an individual's characteristic self-concept as well as views of other people and

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

Hierarchical structure of personality. Some trait terms are quite specific (e.g., "talkative") and describe a narrow range of behaviors, whereas others are quite broad (e.g., Detachment) and characterize a wide range of behavioral propensities. Broad trait dimensions are called domains, and specific trait dimensions are called facets. Personality trait domains comprise a spectrum of more specific personality facets that tend to occur together. For example, withdrawal and anhedonia are specific trait facets in the trait domain of Detachment. Despite some cross-cultural variation in personality trait facets, the broad domains they collectively comprise are relatively consistent across cultures. The Personality Trait Model The Section III personality trait system includes five broad domains of personality trait variation —Negative Affectivity (vs. Emotional Stability), Detachment (vs. Extraversion), Antagonism (vs. Agreeableness), Disinhibition (vs. Conscientiousness), and Psychoticism (vs. Lucidity)— comprising 25 specific personality trait facets. Table 3 provides definitions of all personality domains and facets. These five broad domains are maladaptive variants of the five domains of the extensively validated and replicated personality model known as the "Big Five," or Five Factor Model of personality (FFM), and are also similar to the domains of the Personality Psychopathology Five (PSY-5). The specific 25 facets represent a list of personality facets chosen for their clinical relevance. Although the Trait Model focuses on personality traits associated with psychopathology, there are healthy, adaptive, and resilient personality traits identified as the polar opposites of these traits, as noted in the parentheses above (i.e., Emotional Stability, Extraversion, Agreeableness, Conscientiousness, and Lucidity). Their presence can greatly mitigate the effects of mental disorders and facilitate coping and recovery from traumatic injuries and other medical illness. Distinguishing Traits, Symptoms, and Specific Behaviors Although traits are by no means immutable and do change throughout the life span, they show relative consistency compared with symptoms and specific behaviors. For example, a person may behave impulsively at a specific time for a specific reason (e.g., a person who is rarely impulsive suddenly decides to spend a great deal of money on a particular item because of an unusual opportunity to purchase something of unique value), but it is only when behaviors aggregate across time and circumstance, such that a pattern of behavior distinguishes between individuals, that they reflect traits. Nevertheless, it is important to recognize, for example, that even people who are impulsive are not acting impulsively all of the time. A trait is a tendency or disposition toward specific behaviors; a specific behavior is an instance or manifestation of a trait. Similarly, traits are distinguished from most symptoms because symptoms tend to wax and wane, whereas traits are relatively more stable. For example, individuals with higher levels of

depressivity have a greater likelihood of experiencing discrete episodes of a depressive disorder and of showing the symptoms of these disorders, such as difficulty concentrating. However, even patients who have a trait propensity to depressivity typically cycle through distinguishable episodes of mood disturbance, and specific symptoms such as difficulty concentrating tend to wax and wane in concert with specific episodes, so they do

894 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 DSM5 (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 personalitybased problems are the focus of treatment, then it will be important to assess individuals' trait facets as well as domains. Because personality traits are continuously distributed in the population, an approach to making the judgment that a specific trait is elevated (and therefore is present for diagnostic purposes) could involve comparing individuals' personality trait levels with population norms and/or clinical judgment. If a trait is elevated—that is, formal psychometric testing and/or interview data support the clinical judgment of elevation—then it is considered as contributing to meeting Criterion B of Section III personality disorders. Clinical Utility of the Multidimensional Personality Functioning and Trait Model Disorder and trait constructs each add value to the other in predicting important antecedent (e.g., family history, history of child abuse), concurrent (e.g., functional impairment, medication use), and predictive (e.g., hospitalization, suicide attempts) variables. DSM-5 impairments in personality functioning and pathological personality traits each contribute independently to clinical decisions about degree of disability; risks for self-harm, violence, and criminality; recommended treatment type and intensity; and prognosis—all important aspects of the utility of

psychiatric diagnoses. Notably, knowing the level of an individual's personality functioning and his or her pathological trait profile also provides the clinician with a rich base of information and is valuable in treatment planning and in predicting the course and outcome of many mental disorders

in addition to personality disorders. Therefore, assessment of personality functioning and pathological personality traits may be relevant whether an individual has a personality disorder or not. TABLE 2 Level of Personality Functioning Scale SELF INTERPERSONAL Level of impairment Identity Self-direction Empathy Intimacy 0—Little or no impairment Has ongoing awareness of a unique self; maintains roleappropriate boundaries. Has consistent and self-regulated positive self-esteem, with accurate selfappraisal. Is capable of experiencing, tolerating, and regulating a full range of emotions. Sets and aspires to reasonable goals based on a realistic assessment of personal capacities. Utilizes appropriate standards of behavior, attaining fulfillment in multiple realms. Can reflect on, and make constructive meaning of, internal experience. Is capable of accurately understanding others' experiences and motivations in most situations. Comprehends and appreciates others' perspectives, even if disagreeing. Is aware of the effect of own actions on others. Maintains multiple satisfying and enduring relationships in personal and community life. Desires and engages in a number of caring, close, and reciprocal relationships. Strives for cooperation and mutual benefit and flexibly responds to a range of others' ideas, emotions, and behaviors. 1—Some impairment Has relatively intact sense of self, with some decrease in clarity of boundaries when strong emotions and mental distress are experienced. Self-esteem diminished at times, with overly critical or somewhat distorted selfappraisal. Strong emotions may be distressing, associated with a restriction in range of emotional experience. Is excessively goaldirected, somewhat goal-inhibited, or conflicted about goals. May have an unrealistic or socially inappropriate set of personal standards, limiting some aspects of fulfillment. Is able to reflect on internal experiences, but may overemphasize a single (e.g., intellectual, emotional) type of self-knowledge. Is somewhat compromised in ability to appreciate and understand others' experiences; may tend to see others as having unreasonable expectations or a wish for control. Although capable of considering and understanding different perspectives, resists doing so. Has inconsistent awareness of effect of own behavior on others. Is able to establish enduring relationships in personal and community life, with some limitations on degree of depth and satisfaction. Is capable of forming and desires to form intimate and reciprocal relationships, but may be inhibited in meaningful expression and sometimes constrained if intense emotions or conflicts arise. Cooperation may be inhibited by unrealistic standards; somewhat limited in ability to respect or respond to others' ideas, emotions, and behaviors. 2—Moderate impairment Depends excessively on others for identity definition, with compromised boundary delineation. Has vulnerable selfGoals are more often a means of gaining external approval than self-generated, and thus may lack coherence and/or stability. Is hyperattuned to the experience of others, but only with respect to perceived relevance to self. Is excessively selfreferential; significantly Is capable of forming and desires to form relationships in personal and community life, but connections may be largely superficial. Intimate relationships are

esteem controlled by exaggerated concern about external evaluation, with a wish for approval. Has sense of incompleteness or inferiority, with compensatory inflated, or deflated, self-appraisal. Emotional regulation Personal standards may be unreasonably high (e.g., a need to be special or please others) or low (e.g., not consonant with prevailing social values). Fulfillment is compromised by a sense of lack of authenticity. Has impaired capacity depends on positive external appraisal. Threats to selfesteem may engender strong emotions such as rage or shame. to reflect on internal experience. Has a weak sense of Has difficulty autonomy/agency; experience of a lack of identity, or emptiness. Boundary definition is poor or rigid: may show overidentification with others, overemphasis on independence from others, or vacillation between these. Fragile self-esteem is

establishing and/or achieving personal goals. Internal standards for 3—Severe impairment behavior are unclear or contradictory. Life is experienced as meaningless or dangerous. Has significantly compromised ability to reflect on and understand own mental processes. easily influenced by events, and selfimage lacks coherence. Selfappraisal is unnuanced: selfloathing, selfaggrandizing, or an illogical, unrealistic combination. Emotions may be rapidly shifting or a chronic, unwavering feeling of despair. Experience of a unique Has poor self and sense of agency/autonomy are virtually absent, or are organized around perceived external persecution. Boundaries with others are confused or lacking. Has weak or distorted differentiation of thoughts from actions, so goalsetting ability is severely compromised, with unrealistic or incoherent goals. Internal standards for 4—Extreme impairment behavior are virtually lacking. Genuine fulfillment is virtually inconceivable. self-image easily threatened by interactions with others; significant compromised ability to appreciate and understand others' experiences and to consider alternative perspectives. Is generally unaware of or predominantly based on meeting self-regulatory and self-esteem needs, with an unrealistic expectation of being perfectly understood by others. Tends not to view unconcerned about effect of own behavior on others, or unrealistic appraisal of own effect. relationships in reciprocal terms, and cooperates predominantly for personal gain. Ability to consider and Has some desire to form understand the thoughts, feelings, and behavior of other people is significantly limited; may discern very specific aspects of others' experience, particularly vulnerabilities and suffering. Is generally unable to relationships in community and personal life, but capacity for positive and enduring connections is significantly impaired. Relationships are based on a strong belief in the absolute need for the intimate other(s), and/or expectations of abandonment or abuse. Feelings about intimate involvement with others alternate between fear/rejection and desperate desire for connection. Little mutuality: others are consider alternative perspectives; highly threatened by differences of opinion or alternative viewpoints. Is confused about or unaware of impact of own actions on others; often bewildered about people's thoughts and actions, with destructive motivations frequently misattributed to others. conceptualized primarily in terms of how they affect the self (negatively or positively); cooperative efforts are often disrupted due to the perception of slights from others. Has pronounced inability to Desire for affiliation is consider and understand others' experience and motivation. Attention to others' limited because of profound disinterest or expectation of harm. Engagement with others is detached, disorganized, or consistently negative. Relationships are perspectives is virtually absent (attention is hypervigilant, focused on need fulfillment and harm avoidance). Social interactions can be conceptualized almost exclusively in terms of their ability to provide comfort or inflict pain and suffering. Social/interpersonal behavior confusing and disorienting. is not reciprocal; rather, it

distortions and confusion around self-appraisal. Emotions not congruent with context or internal experience. Hatred and aggression may be dominant affects, although they may be disavowed and attributed to others. Is profoundly unable to constructively reflect on own experience. Personal motivations may be unrecognized and/or experienced as external to self. seeks fulfillment of basic needs or escape from pain. TABLE 3 Definitions of DSM-5 personality disorder trait domains and facets DOMAINS (Polar Opposites) and Facets Definitions NEGATIVE AFFECTIVITY (vs. Emotional Stability) Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/shame, worry, anger) and their behavioral (e.g., self-harm) and interpersonal (e.g., dependency) manifestations. Emotional lability Instability of emotional experiences and mood; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances. Anxiousness Feelings of nervousness, tenseness, or panic in reaction to

diverse situations; frequent worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and apprehensive about uncertainty; expecting the worst to happen. Separation insecurity Fears of being alone due to rejection by—and/or separation from—significant others, based in a lack of confidence in one's ability to care for oneself, both physically and emotionally. Submissiveness Adaptation of one's behavior to the actual or perceived interests and desires of others even when doing so is antithetical to one's own interests, needs, or desires. Hostility Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behavior. See also Antagonism. Perseveration Persistence at tasks or in a particular way of doing things long after the behavior has ceased to be functional or effective; continuance of the same behavior despite repeated failures or clear reasons for stopping. Depressivity See Detachment. Suspiciousness See Detachment. Restricted affectivity (lack of) The lack of this facet characterizes low levels of Negative Affectivity. See Detachment for definition of this facet. DETACHMENT (vs. Extraversion) Avoidance of socioemotional experience, including both withdrawal from interpersonal interactions (ranging from casual, daily interactions to friendships to intimate relationships) and restricted affective experience and expression, particularly limited hedonic capacity. Withdrawal Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact. Intimacy avoidance Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships. Anhedonia Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure and take interest in things. Depressivity Feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame and/or guilt; feelings of inferior self-worth; thoughts of suicide and suicidal behavior. Restricted affectivity Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference and aloofness in normatively engaging situations.

Suspiciousness Expectations of—and sensitivity to signs of—interpersonal ill-intent or harm; doubts about loyalty and fidelity of others; feelings of being mistreated, used, and/or persecuted by others. ANTAGONISM (vs. Agreeableness) Behaviors that put the individual at odds with other people, including an exaggerated sense of self-importance and a concomitant expectation of special treatment, as well as a callous antipathy toward others, encompassing both an unawareness of others' needs and feelings and a readiness to use others in the service of self-enhancement. Manipulativeness Use of subterfuge to influence or control others; use of seduction, charm, glibness, or ingratiation to achieve one's ends. Deceitfulness Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events. Grandiosity Believing that one is superior to others and deserves special treatment; self-centeredness; feelings of entitlement; condescension toward others. Attention seeking Engaging in behavior designed to attract notice and to make oneself the focus of others' attention and admiration. Callousness Lack of concern for the feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others. Hostility See Negative Affectivity. DISINHIBITION (vs. Conscientiousness) Orientation toward immediate gratification, leading to impulsive behavior driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences. Irresponsibility Disregard for—and failure to honor—financial and other obligations or commitments; lack of respect for—and lack of follow-through on—agreements and promises; carelessness with others' property. Impulsivity Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or

consideration of outcomes; difficulty establishing and following plans; a sense of urgency and self-harming behavior under emotional distress. Distractibility Difficulty concentrating and focusing on tasks; attention is easily diverted by extraneous stimuli; difficulty maintaining goal-focused behavior, including both planning and completing tasks. Risk taking Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger; reckless pursuit of goals regardless of the level of risk involved. Rigid perfectionism (lack of) Rigid insistence on everything being flawless, perfect, and without errors or faults, including one's own and others' performance; sacrificing of timeliness to ensure correctness in every detail; believing that there is only one right way to do things; difficulty changing ideas and/or viewpoint; preoccupation with details, organization, and order. The lack of this facet characterizes low levels of Disinhibition. PSYCHOTICISM (vs. Lucidity) Exhibiting a wide range of culturally incongruent odd, eccentric, or unusual behaviors and cognitions, including both process (e.g., perception, dissociation) and content (e.g., beliefs). Unusual beliefs and experiences Belief that one has unusual abilities, such as mind reading, telekinesis, thought-action fusion; unusual experiences of reality, including hallucination-like experiences. Eccentricity Odd, unusual, or bizarre behavior, appearance, and/or speech; having strange and unpredictable thoughts; saying unusual or inappropriate things. Cognitive and perceptual dysregulation Odd or unusual thought processes and experiences, including depersonalization, derealization, and dissociative experiences; mixed sleep-wake state experiences; thought-control experiences.

04 - Conditions for Further Study

Conditions for Further Study

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Conditions for Further Study Proposed criteria sets are presented for conditions on which future research is encouraged. It is hoped that such research will allow the field to better understand these conditions and inform future decisions about possible placement in forthcoming editions of DSM. Notably, persistent complex bereavement disorder, originally located in this section, has been moved to the chapter “Trauma- and Stressor-Related Disorders” as an official diagnosis in Section II. On the basis of thorough reviews finding sufficient evidence of validity, reliability, and clinical utility to justify its new placement, it is now named “prolonged grief disorder” and the criteria have been appropriately reformulated. The specific items, thresholds, and minimum 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. 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 ultimately determined that there was insufficient evidence to warrant inclusion of these proposals as official mental disorder diagnoses in Section II of DSM-5. These proposed criteria sets are therefore not intended for clinical use; only the criteria sets and disorders in Section II of DSM-5 are officially recognized and should be used for clinical purposes. Attenuated Psychosis Syndrome Proposed Criteria A. At least one of the following symptoms is present and is of sufficient severity or frequency to warrant clinical attention:

1. Attenuated delusions.
2. Attenuated hallucinations.
3. Attenuated disorganized speech. B. Symptom(s) must have been present at least once per week for the past month. C. Symptom(s) must have begun or worsened in the past year. D. Symptom(s) is sufficiently distressing and disabling to the individual to warrant clinical attention. E. Symptom(s) is not better explained by another mental disorder, including a depressive or bipolar disorder with psychotic features, and is not attributable to

the physiological effects of a substance or another medical condition. F. Criteria for any psychotic disorder have never been met. Diagnostic Features Attenuated psychotic symptoms, as defined in

Criterion A, are psychosis-like but below the threshold to be considered a psychotic symptom that would count toward the diagnosis of a psychotic disorder. Compared with full psychotic disorders, the symptoms are less severe and more transient. Moreover, the individual maintains reasonable insight into the psychotic-like experiences and generally appreciates that perceptions are altered, and magical ideation is not compelling. Attenuated psychosis does not have the fixed nature that is necessary for the diagnosis of a full-blown psychotic disorder. In attenuated psychosis, doubt about beliefs can be elicited, skepticism about perceptions can be induced, and insight can be tested using open-ended questions, such as “I see that this is how you experience the world—could there be a different explanation?” 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. Changes in experiences and behaviors are noted by the individual or others, suggesting a clinically significant change in mental state (i.e., the symptoms are of sufficient severity or frequency to warrant clinical attention) (Criterion A). Attenuated delusions (Criterion A1) may have suspiciousness/persecutory ideational content, including persecutory ideas of reference. The individual may have a guarded, distrustful attitude. When this type of attenuated delusion is moderate in severity, the individual views others as untrustworthy and may be hypervigilant or sense ill will in others. When the attenuated delusions are severe but below the threshold to be considered psychotic, the individual entertains loosely organized beliefs about danger or hostile intention. Guarded behavior in the interview can interfere with the ability to gather information, and the propensity for viewing the world as hostile and dangerous is strong. On the other hand, attenuated delusions may have grandiose content presenting as an unrealistic sense of superior capacity. When this type of attenuated delusion is moderate in severity, the individual harbors notions of being gifted, influential, or special. When the attenuated 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. Attenuated hallucinations (Criterion A2) include alterations in sensory perceptions, usually auditory and/or visual. When the attenuated 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 attenuated 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. Attenuated 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 becomes meandering and circumstantial and may be odd but understandable. When the disorganization is severe, the individual fails to get to the point without external guidance (tangential). At a more severe level, some thought blocking 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 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 indicated (Criterion A). Measures are available to determine whether Criteria A–E are met or to broadly identify a clinical high-risk state for

psychosis. Associated Features The individual may experience magical thinking, 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 are not diagnostic at the individual level. Prevalence Very little information is available about prevalence. However, in Switzerland, where one of the few relevant studies was conducted, the prevalence of attenuated psychosis syndrome in nonhelp-seeking individuals ages 16–40 years was found to be only 0.3%. Another 2.3% have attenuated symptoms that meet Criterion A, but these symptoms either began prior to the past year or had not worsened in the past year, as required by Criterion C. In up to 7% of the general population across a broad range of countries, individuals acknowledge experiencing attenuated delusions or hallucinations. While the prevalence of Criterion A symptoms can be higher or lower across countries or ethnonational groups, the prevalence of attenuated psychosis symptoms tends to be higher among migrant groups than among native populations, possibly due to higher exposure to trauma and discrimination. 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, or impaired social development. In help-seeking cohorts, those whose presentations met criteria for attenuated psychosis syndrome had an increased probability of developing psychosis compared with those whose presentations did not meet the criteria. In the group whose presentations met criteria, the 3-year cumulative risk was up to 22%, and in the group whose

Temperamental. Genetic and physiological. presentations did not meet criteria, the 3-year cumulative risk of psychosis was 1.54%. Factors predicting progression to a full psychotic disorder (most frequently schizophrenia spectrum disorder) include male sex, lifetime stress/trauma, unemployment, living alone, severity of attenuated positive psychotic symptoms, severity of negative symptoms, disorganized and cognitive symptoms, and poor functioning. Eleven percent of those attenuated psychosis syndrome cases that progress to full psychosis develop affective psychosis (depressive or bipolar disorder with psychotic features), whereas 73% of attenuated psychosis syndrome cases that progress to full psychosis develop a schizophrenia spectrum disorder. Most evidence has validated attenuated psychotic symptom criteria in individuals ages 12–35 years, but there is only limited evidence in the youngest. Although the highest risk for transition to psychosis is within the first 2 years, individuals continue to be at risk for up to 10 years after initial referral, with an overall risk of transition of 34.9% over a 10-year period. Individuals presenting with attenuated psychosis syndrome may display other poor clinical outcomes beyond the development of psychosis, such as persistent attenuated psychotic symptoms, persistent or recurrent comorbid mental disorders, disability, and low functioning. Clinical remission is present in only one-third of individuals with attenuated psychosis syndrome. Overall, about one-third of these individuals would develop psychosis, one-third would remit, and one-third would present persistent disability. Risk and Prognostic Factors Factors predicting prognosis of attenuated psychosis syndrome have not been definitively characterized. In individuals whose symptoms meet criteria for attenuated psychosis syndrome, there is no evidence that a family history of psychosis increases the risk of psychosis compared with control subjects over a 4-year period. Structural, functional, electrophysiological, and neurochemical imaging data are associated with increased risk of transition to psychosis. However, these predictors have not

yet been validated for clinical use. Culture-Related Diagnostic Issues Assessing the presence of attenuated symptoms without considering the impact of sociocultural context can be difficult. Some perceptual experiences (e.g., hearing noises, seeing shadows) and religious or supernatural beliefs (e.g., evil eye, causing illness through curses, influence of spirits) may be considered odd in some cultural contexts and accepted in others. In addition, populations that experience trauma or persecution (e.g., torture, political violence, racism, discrimination) can report symptoms and fears that may be misjudged as attenuated or frank paranoid delusions, because of the impact of trauma on the individual's mood and communication (e.g., some fears may be appropriate to avoid threats, and may commingle with fears of recurrence of trauma or posttraumatic symptoms). Groups at higher risk of misdiagnosis include migrants, socially oppressed ethnic and racialized populations, and other groups facing social adversity and discrimination. The distress and impairment criterion helps to distinguish socioculturally normative experiences from symptoms of attenuated psychosis syndrome (e.g., adaptive wariness toward authority figures by discriminated groups, which may be confused with

Brief psychotic disorder. Schizotypal personality disorder. Reality distortions occurring in other mental disorders. Adjustment reaction of adolescence. Extreme end of perceptual aberration and magical thinking in the non-ill population. Substance/medication-induced psychotic disorder. Attention-deficit/hyperactivity disorder. paranoia). Functional Consequences of Attenuated Psychosis Syndrome Many individuals may experience functional impairments at presentation. Modest-to-moderate impairment in social and role functioning may persist even with abatement of symptoms. Differential Diagnosis When symptoms of attenuated psychosis syndrome initially manifest, they may resemble symptoms of brief psychotic disorder. However, in attenuated psychosis syndrome, the attenuated symptoms (delusions, hallucinations, or disorganized speech) do not cross the psychosis threshold. Symptomatic features of schizotypal personality disorder, particularly during early stages of presentation, are similar to those of attenuated psychosis syndrome. However, schizotypal personality disorder 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 the diagnosis of schizotypal personality disorder. Reality distortions that can resemble attenuated delusions can occur in the context of other mental disorders (e.g., feelings of low selfesteem or attributions of low regard from others in the context of major depressive disorder, a feeling of being the focus of undesired attention in the context of social anxiety disorder, inflated self-esteem in the context of pressured speech and reduced need for sleep in bipolar I or bipolar II disorder, a sense of being unable to experience feelings in the context of an intense fear of real or imagined abandonment and recurrent self-mutilation in borderline personality disorder). If these reality distortions occur only during the course of another mental disorder, an additional diagnosis of attenuated psychosis syndrome would not be made. Mild, transient symptoms typical of normal development and consistent with the degree of stress experienced do not qualify for attenuated psychosis syndrome. This diagnostic possibility should be strongly entertained when reality distortions are not associated with distress and functional impairment and need for care. Attenuated delusions and attenuated hallucinations can occur in the context of intoxication with cannabis, hallucinogens, phencyclidine, inhalants, and stimulants, or during withdrawal from alcohol and sedatives, hypnotics, or anxiolytics. Attenuated psychosis syndrome should not be diagnosed if the attenuated psychotic symptoms occur only during substance use, in which case a diagnosis of substance/medication-induced psychotic disorder may be preferred. 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 Most individuals with attenuated psychosis syndrome experience some comorbid mental disorder, mostly depression (41%) and/or anxiety (15%). A little more than half of individuals have at least one comorbid disorder at follow-up, most of which were present when the individual was first assessed; the persistence of comorbid disorders at follow-up is associated with poor clinical and functional outcomes. Although some individuals with an attenuated psychosis syndrome diagnosis will progress to developing a new diagnosis, including anxiety, depressive, bipolar, and personality disorders, individuals with attenuated psychosis syndrome are not at increased risk of developing new nonpsychotic disorders compared with help-seeking control subjects. 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 2week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. (Note: Do not include symptoms that are clearly attributable to a medical condition.)

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. C. The disturbance is not attributable to the physiological effects of a substance or another medical condition. D. The disturbance is not better explained by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder. At least two lifetime episodes of hypomanic periods that involve the required criterion symptoms below but are of insufficient duration (at least 2 days but less than 4 consecutive days) to meet criteria for a hypomanic episode. The criterion symptoms are as follows: A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased 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:

10. Inflated self-esteem or grandiosity.
11. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
12. More talkative than usual or pressured to keep talking.
13. Flight of ideas or subjective experience that thoughts are racing.
14. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
15. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
16. 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

Genetic and physiological. others. E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic. F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment). Diagnostic Features Individuals with depressive episodes 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 Individuals who have experienced both short-duration hypomania and a major depressive episode, with their increased psychiatric comorbidity, greater family history of bipolar disorder, earlier onset, more recurrent major depressive episodes, and higher rate of suicide attempts, more closely resemble individuals with bipolar disorder than those with major depressive disorder. Prevalence The prevalence of depressive episodes with short-duration hypomania is unclear, as epidemiological studies have yet to be published using the DSM-5 definition. Using somewhat different criteria (subthreshold hypomania defined by either of the following: duration shorter than 4 days or having fewer than three Criterion B symptoms), major depressive disorder with subthreshold hypomania occurs in up to 6.7% of the U.S. population, making it more common than bipolar I or II disorder. In clinical settings studied across diverse countries, however, depressive episodes with short-duration hypomania is about one-fourth as common as depressive episodes with full-duration hypomania. Depressive episodes with short-duration hypomania may be more common in women, who may present with more features of atypical depression. Risk and Prognostic Factors A family history of bipolar disorder is three to four times more common among individuals with depressive episodes with short-duration hypomania than among those with major depressive disorder, whereas family history of bipolar disorder is similar among individuals with depressive episodes and short- versus full-duration hypomania.

Bipolar II disorder. Major depressive disorder. Major depressive disorder with mixed features. Bipolar I disorder. Cyclothymic disorder. Association With Suicidal Thoughts or Behavior Individuals with depressive episodes with short-duration hypomania have higher rates of suicide attempts than individuals with major depressive disorder and similar rates of suicide attempts compared with individuals with depressive episodes and full-duration hypomania (bipolar II disorder). Functional Consequences of Short-Duration Hypomania Functional impairments associated specifically with depressive episodes with short-duration hypomania are as yet not fully determined. However, research suggests that individuals with this disorder have similar global assessment of functioning scores as compared to those with depressive episodes with full-duration hypomania. Differential Diagnosis Bipolar II disorder is characterized by major depressive episodes and hypomanic episodes, whereas depressive episodes with short-duration hypomania are characterized by depressive episodes with periods of 2–3 days of hypomanic symptoms. Once an individual has experienced a full-blown hypomanic episode lasting 4 days or more in addition to lifetime major depressive episodes, the diagnosis changes to and remains bipolar II disorder regardless of the duration of future hypomanic symptom periods. 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 depressive episodes with short-duration hypomania rather than to major depressive disorder. Both major depressive disorder with mixed features and depressive episodes with 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 that manifest concurrently with a major depressive episode, whereas individuals with depressive episodes with short-duration hypomania experience subsyndromal hypomania and fully syndromal major depression at different times. Bipolar I disorder is differentiated from depressive episodes with shortduration hypomania by at least one lifetime manic episode, which is longer (at least 1 week) and more severe (causing marked impairment in social or occupational functioning or necessitating hospitalization to prevent harm to self and others) 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. 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.

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

1. A persistent desire or unsuccessful efforts to cut down or control caffeine use.
2. Continued caffeine use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by caffeine.
3. Withdrawal, as manifested by either of the following: a. The characteristic withdrawal syndrome for caffeine. b. Caffeine (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.
4. Caffeine is often taken in larger amounts or over a longer period than was intended.
5. Recurrent caffeine use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated tardiness or absences from work or school related to caffeine use or withdrawal).

6. Continued caffeine use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of caffeine (e.g., arguments with spouse about consequences of use, medical problems, cost).
7. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of caffeine to achieve desired effect. b. Markedly diminished effect with continued use of the same amount of caffeine.
8. A great deal of time is spent in activities necessary to obtain caffeine, use caffeine, or recover from its effects.
9. Craving or a strong desire or urge to use caffeine. Various research studies have provided documentation and characterization of individuals with problematic caffeine use, and several reviews provide an analysis of this literature. 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 two U.S. population surveys, 14%–17% of caffeine users endorsed caffeine use despite physical or psychological problems, 34%–45% reported a persistent desire or unsuccessful efforts to control caffeine use, and 18%– 27% reported withdrawal or using caffeine to relieve or avoid withdrawal. In these same surveys, some caffeine users reported using more caffeine than intended, spending a great deal of time using or obtaining caffeine (e.g., drinking coffee all day and until the evening), tolerance, a strong desire or craving for caffeine, failure to fulfill major role obligations due to caffeine (e.g., spending family vacation time searching for caffeinated beverages, resulting in relationship distress; repeatedly late for work due to need to get coffee), and, to a much lesser extent, caffeine use despite social or interpersonal problems. Medical and psychological problems attributed to caffeine included heart, stomach, and urinary problems, and complaints of anxiety, depression, insomnia, irritability, and difficulty thinking. In a study of 2,259 Hungarian caffeine consumers, factor analysis of the nine caffeine use disorder criteria resulted in a one-factor solution, suggesting that caffeine use disorder is a unitary construct. In two Baltimore-area caffeine treatment studies, the most commonly endorsed criteria were withdrawal (97%), persistent desire or unsuccessful efforts to control use (91%– 94%), and use despite knowledge of physical or psychological problems caused by caffeine (75%–91%). Among individuals seeking treatment for problematic caffeine use, 88% reported having made prior serious attempts to modify caffeine use, and 43%–47% reported having been advised by a medical professional to reduce or eliminate caffeine. Common reported reasons for modifying caffeine use were health-related (59%) and a desire to not be dependent on caffeine (35%). The text for 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. One populationbased study in Vermont reported that 9% of individuals endorsed the three proposed DSM-5 caffeine use disorder criteria plus tolerance. In a sample of 1,006 caffeine-consuming adults recruited using demographic quotas to reflect the U.S. population, 8% endorsed all three criteria required for a caffeine use disorder diagnosis.

Genetic and physiological. In a sample of caffeine-consuming adolescents presenting for routine medical care in a Boston hospital, 3.9% endorsed all three criteria required for a caffeine use disorder diagnosis. Among a convenience sample of caffeine consumers in Hungary, 13.9% endorsed all three criteria, with 4.3% of those reporting that the symptoms caused significant distress in their everyday life. 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, energy drinks) 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 in the United States tend to increase with age. 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 Heritabilities of heavy caffeine use, caffeine tolerance, and caffeine withdrawal range from 35% to 77%. For caffeine use, alcohol use, and cigarette smoking, a common genetic factor (polysubstance use) underlies the use of these three substances, with 28%–41% of the heritable effects of caffeine use (or heavy use) shared with alcohol and smoking. Caffeine and tobacco use and use disorders are associated with 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. Culture-Related Diagnostic Issues Consumption of caffeine is affected by geographic origin, cultural context, lifestyle, social behavior, and economic status. The type of caffeinated beverage preferred (e.g., tea; coffee; carbonated sodas containing caffeine; mate [a beverage made from the herb yerba mate]) and the mode of preparation vary globally, leading to marked differences in the amounts and types of compounds in a “cup” of coffee, tea, or mate. These differences must be considered when assessing the quantity of caffeine ingested. Association With Suicidal Thoughts or Behavior No research specifically addresses the relationship between caffeine use disorder and suicidal thoughts or behavior. There is contradictory evidence regarding caffeine consumption; namely, that high levels of caffeine consumption either may be associated with increased risk for suicidal thoughts or behavior or may be protective for suicidal thoughts or behavior.

Nonproblematic use of caffeine. Other stimulant use disorder. Anxiety disorders. Functional Consequences of Caffeine Use Disorder One U.S. population survey found that those who fulfilled the criteria for caffeine use disorder were more likely to report greater caffeine-related distress, feeling bad or guilty about caffeine use, sleep problems, anxiety, depression, and stress. A greater number of total symptoms endorsed also predicted these negative outcomes. Caffeine use disorder may predict greater use of caffeine during pregnancy. Differential Diagnosis 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. Problems related to use of other stimulant medications or substances may approximate the features of caffeine use disorder. Chronic heavy caffeine use may mimic generalized anxiety disorder, and acute caffeine consumption may produce and mimic panic attacks. Comorbidity Comorbidities associated with caffeine use disorder include daily cigarette smoking, cannabis use disorder, and a family or personal history of alcohol use disorder. Compared with individuals in the general population, rates of caffeine use disorder are higher among those seeking treatment for problematic caffeine use; individuals who use tobacco; high school and college students; and those with histories of alcohol or illicit drug misuse. Features of caffeine use disorder may be positively associated with several diagnoses: major depression, generalized anxiety disorder, panic disorder, antisocial personality disorder, and alcohol, cannabis, and cocaine use disorders. Internet Gaming Disorder Proposed Criteria Persistent and recurrent use of the Internet to engage in games, often with other players, leading to clinically significant impairment or distress as indicated by five (or more) of the following in a 12-month period:

1. Preoccupation with Internet games. (The individual thinks about previous gaming activity or anticipates playing the next game; Internet gaming becomes the dominant activity in daily life.) Note: This disorder is distinct from Internet gambling, which is included under gambling disorder.
2. Withdrawal symptoms when Internet gaming is taken away. (These symptoms are typically described as irritability, anxiety, or sadness, but there are no physical signs of pharmacological withdrawal.)
3. Tolerance—the need to spend increasing amounts of time engaged in Internet games.
4. Unsuccessful attempts to control the participation in Internet games.
5. Loss of interests in previous hobbies and entertainment as a result of, and with the exception of, Internet games.
6. Continued excessive use of Internet games despite knowledge of psychosocial problems.
7. Has deceived family members, therapists, or others regarding the amount of Internet gaming.
8. Use of Internet games to escape or relieve a negative mood (e.g., feelings of helplessness, guilt, anxiety).
9. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of participation in Internet games. Note: Only nongambling Internet games are included in this disorder. Use of the Internet for required activities in a business or profession is not included; nor is the disorder intended to include other recreational or social Internet use. Similarly, sexual Internet sites are excluded. Specify current severity: Internet gaming disorder can be mild, moderate, or severe depending on the degree of disruption of normal activities. Individuals with less severe Internet gaming disorder may exhibit fewer symptoms and less disruption of their lives. Those with severe Internet gaming disorder will have more hours spent on the computer and more severe loss of relationships or career or school opportunities. Gambling disorder is currently the only non-substance-related disorder included in the DSM5 Section II chapter “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 is considered a public health threat in South Korea, where treatment and prevention systems have been set up. Reports of treatment of this condition have appeared in medical journals, mostly from Asian countries, but also in the United States and other high-income countries. 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 in the West, justified inclusion of this disorder in Section III of DSM-5 and in the Mental, Behavioural, and Neurodevelopmental Disorders chapter in ICD-11. Note that since the publication of DSM-5, the number of clinical reports has continued to accumulate, but many of the issues remain unresolved. Internet gaming disorder has achieved 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. Diagnostic Features The essential feature of Internet gaming disorder is a pattern of excessive and prolonged participation in 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. These Internet-based games typically involve competition between groups of players who are often in different global regions, so that extended duration of play is encouraged by time-zone independence. Although Internet gaming disorder most often involves specific Internet games with multiplayer competition, it can include non-Internet computerized off-line games as well, although these have been less researched. The Internet gaming often includes a significant aspect of social interactions during play, and the team aspects of play appear to be a key motivation. Attempts to direct the individual toward schoolwork or interpersonal activities are strongly resisted. 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 obligations, such as school or work, or family obligations are neglected. 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 Although no consistent personality types associated with Internet gaming disorder have been identified, negative affectivity, detachment, antagonism, disinhibition, and psychoticism have been associated with the disorder. 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.

Environmental. Genetic and physiological. Prevalence The mean prevalence of 12-month Internet gaming disorder is estimated as 4.7% across multiple countries, with a range of 0.7% to 15.6% across studies. Research using the DSM-5 proposed criteria suggests that prevalence is similar in Asian and Western countries. In the United States, based on large Internet-based surveys, the prevalence of DSM-5 Internet gaming disorder is 1% or lower. An international meta-analysis of 16 studies found a pooled prevalence of Internet gaming disorder among adolescents of 4.6%, with adolescent boys/men generally reporting a higher prevalence rate (6.8%) than adolescent girls/women (1.3%). Risk and Prognostic Factors Computer availability with Internet connection allows access to the types of games with which Internet gaming disorder is most often associated. Adolescent men seem to be at greatest risk of developing Internet gaming disorder. Sex- and Gender-Related Diagnostic Issues Internet gaming disorder appears to be more common in adolescent and young adult men than adolescent and young adult women. Adolescent boys ages 12–15 years also may be at greater risk of adverse effects of disordered gaming (e.g., lower school grades, loneliness). There may also be gender differences in the types of games played, in that adolescent girls ages 12–15 tend to choose games that include puzzles, music, and social and educational themes, whereas adolescent boys of the same age more often choose action, fighting, strategy, and role-playing games that may have greater addictive potential. Association With Suicidal Thoughts or Behavior Few studies specifically address suicide in individuals diagnosed with Internet gaming disorder, but studies on a broader phenotype of problematic Internet and online gaming behaviors are available. A nationally representative household survey of Australian youth ages 11–17 years (Young Minds Matter) found that problem Internet and online gaming behavior was associated with higher risk of suicide attempt in the prior year. After controlling for demographics, depression, family support, and self-esteem, a survey study of 9,510 Taiwanese students ages 12–18 years found that Internet addiction, including online gaming, was associated with suicidal thoughts and suicide attempt. In a representative sample of 8,807 students from randomly selected European schools, 3.62% had Internet gaming disorder (using DSM-5 criteria), and 3.11% of the students were considered to have pathological Internet use but were not gamers. Both groups showed similarly increased risks for emotional symptoms, conduct disorder, hyperactivity/inattention, self-injurious behaviors, and suicidal thoughts and behavior. The mental health effects of problematic Internet use, including suicidal thoughts or behavior, appear to be related to and perhaps mediated by the impact of problematic Internet use on sleep. Functional Consequences of Internet Gaming Disorder

Internet gaming disorder may lead to school failure, job loss, or marriage failure. The compulsive gaming behavior tends to crowd out normal social, scholastic, and family activities. Students may show declining grades and eventually failure in school. Family responsibilities may be neglected. Differential Diagnosis Excessive use of the Internet not involving playing of online games (e.g., excessive use of social media, such as Facebook; viewing pornography online) is not considered analogous to Internet gaming disorder, and future research on other excessive uses of the Internet would need to follow similar guidelines as suggested herein. Excessive gambling online may qualify for a separate diagnosis of gambling disorder. Comorbidity Health may be neglected due to compulsive gaming. Other diagnoses that may be associated with Internet gaming disorder include major depressive disorder, ADHD, and obsessivecompulsive disorder. 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:
6. Impairment in mood or behavioral regulation (e.g., mood lability; negative affect or irritability; frequent behavioral outbursts).
7. Attention deficit (e.g., difficulty shifting attention; difficulty sustaining mental effort).
8. 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):
9. Communication deficit (e.g., delayed acquisition of language; difficulty understanding spoken language).
10. Impairment in social communication and interaction (e.g., overly friendly with strangers; difficulty reading social cues; difficulty understanding social consequences).
11. Impairment in daily living skills (e.g., delayed toileting, feeding, or bathing; difficulty managing daily schedule).
12. Impairment in motor skills (e.g., poor fine motor development; delayed attainment of gross motor milestones or ongoing deficits in gross motor function; deficits in coordination and balance). E. Onset of the disorder (symptoms in Criteria B, C, and D) occurs in childhood. F. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning. G. The disorder is not better explained by the direct physiological effects associated with postnatal use of a substance (e.g., a medication, alcohol or other drugs), a general medical condition (e.g., traumatic brain injury, delirium, dementia), another known teratogen (e.g., fetal hydantoin syndrome), a genetic condition (e.g., Williams syndrome, Down syndrome, Cornelia de Lange syndrome), or environmental neglect. Alcohol is a neurobehavioral teratogen, and prenatal alcohol exposure has teratogenic effects on central nervous system (CNS) development and subsequent function. Neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE) is a new clarifying term, intended to encompass the full range of developmental disabilities associated with exposure to alcohol in utero. ND-PAE may 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; specific guidelines for facial dysmorphology have been developed for diverse ethnoracial physiognomies. 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 prior to pregnancy recognition and/or following pregnancy recognition may be required. More than minimal exposure is defined as greater than 13 drinks per month during pregnancy or more than 2 drinks on any one 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 Associated features vary depending on age, degree of alcohol exposure, and the individual’s environment. An individual can be diagnosed with this disorder regardless of socioeconomic or cultural background. However, ongoing parental alcohol/substance misuse, parental mental illness, exposure to domestic or community violence, neglect or abuse, disrupted caregiving relationships, multiple out-of-home placements, and lack of continuity in medical or mental health care are often present. Prevalence In the United States, the prevalence of ND-PAE (encompassing fetal alcohol spectrum disorders) has been estimated as 15.2/1,000 (range: 11.3–50.0/1,000), with higher estimates derived when only children with full evaluations were included (31.1–98.5/1,000). When vulnerable subpopulations are considered, rates of ND-PAE can be much higher (e.g., among children in

Environmental. care settings, 251.5/1,000), according to a meta-analysis of data from multiple countries. In 2012, the mean global prevalence of fetal alcohol spectrum disorder in the general population was 7.7 per 1,000 individuals, with a prevalence of 8.8 per 1,000 in the region of the Americas (including 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 preschoolor 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. Risk and Prognostic Factors Low socioeconomic status and low educational level in the mother are risk factors for fetal alcohol syndrome. This association is related to social, structural, and psychological factors that may increase the risk of maternal drinking or worsen its impact, including social determinants of health, such as the high concentration of liquor stores in lowincome, ethnoracially segregated communities. Culture-Related Diagnostic Issues Socioeconomic and cultural factors affect the consumption of alcohol during pregnancy, which ranges globally from 0.2% in the Eastern Mediterranean region to 25.2% in the European region. Individuals belonging to ethnic groups that have higher proportions of certain alleles of alcoholmetabolizing enzymes (e.g., of aldehyde dehydrogenase 2) may be less likely to exhibit the effects of prenatal alcohol exposure. Association With Suicidal Thoughts or Behavior Suicide is a high-risk outcome, with rates increasing significantly in late adolescence and early adulthood. Analyses of the Canadian national fetal alcohol spectrum disorder (FASD) database show that among individuals with FASD who have impaired affect regulation, there is a markedly higher risk of suicidal thoughts or behavior. In an Alberta-based registry, it was found that individuals with fetal alcohol syndrome are at markedly increased risk for premature death, with 15% dying from suicide. In California, a study of 54 adolescents ages 13–18 years with

FASD also demonstrated markedly higher rates of suicidal thoughts and serious attempts (all by boys) compared with the general U.S. adolescent population. In a Canadian survey, the mothers of individuals with FASD were over six times as likely to die by suicide and almost five times more likely to attempt suicide after giving birth to a child with FASD compared with mothers whose child did not have FASD, suggesting that the increased rates of suicidal ideation and suicide attempts among youth with FASD may be mediated by family factors (genetic and/or environmental), in addition to any risk conferred by the FASD condition itself. 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. Abnormalities have been associated with ND-PAE in multiple organ systems, including the heart, kidney, liver, gastrointestinal tract, and endocrine systems. 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 Other considerations include maternal exposure to other substances during the prenatal period; poor prenatal care; 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]); and environmental neglect. Genetic conditions such as Williams syndrome, Down syndrome, or Cornelia de Lange syndrome and other teratogenic conditions such as fetal hydantoin syndrome and maternal phenylketonuria may have similar physical and behavioral characteristics. A careful review of prenatal exposure history is needed to clarify the teratogenic agent, and an evaluation by a clinical geneticist may be needed to distinguish physical characteristics associated with these and other genetic conditions. Comorbidity Mental health problems have been identified in more than 90% of individuals with

histories of significant prenatal alcohol exposure. The most common co-occurring diagnosis is attentiondeficit/hyperactivity disorder, but research has shown that individuals with ND-PAE differ in neuropsychological characteristics and in their responsiveness to pharmacological 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. Note: ICD-10-CM codes to indicate whether suicidal behavior is part of the current clinical presentation (T14.91A for initial encounter and T14.91D for subsequent encounters) and/or whether there has been a prior history of suicidal behavior (Z91.51) are available for clinical use to accompany any DSM-5 diagnosis; in addition, the codes can be recorded in the absence of a DSM-5 diagnosis. The definition of these codes is included in Section II, “Other Conditions That May Be a Focus of Clinical Attention” (see “Suicidal Behavior”). 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.

Diagnostic Features The essential manifestation of suicidal behavior disorder is a suicide attempt. A suicide attempt is a behavior that the individual has undertaken with at least some intent to die. The behavior might or might not lead to injury or serious medical consequences. Several factors can influence the medical consequences of the suicide attempt, including poor planning, lack of knowledge about the lethality of the method chosen, low intentionality or ambivalence, or chance intervention by others after the behavior has been initiated. These should not be considered in assigning the diagnosis. Determining the degree of intent can be challenging. Individuals might not acknowledge intent, especially in situations where doing so could result in hospitalization or cause distress to loved ones. Markers of risk include degree of planning, including selection of a time and place to minimize rescue or interruption; the individual’s mental state at the time of the behavior, with acute agitation being especially concerning; recent discharge from inpatient care; or recent

discontinuation of a mood stabilizer such as lithium or an antipsychotic such as clozapine in the case of schizophrenia. Examples of environmental “triggers” include recently learning of a potentially fatal medical diagnosis such as cancer, experiencing the sudden and unexpected loss of a close relative or partner, loss of employment, or displacement from housing. Conversely, features such as talking to others about future events or preparedness to sign a contract for safety are less reliable indicators. In order for the criteria to be met, the individual must have made at least one suicide attempt. Suicide attempts can include behaviors in which, after initiating the suicide attempt, the individual changed his or her mind or someone intervened. For example, an individual might intend to ingest a given amount of medication or poison, but either stop or be stopped by another before ingesting the full amount. If the individual is dissuaded by another or changes his or her mind before initiating the behavior, the diagnosis should not be made. The acts qualifying for a diagnosis of suicidal behavior disorder should not have been initiated exclusively during a state of delirium or confusion. If the individual deliberately became intoxicated before initiating the suicidal behavior in order to reduce anticipatory anxiety and to minimize interference with the intended behavior, the diagnosis can still be made. Currently there are no clinical instruments that yield positive predictive values sufficient to make them useful tools for predicting suicidal behavior at the patient level. It is not surprising that single clinical or biological factors are poor indicators of suicide risk, because suicidal behavior emerges from a convergence of multiple risk factors. Moreover, given the clinical heterogeneity of suicidal behavior, it is likely that there are multiple pathways to suicidal behavior that can only be captured if this heterogeneity is considered. Similarly, numerous biomarkers have been studied, but no robust predictor has emerged. Development and Course Suicidal behavior disorder can occur at any time in the life span but is rarely seen in children under the age of 5. Approximately 25%–30% of persons who attempt suicide will go on to make more attempts. There is significant variability in terms of frequency, method, and lethality of attempts. However, this is not different from what is observed in other illnesses, such as major depressive disorder, in which frequency of episode, subtype of episode, and impairment for a given episode can vary significantly.

Genetic and physiological. Risk and Prognostic Factors The largest genome-wide association study of suicide attempt to date, from the Psychiatric Genomics Consortium, found that the genetic risk for depression increases the risk for suicide attempt across diagnostic cohorts with major depressive disorder, bipolar disorder, and schizophrenia. In other words, across diagnostic categories, attempters carry more risk alleles for depression than nonattempters, rather than simply for their primary psychiatric diagnosis. These results suggest that the genetic associations with suicide attempt are partly unique and partly shared with the genetic associations with depression. Culture-Related Diagnostic Issues Cultural contexts affect the frequency and form of suicidal behavior disorder, including variations in incidence and prevalence, methods used (e.g., poisoning with pesticides in lowincome countries; gunshot wounds in the southwestern United States), motivations, circumstances, and meanings. These patterns vary over time, by migrant or ethnic group, and by service setting. Culturally mediated social stressors and predicaments such as family breakdowns, perceived loss of dignity or interpersonal status, conflicting intergenerational roles and expectations due to differential acculturation, changing levels of sociocultural integration, stigma and self-stigma about suicide, and systemic discrimination and structural inequity (institutionalized socioeconomic bias and oppression) may contribute to the risk of suicidal behavior disorder. Attitudes toward suicide and suicidal behaviors are influenced by historical, environmental, economic, political, legal, social, cultural, moral, and spiritual or religious factors.

For example, in a longitudinal U.S. sample followed across generations, parental belief (self-identified as mostly Protestant and Catholic) in the importance of religion was associated with lower risk of suicidal behavior in their offspring, independent of an offspring's own belief about religious importance and other known parental factors, such as parental depression, suicidal behavior, and divorce. The reasons for suicide attempts and choice of suicide methods may have cultural significance, which may be associated with specific individual and social responses (e.g., of stigma, shame, or respect). Sex- and Gender-Related Diagnostic Issues Suicidal behavior disorder varies in prevalence and form across sex and gender. On average, suicides are about twice as common in men compared with women, although the prevalence ratio varies by country and cultural context. Estimates also vary because the intent of self-harm behaviors is not always clearly measured; however, suicidal behavior that does not result in death is more common in women than in men. Men generally use more lethal methods such as gunshots and hanging, whereas less lethal means such as self-poisoning are more common in women. The frequency of suicidal behaviors is higher in women (i.e., the average number of suicide attempts for a woman is generally higher than the average number for a man), but this could be explained by the more frequent use of less lethal methods among women. Suicide rates among individuals who identify as transgender are high, and transgender individuals are also at higher risk for suicidal behavior than cisgender individuals.

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. Comorbidity Suicidal behavior disorder is seen in the context of a variety of mental disorders, most commonly bipolar disorder, major depressive disorder, schizophrenia, schizoaffective disorder, anxiety disorders (in particular, panic disorders associated with catastrophic content and PTSD flashbacks), substance use disorders (especially alcohol use disorders), borderline personality disorder, antisocial personality disorder, eating disorders, and adjustment disorders. Nonsuicidal Self-Injury Disorder 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:
4. 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.
5. 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 developmental disorder [intellectual disability], Lesch-Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania [hair-pulling disorder], excoriation [skin-picking] disorder). Note: ICD-10-CM codes to indicate whether nonsuicidal self-injury is part of the current clinical presentation (R45.88) and/or whether there has been a prior history of nonsuicidal self-injury (Z91.52) are available for clinical use to accompany any DSM-5 diagnosis; in addition, the codes can be recorded in the absence of a DSM-5 diagnosis. The definition of these codes is included in Section II, “Other Conditions That May Be a Focus of Clinical Attention” (see “Nonsuicidal Self-Injury”). Diagnostic Features The essential feature of nonsuicidal self-injury disorder is that the individual repeatedly inflicts minor-to-moderate, often painful injuries to the surface of his or her body without suicidal intent. Most commonly, the purpose is to reduce negative emotions, such as tension, anxiety, sadness, or self-reproach, or less often 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. Cutting is the most common method of injury and is most often inflicted with a knife, needle, razor, or other sharp object. Common areas for injury include the dorsal side of the forearm and frontal area of the thighs. 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 often leave a characteristic pattern of scars. Other relatively common methods used include superficial scratching or burning of the skin, as well as self-hitting or banging, biting, and interfering with wound healing. Many will use different methods over time, and use of multiple methods is associated with more severe

psychopathology, including engagement in suicide attempts. Many, and possibly most, of those who engage in nonsuicidal self-injury do not seek clinical attention. This tendency may reflect a reluctance to disclose self-injury due to concerns over stigma. In addition, many individuals who engage in these behaviors experience them positively because of the effectiveness of nonsuicidal self-injury in regulating negative emotion, thereby reducing or eliminating motivation for treatment. Children and adolescents 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. Associated Features Nonsuicidal self-injury disorder appears predominantly maintained by negative reinforcement, in that the behavior is reported to quickly reduce negative emotion and aversive emotional arousal. Some who engage in the behavior also report that nonsuicidal self-injury can quickly reduce unwanted dissociative experiences and even suicidal ideation, as well as serve as a way to cope with trauma-related symptoms such as self-directed anger and/or disgust. However, other forms of social and emotional reinforcement can also sustain the behavior, such as a desire to elicit reactions from others or generate positive

feelings. Prevalence In an international meta-analysis, prevalence of nonsuicidal self-injury disorder was found overall to be modestly higher in girls/women than in boys/men. This is in contrast to suicidal behavior, in which the gender ratio of girls/women to boys/men is much higher. The gender difference for nonsuicidal self-injury disorder is more pronounced in clinical samples. Across cultural contexts, the gender ratio of nonsuicidal self-injury may vary, being more prevalent among girls/women in some contexts (e.g., among high school students in rural areas of China) and among boys/men in others (e.g., among youth ages 11–19 in Jordan). Nonsuicidal self-injury disorder is substantially more common among sexual minorities, especially those who identify as bisexual. Development and Course Nonsuicidal self-injury disorder most often starts in the early to mid-teen years and can continue for many years, with earlier ages at onset being associated with more severe manifestations. Nonsuicidal self-injury disorder may peak in late adolescence and the early 20s and then decline into adulthood. Additional prospective research is needed to outline the natural history of nonsuicidal self-injury disorder and the factors that promote or inhibit its course. Individuals often learn of the behavior on the recommendation or observation of another, through media outlets, and through social media. Individuals exposed to others who self-injure, including in inpatient, school, correctional, and community settings, are more likely to initiate self-injury, potentially through social modeling or social learning mechanisms. Culture-Related Diagnostic Issues

Borderline personality disorder. Suicidal behavior. Trichotillomania (hair-pulling disorder). Nonsuicidal self-injury disorder should not be diagnosed if the behavior is motivated by a widely accepted cultural practice. This is true even if the practice is only carried out by a minority of the population (e.g., engaging in self-flagellation as a collective activity during religious festivals). Nonsuicidal self-injury may be a way of expressing group belongingness rather than individual distress or emotion regulation, as suggested by research with “alternative” (i.e., Goth, Emo, and Punk) youth groups in Germany, and nonsuicidal self-injury disorder should also not be diagnosed in such instances. Association With Suicidal Thoughts or Behavior Because individuals with nonsuicidal self-injury can and do attempt suicide, it is important to evaluate these individuals for suicide risk and to obtain information from a third party concerning any recent change in stress exposure and mood. Likelihood of a suicide attempt has been associated with a history of nonsuicidal self-injury, with the onset of nonsuicidal self-injury typically preceding suicide attempts by approximately 1–2 years, as shown by research in clinical and community settings in three high-income countries. The use of multiple previous methods of nonsuicidal self-injury, high frequencies of self-injurious acts, younger age at onset, and using nonsuicidal self-injury to obtain relief from internal distress or for self-punishment are strongly predictive of both suicidal ideation and suicide attempts. Functional Consequences of Nonsuicidal Self-Injury Disorder The act of cutting might be performed with shared implements, raising the possibility of bloodborne disease transmission. Severe burns, infection from poor care of injuries, and permanent scarring can also result, negatively impacting the individual. Differential Diagnosis Many have regarded nonsuicidal self-injury as pathognomonic of borderline personality disorder. However, although nonsuicidal self-injury disorder is often comorbid with borderline personality disorder, many individuals with nonsuicidal self-injury disorder do not have a personality pattern that meets criteria for borderline personality disorder. Nonsuicidal self-injury disorder not only occurs without borderline personality disorder but frequently co-occurs with many other disorders, including depressive disorders, eating disorders, and substance disorders. The differentiation between nonsuicidal self-injury disorder and suicidal behavior is based on the stated goal of the behavior, either as a wish to die (suicidal

behavior) or to experience relief (as described in the criteria for nonsuicidal self-injury disorder). In contrast to suicidal behavior, nonsuicidal self-injury episodes are, in the short-term, typically benign in individuals with a history of frequent episodes. Further, some individuals report using their nonsuicidal self-injury to avoid attempting suicide. Trichotillomania is defined by self-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

Stereotypic movement disorder. Excoriation (skin-picking) disorder. period of relaxation or distraction. If the self-injurious behavior is confined to hair-pulling, trichotillomania should be diagnosed instead of nonsuicidal self-injury disorder. Stereotypic movement disorder involves repetitive, seemingly driven, and apparently purposeless motor behavior (e.g., hand shaking or waving, body rocking, head banging, self-biting, hitting own body) that can sometimes result in self-injury and is often associated with a known medical or genetic condition, neurodevelopmental disorder, or environmental factor (e.g., Lesch-Nyhan syndrome, intellectual developmental disorder, intrauterine alcohol exposure). If the self-injurious behavior meets criteria for stereotypic movement disorder, it should be diagnosed instead of nonsuicidal self-injury disorder. Excoriation disorder 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. If the self-injurious behavior is confined to skin-picking, excoriation disorder should be diagnosed instead of nonsuicidal self-injury disorder.