cal patients. The presence of an Adjustment Disorder may complicate the course of illness in individuals who have a general medical condition (e.g., decreased compliance with the recommended medical regimen or increased length of hospital stay).

Specific Culture, Age, and Gender Features

The context of the individual's cultural setting should be taken into account in making the clinical judgment of whether the individual's response to the stressor is maladaptive or whether the associated distress is in excess of what would be expected. The nature, meaning, and experience of the stressors and the evaluation of the response to the stressors may vary across cultures. Adjustment Disorders may occur in any age group. In clinical samples of adults, women are given the diagnosis twice as often as men. In contrast, in clinical samples of children and adolescents, boys and girls are equally likely to receive this diagnosis.

Prevalence

Adjustment Disorders are apparently common, although prevalence rates vary widely as a function of the population studied and the assessment methods used. The prevalence of Adjustment Disorder has been reported to be between 2% and 8% in community samples of children and adolescents and the elderly. Adjustment Disorder has been diagnosed in up to 12% of general hospital inpatients who are referred for a mental health consultation, in 10%–30% of those in mental health outpatient settings, and in as many as 50% in special populations that have experienced a specific stressor (e.g., following cardiac surgery). Individuals from disadvantaged life circumstances experience a high rate of stressors and may be at increased risk for the disorder.

Course

By definition, the disturbance in Adjustment Disorder begins within 3 months of onset of a stressor and lasts no longer than 6 months after the stressor or its consequences have ceased. If the stressor is an acute event (e.g., being fired from a job), the onset of the disturbance is usually immediate (or within a few days) and the duration is relatively brief (e.g., no more than a few months). If the stressor or its consequences persist, the Adjustment Disorder may also persist. The persistence of Adjustment Disorder or its progression to other, more severe mental disorders (e.g., Major Depressive Disorder) may be more likely in children and adolescents than in adults. However, some or all of this increased risk may be attributable to the presence of comorbid conditions (e.g., Attention-Deficit/Hyperactivity Disorder) or to the possibility that the Adjustment Disorder actually represented a subclinical prodrome manifestation of the more severe mental disorder.

Differential Diagnosis

Adjustment Disorder is a residual category used to describe presentations that are a response to an identifiable stressor and that do not meet the criteria for another spe-

cific Axis I disorder. For example, if an individual has symptoms that meet criteria for a Major Depressive Episode in response to a stressor, the diagnosis of Adjustment Disorder is not applicable. Adjustment Disorder can be diagnosed in addition to another Axis I disorder only if the latter does not account for the particular symptoms that occur in reaction to the stressor. For example, an individual may develop Adjustment Disorder With Depressed Mood after losing a job and at the same time have a diagnosis of Obsessive-Compulsive Disorder.

Because **Personality Disorders** are frequently exacerbated by stress, the additional diagnosis of Adjustment Disorder is usually not made. However, if symptoms that are not characteristic of the Personality Disorder appear in response to a stressor (e.g., a person with Paranoid Personality Disorder develops depressed mood in response to job loss), the additional diagnosis of Adjustment Disorder may be appropriate.

The diagnosis of Adjustment Disorder requires the presence of an identifiable stressor, in contrast to the atypical or subthreshold presentations that would be diagnosed as a **Not Otherwise Specified disorder** (e.g., Anxiety Disorder Not Otherwise Specified). If the symptoms of Adjustment Disorder persist for more than 6 months after the stressor or its consequences have ceased, the diagnosis should be changed to another mental disorder, usually in the appropriate Not Otherwise Specified category.

Adjustment Disorder, **Posttraumatic Stress Disorder,** and **Acute Stress Disorder** all require the presence of a stressor. Posttraumatic Stress Disorder and Acute Stress Disorder are characterized by the presence of an extreme stressor and a specific constellation of symptoms. In contrast, Adjustment Disorder can be triggered by a stressor of any severity and may involve a wide range of possible symptoms.

In **Psychological Factors Affecting Medical Condition,** specific psychological symptoms, behaviors, or other factors exacerbate a general medical condition, complicate treatment for a general medical condition, or otherwise increase the risks of developing a general medical condition. In Adjustment Disorder, the relationship is the reverse (i.e., the psychological symptoms develop in response to the stress of having or being diagnosed with a general medical condition). Both conditions may be present in some individuals.

Bereavement is generally diagnosed instead of Adjustment Disorder when the reaction is an expectable response to the death of a loved one. The diagnosis of Adjustment Disorder may be appropriate when the reaction is in excess of, or more prolonged than, what would be expected. Adjustment Disorder should also be distinguished from other **nonpathological reactions to stress** that do not lead to marked distress in excess of what is expected and that do not cause significant impairment in social or occupational functioning. Adjustment Disorder should not be diagnosed when the symptoms are due to the **direct physiological effects of a General Medical Condition** (such as the usual transient functional impairment that is associated with a course of chemotherapy).

Diagnostic criteria for Adjustment Disorders

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

B. These symptoms or behaviors are clinically significant as evidenced by either of the following:

(1) marked distress that is in excess of what would be expected from exposure to the stressor
(2) significant impairment in social or occupational (academic) functioning

C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

D. The symptoms do not represent Bereavement.

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if:

Acute: if the disturbance lasts less than 6 months
Chronic: if the disturbance lasts for 6 months or longer

Adjustment Disorders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(s) can be specified on Axis IV.

309.0 With Depressed Mood
309.24 With Anxiety
309.28 With Mixed Anxiety and Depressed Mood
309.3 With Disturbance of Conduct
309.4 With Mixed Disturbance of Emotions and Conduct
309.9 Unspecified

Personality Disorders

This section begins with a general definition of Personality Disorder that applies to each of the 10 specific Personality Disorders. A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. The Personality Disorders included in this section are listed below.

Paranoid Personality Disorder is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.

Schizoid Personality Disorder is a pattern of detachment from social relationships and a restricted range of emotional expression.

Schizotypal Personality Disorder is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.

Antisocial Personality Disorder is a pattern of disregard for, and violation of, the rights of others.

Borderline Personality Disorder is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.

Histrionic Personality Disorder is a pattern of excessive emotionality and attention seeking.

Narcissistic Personality Disorder is a pattern of grandiosity, need for admiration, and lack of empathy.

Avoidant Personality Disorder is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.

Dependent Personality Disorder is a pattern of submissive and clinging behavior related to an excessive need to be taken care of.

Obsessive-Compulsive Personality Disorder is a pattern of preoccupation with orderliness, perfectionism, and control.

Personality Disorder Not Otherwise Specified is a category provided for two situations: 1) the individual's personality pattern meets the general criteria for a Personality Disorder and traits of several different Personality Disorders are present, but the criteria for any specific Personality Disorder are not met; or 2) the individual's personality pattern meets the general criteria for a Personality Disorder, but the individual is considered to have a Personality Disorder that is not included in the Classification (e.g., passive-aggressive personality disorder).

The Personality Disorders are grouped into three clusters based on descriptive similarities. Cluster A includes the Paranoid, Schizoid, and Schizotypal Personality Disorders. Individuals with these disorders often appear odd or eccentric. Cluster B includes the Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders. Individuals with these disorders often appear dramatic, emotional, or erratic. Cluster C

includes the Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders. Individuals with these disorders often appear anxious or fearful. It should be noted that this clustering system, although useful in some research and educational situations, has serious limitations and has not been consistently validated. Moreover, individuals frequently present with co-occurring Personality Disorders from different clusters.

Diagnostic Features

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

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

Recording Procedures

Personality Disorders are coded on Axis II. When (as is often the case) an individual's pattern of behavior meets criteria for more than one Personality Disorder, the clinician should list all relevant Personality Disorder diagnoses in order of importance.

When an Axis I disorder is not the principal diagnosis or the reason for visit, the clinician is encouraged to indicate which Personality Disorder is the principal diagnosis or the reason for visit by noting "Principal Diagnosis" or "Reason for Visit" in parentheses. In most cases, the principal diagnosis or the reason for visit is also the main focus of attention or treatment. Personality Disorder Not Otherwise Specified is the appropriate diagnosis for a "mixed" presentation in which criteria are not met for any single Personality Disorder but features of several Personality Disorders are present and involve clinically significant impairment.

Specific maladaptive personality traits that do not meet the threshold for a Personality Disorder may also be listed on Axis II. In such instances, no specific code should be used; for example, the clinician might record "Axis II: V71.09 No diagnosis on Axis II, histrionic personality traits." The use of particular defense mechanisms may also be indicated on Axis II. For example, a clinician might record "Axis II: 301.6 Dependent Personality Disorder; Frequent use of denial." Glossary definitions for specific defense mechanisms and the Defensive Functioning Scale appear in Appendix B (p. 807).

When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophrenia) that was preceded by a preexisting Personality Disorder (e.g., Schizotypal, Schizoid, Paranoid), the Personality Disorder should be recorded on Axis II, followed by "Premorbid" in parentheses. For example: Axis I: 295.30 Schizophrenia, Paranoid Type; Axis II: 301.20 Schizoid Personality Disorder (Premorbid).

Specific Culture, Age, and Gender Features

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

Personality Disorder categories may be applied to children or adolescents in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or an episode of an Axis I disorder. It should be recognized that the traits of a Personality Disorder that appear in childhood will often not persist unchanged into adult life. To diagnose a Personality Disorder in an individual under age 18 years, the features must have been present for at least 1 year. The one exception to this is Antisocial Personality Disorder, which cannot be diagnosed in individuals under age 18 years (see p. 701). Although, by definition, a Personality Disorder requires an onset no later than early adulthood, individuals may not come to clinical attention until relatively late in life. A Personality Disorder may be exacerbated following the loss of significant supporting persons (e.g., a spouse) or previously stabilizing social situations (e.g., a job). However, the development of a change in personality in middle adulthood or later life warrants a thorough evaluation to determine the possible presence of a Personality Change Due to a General Medical Condition or an unrecognized Substance-Related Disorder.

Certain Personality Disorders (e.g., Antisocial Personality Disorder) are diagnosed more frequently in men. Others (e.g., Borderline, Histrionic, and Dependent Personality Disorders) are diagnosed more frequently in women. Although these differences in prevalence probably reflect real gender differences in the presence of such patterns, clinicians must be cautious not to overdiagnose or underdiagnose certain Personality Disorders in females or in males because of social stereotypes about typical gender roles and behaviors.

Course

The features of a Personality Disorder usually become recognizable during adolescence or early adult life. By definition, a Personality Disorder is an enduring pattern of thinking, feeling, and behaving that is relatively stable over time. Some types of Personality Disorder (notably, Antisocial and Borderline Personality Disorders) tend to become less evident or to remit with age, whereas this appears to be less true for some other types (e.g., Obsessive-Compulsive and Schizotypal Personality Disorders).

Differential Diagnosis

Many of the specific criteria for the Personality Disorders describe features (e.g., suspiciousness, dependency, or insensitivity) that are also characteristic of episodes of **Axis I mental disorders.** A Personality Disorder should be diagnosed only when the defining characteristics appeared before early adulthood, are typical of the individual's long-term functioning, and do not occur exclusively during an episode of an Axis I disorder. It may be particularly difficult (and not particularly useful) to distinguish Personality Disorders from those Axis I disorders (e.g., Dysthymic Disorder) that have an early onset and a chronic, relatively stable course. Some Personality Disorders may have a "spectrum" relationship to particular Axis I conditions (e.g., Schizotypal Personality Disorder with Schizophrenia; Avoidant Personality Disorder with Social Phobia) based on phenomenological or biological similarities or familial aggregation.

For the three Personality Disorders that may be related to the **Psychotic Disorders** (i.e., Paranoid, Schizoid, and Schizotypal), there is an exclusion criterion stating that the pattern of behavior must not have occurred exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder. When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophrenia) that was preceded by a preexisting Personality Disorder, the Personality Disorder should also be recorded, on Axis II, followed by "Premorbid" in parentheses.

The clinician must be cautious in diagnosing Personality Disorders during an episode of a **Mood Disorder** or an **Anxiety Disorder** because these conditions may have cross-sectional symptom features that mimic personality traits and may make it more difficult to evaluate retrospectively the individual's long-term patterns of functioning. When personality changes emerge and persist after an individual has been exposed to extreme stress, a diagnosis of **Posttraumatic Stress Disorder** should be considered (see p. 463). When a person has a **Substance-Related Disorder,** it is important not to make a Personality Disorder diagnosis based solely on behaviors that are consequences of Substance Intoxication or Withdrawal or that are associated with

activities in the service of sustaining a dependency (e.g., antisocial behavior). When enduring changes in personality arise as a result of the direct physiological effects of a general medical condition (e.g., brain tumor), a diagnosis of **Personality Change Due to a General Medical Condition** (p. 187) should be considered.

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

General diagnostic criteria for a Personality Disorder

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

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

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

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

Dimensional Models for Personality Disorders

The diagnostic approach used in this manual represents the categorical perspective that Personality Disorders are qualitatively distinct clinical syndromes. An alternative to the categorical approach is the dimensional perspective that Personality Disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another. There have been many different attempts to identify the most fundamental dimensions that underlie the entire domain of normal and pathological personality functioning. One model consists of the following five dimensions: neuroticism, introversion versus extroversion, closedness versus openness to experience, antagonism versus agreeableness, and conscientiousness. Another ap-

proach is to describe more specific areas of personality dysfunction, including as many as 15–40 dimensions (e.g., affective reactivity, social apprehensiveness, cognitive distortion, impulsivity, insincerity, self-centeredness). Other dimensional models that have been proposed include positive affectivity, negative affectivity, and constraint; novelty seeking, reward dependence, harm avoidance, persistence, self-directedness, cooperativeness, and self-transcendence; power (dominance vs. submission) and affiliation (love vs. hate); and pleasure seeking versus pain avoidance, passive accommodation versus active modification, and self-propagation versus other nurturance. The DSM-IV Personality Disorder clusters (i.e., odd-eccentric, dramatic-emotional, and anxious-fearful) may also be viewed as dimensions representing spectra of personality dysfunction on a continuum with Axis I mental disorders. The alternative dimensional models share much in common and together appear to cover the important areas of personality dysfunction. Their integration, clinical utility, and relationship with the Personality Disorder diagnostic categories and various aspects of personality dysfunction are under active investigation.

Cluster A Personality Disorders

301.0 Paranoid Personality Disorder

Diagnostic Features

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

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

Individuals with this disorder are reluctant to confide in or become close to others because they fear that the information they share will be used against them (Criterion A3). They may refuse to answer personal questions, saying that the information is "nobody's business." They read hidden meanings that are demeaning and threatening into benign remarks or events (Criterion A4). For example, an individual with this disorder may misinterpret an honest mistake by a store clerk as a deliberate attempt to shortchange or may view a casual humorous remark by a co-worker as a serious

character attack. Compliments are often misinterpreted (e.g., a compliment on a new acquisition is misinterpreted as a criticism for selfishness; a compliment on an accomplishment is misinterpreted as an attempt to coerce more and better performance). They may view an offer of help as a criticism that they are not doing well enough on their own.

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

Paranoid Personality Disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder or if it is due to the direct physiological effects of a neurological (e.g., temporal lobe epilepsy) or other general medical condition (Criterion B).

Associated Features and Disorders

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

Because individuals with Paranoid Personality Disorder lack trust in others, they have an excessive need to be self-sufficient and a strong sense of autonomy. They also need to have a high degree of control over those around them. They are often rigid, critical of others, and unable to collaborate, although they have great difficulty accepting criticism themselves. They may blame others for their own shortcomings. Because of their quickness to counterattack in response to the threats they perceive around them, they may be litigious and frequently become involved in legal disputes. Individuals with this disorder seek to confirm their preconceived negative notions regarding people or situations they encounter, attributing malevolent motivations to others that are projections of their own fears. They may exhibit thinly hidden, unrealistic grandiose fantasies, are often attuned to issues of power and rank, and tend to develop negative stereotypes of others, particularly those from population groups

distinct from their own. Attracted by simplistic formulations of the world, they are often wary of ambiguous situations. They may be perceived as "fanatics" and form tightly knit "cults" or groups with others who share their paranoid belief systems.

Particularly in response to stress, individuals with this disorder may experience very brief psychotic episodes (lasting minutes to hours). In some instances, Paranoid Personality Disorder may appear as the premorbid antecedent of Delusional Disorder or Schizophrenia. Individuals with this disorder may develop Major Depressive Disorder and may be at increased risk for Agoraphobia and Obsessive-Compulsive Disorder. Alcohol and other Substance Abuse or Dependence frequently occur. The most common co-occurring Personality Disorders appear to be Schizotypal, Schizoid, Narcissistic, Avoidant, and Borderline.

Specific Culture, Age, and Gender Features

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

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

Prevalence

The prevalence of Paranoid Personality Disorder has been reported to be 0.5%–2.5% in the general population, 10%–30% among those in inpatient psychiatric settings, and 2%–10% among those in outpatient mental health clinics.

Familial Pattern

There is some evidence for an increased prevalence of Paranoid Personality Disorder in relatives of probands with chronic Schizophrenia and for a more specific familial relationship with Delusional Disorder, Persecutory Type.

Differential Diagnosis

Paranoid Personality Disorder can be distinguished from **Delusional Disorder, Persecutory Type, Schizophrenia, Paranoid Type,** and **Mood Disorder With Psychotic**

Features because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). To give an additional diagnosis of Paranoid Personality Disorder, the Personality Disorder must have been present before the onset of psychotic symptoms and must persist when the psychotic symptoms are in remission. When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophrenia) that was preceded by Paranoid Personality Disorder, Paranoid Personality Disorder should be recorded on Axis II, followed by "Premorbid" in parentheses.

Paranoid Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified). Finally, it must also be distinguished from **paranoid traits associated with the development of physical handicaps** (e.g., a hearing impairment).

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

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

Diagnostic criteria for 301.0 Paranoid Personality Disorder

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
(2) is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
(3) is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
(4) reads hidden demeaning or threatening meanings into benign remarks or events
(5) persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
(6) perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
(7) has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of a general medical condition.

Note: If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Paranoid Personality Disorder (Premorbid)."

301.20 Schizoid Personality Disorder

Diagnostic Features

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

Individuals with Schizoid Personality Disorder appear to lack a desire for intimacy, seem indifferent to opportunities to develop close relationships, and do not seem to derive much satisfaction from being part of a family or other social group (Criterion A1). They prefer spending time by themselves, rather than being with other people. They often appear to be socially isolated or "loners" and almost always choose solitary activities or hobbies that do not include interaction with others (Criterion A2). They prefer mechanical or abstract tasks, such as computer or mathematical games. They may have very little interest in having sexual experiences with another person (Criterion A3) and take pleasure in few, if any, activities (Criterion A4). There is usually a reduced experience of pleasure from sensory, bodily, or interpersonal experiences, such as walking on a beach at sunset or having sex. These individuals have

no close friends or confidants, except possibly a first-degree relative (Criterion A5).

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

Schizoid Personality Disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder or if it is due to the direct physiological effects of a neurological (e.g., temporal lobe epilepsy) or other general medical condition (Criterion B).

Associated Features and Disorders

Individuals with Schizoid Personality Disorder may have particular difficulty expressing anger, even in response to direct provocation, which contributes to the impression that they lack emotion. Their lives sometimes seem directionless, and they may appear to "drift" in their goals. Such individuals often react passively to adverse circumstances and have difficulty responding appropriately to important life events. Because of their lack of social skills and lack of desire for sexual experiences, individuals with this disorder have few friendships, date infrequently, and often do not marry. Occupational functioning may be impaired, particularly if interpersonal involvement is required, but individuals with this disorder may do well when they work under conditions of social isolation. Particularly in response to stress, individuals with this disorder may experience very brief psychotic episodes (lasting minutes to hours). In some instances, Schizoid Personality Disorder may appear as the premorbid antecedent of Delusional Disorder or Schizophrenia. Individuals with this disorder may sometimes develop Major Depressive Disorder. Schizoid Personality Disorder most often co-occurs with Schizotypal, Paranoid, and Avoidant Personality Disorders.

Specific Culture, Age, and Gender Features

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

Schizoid Personality Disorder may be first apparent in childhood and adolescence

with solitariness, poor peer relationships, and underachievement in school, which mark these children or adolescents as different and make them subject to teasing.

Schizoid Personality Disorder is diagnosed slightly more often in males and may cause more impairment in them.

Prevalence

Schizoid Personality Disorder is uncommon in clinical settings.

Familial Pattern

Schizoid Personality Disorder may have increased prevalence in the relatives of individuals with Schizophrenia or Schizotypal Personality Disorder.

Differential Diagnosis

Schizoid Personality Disorder can be distinguished from **Delusional Disorder, Schizophrenia,** and **Mood Disorder With Psychotic Features** because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delusions and hallucinations). To give an additional diagnosis of Schizoid Personality Disorder, the Personality Disorder must have been present before the onset of psychotic symptoms and must persist when the psychotic symptoms are in remission. When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophrenia) that was preceded by Schizoid Personality Disorder, Schizoid Personality Disorder should be recorded on Axis II followed by "Premorbid" in parentheses.

There may be great difficulty differentiating individuals with Schizoid Personality Disorder from those with milder forms of **Autistic Disorder** and from those with **Asperger's Disorder.** Milder forms of Autistic Disorder and Asperger's Disorder are differentiated by more severely impaired social interaction and stereotyped behaviors and interests.

Schizoid Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

Other Personality Disorders may be confused with Schizoid Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Schizoid Personality Disorder, all can be diagnosed. Although characteristics of social isolation and restricted affectivity are common to Schizoid, Schizotypal, and Paranoid Personality Disorders, Schizoid Personality Disorder can be distinguished from **Schizotypal Personality Disorder** by the lack of cognitive and perceptual distortions and from **Paranoid Personality Disorder** by the lack of suspiciousness and paranoid ideation. The social isolation of Schizoid Personality Disorder can be distinguished from that of **Avoidant Personality Disorder,** which is due to fear of being embarrassed or found inadequate and excessive antici-

pation of rejection. In contrast, people with Schizoid Personality Disorder have a more pervasive detachment and limited desire for social intimacy. Individuals with **Obsessive-Compulsive Personality Disorder** may also show an apparent social detachment stemming from devotion to work and discomfort with emotions, but they do have an underlying capacity for intimacy.

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

Diagnostic criteria for 301.20 Schizoid Personality Disorder

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

   (1) neither desires nor enjoys close relationships, including being part of a family
   (2) almost always chooses solitary activities
   (3) has little, if any, interest in having sexual experiences with another person
   (4) takes pleasure in few, if any, activities
   (5) lacks close friends or confidants other than first-degree relatives
   (6) appears indifferent to the praise or criticism of others
   (7) shows emotional coldness, detachment, or flattened affectivity

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder and is not due to the direct physiological effects of a general medical condition.

Note: If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Schizoid Personality Disorder (Premorbid)."

301.22 Schizotypal Personality Disorder

Diagnostic Features

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

Individuals with Schizotypal Personality Disorder often have ideas of reference (i.e., incorrect interpretations of casual incidents and external events as having a particular and unusual meaning specifically for the person) (Criterion A1). These should be distinguished from delusions of reference, in which the beliefs are held with delusional conviction. These individuals may be superstitious or preoccupied with paranormal phenomena that are outside the norms of their subculture (Criterion A2).

They may feel that they have special powers to sense events before they happen or to read others' thoughts. They may believe that they have magical control over others, which can be implemented directly (e.g., believing that their spouse's taking the dog out for a walk is the direct result of thinking an hour earlier it should be done) or indirectly through compliance with magical rituals (e.g., walking past a specific object three times to avoid a certain harmful outcome). Perceptual alterations may be present (e.g., sensing that another person is present or hearing a voice murmuring his or her name) (Criterion A3). Their speech may include unusual or idiosyncratic phrasing and construction. It is often loose, digressive, or vague, but without actual derailment or incoherence (Criterion A4). Responses can be either overly concrete or overly abstract, and words or concepts are sometimes applied in unusual ways (e.g., the person may state that he or she was not "talkable" at work).

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

Individuals with Schizotypal Personality Disorder experience interpersonal relatedness as problematic and are uncomfortable relating to other people. Although they may express unhappiness about their lack of relationships, their behavior suggests a decreased desire for intimate contacts. As a result, they usually have no or few close friends or confidants other than a first-degree relative (Criterion A8). They are anxious in social situations, particularly those involving unfamiliar people (Criterion A9). They will interact with other people when they have to, but prefer to keep to themselves because they feel that they are different and just do not "fit in." Their social anxiety does not easily abate, even when they spend more time in the setting or become more familiar with the other people, because their anxiety tends to be associated with suspiciousness regarding others' motivations. For example, when attending a dinner party, the individual with Schizotypal Personality Disorder will not become more relaxed as time goes on, but rather may become increasingly tense and suspicious.

Schizotypal Personality Disorder should not be diagnosed if the pattern of behavior occurs exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder (Criterion B).

Associated Features and Disorders

Individuals with Schizotypal Personality Disorder often seek treatment for the associated symptoms of anxiety, depression, or other dysphoric affects rather than for the personality disorder features per se. Particularly in response to stress, individuals with this disorder may experience transient psychotic episodes (lasting minutes to

hours), although they usually are insufficient in duration to warrant an additional diagnosis such as Brief Psychotic Disorder or Schizophreniform Disorder. In some cases, clinically significant psychotic symptoms may develop that meet criteria for Brief Psychotic Disorder, Schizophreniform Disorder, Delusional Disorder, or Schizophrenia. Over half may have a history of at least one Major Depressive Episode. From 30% to 50% of individuals diagnosed with this disorder have a concurrent diagnosis of Major Depressive Disorder when admitted to a clinical setting. There is considerable co-occurrence with Schizoid, Paranoid, Avoidant, and Borderline Personality Disorders.

Specific Culture, Age, and Gender Features

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

Schizotypal Personality Disorder may be first apparent in childhood and adolescence with solitariness, poor peer relationships, social anxiety, underachievement in school, hypersensitivity, peculiar thoughts and language, and bizarre fantasies. These children may appear "odd" or "eccentric" and attract teasing. Schizotypal Personality Disorder may be slightly more common in males.

Prevalence

Schizotypal Personality Disorder has been reported to occur in approximately 3% of the general population.

Course

Schizotypal Personality Disorder has a relatively stable course, with only a small proportion of individuals going on to develop Schizophrenia or another Psychotic Disorder.

Familial Pattern

Schizotypal Personality Disorder appears to aggregate familially and is more prevalent among the first-degree biological relatives of individuals with Schizophrenia than among the general population. There may also be a modest increase in Schizophrenia and other Psychotic Disorders in the relatives of probands with Schizotypal Personality Disorder.

Differential Diagnosis

Schizotypal Personality Disorder can be distinguished from **Delusional Disorder, Schizophrenia,** and **Mood Disorder With Psychotic Features** because these disorders are all characterized by a period of persistent psychotic symptoms (e.g., delu-

sions and hallucinations). To give an additional diagnosis of Schizotypal Personality Disorder, the Personality Disorder must have been present before the onset of psychotic symptoms and persist when the psychotic symptoms are in remission. When an individual has a chronic Axis I Psychotic Disorder (e.g., Schizophrenia) that was preceded by Schizotypal Personality Disorder, Schizotypal Personality Disorder should be recorded on Axis II followed by "Premorbid" in parentheses.

There may be great difficulty differentiating children with Schizotypal Personality Disorder from the heterogeneous group of solitary, odd children whose behavior is characterized by marked social isolation, eccentricity, or peculiarities of language and whose diagnoses would probably include milder forms of **Autistic Disorder, Asperger's Disorder,** and **Expressive** and **Mixed Receptive-Expressive Language Disorders. Communication Disorders** may be differentiated by the primacy and severity of the disorder in language accompanied by compensatory efforts by the child to communicate by other means (e.g., gestures) and by the characteristic features of impaired language found in a specialized language assessment. Milder forms of Autistic Disorder and Asperger's Disorder are differentiated by the even greater lack of social awareness and emotional reciprocity and stereotyped behaviors and interests.

Schizotypal Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

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

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

Diagnostic criteria for 301.22 Schizotypal Personality Disorder

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

   (1) ideas of reference (excluding delusions of reference)
   (2) odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
   (3) unusual perceptual experiences, including bodily illusions
   (4) odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
   (5) suspiciousness or paranoid ideation
   (6) inappropriate or constricted affect
   (7) behavior or appearance that is odd, eccentric, or peculiar
   (8) lack of close friends or confidants other than first-degree relatives
   (9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder.

Note: If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Schizotypal Personality Disorder (Premorbid)."

Cluster B Personality Disorders

301.7 Antisocial Personality Disorder

Diagnostic Features

The essential feature of Antisocial Personality Disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood.

This pattern has also been referred to as psychopathy, sociopathy, or dyssocial personality disorder. Because deceit and manipulation are central features of Antisocial Personality Disorder, it may be especially helpful to integrate information acquired from systematic clinical assessment with information collected from collateral sources.

For this diagnosis to be given, the individual must be at least age 18 years (Criterion B) and must have had a history of some symptoms of Conduct Disorder before age 15 years (Criterion C). Conduct Disorder involves a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. The specific behaviors characteristic of Conduct Disorder fall into one of four categories: aggression to people and animals, destruction of property, deceitfulness or theft, or serious violation of rules. These are described in more detail on p. 93.

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

Individuals with Antisocial Personality Disorder also tend to be consistently and extremely irresponsible (Criterion A6). Irresponsible work behavior may be indicated by significant periods of unemployment despite available job opportunities, or by abandonment of several jobs without a realistic plan for getting another job. There may also be a pattern of repeated absences from work that are not explained by illness either in themselves or in their family. Financial irresponsibility is indicated by acts such as defaulting on debts, failing to provide child support, or failing to support other dependents on a regular basis. Individuals with Antisocial Personality Disorder show little remorse for the consequences of their acts (Criterion A7). They may be indifferent to, or provide a superficial rationalization for, having hurt, mistreated, or stolen from someone (e.g., "life's unfair," "losers deserve to lose," or "he had it coming anyway"). These individuals may blame the victims for being foolish, helpless, or deserving their fate; they may minimize the harmful consequences of their actions; or they may simply indicate complete indifference. They generally fail to compensate

or make amends for their behavior. They may believe that everyone is out to "help number one" and that one should stop at nothing to avoid being pushed around.

The antisocial behavior must not occur exclusively during the course of Schizophrenia or a Manic Episode (Criterion D).

Associated Features and Disorders

Individuals with Antisocial Personality Disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others. They may have an inflated and arrogant self-appraisal (e.g., feel that ordinary work is beneath them or lack a realistic concern about their current problems or their future) and may be excessively opinionated, self-assured, or cocky. They may display a glib, superficial charm and can be quite voluble and verbally facile (e.g., using technical terms or jargon that might impress someone who is unfamiliar with the topic). Lack of empathy, inflated self-appraisal, and superficial charm are features that have been commonly included in traditional conceptions of psychopathy that may be particularly distinguishing of the disorder and more predictive of recidivism in prison or forensic settings where criminal, delinquent, or aggressive acts are likely to be nonspecific. These individuals may also be irresponsible and exploitative in their sexual relationships. They may have a history of many sexual partners and may never have sustained a monogamous relationship. They may be irresponsible as parents, as evidenced by malnutrition of a child, an illness in the child resulting from a lack of minimal hygiene, a child's dependence on neighbors or nonresident relatives for food or shelter, a failure to arrange for a caretaker for a young child when the individual is away from home, or repeated squandering of money required for household necessities. These individuals may receive dishonorable discharges from the armed services, may fail to be self-supporting, may become impoverished or even homeless, or may spend many years in penal institutions. Individuals with Antisocial Personality Disorder are more likely than people in the general population to die prematurely by violent means (e.g., suicide, accidents, and homicides).

Individuals with this disorder may also experience dysphoria, including complaints of tension, inability to tolerate boredom, and depressed mood. They may have associated Anxiety Disorders, Depressive Disorders, Substance-Related Disorders, Somatization Disorder, Pathological Gambling, and other disorders of impulse control. Individuals with Antisocial Personality Disorder also often have personality features that meet criteria for other Personality Disorders, particularly Borderline, Histrionic, and Narcissistic Personality Disorders. The likelihood of developing Antisocial Personality Disorder in adult life is increased if the individual experienced an early onset of Conduct Disorder (before age 10 years) and accompanying Attention-Deficit/Hyperactivity Disorder. Child abuse or neglect, unstable or erratic parenting, or inconsistent parental discipline may increase the likelihood that Conduct Disorder will evolve into Antisocial Personality Disorder.

Specific Culture, Age, and Gender Features

Antisocial Personality Disorder appears to be associated with low socioeconomic status and urban settings. Concerns have been raised that the diagnosis may at times be

misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy. In assessing antisocial traits, it is helpful for the clinician to consider the social and economic context in which the behaviors occur.

By definition, Antisocial Personality cannot be diagnosed before age 18 years. Antisocial Personality Disorder is much more common in males than in females. There has been some concern that Antisocial Personality Disorder may be underdiagnosed in females, particularly because of the emphasis on aggressive items in the definition of Conduct Disorder.

Prevalence

The overall prevalence of Antisocial Personality Disorder in community samples is about 3% in males and about 1% in females. Prevalence estimates within clinical settings have varied from 3% to 30%, depending on the predominant characteristics of the populations being sampled. Even higher prevalence rates are associated with substance abuse treatment settings and prison or forensic settings.

Course

Antisocial Personality Disorder has a chronic course but may become less evident or remit as the individual grows older, particularly by the fourth decade of life. Although this remission tends to be particularly evident with respect to engaging in criminal behavior, there is likely to be a decrease in the full spectrum of antisocial behaviors and substance use.

Familial Pattern

Antisocial Personality Disorder is more common among the first-degree biological relatives of those with the disorder than among the general population. The risk to biological relatives of females with the disorder tends to be higher than the risk to biological relatives of males with the disorder. Biological relatives of persons with this disorder are also at increased risk for Somatization Disorder and Substance-Related Disorders. Within a family that has a member with Antisocial Personality Disorder, males more often have Antisocial Personality Disorder and Substance-Related Disorders, whereas females more often have Somatization Disorder. However, in such families, there is an increase in prevalence of all of these disorders in both males and females compared with the general population. Adoption studies indicate that both genetic and environmental factors contribute to the risk of this group of disorders. Both adopted and biological children of parents with Antisocial Personality Disorder have an increased risk of developing Antisocial Personality Disorder, Somatization Disorder, and Substance-Related Disorders. Adopted-away children resemble their biological parents more than their adoptive parents, but the adoptive family environment influences the risk of developing a Personality Disorder and related psychopathology.

Differential Diagnosis

The diagnosis of Antisocial Personality Disorder is not given to individuals under age 18 years and is given only if there is a history of some symptoms of Conduct Disorder before age 15 years. For individuals over age 18 years, a diagnosis of Conduct Disorder is given only if the criteria for Antisocial Personality Disorder are not met.

When antisocial behavior in an adult is associated with a **Substance-Related Disorder,** the diagnosis of Antisocial Personality Disorder is not made unless the signs of Antisocial Personality Disorder were also present in childhood and have continued into adulthood. When substance use and antisocial behavior both began in childhood and continued into adulthood, both a Substance-Related Disorder and Antisocial Personality Disorder should be diagnosed if the criteria for both are met, even though some antisocial acts may be a consequence of the Substance-Related Disorder (e.g., illegal selling of drugs or thefts to obtain money for drugs). Antisocial behavior that occurs exclusively during the course of **Schizophrenia** or a **Manic Episode** should not be diagnosed as Antisocial Personality Disorder.

Other Personality Disorders may be confused with Antisocial Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Antisocial Personality Disorder, all can be diagnosed. Individuals with Antisocial Personality Disorder and **Narcissistic Personality Disorder** share a tendency to be tough-minded, glib, superficial, exploitative, and unempathic. However, Narcissistic Personality Disorder does not include characteristics of impulsivity, aggression, and deceit. In addition, individuals with Antisocial Personality Disorder may not be as needy of the admiration and envy of others, and persons with Narcissistic Personality Disorder usually lack the history of Conduct Disorder in childhood or criminal behavior in adulthood. Individuals with Antisocial Personality Disorder and **Histrionic Personality Disorder** share a tendency to be impulsive, superficial, excitement seeking, reckless, seductive, and manipulative, but persons with Histrionic Personality Disorder tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behaviors. Individuals with Histrionic and **Borderline Personality Disorders** are manipulative to gain nurturance, whereas those with Antisocial Personality Disorder are manipulative to gain profit, power, or some other material gratification. Individuals with Antisocial Personality Disorder tend to be less emotionally unstable and more aggressive than those with Borderline Personality Disorder. Although antisocial behavior may be present in some individuals with **Paranoid Personality Disorder,** it is not usually motivated by a desire for personal gain or to exploit others as in Antisocial Personality Disorder, but rather is more often due to a desire for revenge.

Antisocial Personality Disorder must be distinguished from criminal behavior undertaken for gain that is not accompanied by the personality features characteristic of this disorder. **Adult Antisocial Behavior** (listed in the "Other Conditions That May Be a Focus of Clinical Attention" section, p. 740) can be used to describe criminal, aggressive, or other antisocial behavior that comes to clinical attention but that does not meet the full criteria for Antisocial Personality Disorder. Only when antisocial personality traits are inflexible, maladaptive, and persistent and cause significant func-

tional impairment or subjective distress do they constitute Antisocial Personality Disorder.

Diagnostic criteria for 301.7 Antisocial Personality Disorder

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

B. The individual is at least age 18 years.

C. There is evidence of Conduct Disorder (see p. 98) with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

301.83 Borderline Personality Disorder

Diagnostic Features

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

Individuals with Borderline Personality Disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician's announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this "abandonment" implies they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors, which are described separately in Criterion 5.

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

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

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

Individuals with Borderline Personality Disorder may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) (Criterion 6). The basic dysphoric mood of those with Borderline Personality Disorder is often disrupted by periods of anger, panic, or despair and is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual's extreme reactivity to interpersonal stresses. Individuals with Borderline Personality Disorder may be troubled by chronic feelings of emptiness (Criterion 7). Easily bored, they may constantly seek something to do. Individuals with Borderline Personality Disorder frequently express inappropriate, intense anger or have difficulty controlling their anger (Criterion 8). They may display extreme sarcasm, enduring bitterness, or verbal outbursts. The anger is often elicited when a caregiver or lover is seen as

neglectful, withholding, uncaring, or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil. During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g., depersonalization) may occur (Criterion 9), but these are generally of insufficient severity or duration to warrant an additional diagnosis. These episodes occur most frequently in response to a real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived return of the caregiver's nurturance may result in a remission of symptoms.

Associated Features and Disorders

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

Specific Culture, Age, and Gender Features

The pattern of behavior seen in Borderline Personality Disorder has been identified in many settings around the world. Adolescents and young adults with identity problems (especially when accompanied by substance use) may transiently display behaviors that misleadingly give the impression of Borderline Personality Disorder. Such situations are characterized by emotional instability, "existential" dilemmas, uncertainty, anxiety-provoking choices, conflicts about sexual orientation, and competing social pressures to decide on careers. Borderline Personality Disorder is diagnosed predominantly (about 75%) in females.

Prevalence

The prevalence of Borderline Personality Disorder is estimated to be about 2% of the general population, about 10% among individuals seen in outpatient mental health clinics, and about 20% among psychiatric inpatients. It ranges from 30% to 60% among clinical populations with Personality Disorders.

Course

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

Familial Pattern

Borderline Personality Disorder is about five times more common among first-degree biological relatives of those with the disorder than in the general population. There is also an increased familial risk for Substance-Related Disorders, Antisocial Personality Disorder, and Mood Disorders.

Differential Diagnosis

Borderline Personality Disorder often co-occurs with **Mood Disorders,** and when criteria for both are met, both may be diagnosed. Because the cross-sectional presentation of Borderline Personality Disorder can be mimicked by an episode of Mood Disorder, the clinician should avoid giving an additional diagnosis of Borderline Personality Disorder based only on cross-sectional presentation without having documented that the pattern of behavior has an early onset and a long-standing course.

Other Personality Disorders may be confused with Borderline Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Borderline Personality Disorder, all can be diagnosed. Although **Histrionic Personality Disorder** can also be characterized by attention seeking, manipulative behavior, and rapidly shifting emotions, Borderline Personality Disorder is distinguished by self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and loneliness. Paranoid ideas or illusions may be present in both Borderline Personality Disorder and **Schizotypal Personality Disorder,** but these symptoms are more transient, interpersonally reactive, and responsive to external structuring in Borderline Personality Disorder. Although **Paranoid Personality Disorder** and **Narcissistic Personality Disorder** may also be characterized by an angry reaction to minor stimuli, the relative stability of self-image as well as the relative lack of self-destructiveness, impulsivity, and abandonment concerns distinguish these disorders from Borderline Personality Dis-

order. Although **Antisocial Personality Disorder** and Borderline Personality Disorder are both characterized by manipulative behavior, individuals with Antisocial Personality Disorder are manipulative to gain profit, power, or some other material gratification, whereas the goal in Borderline Personality Disorder is directed more toward gaining the concern of caretakers. Both **Dependent Personality Disorder** and Borderline Personality Disorder are characterized by fear of abandonment; however, the individual with Borderline Personality Disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with Dependent Personality Disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support. Borderline Personality Disorder can further be distinguished from Dependent Personality Disorder by the typical pattern of unstable and intense relationships.

Borderline Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

Borderline Personality Disorder should be distinguished from **Identity Problem** (see p. 741), which is reserved for identity concerns related to a developmental phase (e.g., adolescence) and does not qualify as a mental disorder.

Diagnostic criteria for 301.83 Borderline Personality Disorder

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

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

301.50 Histrionic Personality Disorder

Diagnostic Features

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

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

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

These individuals have a style of speech that is excessively impressionistic and lacking in detail (Criterion 5). Strong opinions are expressed with dramatic flair, but underlying reasons are usually vague and diffuse, without supporting facts and details. For example, an individual with Histrionic Personality Disorder may comment that a certain individual is a wonderful human being, yet be unable to provide any specific examples of good qualities to support this opinion. Individuals with this disorder are characterized by self-dramatization, theatricality, and an exaggerated expression of emotion (Criterion 6). They may embarrass friends and acquaintances by an excessive public display of emotions (e.g., embracing casual acquaintances with excessive ardor, sobbing uncontrollably on minor sentimental occasions, or having temper tantrums). However, their emotions often seem to be turned on and off too quickly to be deeply felt, which may lead others to accuse the individual of faking these feelings.

Individuals with Histrionic Personality Disorder have a high degree of suggestibility (Criterion 7). Their opinions and feelings are easily influenced by others and by current fads. They may be overly trusting, especially of strong authority figures whom they see as magically solving their problems. They have a tendency to play

hunches and to adopt convictions quickly. Individuals with this disorder often consider relationships more intimate than they actually are, describing almost every acquaintance as "my dear, dear friend" or referring to physicians met only once or twice under professional circumstances by their first names (Criterion 8). Flights into romantic fantasy are common.

Associated Features and Disorders

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

The actual risk of suicide is not known, but clinical experience suggests that individuals with this disorder are at increased risk for suicidal gestures and threats to get attention and coerce better caregiving. Histrionic Personality Disorder has been associated with higher rates of Somatization Disorder, Conversion Disorder, and Major Depressive Disorder. Borderline, Narcissistic, Antisocial, and Dependent Personality Disorders often co-occur.

Specific Culture, Age, and Gender Features

Norms for interpersonal behavior, personal appearance, and emotional expressiveness vary widely across cultures, genders, and age groups. Before considering the various traits (e.g., emotionality, seductiveness, dramatic interpersonal style, novelty seeking, sociability, charm, impressionability, and a tendency to somatization) to be evidence of Histrionic Personality Disorder, it is important to evaluate whether they cause clinically significant impairment or distress. In clinical settings, this disorder has been diagnosed more frequently in females; however, the sex ratio is not significantly different than the sex ratio of females within the respective clinical setting. In contrast, some studies using structured assessments report similar prevalence rates among males and females. The behavioral expression of Histrionic Personality Disorder may be influenced by sex role stereotypes. For example, a man with this disorder may dress and behave in a manner often identified as "macho" and may seek to be the center of attention by bragging about athletic skills, whereas a woman, for example, may choose very feminine clothes and talk about how much she impressed her dance instructor.

Prevalence

Limited data from general population studies suggest a prevalence of Histrionic Personality Disorder of about 2%–3%. Rates of about 10%–15% have been reported in inpatient and outpatient mental health settings when structured assessment is used.

Differential Diagnosis

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

Histrionic Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

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

Diagnostic criteria for 301.50 Histrionic Personality Disorder

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

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

301.81 Narcissistic Personality Disorder

Diagnostic Features

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

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

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

Individuals with this disorder generally require excessive admiration (Criterion 4). Their self-esteem is almost invariably very fragile. They may be preoccupied with

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

Individuals with Narcissistic Personality Disorder generally have a lack of empathy and have difficulty recognizing the desires, subjective experiences, and feelings of others (Criterion 7). They may assume that others are totally concerned about their welfare. They tend to discuss their own concerns in inappropriate and lengthy detail, while failing to recognize that others also have feelings and needs. They are often contemptuous and impatient with others who talk about their own problems and concerns. These individuals may be oblivious to the hurt their remarks may inflict (e.g., exuberantly telling a former lover that "I am now in the relationship of a lifetime!"; boasting of health in front of someone who is sick). When recognized, the needs, desires, or feelings of others are likely to be viewed disparagingly as signs of weakness or vulnerability. Those who relate to individuals with Narcissistic Personality Disorder typically find an emotional coldness and lack of reciprocal interest.

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

Associated Features and Disorders

Vulnerability in self-esteem makes individuals with Narcissistic Personality Disorder very sensitive to "injury" from criticism or defeat. Although they may not show it outwardly, criticism may haunt these individuals and may leave them feeling humiliated, degraded, hollow, and empty. They may react with disdain, rage, or defiant counterattack. Such experiences often lead to social withdrawal or an appearance of

humility that may mask and protect the grandiosity. Interpersonal relations are typically impaired due to problems derived from entitlement, the need for admiration, and the relative disregard for the sensitivities of others. Though overweening ambition and confidence may lead to high achievement, performance may be disrupted due to intolerance of criticism or defeat. Sometimes vocational functioning can be very low, reflecting an unwillingness to take a risk in competitive or other situations in which defeat is possible. Sustained feelings of shame or humiliation and the attendant self-criticism may be associated with social withdrawal, depressed mood, and Dysthymic or Major Depressive Disorder. In contrast, sustained periods of grandiosity may be associated with a hypomanic mood. Narcissistic Personality Disorder is also associated with Anorexia Nervosa and Substance-Related Disorders (especially related to cocaine). Histrionic, Borderline, Antisocial, and Paranoid Personality Disorders may be associated with Narcissistic Personality Disorder.

Specific Age and Gender Features

Narcissistic traits may be particularly common in adolescents and do not necessarily indicate that the individual will go on to have Narcissistic Personality Disorder. Individuals with Narcissistic Personality Disorder may have special difficulties adjusting to the onset of physical and occupational limitations that are inherent in the aging process. Of those diagnosed with Narcissistic Personality Disorder, 50%–75% are male.

Prevalence

Estimates of prevalence of Narcissistic Personality Disorder range from 2% to 16% in the clinical population and are less than 1% in the general population.

Differential Diagnosis

Other Personality Disorders may be confused with Narcissistic Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Narcissistic Personality Disorder, all can be diagnosed. The most useful feature in discriminating Narcissistic Personality Disorder from **Histrionic, Antisocial,** and **Borderline Personality Disorders,** whose interactive styles are respectively coquettish, callous, and needy, is the grandiosity characteristic of Narcissistic Personality Disorder. The relative stability of self-image as well as the relative lack of self-destructiveness, impulsivity, and abandonment concerns also help distinguish Narcissistic Personality Disorder from Borderline Personality Disorder. Excessive pride in achievements, a relative lack of emotional display, and disdain for others' sensitivities help distinguish Narcissistic Personality Disorder from Histrionic Personality Disorder. Although individuals with Borderline, Histrionic, and Narcissistic Personality Disorders may require much attention, those with Narcissistic Personality Disorder specifically need that attention to be admiring. Individuals with Antisocial and Narcissistic Personality Disorders will share a tendency to be tough-minded, glib, superficial, exploitative, and unempathic. However,

Narcissistic Personality Disorder does not necessarily include characteristics of impulsivity, aggression, and deceit. In addition, individuals with Antisocial Personality Disorder may not be as needy of the admiration and envy of others, and persons with Narcissistic Personality Disorder usually lack the history of Conduct Disorder in childhood or criminal behavior in adulthood. In both Narcissistic Personality Disorder and **Obsessive-Compulsive Personality Disorder,** the individual may profess a commitment to perfectionism and believe that others cannot do things as well. In contrast to the accompanying self-criticism of those with Obsessive-Compulsive Personality Disorder, individuals with Narcissistic Personality Disorder are more likely to believe that they have achieved perfection. Suspiciousness and social withdrawal usually distinguish those with **Schizotypal** or **Paranoid Personality Disorder** from those with Narcissistic Personality Disorder. When these qualities are present in individuals with Narcissistic Personality Disorder, they derive primarily from fears of having imperfections or flaws revealed. Grandiosity may emerge as part of **Manic** or **Hypomanic Episodes,** but the association with mood change or functional impairments helps distinguish these episodes from Narcissistic Personality Disorder. Narcissistic Personality Disorder must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

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

Diagnostic criteria for 301.81 Narcissistic Personality Disorder

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

(1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
(3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
(4) requires excessive admiration
(5) has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
(6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
(7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
(8) is often envious of others or believes that others are envious of him or her
(9) shows arrogant, haughty behaviors or attitudes

Cluster C Personality Disorders

301.82 Avoidant Personality Disorder

Diagnostic Features

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

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

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

Associated Features and Disorders

Individuals with Avoidant Personality Disorder often vigilantly appraise the movements and expressions of those with whom they come into contact. Their fearful and tense demeanor may elicit ridicule and derision from others, which in turn confirms their self-doubts. They are very anxious about the possibility that they will react to criticism with blushing or crying. They are described by others as being "shy," "timid," "lonely," and "isolated." The major problems associated with this disorder occur in social and occupational functioning. The low self-esteem and hypersensitivity to rejection are associated with restricted interpersonal contacts. These individuals may become relatively isolated and usually do not have a large social support network that can help them weather crises. They desire affection and acceptance and may fantasize about idealized relationships with others. The avoidant behaviors can also adversely affect occupational functioning because these individuals try to avoid the types of social situations that may be important for meeting the basic demands of the job or for advancement.

Other disorders that are commonly diagnosed with Avoidant Personality Disorder include Mood and Anxiety Disorders (especially Social Phobia of the Generalized Type). Avoidant Personality Disorder is often diagnosed with Dependent Personality Disorder, because individuals with Avoidant Personality Disorder become very attached to and dependent on those few other people with whom they are friends. Avoidant Personality Disorder also tends to be diagnosed with Borderline Personality Disorder and with the Cluster A Personality Disorders (i.e., Paranoid, Schizoid, or Schizotypal Personality Disorders).

Specific Culture, Age, and Gender Features

There may be variation in the degree to which different cultural and ethnic groups regard diffidence and avoidance as appropriate. Moreover, avoidant behavior may be the result of problems in acculturation following immigration. This diagnosis should be used with great caution in children and adolescents for whom shy and avoidant behavior may be developmentally appropriate. Avoidant Personality Disorder appears to be equally frequent in males and females.

Prevalence

The prevalence of Avoidant Personality Disorder in the general population is between 0.5% and 1.0%. Avoidant Personality Disorder has been reported to be present in about 10% of outpatients seen in mental health clinics.

Course

The avoidant behavior often starts in infancy or childhood with shyness, isolation, and fear of strangers and new situations. Although shyness in childhood is a common precursor of Avoidant Personality Disorder, in most individuals it tends to gradually dissipate as they get older. In contrast, individuals who go on to develop Avoidant Personality Disorder may become increasingly shy and avoidant during adolescence

and early adulthood, when social relationships with new people become especially important. There is some evidence that in adults Avoidant Personality Disorder tends to become less evident or to remit with age.

Differential Diagnosis

There appears to be a great deal of overlap between Avoidant Personality Disorder and **Social Phobia, Generalized Type,** so much so that they may be alternative conceptualizations of the same or similar conditions. Avoidance also characterizes both Avoidant Personality Disorder and **Panic Disorder With Agoraphobia,** and they often co-occur. The avoidance in Panic Disorder With Agoraphobia typically starts after the onset of Panic Attacks and may vary based on their frequency and intensity. In contrast, the avoidance in Avoidant Personality Disorder tends to have an early onset, an absence of clear precipitants, and a stable course.

Other Personality Disorders may be confused with Avoidant Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more Personality Disorders in addition to Avoidant Personality Disorder, all can be diagnosed. Both Avoidant Personality Disorder and **Dependent Personality Disorder** are characterized by feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance. Although the primary focus of concern in Avoidant Personality Disorder is avoidance of humiliation and rejection, in Dependent Personality Disorder the focus is on being taken care of. However, Avoidant Personality Disorder and Dependent Personality Disorder are particularly likely to co-occur. Like Avoidant Personality Disorder, **Schizoid Personality Disorder** and **Schizotypal Personality Disorder** are characterized by social isolation. However, individuals with Avoidant Personality Disorder want to have relationships with others and feel their loneliness deeply, whereas those with Schizoid or Schizotypal Personality Disorder may be content with and even prefer their social isolation. **Paranoid Personality Disorder** and Avoidant Personality Disorder are both characterized by a reluctance to confide in others. However, in Avoidant Personality Disorder, this reluctance is due more to a fear of being embarrassed or being found inadequate than to a fear of others' malicious intent.

Avoidant Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

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

Diagnostic criteria for 301.82 Avoidant Personality Disorder

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

(1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
(2) is unwilling to get involved with people unless certain of being liked
(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed
(4) is preoccupied with being criticized or rejected in social situations
(5) is inhibited in new interpersonal situations because of feelings of inadequacy
(6) views self as socially inept, personally unappealing, or inferior to others
(7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

301.6 Dependent Personality Disorder

Diagnostic Features

The essential feature of Dependent Personality Disorder is a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation. This pattern begins by early adulthood and is present in a variety of contexts. The dependent and submissive behaviors are designed to elicit caregiving and arise from a self-perception of being unable to function adequately without the help of others.

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

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

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

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

When a close relationship ends (e.g., a breakup with a lover; the death of a caregiver), individuals with Dependent Personality Disorder may urgently seek another relationship to provide the care and support they need (Criterion 7). Their belief that they are unable to function in the absence of a close relationship motivates these individuals to become quickly and indiscriminately attached to another person. Individuals with this disorder are often preoccupied with fears of being left to care for themselves (Criterion 8). They see themselves as so totally dependent on the advice and help of an important other person that they worry about being abandoned by that person when there are no grounds to justify such fears. To be considered as evidence of this criterion, the fears must be excessive and unrealistic. For example, an elderly man with cancer who moves into his son's household for care is exhibiting dependent behavior that is appropriate given this person's life circumstances.

Associated Features and Disorders

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

Specific Culture, Age, and Gender Features

The degree to which dependent behaviors are considered to be appropriate varies substantially across different age and sociocultural groups. Age and cultural factors need to be considered in evaluating the diagnostic threshold of each criterion. Dependent behavior should be considered characteristic of the disorder only when it is clearly in excess of the individual's cultural norms or reflects unrealistic concerns. An emphasis on passivity, politeness, and deferential treatment is characteristic of some societies and may be misinterpreted as traits of Dependent Personality Disorder. Similarly, societies may differentially foster and discourage dependent behavior in males and females. This diagnosis should be used with great caution, if at all, in children and adolescents, for whom dependent behavior may be developmentally appropriate. In clinical settings, this disorder has been diagnosed more frequently in females, although some studies report similar prevalence rates among males and females.

Prevalence

Dependent Personality Disorder is among the most frequently reported Personality Disorders encountered in mental health clinics.

Differential Diagnosis

Dependent Personality Disorder must be distinguished from dependency arising as a consequence of Axis I disorders (e.g., **Mood Disorders, Panic Disorder,** and **Agoraphobia**) and as a result of **general medical conditions.** Dependent Personality Disorder has an early onset, chronic course, and a pattern of behavior that does not occur exclusively during an Axis I or Axis III disorder.

Other Personality Disorders may be confused with Dependent Personality Disorder because they have certain features in common. It is, therefore, important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more

Personality Disorders in addition to Dependent Personality Disorder, all can be diagnosed. Although many Personality Disorders are characterized by dependent features, Dependent Personality Disorder can be distinguished by its predominantly submissive, reactive, and clinging behavior. Both Dependent Personality Disorder and **Borderline Personality Disorder** are characterized by fear of abandonment; however, the individual with Borderline Personality Disorder reacts to abandonment with feelings of emotional emptiness, rage, and demands, whereas the individual with Dependent Personality Disorder reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support. Borderline Personality Disorder can further be distinguished from Dependent Personality Disorder by a typical pattern of unstable and intense relationships. Individuals with **Histrionic Personality Disorder,** like those with Dependent Personality Disorder, have a strong need for reassurance and approval and may appear childlike and clinging. However, unlike Dependent Personality Disorder, which is characterized by self-effacing and docile behavior, Histrionic Personality Disorder is characterized by gregarious flamboyance with active demands for attention. Both Dependent Personality Disorder and **Avoidant Personality Disorder** are characterized by feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance; however, individuals with Avoidant Personality Disorder have such a strong fear of humiliation and rejection that they withdraw until they are certain they will be accepted. In contrast, individuals with Dependent Personality Disorder have a pattern of seeking and maintaining connections to important others, rather than avoiding and withdrawing from relationships.

Dependent Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

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

Diagnostic criteria for 301.6 Dependent Personality Disorder

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

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

301.4 Obsessive-Compulsive Personality Disorder

Diagnostic Features

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

Individuals with Obsessive-Compulsive Personality Disorder attempt to maintain a sense of control through painstaking attention to rules, trivial details, procedures, lists, schedules, or form to the extent that the major point of the activity is lost (Criterion 1). They are excessively careful and prone to repetition, paying extraordinary attention to detail and repeatedly checking for possible mistakes. They are oblivious to the fact that other people tend to become very annoyed at the delays and inconveniences that result from this behavior. For example, when such individuals misplace a list of things to be done, they will spend an inordinate amount of time looking for the list rather than spending a few moments re-creating it from memory and proceeding to accomplish the tasks. Time is poorly allocated, the most important tasks being left to the last moment. The perfectionism and self-imposed high standards of performance cause significant dysfunction and distress in these individuals. They may become so involved in making every detail of a project absolutely perfect that the project is never finished (Criterion 2). For example, the completion of a written report is delayed by numerous time-consuming rewrites that all come up short of "perfec-

tion." Deadlines are missed, and aspects of the individual's life that are not the current focus of activity may fall into disarray.

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

Individuals with Obsessive-Compulsive Personality Disorder may be excessively conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (Criterion 4). They may force themselves and others to follow rigid moral principles and very strict standards of performance. They may also be mercilessly self-critical about their own mistakes. Individuals with this disorder are rigidly deferential to authority and rules and insist on quite literal compliance, with no rule bending for extenuating circumstances. For example, the individual will not lend a quarter to a friend who needs one to make a telephone call, because "neither a borrower or lender be" or because it would be "bad" for the person's character. These qualities should not be accounted for by the individual's cultural or religious identification.

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

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

Individuals with this disorder may be miserly and stingy and maintain a standard of living far below what they can afford, believing that spending must be tightly controlled to provide for future catastrophes (Criterion 7). Individuals with Obsessive-Compulsive Personality Disorder are characterized by rigidity and stubbornness (Criterion 8). They are so concerned about having things done the one "correct" way

that they have trouble going along with anyone else's ideas. These individuals plan ahead in meticulous detail and are unwilling to consider changes. Totally wrapped up in their own perspective, they have difficulty acknowledging the viewpoints of others. Friends and colleagues may become frustrated by this constant rigidity. Even when individuals with Obsessive-Compulsive Personality Disorder recognize that it may be in their interest to compromise, they may stubbornly refuse to do so, arguing that it is "the principle of the thing."

Associated Features and Disorders

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

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

Individuals with Anxiety Disorders, including Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Social Phobia, and Specific Phobias, have an increased likelihood of having a personality disturbance that meets criteria for Obsessive-Compulsive Personality Disorder. Even so, it appears that the majority of individuals with Obsessive-Compulsive Disorder do not have a pattern of behavior that meets criteria for this Personality Disorder. Many of the features of Obsessive-Compulsive Personality Disorder overlap with "type A" personality characteristics (e.g., preoccupation with work, competitiveness, and time urgency), and these features may be present in people at risk for myocardial infarction. There may be an association between Obsessive-Compulsive Personality Disorder and Mood and Eating Disorders.

Specific Culture and Gender Features

In assessing an individual for Obsessive-Compulsive Personality Disorder, the clinician should not include those behaviors that reflect habits, customs, or interpersonal styles that are culturally sanctioned by the individual's reference group. Certain cultures place substantial emphasis on work and productivity; the resulting behaviors in members of those societies need not be considered indications of Obsessive-Compulsive Personality Disorder. In systematic studies, the disorder appears to be diagnosed about twice as often among males.

Prevalence

Studies that have used systematic assessment suggest prevalence estimates of Obsessive-Compulsive Personality Disorder of about 1% in community samples and about 3%–10% in individuals presenting to mental health clinics.

Differential Diagnosis

Despite the similarity in names, **Obsessive-Compulsive Disorder** is usually easily distinguished from Obsessive-Compulsive Personality Disorder by the presence of true obsessions and compulsions. A diagnosis of Obsessive-Compulsive Disorder should be considered especially when hoarding is extreme (e.g., accumulated stacks of worthless objects present a fire hazard and make it difficult for others to walk through the house). When criteria for both disorders are met, both diagnoses should be recorded.

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

Obsessive-Compulsive Personality Disorder must be distinguished from **Personality Change Due to a General Medical Condition,** in which the traits emerge due to the direct effects of a general medical condition on the central nervous system. It must also be distinguished from **symptoms that may develop in association with chronic substance use** (e.g., Cocaine-Related Disorder Not Otherwise Specified).

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

Diagnostic criteria for 301.4 Obsessive-Compulsive Personality Disorder

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

(1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
(2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
(3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
(4) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
(5) is unable to discard worn-out or worthless objects even when they have no sentimental value
(6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
(7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
(8) shows rigidity and stubbornness

301.9 Personality Disorder Not Otherwise Specified

This category is for disorders of personality functioning (refer to the general diagnostic criteria for a Personality Disorder on p. 689) that do not meet criteria for any specific Personality Disorder. An example is the presence of features of more than one specific Personality Disorder that do not meet the full criteria for any one Personality Disorder ("mixed personality"), but that together cause clinically significant distress or impairment in one or more important areas of functioning (e.g., social or occupational). This category can also be used when the clinician judges that a specific Personality Disorder that is not included in the Classification is appropriate. Examples include depressive personality disorder and passive-aggressive personality disorder (see p. 789 and p. 791, respectively, for suggested research criteria).

Other Conditions That May Be a Focus of Clinical Attention

This section covers other conditions or problems that may be a focus of clinical attention. These are related to the mental disorders described previously in this manual in one of the following ways: 1) the problem is the focus of diagnosis or treatment and the individual has no mental disorder (e.g., a Partner Relational Problem in which neither partner has symptoms that meet criteria for a mental disorder, in which case only the Partner Relational Problem is coded); 2) the individual has a mental disorder but it is unrelated to the problem (e.g., a Partner Relational Problem in which one of the partners has an incidental Specific Phobia, in which case both can be coded); 3) the individual has a mental disorder that is related to the problem, but the problem is sufficiently severe to warrant independent clinical attention (e.g., a Partner Relational Problem sufficiently problematic to be a focus of treatment that is also associated with Major Depressive Disorder in one of the partners, in which case both can be coded). The conditions and problems in this section are coded on Axis I.

Psychological Factors Affecting Medical Condition

316 Psychological Factor Affecting Medical Condition

Diagnostic Features

The essential feature of Psychological Factor Affecting Medical Condition is the presence of one or more specific psychological or behavioral factors that adversely affect a general medical condition. There are several different ways in which these factors can adversely affect the general medical condition. The factors can influence the course of the general medical condition (which can be inferred by a close temporal association between the factors and the development or exacerbation of, or delayed recovery from, the medical condition). The factors may interfere with treatment of the general medical condition. The factors may constitute an additional health risk for the individual (e.g., continued overeating in an individual with weight-related diabetes). They may precipitate or exacerbate symptoms of a general medical condition by eliciting stress-related physiological responses (e.g., causing chest pain in individuals

with coronary artery disease, or bronchospasm in individuals with asthma).

The psychological or behavioral factors that influence general medical conditions include Axis I disorders, Axis II disorders, psychological symptoms or personality traits that do not meet the full criteria for a specific mental disorder, maladaptive health behaviors, or physiological responses to environmental or social stressors.

Psychological or behavioral factors play a potential role in the presentation or treatment of almost every general medical condition. This category should be reserved for those situations in which the psychological factors have a clinically significant effect on the course or outcome of the general medical condition or place the individual at a significantly higher risk for an adverse outcome. There must be reasonable evidence to suggest an association between the psychological factors and the medical condition, although it may often not be possible to demonstrate direct causality or the mechanisms underlying the relationship. Psychological and behavioral factors may affect the course of almost every major category of disease, including cardiovascular conditions, dermatological conditions, endocrinological conditions, gastrointestinal conditions, neoplastic conditions, neurological conditions, pulmonary conditions, renal conditions, and rheumatological conditions.

The Psychological Factor Affecting Medical Condition diagnosis is coded on Axis I, and the accompanying general medical condition is coded on Axis III. (See Appendix G for a list of diagnostic codes for general medical conditions.) To provide greater specificity regarding the type of psychological factor, the name is chosen from the list below. When more than one type of factor is present, the most prominent should be specified.

Mental Disorder Affecting . . . ***[Indicate the General Medical Condition].*** A specific Axis I or Axis II disorder significantly affects the course or treatment of a general medical condition (e.g., Major Depressive Disorder adversely affecting the prognosis of myocardial infarction, renal failure, or hemodialysis; Schizophrenia complicating the treatment of diabetes mellitus). In addition to coding this condition on Axis I, the specific mental disorder is also coded on Axis I or Axis II.

Psychological Symptoms Affecting . . . ***[Indicate the General Medical Condition].*** Symptoms that do not meet full criteria for an Axis I disorder significantly affect the course or treatment of a general medical condition (e.g., symptoms of anxiety or depression affecting the course and severity of irritable bowel syndrome or peptic ulcer disease, or complicating recovery from surgery).

Personality Traits or Coping Style Affecting . . . ***[Indicate the General Medical Condition].*** A personality trait or a maladaptive coping style significantly affects the course or treatment of a general medical condition. Personality traits can be subthreshold for an Axis II disorder or represent another pattern that has been demonstrated to be a risk factor for certain illnesses (e.g., "type A," pressured, hostile behavior for coronary artery disease). Problematic personality traits and maladaptive coping styles can impede the working relationship with health care personnel.

Maladaptive Health Behaviors Affecting . . . ***[Indicate the General Medical Condition].*** Maladaptive health behaviors (e.g., sedentary lifestyle, unsafe sexual

practices, overeating, excessive alcohol and drug use) significantly affect the course or treatment of a general medical condition. If the maladaptive behaviors are better accounted for by an Axis I disorder (e.g., overeating as part of Bulimia Nervosa, alcohol use as part of Alcohol Dependence), the name "Mental Disorder Affecting Medical Condition" should be used instead.

Stress-Related Physiological Response Affecting . . . ***[Indicate the General Medical Condition].*** Stress-related physiological responses significantly affect the course or treatment of a general medical condition (e.g., precipitate chest pain or arrhythmia in a patient with coronary artery disease).

Other or Unspecified Factors Affecting . . . ***[Indicate the General Medical Condition].*** A factor not included in the subtypes specified above or an unspecified psychological or behavioral factor significantly affects the course or treatment of a general medical condition.

Differential Diagnosis

A temporal association between symptoms of a mental disorder and a general medical condition is also characteristic of a **Mental Disorder Due to a General Medical Condition,** but the presumed causality is in the opposite direction. In a Mental Disorder Due to a General Medical Condition, the general medical condition is judged to be causing the mental disorder through a direct physiological mechanism. In Psychological Factor Affecting Medical Condition, the psychological or behavioral factors are judged to affect the course of the general medical condition.

Substance Use Disorders (e.g., Alcohol Dependence, Nicotine Dependence) adversely affect the prognosis of many general medical conditions. If an individual has a coexisting Substance Use Disorder that adversely affects or causes a general medical condition, Mental Disorder Affecting General Medical Condition can be coded on Axis I in addition to the Substance Use Disorder. For substance use patterns affecting a general medical condition that do not meet the criteria for a Substance Use Disorder, Maladaptive Health Behaviors Affecting Medical Condition can be specified.

Somatoform Disorders are characterized by the presence of both psychological factors and physical symptoms, but there is no general medical condition that can completely account for the physical symptoms. In contrast, in Psychological Factors Affecting Medical Condition, the psychological factors adversely affect a diagnosable general medical condition. Psychological factors affecting pain syndromes are not diagnosed as Psychological Factor Affecting Medical Condition but rather as **Pain Disorder Associated With Psychological Factors** or **Pain Disorder Associated With Both Psychological Factors and a General Medical Condition.**

When noncompliance with treatment for a general medical condition results from psychological factors but becomes the major focus of clinical attention, **Noncompliance With Treatment** (see p. 739) should be coded.

316 . . . *[Specified Psychological Factor]* Affecting . . . *[Indicate the General Medical Condition]*

A. A general medical condition (coded on Axis III) is present.

B. Psychological factors adversely affect the general medical condition in one of the following ways:

(1) the factors have influenced the course of the general medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the general medical condition
(2) the factors interfere with the treatment of the general medical condition
(3) the factors constitute additional health risks for the individual
(4) stress-related physiological responses precipitate or exacerbate symptoms of the general medical condition

Choose name based on the nature of the psychological factors (if more than one factor is present, indicate the most prominent):

Mental Disorder Affecting . . . *[Indicate the General Medical Condition]* (e.g., an Axis I disorder such as Major Depressive Disorder delaying recovery from a myocardial infarction)

Psychological Symptoms Affecting . . . *[Indicate the General Medical Condition]* (e.g., depressive symptoms delaying recovery from surgery; anxiety exacerbating asthma)

Personality Traits or Coping Style Affecting . . . *[Indicate the General Medical Condition]* (e.g., pathological denial of the need for surgery in a patient with cancer; hostile, pressured behavior contributing to cardiovascular disease)

Maladaptive Health Behaviors Affecting . . . *[Indicate the General Medical Condition]* (e.g., overeating; lack of exercise; unsafe sex)

Stress-Related Physiological Response Affecting . . . *[Indicate the General Medical Condition]* (e.g., stress-related exacerbations of ulcer, hypertension, arrhythmia, or tension headache)

Other or Unspecified Psychological Factors Affecting . . . *[Indicate the General Medical Condition]* (e.g., interpersonal, cultural, or religious factors)

Medication-Induced Movement Disorders

The following Medication-Induced Movement Disorders are included because of their frequent importance in 1) the management by medication of mental disorders or general medical conditions; and 2) the differential diagnosis with Axis I disorders (e.g., Anxiety Disorder versus Neuroleptic-Induced Akathisia; catatonia versus Neuroleptic Malignant Syndrome). Although these disorders are labeled "medication induced," it is often difficult to establish the causal relationship between medication

exposure and the development of the movement disorder, especially because some of these movement disorders also occur in the absence of medication exposure. The term *neuroleptic* is used broadly in this manual to refer to medications with dopamine-antagonist properties. Although this term is becoming outdated because it highlights the propensity of antipsychotic medications to cause abnormal movements, the term *neuroleptic* remains appropriate. Although newer antipsychotic medications are less likely to cause Medication-Induced Movement Disorders, these syndromes still occur. Neuroleptic medications include so-called conventional or typical antipsychotic agents (e.g., chlorpromazine, haloperidol, fluphenazine), the newer "atypical" antipsychotic agents (e.g., clozapine, risperidone, olanzapine, quetiapine), certain dopamine receptor blocking drugs used in the treatment of symptoms such as nausea and gastroparesis (e.g., prochlorperazine, promethazine, trimethobenzamide, thiethylperazine, and metoclopramide), and amoxapine, which is marketed as an antidepressant. Medication-Induced Movement Disorders should be coded on Axis I.

332.1 Neuroleptic-Induced Parkinsonism

Parkinsonian tremor, muscular rigidity, or akinesia developing within a few weeks of starting or raising the dose of a neuroleptic medication (or after reducing a medication used to treat extrapyramidal symptoms). (See p. 795 for suggested research criteria.)

333.92 Neuroleptic Malignant Syndrome

Severe muscle rigidity, elevated temperature, and other related findings (e.g., diaphoresis, dysphagia, incontinence, changes in level of consciousness ranging from confusion to coma, mutism, elevated or labile blood pressure, elevated creatine phosphokinase [CPK]) developing in association with the use of neuroleptic medication. (See p. 798 for suggested research criteria.)

333.7 Neuroleptic-Induced Acute Dystonia

Abnormal positioning or spasm of the muscles of the head, neck, limbs, or trunk developing within a few days of starting or raising the dose of a neuroleptic medication (or after reducing a medication used to treat extrapyramidal symptoms). (See p. 800 for suggested research criteria.)

333.99 Neuroleptic-Induced Acute Akathisia

Subjective complaints of restlessness accompanied by observed movements (e.g., fidgety movements of the legs, rocking from foot to foot, pacing, or inability to sit or stand still) developing within a few weeks of starting or raising the dose of a neuroleptic medication (or after reducing a medication used to treat extrapyramidal symptoms). (See p. 802 for suggested research criteria.)

333.82 Neuroleptic-Induced Tardive Dyskinesia

Involuntary choreiform, athetoid, or rhythmic movements (lasting at least a few weeks) of the tongue, jaw, or extremities developing in association with the use of neuroleptic medication for at least a few months (may be for a shorter period of time in elderly persons). (See p. 805 for suggested research criteria.)

333.1 Medication-Induced Postural Tremor

Fine tremor occurring during attempts to maintain a posture that develops in association with the use of medication (e.g., lithium, antidepressants, valproate). (See p. 807 for suggested research criteria.)

333.90 Medication-Induced Movement Disorder Not Otherwise Specified

This category is for Medication-Induced Movement Disorders not classified by any of the specific disorders listed above. Examples include 1) parkinsonism, acute akathisia, acute dystonia, or dyskinetic movement that is associated with a medication other than a neuroleptic; 2) a presentation that resembles neuroleptic malignant syndrome that is associated with a medication other than a neuroleptic; or 3) tardive dystonia.

Other Medication-Induced Disorder

995.2 Adverse Effects of Medication Not Otherwise Specified

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

Relational Problems

Relational problems include patterns of interaction between or among members of a relational unit that are associated with clinically significant impairment in functioning, or symptoms among one or more members of the relational unit, or impairment in the functioning of the relational unit itself. The following relational problems are included because they are frequently a focus of clinical attention among individuals seen by health professionals. These problems may exacerbate or complicate the management of a mental disorder or general medical condition in one or more members

of the relational unit, may be a result of a mental disorder or a general medical condition, may be independent of other conditions that are present, or can occur in the absence of any other condition. When these problems are the principal focus of clinical attention, they should be listed on Axis I. Otherwise, if they are present but not the principal focus of clinical attention, they may be listed on Axis IV. The relevant category is generally applied to all members of a relational unit who are being treated for the problem.

V61.9 Relational Problem Related to a Mental Disorder or General Medical Condition

This category should be used when the focus of clinical attention is a pattern of impaired interaction that is associated with a mental disorder or a general medical condition in a family member.

V61.20 Parent-Child Relational Problem

This category should be used when the focus of clinical attention is a pattern of interaction between parent and child (e.g., impaired communication, overprotection, inadequate discipline) that is associated with clinically significant impairment in individual or family functioning or the development of clinically significant symptoms in parent or child.

V61.10 Partner Relational Problem

This category should be used when the focus of clinical attention is a pattern of interaction between spouses or partners characterized by negative communication (e.g., criticisms), distorted communication (e.g., unrealistic expectations), or noncommunication (e.g., withdrawal) that is associated with clinically significant impairment in individual or family functioning or the development of symptoms in one or both partners.

V61.8 Sibling Relational Problem

This category should be used when the focus of clinical attention is a pattern of interaction among siblings that is associated with clinically significant impairment in individual or family functioning or the development of symptoms in one or more of the siblings.

V62.81 Relational Problem Not Otherwise Specified

This category should be used when the focus of clinical attention is on relational problems that are not classifiable by any of the specific problems listed above (e.g., difficulties with co-workers).

Problems Related to Abuse or Neglect

This section includes categories that should be used when the focus of clinical attention is severe mistreatment of one individual by another through physical abuse, sexual abuse, or child neglect. These problems are included because they are frequently a focus of clinical attention among individuals seen by health professionals. The appropriate V code applies if the focus of attention is on the perpetrator of the abuse or neglect or on the relational unit in which it occurs. If the individual being evaluated or treated is the victim of the abuse or neglect, code 995.52, 995.53, or 995.54 for a child or 995.81 or 995.83 for an adult (depending on the type of abuse).

V61.21 Physical Abuse of Child

This category should be used when the focus of clinical attention is physical abuse of a child.

Coding note: *Specify* **995.54** *if focus of clinical attention is on the victim.*

V61.21 Sexual Abuse of Child

This category should be used when the focus of clinical attention is sexual abuse of a child.

Coding note: *Specify* **995.53** *if focus of clinical attention is on the victim.*

V61.21 Neglect of Child

This category should be used when the focus of clinical attention is child neglect.

Coding note: *Specify* **995.52** *if focus of clinical attention is on the victim.*

Physical Abuse of Adult

This category should be used when the focus of clinical attention is physical abuse of an adult (e.g., spouse beating, abuse of elderly parent).

Coding note: *Code*

V61.12 *if focus of clinical attention is on the perpetrator and abuse is by partner*

V62.83 *if focus of clinical attention is on the perpetrator and abuse is by person other than partner*

995.81 *if focus of clinical attention is on the victim*

Sexual Abuse of Adult

This category should be used when the focus of clinical attention is sexual abuse of an adult (e.g., sexual coercion, rape).

Coding note: *Code*

V61.12 *if focus of clinical attention is on the perpetrator and abuse is by partner*
V62.83 *if focus of clinical attention is on the perpetrator and abuse is by person other than partner*
995.83 *if focus of clinical attention is on the victim*

Additional Conditions That May Be a Focus of Clinical Attention

V15.81 Noncompliance With Treatment

This category can be used when the focus of clinical attention is noncompliance with an important aspect of the treatment for a mental disorder or a general medical condition. The reasons for noncompliance may include discomfort resulting from treatment (e.g., medication side effects), expense of treatment, decisions based on personal value judgments or religious or cultural beliefs about the advantages and disadvantages of the proposed treatment, maladaptive personality traits or coping styles (e.g., denial of illness), or the presence of a mental disorder (e.g., Schizophrenia, Avoidant Personality Disorder). This category should be used only when the problem is sufficiently severe to warrant independent clinical attention.

V65.2 Malingering

The essential feature of Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Under some circumstances, Malingering may represent adaptive behavior—for example, feigning illness while a captive of the enemy during wartime.

Malingering should be strongly suspected if any combination of the following is noted:

1. Medicolegal context of presentation (e.g., the person is referred by an attorney to the clinician for examination)
2. Marked discrepancy between the person's claimed stress or disability and the objective findings
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen
4. The presence of Antisocial Personality Disorder

Malingering differs from Factitious Disorder in that the motivation for the symptom production in Malingering is an external incentive, whereas in Factitious Disorder external incentives are absent. Evidence of an intrapsychic need to maintain the sick role suggests Factitious Disorder. Malingering is differentiated from Conversion Disorder and other Somatoform Disorders by the intentional production of symp-

toms and by the obvious, external incentives associated with it. In Malingering (in contrast to Conversion Disorder), symptom relief is not often obtained by suggestion or hypnosis.

V71.01 Adult Antisocial Behavior

This category can be used when the focus of clinical attention is adult antisocial behavior that is not due to a mental disorder (e.g., Conduct Disorder, Antisocial Personality Disorder, or an Impulse-Control Disorder). Examples include the behavior of some professional thieves, racketeers, or dealers in illegal substances.

V71.02 Child or Adolescent Antisocial Behavior

This category can be used when the focus of clinical attention is antisocial behavior in a child or adolescent that is not due to a mental disorder (e.g., Conduct Disorder or an Impulse-Control Disorder). Examples include isolated antisocial acts of children or adolescents (not a pattern of antisocial behavior).

V62.89 Borderline Intellectual Functioning

This category can be used when the focus of clinical attention is associated with borderline intellectual functioning, that is, an IQ in the 71–84 range. Differential diagnosis between Borderline Intellectual Functioning and Mental Retardation (an IQ of 70 or below) is especially difficult when the coexistence of certain mental disorders (e.g., Schizophrenia) is involved.
Coding note: *This is coded on Axis II.*

780.9 Age-Related Cognitive Decline

This category can be used when the focus of clinical attention is an objectively identified decline in cognitive functioning consequent to the aging process that is within normal limits given the person's age. Individuals with this condition may report problems remembering names or appointments or may experience difficulty in solving complex problems. This category should be considered only after it has been determined that the cognitive impairment is not attributable to a specific mental disorder or neurological condition.

V62.82 Bereavement

This category can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a Major Depressive Episode (e.g., feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss). The bereaved individual typically regards the depressed mood as "normal," although the person may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of "normal" bereavement vary consider-

ably among different cultural groups. The diagnosis of Major Depressive Disorder is generally not given unless the symptoms are still present 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode. These include 1) guilt about things other than actions taken or not taken by the survivor at the time of the death; 2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; 3) morbid preoccupation with worthlessness; 4) marked psychomotor retardation; 5) prolonged and marked functional impairment; and 6) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person.

V62.3 Academic Problem

This category can be used when the focus of clinical attention is an academic problem that is not due to a mental disorder or, if due to a mental disorder, is sufficiently severe to warrant independent clinical attention. An example is a pattern of failing grades or of significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for the problem.

V62.2 Occupational Problem

This category can be used when the focus of clinical attention is an occupational problem that is not due to a mental disorder or, if it is due to a mental disorder, is sufficiently severe to warrant independent clinical attention. Examples include job dissatisfaction and uncertainty about career choices.

313.82 Identity Problem

This category can be used when the focus of clinical attention is uncertainty about multiple issues relating to identity such as long-term goals, career choice, friendship patterns, sexual orientation and behavior, moral values, and group loyalties.

V62.89 Religious or Spiritual Problem

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

V62.4 Acculturation Problem

This category can be used when the focus of clinical attention is a problem involving adjustment to a different culture (e.g., following migration).

V62.89 Phase of Life Problem

This category can be used when the focus of clinical attention is a problem associated with a particular developmental phase or some other life circumstance that is not due to a mental disorder or, if it is due to a mental disorder, is sufficiently severe to warrant independent clinical attention. Examples include problems associated with entering school, leaving parental control, starting a new career, and changes involved in marriage, divorce, and retirement.

Additional Codes

300.9 Unspecified Mental Disorder (nonpsychotic)

There are several circumstances in which it may be appropriate to assign this code: 1) for a specific mental disorder not included in the DSM-IV Classification, 2) when none of the available Not Otherwise Specified categories is appropriate, or 3) when it is judged that a nonpsychotic mental disorder is present but there is not enough information available to diagnose one of the categories provided in the Classification. In some cases, the diagnosis can be changed to a specific disorder after more information is obtained.

V71.09 No Diagnosis or Condition on Axis I

When no Axis I diagnosis or condition is present, this should be indicated. There may or may not be an Axis II diagnosis.

799.9 Diagnosis or Condition Deferred on Axis I

When there is insufficient information to make any diagnostic judgment about an Axis I diagnosis or condition, this should be noted as Diagnosis or Condition Deferred on Axis I.

V71.09 No Diagnosis on Axis II

When no Axis II diagnosis (e.g., no Personality Disorder) is present, this should be indicated. There may or may not be an Axis I diagnosis or condition.

799.9 Diagnosis Deferred on Axis II

When there is insufficient information to make any diagnostic judgment about an Axis II diagnosis, this should be noted as Diagnosis Deferred on Axis II.

Appendix A

Decision Trees for Differential Diagnosis

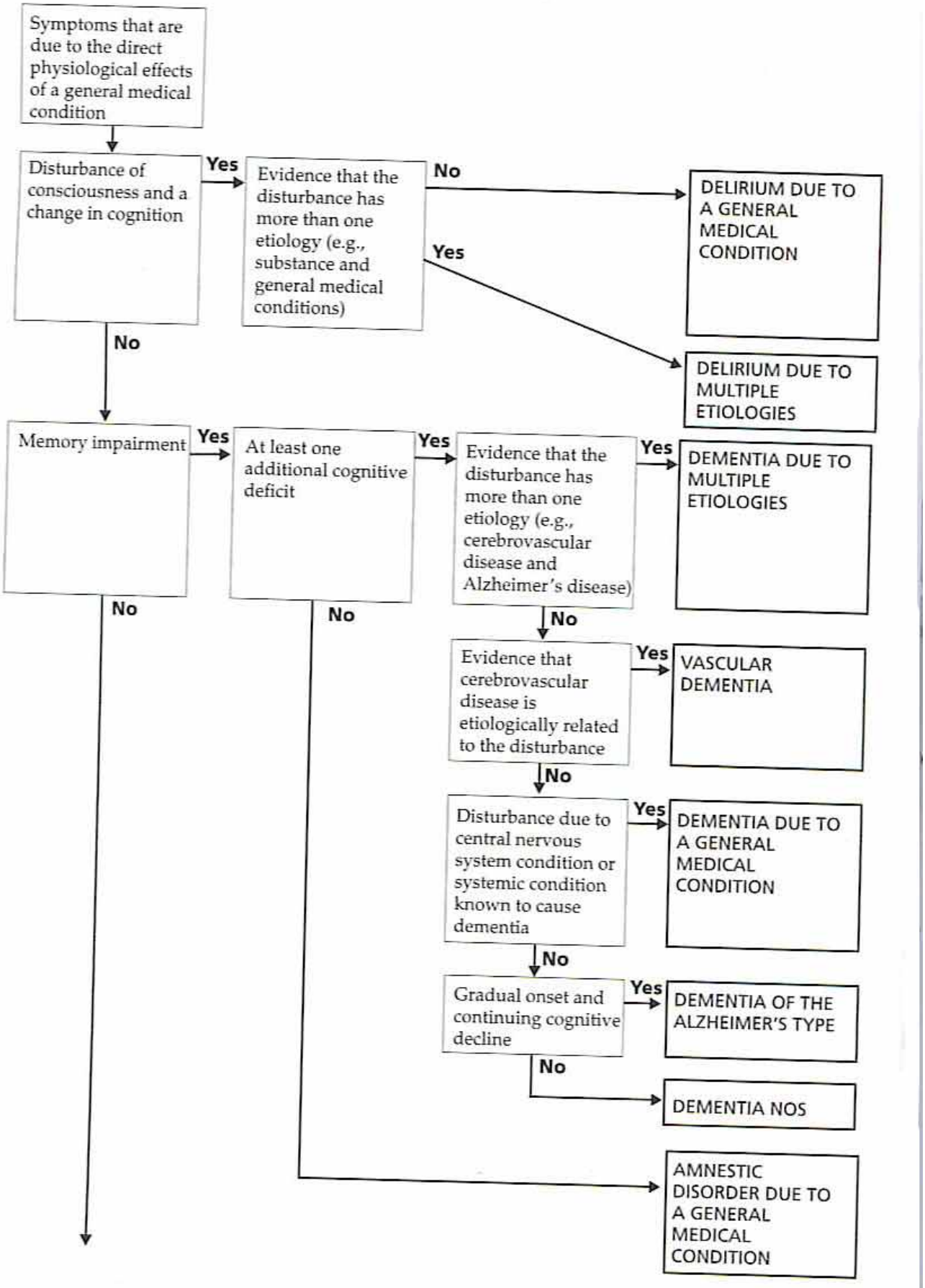
The purpose of these decision trees is to aid the clinician in understanding the organization and hierarchical structure of the DSM-IV Classification. Each decision tree starts with a set of clinical features. When one of these features is a prominent part of the presenting clinical picture, the clinician can follow the series of questions to rule in or rule out various disorders. Note that the questions are only approximations of the diagnostic criteria and are not meant to replace them.

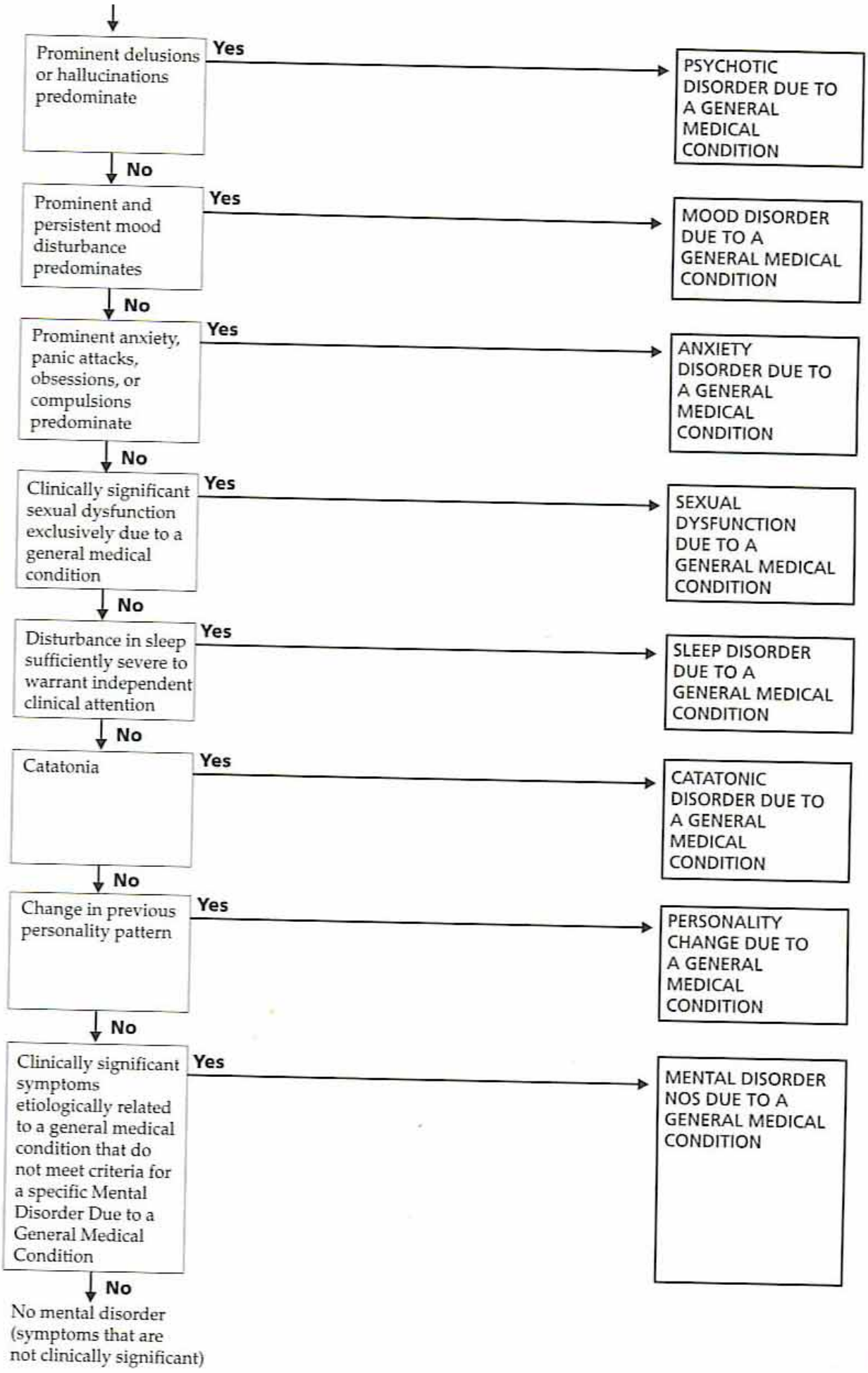
The Psychotic Disorders decision tree is the only one that contains disorders that are mutually exclusive (i.e., only one disorder from that section can be diagnosed in a given individual for a particular episode). For the other decision trees, it is important to refer to the individual criteria sets to determine when more than one diagnosis may apply.

Contents

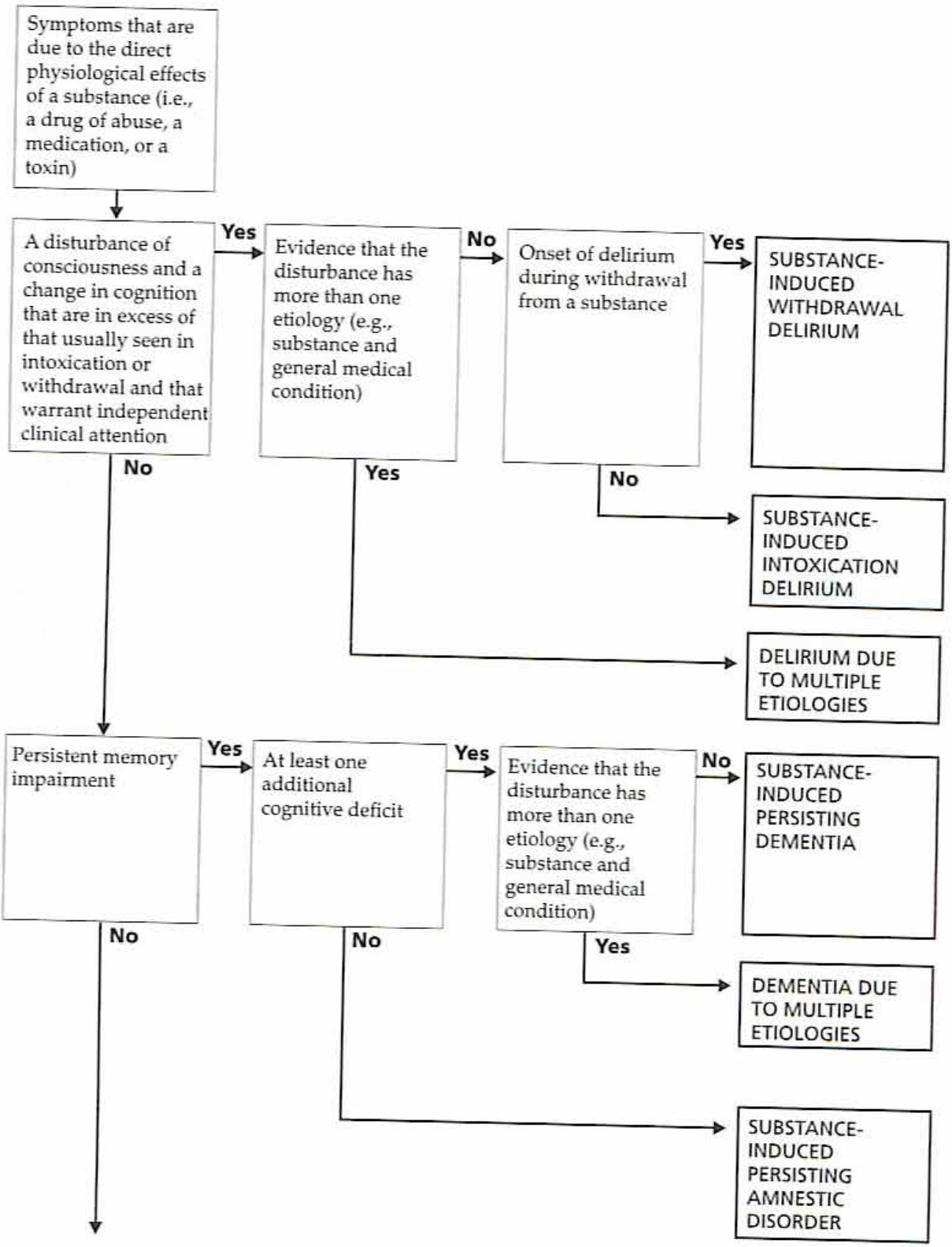
Note: Prepared by Michael B. First, M.D., Allen Frances, M.D., and Harold Alan Pincus, M.D.

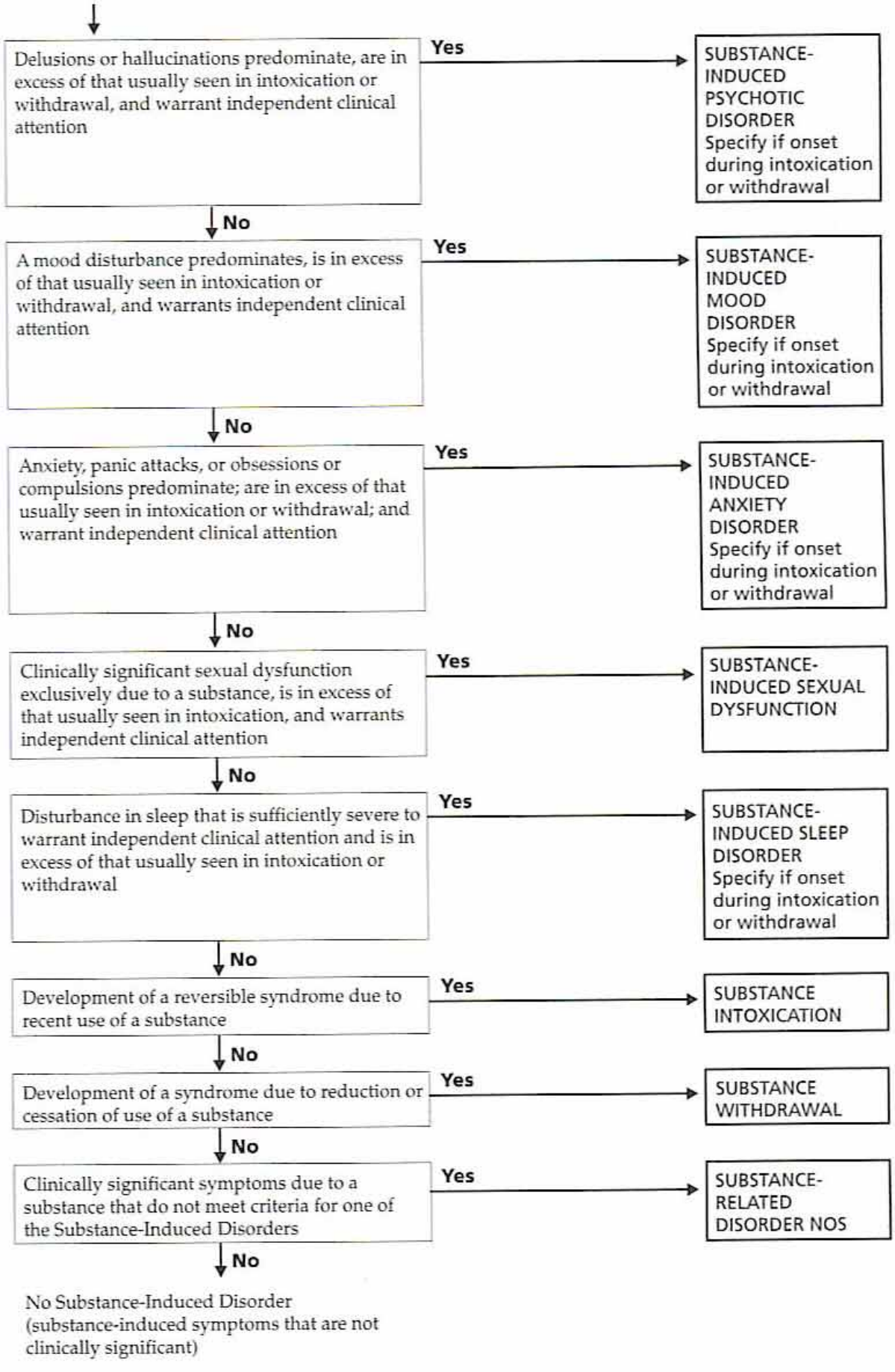
Differential Diagnosis of Mental Disorders Due to a General Medical Condition



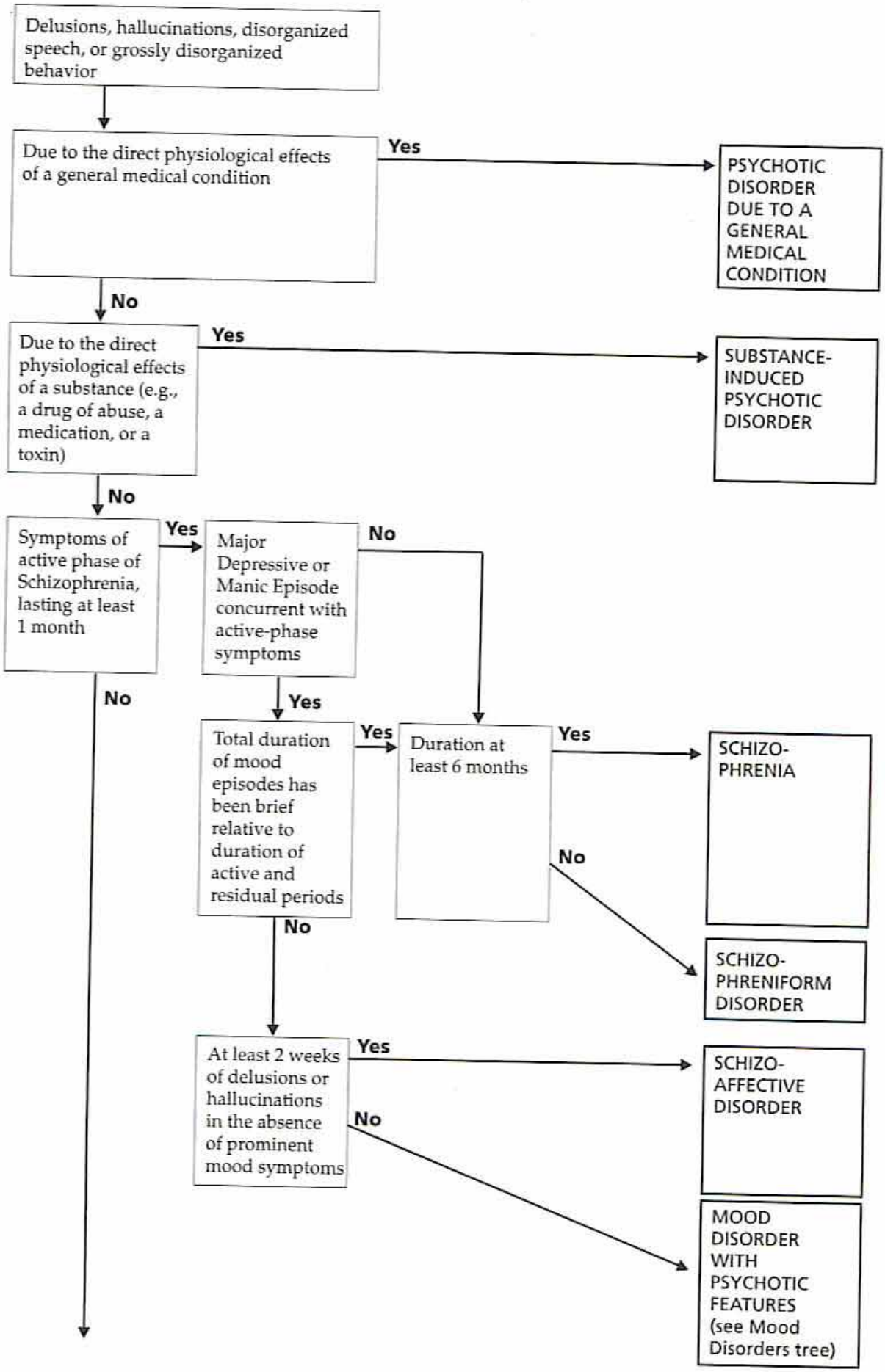

Prominent delusions or hallucinations predominate
Yes
PSYCHOTIC DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Prominent and persistent mood disturbance predominates
Yes
MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Prominent anxiety, panic attacks, obsessions, or compulsions predominate
Yes
ANXIETY DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Clinically significant sexual dysfunction exclusively due to a general medical condition
Yes
SEXUAL DYSFUNCTION DUE TO A GENERAL MEDICAL CONDITION
No
Disturbance in sleep sufficiently severe to warrant independent clinical attention
Yes
SLEEP DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Catatonia
Yes
CATATONIC DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Change in previous personality pattern
Yes
PERSONALITY CHANGE DUE TO A GENERAL MEDICAL CONDITION
No
Clinically significant symptoms etiologically related to a general medical condition that do not meet criteria for a specific Mental Disorder Due to a General Medical Condition
Yes
MENTAL DISORDER NOS DUE TO A GENERAL MEDICAL CONDITION
No
No mental disorder (symptoms that are not clinically significant)

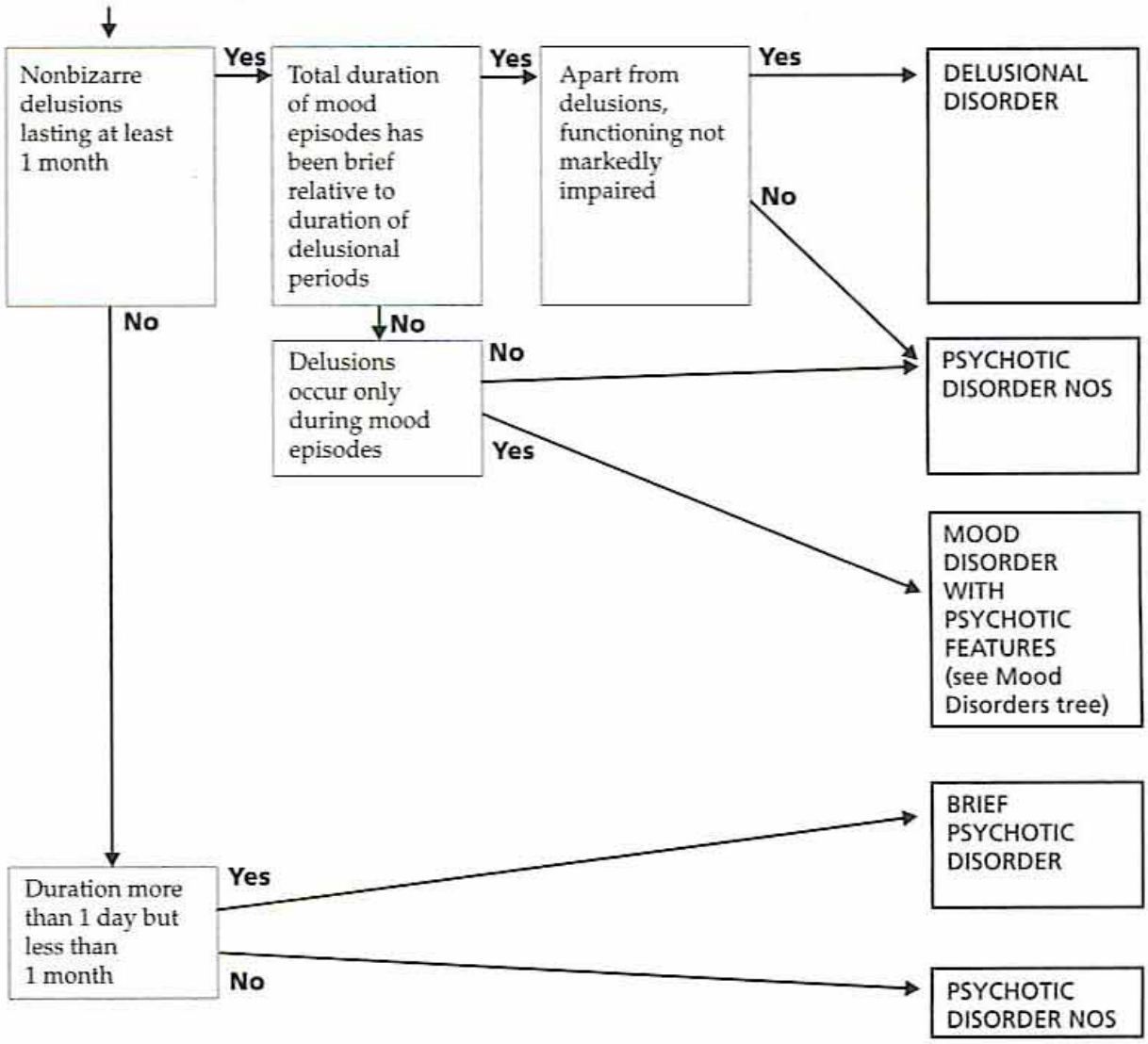
Differential Diagnosis of Substance-Induced Disorders (Not Including Dependence and Abuse)



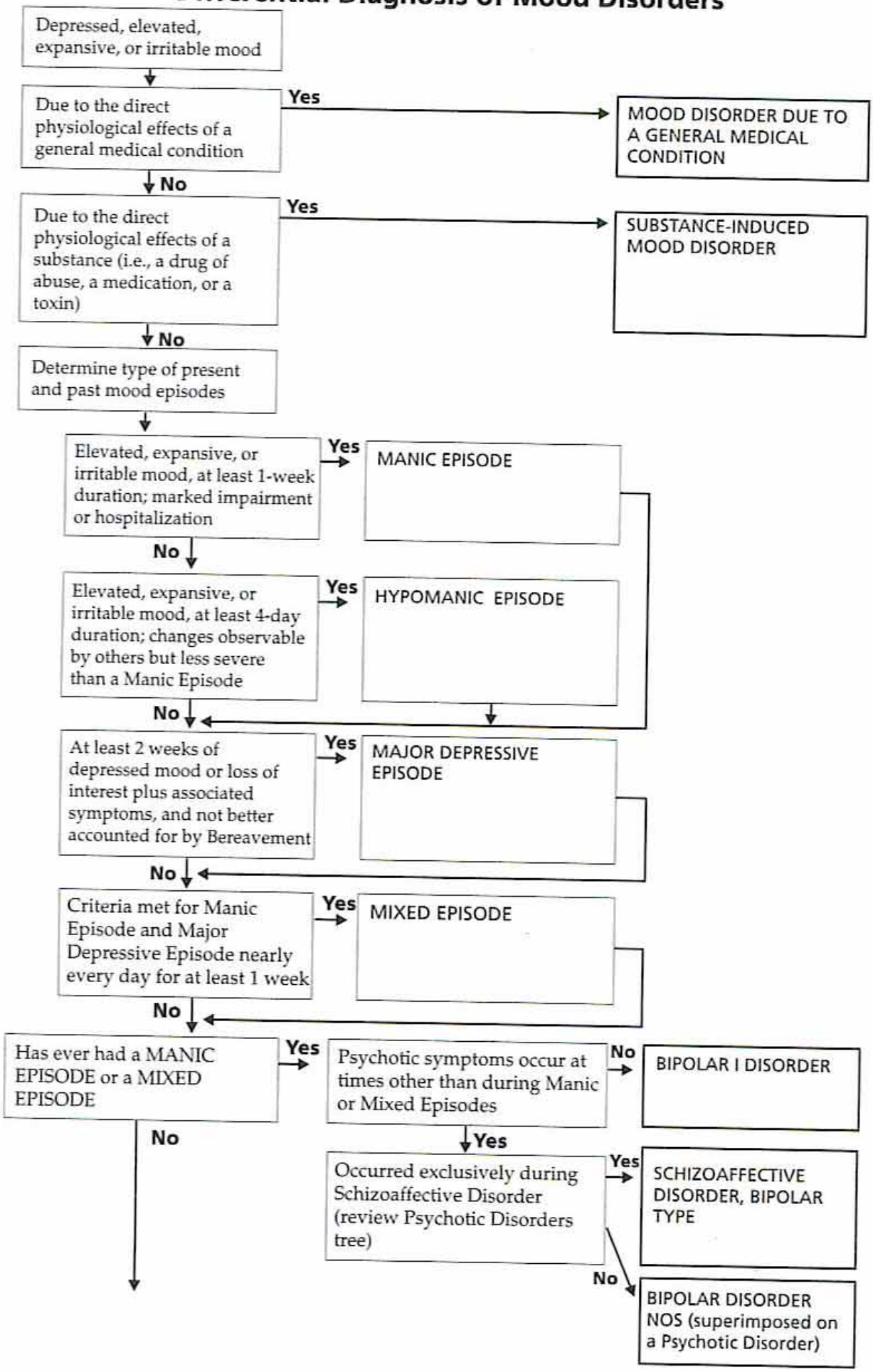

Delusions or hallucinations predominate, are in excess of that usually seen in intoxication or withdrawal, and warrant independent clinical attention
Yes
SUBSTANCE-INDUCED PSYCHOTIC DISORDER
Specify if onset during intoxication or withdrawal
No
A mood disturbance predominates, is in excess of that usually seen in intoxication or withdrawal, and warrants independent clinical attention
Yes
SUBSTANCE-INDUCED MOOD DISORDER
Specify if onset during intoxication or withdrawal
No
Anxiety, panic attacks, or obsessions or compulsions predominate; are in excess of that usually seen in intoxication or withdrawal; and warrant independent clinical attention
Yes
SUBSTANCE-INDUCED ANXIETY DISORDER
Specify if onset during intoxication or withdrawal
No
Clinically significant sexual dysfunction exclusively due to a substance, is in excess of that usually seen in intoxication, and warrants independent clinical attention
Yes
SUBSTANCE-INDUCED SEXUAL DYSFUNCTION
No
Disturbance in sleep that is sufficiently severe to warrant independent clinical attention and is in excess of that usually seen in intoxication or withdrawal
Yes
SUBSTANCE-INDUCED SLEEP DISORDER
Specify if onset during intoxication or withdrawal
No
Development of a reversible syndrome due to recent use of a substance
Yes
SUBSTANCE INTOXICATION
No
Development of a syndrome due to reduction or cessation of use of a substance
Yes
SUBSTANCE WITHDRAWAL
No
Clinically significant symptoms due to a substance that do not meet criteria for one of the Substance-Induced Disorders
Yes
SUBSTANCE-RELATED DISORDER NOS
No
No Substance-Induced Disorder (substance-induced symptoms that are not clinically significant)

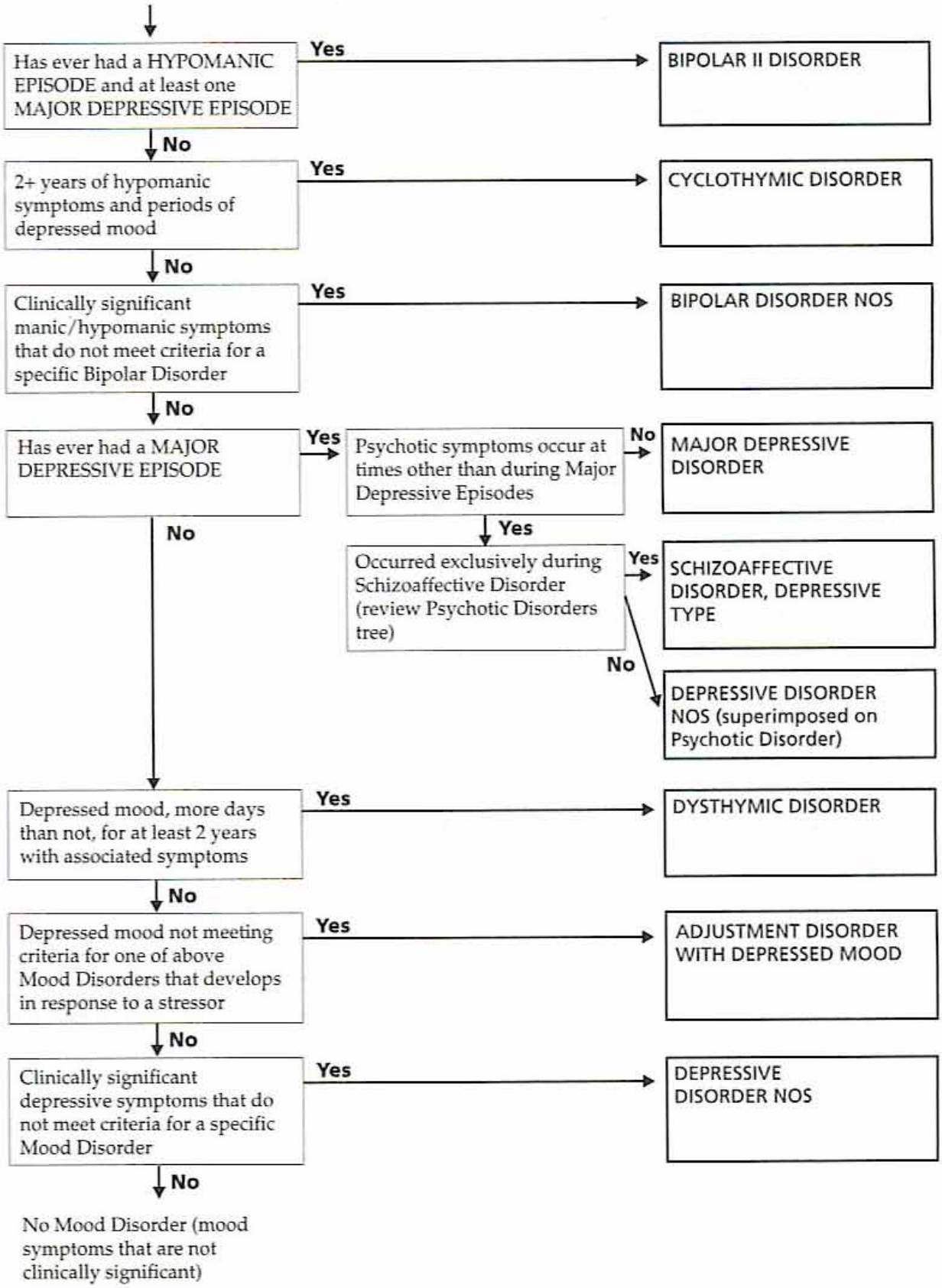
Differential Diagnosis of Psychotic Disorders



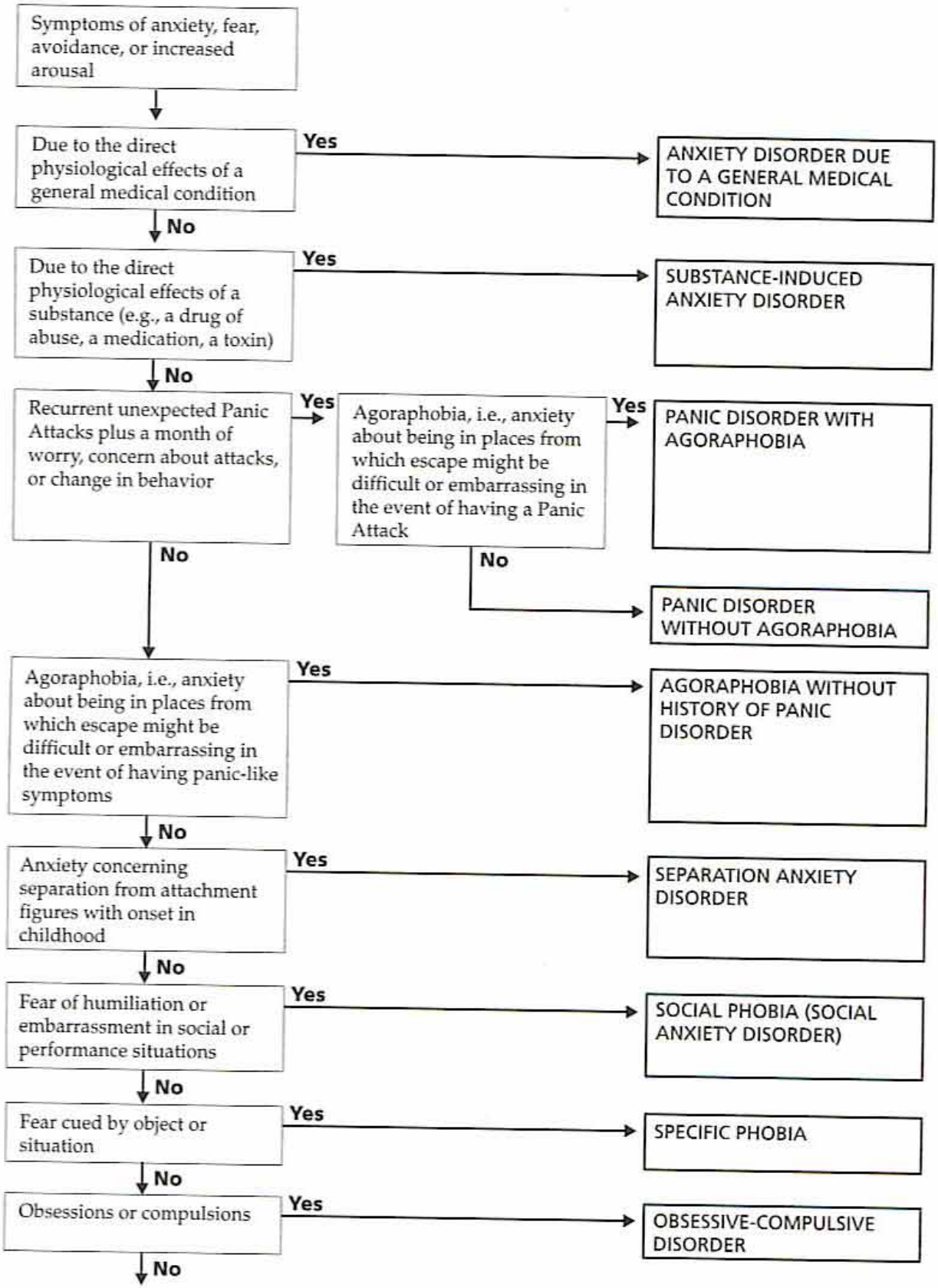

Nonbizarre delusions lasting at least 1 month
Yes
Total duration of mood episodes has been brief relative to duration of delusional periods
Yes
Apart from delusions, functioning not markedly impaired
Yes
DELUSIONAL DISORDER
No
PSYCHOTIC DISORDER NOS
No
Delusions occur only during mood episodes
No
Yes
MOOD DISORDER WITH PSYCHOTIC FEATURES (see Mood Disorders tree)
No
Duration more than 1 day but less than 1 month
Yes
BRIEF PSYCHOTIC DISORDER
No
PSYCHOTIC DISORDER NOS

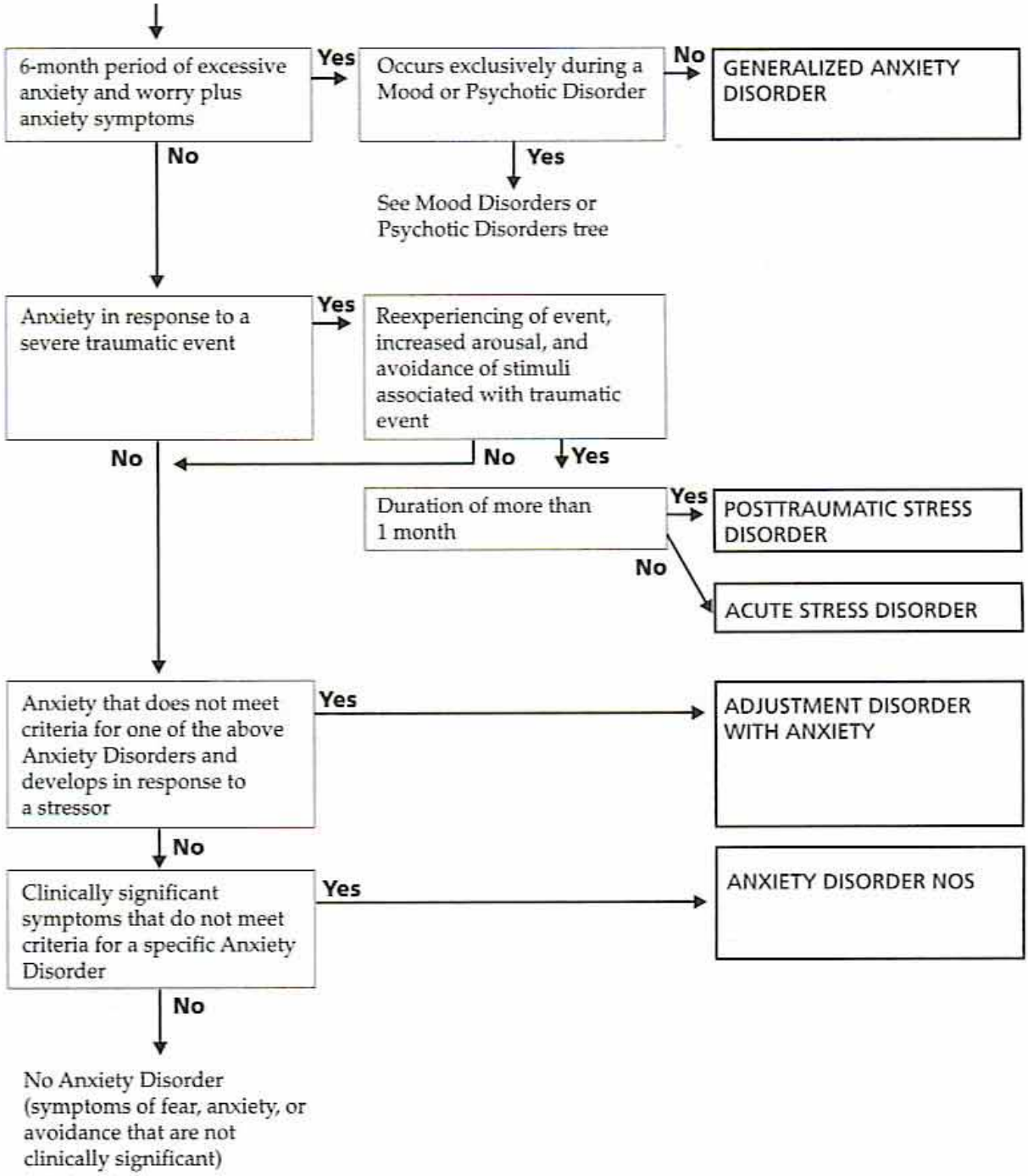
Differential Diagnosis of Mood Disorders



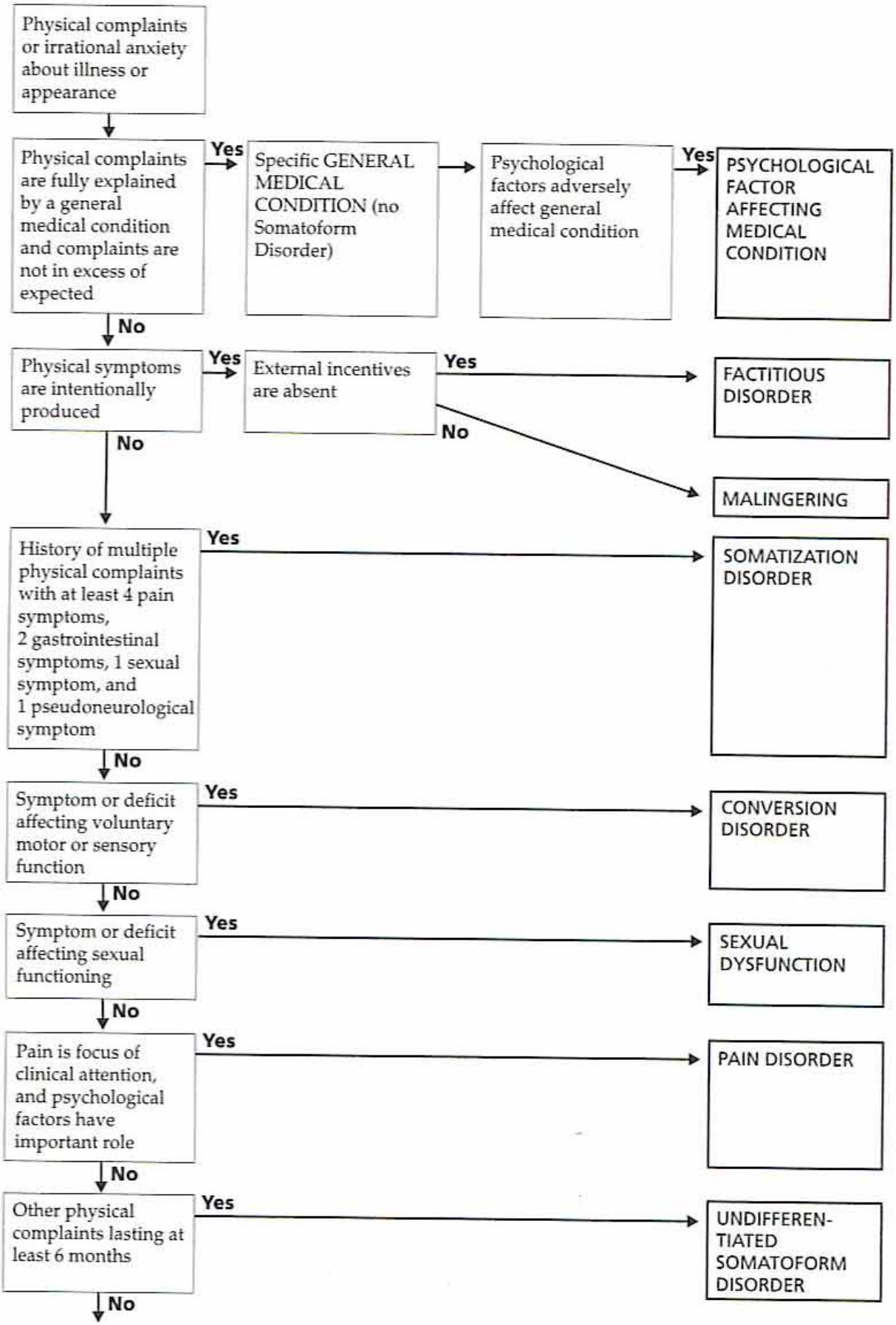

Has ever had a HYPOMANIC EPISODE and at least one MAJOR DEPRESSIVE EPISODE
Yes
BIPOLAR II DISORDER
No
2+ years of hypomanic symptoms and periods of depressed mood
Yes
CYCLOTHYMIC DISORDER
No
Clinically significant manic/hypomanic symptoms that do not meet criteria for a specific Bipolar Disorder
Yes
BIPOLAR DISORDER NOS
No
Has ever had a MAJOR DEPRESSIVE EPISODE
Yes
Psychotic symptoms occur at times other than during Major Depressive Episodes
No
MAJOR DEPRESSIVE DISORDER
Yes
Occurred exclusively during Schizoaffective Disorder (review Psychotic Disorders tree)
Yes
SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE
No
DEPRESSIVE DISORDER NOS (superimposed on Psychotic Disorder)
No
Depressed mood, more days than not, for at least 2 years with associated symptoms
Yes
DYSTHYMIC DISORDER
No
Depressed mood not meeting criteria for one of above Mood Disorders that develops in response to a stressor
Yes
ADJUSTMENT DISORDER WITH DEPRESSED MOOD
No
Clinically significant depressive symptoms that do not meet criteria for a specific Mood Disorder
Yes
DEPRESSIVE DISORDER NOS
No
No Mood Disorder (mood symptoms that are not clinically significant)

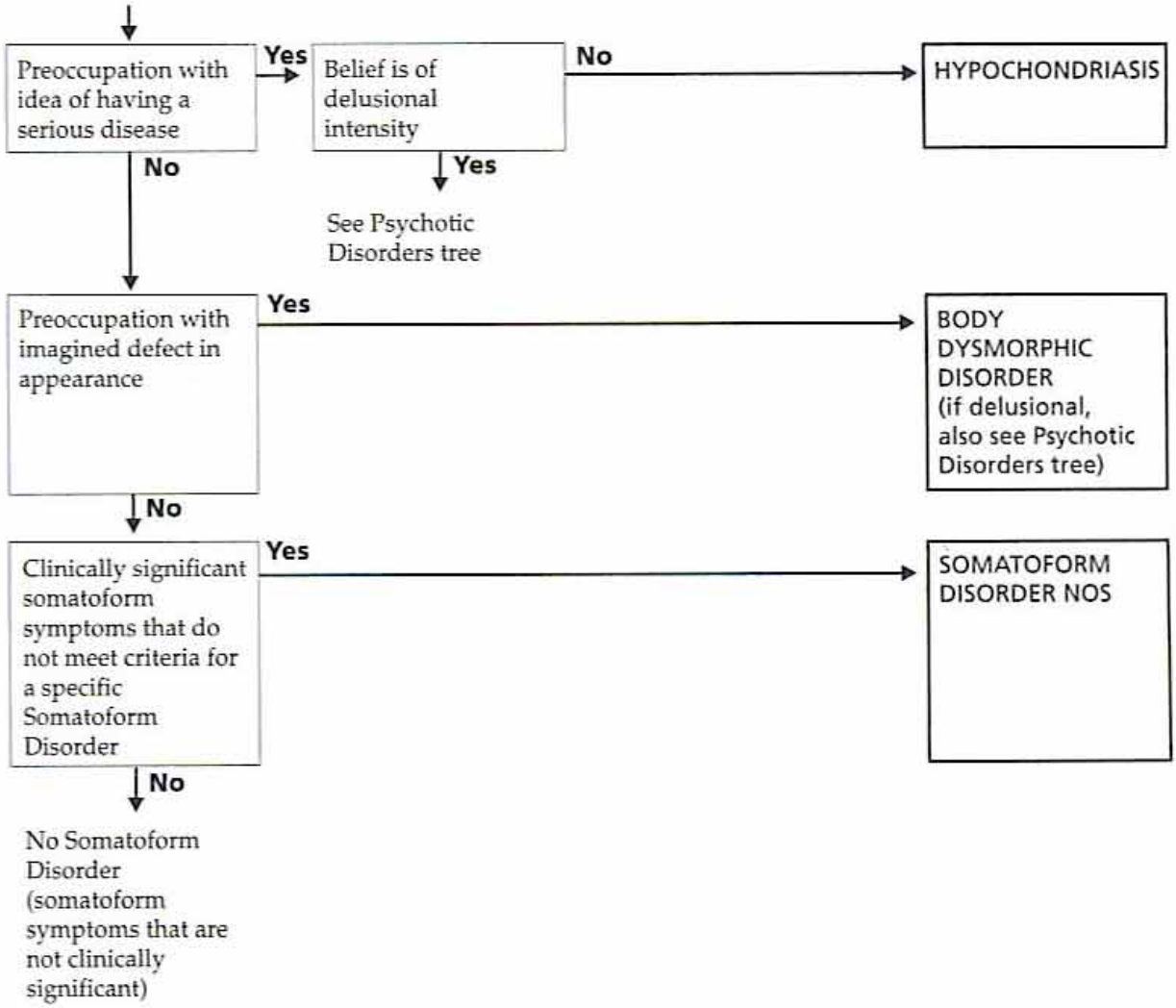
Differential Diagnosis of Anxiety Disorders




6-month period of excessive anxiety and worry plus anxiety symptoms
Yes
Occurs exclusively during a Mood or Psychotic Disorder
No
GENERALIZED ANXIETY DISORDER
No
Yes
See Mood Disorders or Psychotic Disorders tree
Anxiety in response to a severe traumatic event
Yes
Reexperiencing of event, increased arousal, and avoidance of stimuli associated with traumatic event
No
No
Yes
Duration of more than 1 month
Yes
POSTTRAUMATIC STRESS DISORDER
No
ACUTE STRESS DISORDER
Anxiety that does not meet criteria for one of the above Anxiety Disorders and develops in response to a stressor
Yes
ADJUSTMENT DISORDER WITH ANXIETY
No
Clinically significant symptoms that do not meet criteria for a specific Anxiety Disorder
Yes
ANXIETY DISORDER NOS
No
No Anxiety Disorder (symptoms of fear, anxiety, or avoidance that are not clinically significant)

Differential Diagnosis of Somatoform Disorders




Preoccupation with idea of having a serious disease
Yes
Belief is of delusional intensity
No
HYPOCHONDRIASIS
No
Yes
See Psychotic Disorders tree
Preoccupation with imagined defect in appearance
Yes
BODY DYSMORPHIC DISORDER (if delusional, also see Psychotic Disorders tree)
No
Clinically significant somatoform symptoms that do not meet criteria for a specific Somatoform Disorder
Yes
SOMATOFORM DISORDER NOS
No
No Somatoform Disorder (somatoform symptoms that are not clinically significant)

Appendix B

Criteria Sets and Axes Provided for Further Study

This appendix contains a number of proposals for new categories and axes that were suggested for possible inclusion in DSM-IV. The DSM-IV Task Force and Work Groups subjected each of these proposals to a careful empirical review and invited wide commentary from the field. The Task Force determined that there was insufficient information to warrant inclusion of these proposals as official categories or axes in DSM-IV.

The items, thresholds, and durations contained in the research criteria sets are intended to provide a common language for researchers and clinicians who are interested in studying these disorders. It is hoped that such research will help to determine the possible utility of these proposed categories and will result in refinement of the criteria sets. The specific thresholds and durations were set by expert consensus (informed by literature review, data reanalysis, and field-trial results when such information was available) and, as such, should be considered tentative. It would be highly desirable for researchers to study alternative items, thresholds, or durations whenever this is possible.

The following proposals are included in this appendix:

Postconcussional disorder
Mild neurocognitive disorder
Caffeine withdrawal
Alternative dimensional descriptors for Schizophrenia
Postpsychotic depressive disorder of Schizophrenia
Simple deteriorative disorder (simple Schizophrenia)
Premenstrual dysphoric disorder
Alternative Criterion B for Dysthymic Disorder
Minor depressive disorder
Recurrent brief depressive disorder
Mixed anxiety-depressive disorder
Factitious disorder by proxy
Dissociative trance disorder
Binge-eating disorder
Depressive personality disorder
Passive-aggressive personality disorder (negativistic personality disorder)

Medication-Induced Movement Disorders
- Neuroleptic-Induced Parkinsonism
- Neuroleptic Malignant Syndrome
- Neuroleptic-Induced Acute Dystonia
- Neuroleptic-Induced Acute Akathisia
- Neuroleptic-Induced Tardive Dyskinesia
- Medication-Induced Postural Tremor
- Medication-Induced Movement Disorder Not Otherwise Specified

(**Note:** These categories are included in the "Other Conditions That May Be a Focus of Clinical Attention" section. Text and research criteria sets for these conditions are included here.)

Defensive Functioning Scale
Global Assessment of Relational Functioning (GARF) Scale
Social and Occupational Functioning Assessment Scale (SOFAS)

Postconcussional Disorder

Features

The essential feature is an acquired impairment in cognitive functioning, accompanied by specific neurobehavioral symptoms, that occurs as a consequence of closed head injury of sufficient severity to produce a significant cerebral concussion. The manifestations of concussion include loss of consciousness, posttraumatic amnesia, and less commonly, posttraumatic onset of seizures. Specific approaches for defining this criterion need to be refined by further research. Although there is insufficient evidence to establish a definite threshold for the severity of the closed head injury, specific criteria have been suggested, for example, two of the following: 1) a period of unconsciousness lasting more than 5 minutes, 2) a period of posttraumatic amnesia that lasts more than 12 hours after the closed head injury, or 3) a new onset of seizures (or marked worsening of a preexisting seizure disorder) that occurs within the first 6 months after the closed head injury. There must also be documented cognitive deficits in either attention (concentration, shifting focus of attention, performing simultaneous cognitive tasks) or memory (learning or recalling information). Accompanying the cognitive disturbances, there must be three (or more) symptoms that are present for at least 3 months following the closed head injury. These include becoming fatigued easily; disordered sleep; headache; vertigo or dizziness; irritability or aggression on little or no provocation; anxiety, depression, or affective lability; apathy or lack of spontaneity; and other changes in personality (e.g., social or sexual inappropriateness). The cognitive disturbances and the somatic and behavioral symptoms develop after the head trauma has occurred or represent a significant worsening of preexisting symptoms. The cognitive and neurobehavioral sequelae are accompanied by significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning. In the case of school-age children, there may be significant worsening in academic achievement dating from the trauma. This proposed disorder should not be considered if the individual's symptoms meet the criteria for Dementia Due to Head Trauma or if the symptoms are better accounted for by another mental disorder.

Associated Features

Additional features that may be sequelae of closed head injury include visual or hearing impairments and anosmia (loss of sense of smell). The latter may be related to a lack of interest in food. Specific orthopedic and neurological complications may be present, depending on the cause, nature, and extent of the trauma. Substance-Related Disorders are frequently associated with closed head injury. Closed head injury occurs more often in young males and has been associated with risk-taking behaviors.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Cognitive Disorder Not Otherwise Specified.**

If the head trauma results in a **dementia** (e.g., memory impairment and at least one other cognitive impairment), postconcussional disorder should not be considered. **Mild neurocognitive disorder,** like postconcussional disorder, is included in this appendix (see p. 762). Postconcussional disorder can be differentiated from mild neurocognitive disorder by the specific pattern of cognitive, somatic, and behavioral symptoms and the presence of a specific etiology (i.e., closed head injury). Individuals with **Somatization Disorder** and **Undifferentiated Somatoform Disorder** may manifest similar behavioral or somatic symptoms; however, these disorders do not have a specific etiology (i.e., closed head injury) or measurable impairment in cognitive functioning. Postconcussional disorder must be distinguished from **Factitious Disorder** (the need to assume the sick role) and **Malingering** (in which the desire for compensation may lead to the production or prolongation of symptoms due to closed head injury).

Research criteria for postconcussional disorder

A. A history of head trauma that has caused significant cerebral concussion.

Note: The manifestations of concussion include loss of consciousness, posttraumatic amnesia, and, less commonly, posttraumatic onset of seizures. The specific method of defining this criterion needs to be established by further research.

B. Evidence from neuropsychological testing or quantified cognitive assessment of difficulty in attention (concentrating, shifting focus of attention, performing simultaneous cognitive tasks) or memory (learning or recalling information).

C. Three (or more) of the following occur shortly after the trauma and last at least 3 months:

(1) becoming fatigued easily
(2) disordered sleep
(3) headache
(4) vertigo or dizziness
(5) irritability or aggression on little or no provocation
(6) anxiety, depression, or affective lability
(7) changes in personality (e.g., social or sexual inappropriateness)
(8) apathy or lack of spontaneity

Research criteria for postconcussional disorder *(continued)*

D. The symptoms in Criteria B and C have their onset following head trauma or else represent a substantial worsening of preexisting symptoms.

E. The disturbance causes significant impairment in social or occupational functioning and represents a significant decline from a previous level of functioning. In school-age children, the impairment may be manifested by a significant worsening in school or academic performance dating from the trauma.

F. The symptoms do not meet criteria for Dementia Due to Head Trauma and are not better accounted for by another mental disorder (e.g., Amnestic Disorder Due to Head Trauma, Personality Change Due to Head Trauma).

Mild Neurocognitive Disorder

Features

The essential feature is the development of impairment in neurocognitive functioning that is due to a general medical condition. By definition, the level of cognitive impairment and the impact on everyday functioning is mild (e.g., the individual is able to partially compensate for cognitive impairment with additional effort). Individuals with this condition have a new onset of deficits in at least two areas of cognitive functioning. These may include disturbances in memory (learning or recalling new information), executive functioning (e.g., planning, reasoning), attention or speed of information processing (e.g., concentration, rapidity of assimilating or analyzing information), perceptual motor abilities (e.g., integrating visual, tactile, or auditory information with motor activities), or language (e.g., word-finding difficulties, reduced fluency). The report of cognitive impairment must be corroborated by the results of neuropsychological testing or bedside standardized cognitive assessment techniques. Furthermore, the cognitive deficits cause marked distress or interfere with the individual's social, occupational, or other important areas of functioning and represent a decline from a previous level of functioning. The cognitive disturbance does not meet criteria for a delirium, a dementia, or an amnestic disorder and is not better accounted for by another mental disorder (e.g., a Substance-Related Disorder, Major Depressive Disorder).

Associated Features

The associated features depend on the underlying general medical condition. In the case of certain chronic disorders (e.g., hypoxemia, electrolyte imbalances), the cognitive profile is usually one of a generalized reduction in all cognitive functions. Some neurological and other general medical conditions produce patterns of cognitive impairment that suggest more "subcortical" brain involvement (i.e., disproportionate impairment in the ability to concentrate and learn new facts and in the speed and efficiency of processing information). These include the early phases of Huntington's

disease, HIV-associated neurocognitive disorder, and Parkinson's disease. Other conditions (e.g., systemic lupus erythematosus) are more frequently associated with a multifocal or patchy pattern of cognitive loss. The EEG may show mild slowing of background activity or disturbance in evoked potentials. Mild cognitive impairment, even in cases of early Alzheimer's disease, is frequently present without specific changes on neuroanatomical studies using magnetic resonance imaging (MRI) or computed tomography (CT). Abnormalities are more likely to be present in functional brain imaging studies (single photon emission computed tomography [SPECT], positron-emission tomography [PET], functional MRI). The course depends on the underlying etiology. In some instances, the cognitive impairment slowly worsens so that ultimately a diagnosis of dementia becomes appropriate (e.g., early phases of Alzheimer's disease, Huntington's disease, and other slowly progressive neurodegenerative conditions). In other instances, the disturbance may improve slowly, as in gradual recovery from hypothyroidism. In some instances, cognitive disturbances due to severe metabolic derangements or infectious diseases may resolve partially but be characterized by a residual impairment that is permanent.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Cognitive Disorder Not Otherwise Specified.**

Although there is no clear boundary between mild neurocognitive disorder and **dementia,** mild neurocognitive disorder has less cognitive impairment and less impact on daily activities, and memory impairment is not a requirement. Mild neurocognitive disorder may be confused with a slowly evolving **delirium,** especially early in its course. Mild neurocognitive disorder can be distinguished from an **amnestic disorder** by the requirement that there be cognitive impairment in at least two areas. Mild neurocognitive disorder should not be considered if an individual's symptoms meet criteria for a **Substance-Related Disorder** (including medication side effects). In such cases, the appropriate Substance-Related Disorder Not Otherwise Specified should be diagnosed.

Postconcussional disorder, another category listed in this appendix (see p. 760), is distinguished from mild neurocognitive disorder by the presence of a specific pattern of symptoms and a specific etiology (i.e., closed head injury).

Mild neurocognitive disturbances are a common associated feature of a number of **mental disorders** (e.g., Major Depressive Disorder). Mild neurocognitive disorder should only be considered if the cognitive impairment is better accounted for by the direct effects of a general medical condition than by a mental disorder. Individuals with **Age-Related Cognitive Decline** may have similar levels of cognitive impairment, but the decline is considered to be part of the normative aging process rather than attributable to a general medical condition. Individuals may report **subjective complaints of impairment in cognitive functioning** that cannot be corroborated by neuropsychological testing or are judged not to be associated with a general medical condition. This proposed disorder should not be considered for such presentations.

Research criteria for mild neurocognitive disorder

A. The presence of two (or more) of the following impairments in cognitive functioning, lasting most of the time for a period of at least 2 weeks (as reported by the individual or a reliable informant):

   (1) memory impairment as identified by a reduced ability to learn or recall information
   (2) disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)
   (3) disturbance in attention or speed of information processing
   (4) impairment in perceptual-motor abilities
   (5) impairment in language (e.g., comprehension, word finding)

B. There is objective evidence from physical examination or laboratory findings (including neuroimaging techniques) of a neurological or general medical condition that is judged to be etiologically related to the cognitive disturbance.

C. There is evidence from neuropsychological testing or quantified cognitive assessment of an abnormality or decline in performance.

D. The cognitive deficits cause marked distress or impairment in social, occupational, or other important areas of functioning and represent a decline from a previous level of functioning.

E. The cognitive disturbance does not meet criteria for a delirium, a dementia, or an amnestic disorder and is not better accounted for by another mental disorder (e.g., a Substance-Related Disorder, Major Depressive Disorder).

Caffeine Withdrawal

Features

The essential feature is a characteristic withdrawal syndrome due to the abrupt cessation of, or reduction in, the use of caffeine-containing products after prolonged daily use. The syndrome includes headache and one (or more) of the following symptoms: marked fatigue or drowsiness, marked anxiety or depression, or nausea or vomiting. These symptoms appear to be more prevalent in individuals with heavy use (500 mg/day) but may occur in individuals with light use (100 mg/day). The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms must not be due to the direct physiological effects of a general medical condition and must not be better accounted for by another mental disorder.

Associated Features

Associated symptoms include a strong desire for caffeine and worsened cognitive performance (especially on vigilance tasks). Symptoms can begin within 12 hours of

cessation of caffeine use, peak around 24–48 hours, and last up to 1 week. Some individuals may seek medical treatment for these symptoms without realizing they are due to caffeine withdrawal.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Caffeine-Related Disorder Not Otherwise Specified.**

For a general discussion of the differential diagnosis of Substance-Related Disorders, see p. 207. The symptoms must not be due to the direct physiological effects of a **general medical condition** (e.g., migraine, viral illness) and must not be better accounted for by **another mental disorder.** Headaches, fatigue, nausea, or vomiting due to a general medical condition or due to the **initiation or cessation of a medication** can cause a clinical picture similar to caffeine withdrawal. Drowsiness, fatigue, and mood changes from caffeine withdrawal can mimic **Amphetamine** or **Cocaine Withdrawal.** The temporal relationship of symptoms to caffeine cessation and the time-limited course of the symptoms usually establish the diagnosis. If the diagnosis is unclear, a diagnostic trial of caffeine can be of help.

Research criteria for caffeine withdrawal

A. Prolonged daily use of caffeine.

B. Abrupt cessation of caffeine use, or reduction in the amount of caffeine used, closely followed by headache and one (or more) of the following symptoms:

   (1) marked fatigue or drowsiness
   (2) marked anxiety or depression
   (3) nausea or vomiting

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

D. The symptoms are not due to the direct physiological effects of a general medical condition (e.g., migraine, viral illness) and are not better accounted for by another mental disorder.

Alternative Dimensional Descriptors for Schizophrenia

Because of limitations in the classical subtyping of Schizophrenia (see p. 313), a three-factor dimensional model (psychotic, disorganized, and negative) has been suggested to describe current and lifetime symptomatology. The psychotic factor includes delusions and hallucinations. The disorganized factor includes disorganized speech, disorganized behavior, and inappropriate affect. The negative factor includes the various negative symptoms. Studies suggest that the severity of symptoms within each of these three factors tends to vary together, both cross-sectionally and over

time, whereas this is less true for symptoms across factors. For example, as delusions become more severe, hallucinations tend to become more severe as well. In contrast, the severity of negative or disorganized symptoms is less related to the severity of hallucinations or delusions. One model for understanding the clinical heterogeneity of Schizophrenia suggests that each of these three dimensions may have different underlying pathophysiological processes and treatment responses. Various combinations of severity on the three dimensions are encountered in clinical practice, and it is relatively uncommon for one dimension to be present in the complete absence of both of the others. The following is a system for applying these dimensions in research and clinical studies.

Alternative dimensional descriptors for Schizophrenia

Specify: absent, mild, moderate, severe for each dimension. The prominence of these dimensions may be specified for either (or both) the current episode (i.e., previous 6 months) or the lifetime course of the disorder.

psychotic (hallucinations/delusions) dimension: describes the degree to which hallucinations or delusions have been present

disorganized dimension: describes the degree to which disorganized speech, disorganized behavior, or inappropriate affect have been present

negative (deficit) dimension: describes the degree to which negative symptoms (i.e., affective flattening, alogia, avolition) have been present. **Note:** Do not include symptoms that appear to be secondary to depression, medication side effects, or hallucinations or delusions.

Two examples that include the DSM-IV subtype, course specifiers, and the proposed dimensional approach are

Example 1

295.30 Schizophrenia, Paranoid Type, Continuous

Current:

With severe psychotic dimension
With absent disorganized dimension
With moderate negative dimension

Lifetime:

With mild psychotic dimension
With absent disorganized dimension
With mild negative dimension

Example 2

295.60 Schizophrenia, Residual Type, Episodic With Residual Symptoms

Current:

With mild psychotic dimension
With mild disorganized dimension
With mild negative dimension

Lifetime:
With moderate psychotic dimension
With mild disorganized dimension
With mild negative dimension

Postpsychotic Depressive Disorder of Schizophrenia

Features

The essential feature is a Major Depressive Episode (see p. 349) that is superimposed on, and occurs during, the residual phase of Schizophrenia. The residual phase of Schizophrenia follows the active phase (i.e., symptoms meeting Criterion A) of Schizophrenia. It is characterized by the persistence of negative symptoms or of active-phase symptoms that are in an attenuated form (e.g., odd beliefs, unusual perceptual experiences). The superimposed Major Depressive Episode must include depressed mood (i.e., loss of interest or pleasure cannot serve as an alternate for sad or depressed mood). Often, the Major Depressive Episode follows immediately after remission of the active-phase symptoms of the psychotic episode. Sometimes, however, it may follow after a short or extended interval during which there are no psychotic symptoms. Mood symptoms due to the direct physiological effects of a drug of abuse, a medication, or a general medical condition are not counted toward postpsychotic depressive disorder of Schizophrenia.

Associated Features

As compared with individuals with Schizophrenia without postpsychotic depressive episodes, these individuals are more likely to be living alone and to have fewer social supports. Other associated features may include a larger number of previous hospitalizations, history of psychotic relapses while being treated with antipsychotic medications, insidious onset of psychotic episodes, prior episodes of depression, and prior suicide attempts. There may be recent losses, undesirable life events, or other stressors. Reported prevalence rates vary, but up to 25% of individuals with Schizophrenia have been described as having this condition sometime in the course of their illness. These individuals appear more likely to relapse into a psychotic episode or to be rehospitalized than those without depression. Individuals with Schizophrenia who also have first-degree biological relatives with histories of Major Depressive Disorder may be at higher risk for postpsychotic depressions. This condition is associated with suicidal ideation, suicide attempts, and completed suicides.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Depressive Disorder Not Otherwise Specified.**

Mood Disorder Due to a General Medical Condition is distinguished from this disturbance by the fact that the depressive symptoms are due to the direct physiolog-

ical effects of a general medical condition (e.g., hypothyroidism). **Substance-Induced Mood Disorder** is distinguished from this disturbance by the fact that the depressive symptoms are due to the direct physiological effects of a drug of abuse (e.g., alcohol, cocaine) or the side effects of a medication. Individuals with Schizophrenia are often on maintenance neuroleptic medications, which can cause dysphoria or Medication-Induced Movement Disorders as side effects. These side effects can be confused with depressive symptoms. **Neuroleptic-Induced Parkinsonism** with akinesia (see p. 792) is characterized by a reduced ability to initiate or sustain behaviors, which can lead to a lack of spontaneity or anhedonia. **Neuroleptic-Induced Acute Akathisia** (see p. 800) may be mistaken for anxiety or agitation, and depressed mood or suicidal ideation may be associated. Adjusting the medication type or dose may assist in reducing these side effects and clarifying the cause of such symptoms.

The differential diagnosis between postpsychotic depressive symptoms and the **negative symptoms of Schizophrenia** (i.e., avolition, alogia, affective flattening) may be particularly difficult. Negative symptoms must be distinguished from the other symptoms of depression (e.g., sadness, guilt, shame, hopelessness, helplessness, and low self-esteem). In **Schizoaffective Disorder** and **Mood Disorder With Psychotic Features,** there must be a substantial period of overlap between the full psychotic episode and the mood episode. In contrast, this proposed disorder is diagnosed only during the residual phase of Schizophrenia.

Demoralization may occur during the course of Schizophrenia but should not be considered postpsychotic depression unless the full criteria for a Major Depressive Episode are met. **Adjustment Disorder With Depressed Mood** is distinguished from postpsychotic depressive disorder of Schizophrenia because the depressive symptoms in Adjustment Disorder do not meet the criteria for a Major Depressive Episode.

Research criteria for postpsychotic depressive disorder of Schizophrenia

A. Criteria are met for a Major Depressive Episode.

Note: The Major Depressive Episode must include Criterion A1: depressed mood. Do not include symptoms that are better accounted for as medication side effects or negative symptoms of Schizophrenia.

B. The Major Depressive Episode is superimposed on and occurs only during the residual phase of Schizophrenia.

C. The Major Depressive Episode is not due to the direct physiological effects of a substance or a general medical condition.

Simple Deteriorative Disorder (Simple Schizophrenia)

Features

The essential feature is the development of prominent negative symptoms, which represent a clear change from a preestablished baseline. These symptoms are severe enough to result in a marked decline in occupational or academic functioning. If positive psychotic symptoms (e.g., hallucinations, delusions, disorganized speech, disorganized behavior, catatonic behavior) have ever been present, they have not been prominent. This pattern should be considered only after all other possible causes for the deterioration have been ruled out, that is, the presentation is not better accounted for by Schizotypal or Schizoid Personality Disorder; a Psychotic, Mood, or Anxiety Disorder; a dementia; or Mental Retardation; nor are the symptoms due to the direct physiological effects of a substance or a general medical condition. There is an insidious and progressive development of negative symptoms over a period of at least 1 year beginning in adolescence or later. Emotional responses become blunted, shallow, flat, and empty. Speech becomes impoverished of words and meanings. There is a definite change in "personality," with a marked loss of interpersonal rapport. Close relationships lose warmth and mutuality, social interaction generally becomes awkward, and isolation and withdrawal result. Initiative gives way to apathy, and ambition to avolition. Loss of interest extends to the daily details of self-care. The person may appear forgetful and absentminded. Academic or job skills are lost, resulting in a pattern of brief, simple jobs and frequent unemployment.

Associated Features

Any of the features of Schizoid or Schizotypal Personality Disorder may be present. Most common are peculiarities of grooming and behavior, lapses in hygiene, overinvestment in odd ideas, or unusual perceptual experiences such as illusions. This proposed disorder may occur in adolescents and adults of both sexes. Good estimates of prevalence and incidence are not available, but it is clear that the disorder is rare. The course, at least for the first few years, is progressively downhill, with prominent deterioration of functioning. This deterioration in functioning resembles the characteristic course of Schizophrenia and distinguishes this condition from Schizoid and Schizotypal Personality Disorders. Symptoms meeting Criterion A for Schizophrenia may emerge, at which time the diagnosis is changed to Schizophrenia. In these instances, this pattern proves to have been a prolonged prodrome to Schizophrenia. In other cases this pattern recedes in severity, as can happen with Schizophrenia. For the majority of individuals, the course is continuous, with deterioration occurring within the first few years after prodromal symptoms and then plateauing to a marginal and reduced, but stable, functional capacity.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Unspecified Mental Disorder.**

This pattern should be considered only after all other possible causes of deterioration in functioning have been ruled out. This pattern is distinguished from the disorders included in the "Schizophrenia and Other Psychotic Disorders" section by the absence of prominent positive psychotic symptoms. These disorders include **Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, Delusional Disorder, Shared Psychotic Disorder,** and **Psychotic Disorder Not Otherwise Specified,** all of which require at least one positive symptom for some period of time. This proposed disorder is distinguished from **Schizoid** and **Schizotypal Personality Disorders** as well as other Personality Disorders by the requirement of a clear change in personality and marked deterioration in functioning. In contrast, the Personality Disorders represent lifelong patterns without progressive deterioration. **Mood Disorders** may mimic the apathy and anhedonia of simple deteriorative disorder, but in a Mood Disorder depressive affect (sadness, hopelessness, helplessness, painful guilt) is experienced, and the course tends to be episodic. Furthermore, in simple deteriorative disorder, there is a sense of emptiness rather than a painful or prominently depressive mood, and the course is continuous and progressive. The distinction can be more difficult with **Dysthymic Disorder,** in which the course may also be continuous and in which vegetative symptoms and painfully depressive mood may not be prominent. This proposed disorder may mimic **chronic Substance Dependence** and should only be considered if the personality change and deterioration precede extensive substance use. **Personality Change Due to a General Medical Condition** is distinguished by the presence of an etiological general medical condition. The cognitive impairment of simple deteriorative disorder may be mistaken for **Mental Retardation** or **dementia.** Mental Retardation is distinguished by its typical onset in infancy or childhood. Dementia is distinguished by the presence of an etiological general medical condition or substance use.

Perhaps the most difficult differential diagnosis is with **no mental disorder.** Simple deteriorative disorder often leads a person to become a marginal member of society. It does not follow, however, that marginal members of society necessarily have this proposed disorder. The defining features of simple deteriorative disorder involve negative symptoms, which tend to be more on a continuum with normality than are positive symptoms and which may be mimicked by a variety of factors (see the relevant discussion in the "Schizophrenia" section, p. 301). Therefore, special caution must be taken not to apply this proposed disorder too broadly.

Research criteria for simple deteriorative disorder (simple Schizophrenia)

A. Progressive development over a period of at least a year of all of the following:

(1) marked decline in occupational or academic functioning
(2) gradual appearance and deepening of negative symptoms such as affective flattening, alogia, and avolition
(3) poor interpersonal rapport, social isolation, or social withdrawal

B. Criterion A for Schizophrenia has never been met.

C. The symptoms are not better accounted for by Schizotypal or Schizoid Personality Disorder, a Psychotic Disorder, a Mood Disorder, an Anxiety Disorder, a dementia, or Mental Retardation and are not due to the direct physiological effects of a substance or a general medical condition.

Premenstrual Dysphoric Disorder

Features

The essential features are symptoms such as markedly depressed mood, marked anxiety, marked affective lability, and decreased interest in activities. These symptoms have regularly occurred during the last week of the luteal phase in most menstrual cycles during the past year. The symptoms begin to remit within a few days of the onset of menses (the follicular phase) and are always absent in the week following menses.

Five (or more) of the following symptoms must have been present most of the time during the last week of the luteal phase, with at least one of the symptoms being one of the first four: 1) feeling sad, hopeless, or self-deprecating; 2) feeling tense, anxious or "on edge"; 3) marked lability of mood interspersed with frequent tearfulness; 4) persistent irritability, anger, and increased interpersonal conflicts; 5) decreased interest in usual activities, which may be associated with withdrawal from social relationships; 6) difficulty concentrating; 7) feeling fatigued, lethargic, or lacking in energy; 8) marked changes in appetite, which may be associated with binge eating or craving certain foods; 9) hypersomnia or insomnia; 10) a subjective feeling of being overwhelmed or out of control; and 11) physical symptoms such as breast tenderness or swelling, headaches, or sensations of "bloating" or weight gain, with tightness of fit of clothing, shoes, or rings. There may also be joint or muscle pain. The symptoms may be accompanied by suicidal thoughts.

This pattern of symptoms must have occurred most months for the previous 12 months. The symptoms disappear completely shortly after the onset of menstruation. The most typical pattern seems to be that of dysfunction during the week prior to menses that ends mid-menses. Atypically, some females also have symptoms for a few days around ovulation; a few females with short cycles might, therefore, be symptom free for only 1 week per cycle.

Typically, the symptoms are of comparable severity (but not duration) to those of another mental disorder such as Major Depressive Episode or Generalized Anxiety Disorder and must cause an obvious and marked impairment in the ability to function socially or occupationally in the week prior to menses. Impairment in social functioning may be manifested by marital discord and problems with friends and family. It is very important not to confuse long-standing marital or job problems with the dysfunction that occurs only premenstrually. There is a great contrast between the woman's depressed feelings and difficulty in functioning during these days and her mood and capabilities the rest of the month. These symptoms may be superimposed on another disorder but are not merely an exacerbation of the symptoms of another disorder, such as Major Depressive, Panic, or Dysthymic Disorder, or a Personality Disorder. The presence of the cyclical pattern of symptoms must be confirmed by at least 2 consecutive months of prospective daily symptom ratings. Daily symptom ratings must be done by the woman and can also be done by someone with whom she lives. It is important that these diaries be kept on a daily basis rather than composed retrospectively from memory.

Associated Features

Frequently there is a history of prior Mood and Anxiety Disorders. Delusions and hallucinations have been described in the late luteal phase of the menstrual cycle but are very rare. Whether they represent an exacerbation of a preexisting mental disorder or instead are symptomatic of Premenstrual Dysphoric Disorder is unknown. Premenstrually related mood and somatic symptoms tend to run in families and are at least in part hereditary.

Although women with the combination of dysmenorrhea (painful menses) and premenstrual dysphoric disorder are somewhat more likely to seek treatment than women with only one of these conditions, most women with either of the conditions do not have the other condition. A wide range of general medical conditions may worsen in the premenstrual or luteal phase (e.g., migraine, asthma, allergies, and seizure disorders). There are no specific laboratory tests that are diagnostic of the disturbance. However, in several small preliminary studies, certain laboratory findings (e.g., serotonin or melatonin secretion patterns, sleep EEG findings) have been noted to be abnormal in groups of women with this proposed disorder relative to control subjects.

It is estimated that at least 75% of women report minor or isolated premenstrual changes. Limited studies suggest an occurrence of "premenstrual syndrome" (variably defined) of 20%–50%, and that 3%–5% of women experience symptoms that may meet the criteria for this proposed disorder. There has been very little systematic study on the course and stability of this condition. Premenstrual symptoms can begin at any age after menarche. Although the majority of women whose symptoms meet research diagnostic criteria for this proposed disorder and participate in research studies are in their early to mid-30s, women across the reproductive age span report clinically significant premenstrually related symptoms. Although symptoms do not necessarily occur every cycle, they are present for the majority of the cycles. Some months the symptoms may be worse than others. Women commonly report that their symptoms worsen with age until relieved by the onset of menopause.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Depressive Disorder Not Otherwise Specified.**

The transient mood changes that many women experience around the time of their period should not be considered a mental disorder. Premenstrual dysphoric disorder should be considered only when the symptoms markedly interfere with work or school or with usual social activities and relationships with others (e.g., avoidance of social activities, decreased productivity and efficiency at work or school). Premenstrual dysphoric disorder can be distinguished from the far more common **"premenstrual syndrome"** by using prospective daily ratings and the strict criteria listed below. It differs from the "premenstrual syndrome" in its characteristic pattern of symptoms, their severity, and the resulting impairment.

Premenstrual dysphoric disorder must be distinguished from the **premenstrual exacerbation of a current mental disorder** (e.g., Mood Disorders, Anxiety Disorders, Somatoform Disorders, Bulimia Nervosa, Substance Use Disorders, and Personality Disorders). In such situations (which are far more common than premenstrual dysphoric disorder), there is a premenstrual worsening of the symptoms but the symptoms persist throughout the menstrual cycle. Although this condition should not be considered in women who are experiencing only a premenstrual exacerbation of another mental disorder, it can be considered in addition to the diagnosis of another current mental disorder if the woman experiences symptoms and changes in level of functioning that are characteristic of premenstrual dysphoric disorder and are markedly different from the symptoms experienced as part of the ongoing disorder.

Some individuals with **general medical conditions** may present with dysphoria and fatigue that are exacerbated during the premenstrual period. Examples include seizure disorders, thyroid and other endocrine disorders, cancer, systemic lupus erythematosus, anemias, endometriosis, and various infections. Attempts should be made to distinguish these general medical conditions from premenstrual dysphoric disorder by history, laboratory testing, or physical examination.

Research criteria for premenstrual dysphoric disorder

A. In most menstrual cycles during the past year, five (or more) of the following symptoms were present for most of the time during the last week of the luteal phase, began to remit within a few days after the onset of the follicular phase, and were absent in the week postmenses, with at least one of the symptoms being either (1), (2), (3), or (4):

(1) markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts
(2) marked anxiety, tension, feelings of being "keyed up," or "on edge"
(3) marked affective lability (e.g., feeling suddenly sad or tearful or increased sensitivity to rejection)
(4) persistent and marked anger or irritability or increased interpersonal conflicts
(5) decreased interest in usual activities (e.g., work, school, friends, hobbies)
(6) subjective sense of difficulty in concentrating
(7) lethargy, easy fatigability, or marked lack of energy
(8) marked change in appetite, overeating, or specific food cravings
(9) hypersomnia or insomnia
(10) a subjective sense of being overwhelmed or out of control
(11) other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of "bloating," weight gain

Note: In menstruating females, the luteal phase corresponds to the period between ovulation and the onset of menses, and the follicular phase begins with menses. In nonmenstruating females (e.g., those who have had a hysterectomy), the timing of luteal and follicular phases may require measurement of circulating reproductive hormones.

B. The disturbance markedly interferes with work or school or with usual social activities and relationships with others (e.g., avoidance of social activities, decreased productivity and efficiency at work or school).

C. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depressive Disorder, Panic Disorder, Dysthymic Disorder, or a Personality Disorder (although it may be superimposed on any of these disorders).

D. Criteria A, B, and C must be confirmed by prospective daily ratings during at least two consecutive symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation.)

Alternative Criterion B for Dysthymic Disorder

There has been some controversy concerning which symptoms best define Dysthymic Disorder. The results of the DSM-IV Mood Disorders field trial suggest that the following alternative version of Criterion B may be more characteristic of Dysthymic Disorder than the version of Criterion B that was in DSM-III-R and is in DSM-IV.

However, it was decided that additional confirmatory evidence needs to be collected before these items are incorporated in the official definition of Dysthymic Disorder.

Alternative Research Criterion B for Dysthymic Disorder

B. Presence, while depressed, of three (or more) of the following:

(1) low self-esteem or self-confidence, or feelings of inadequacy
(2) feelings of pessimism, despair, or hopelessness
(3) generalized loss of interest or pleasure
(4) social withdrawal
(5) chronic fatigue or tiredness
(6) feelings of guilt, brooding about the past
(7) subjective feelings of irritability or excessive anger
(8) decreased activity, effectiveness, or productivity
(9) difficulty in thinking, reflected by poor concentration, poor memory, or indecisiveness

Minor Depressive Disorder

Features

The essential feature is one or more periods of depressive symptoms that are identical to Major Depressive Episodes in duration, but which involve fewer symptoms and less impairment. An episode involves either a sad or "depressed" mood or loss of interest or pleasure in nearly all activities. In total, at least two but less than five additional symptoms must be present. See the text for a Major Depressive Episode (p. 349) for a more detailed description of the characteristic symptoms. At the onset of the episode, the symptoms are either newly present or must be clearly worsened compared with the person's preepisode status. During the episode, these symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In some individuals, there may be near-normal functioning, but this is accomplished with significantly increased effort.

A number of disorders exclude consideration of this proposed disorder. There has never been a Major Depressive, Manic, Mixed, or Hypomanic Episode, and criteria are not met for Dysthymic or Cyclothymic Disorder. The mood disturbance does not occur exclusively during Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Associated Features

The prevalence of this proposed disorder as defined here is unclear, but it may be relatively common, especially in primary care and outpatient mental health settings. A number of general medical conditions (e.g., stroke, cancer, and diabetes) appear to be associated. Family studies suggest an increase in this symptom pattern among relatives of probands with Major Depressive Disorder.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Adjustment Disorder With Depressed Mood** if the depressive symptoms occur in response to a psychosocial stressor; otherwise, the appropriate diagnosis is **Depressive Disorder Not Otherwise Specified.**

An episode of minor depressive disorder is distinguished from a **Major Depressive Episode** by the required number of symptoms (two to four symptoms for minor depressive disorder and at least five symptoms for a Major Depressive Episode). This proposed disorder is considered to be a residual category and is not to be used if there is a history of a **Major Depressive Episode, Manic Episode, Mixed Episode,** or **Hypomanic Episode,** or if the presentation meets criteria for **Dysthymic** or **Cyclothymic Disorder.** Symptoms meeting research criteria for minor depressive disorder can be difficult to distinguish from **periods of sadness** that are an inherent part of everyday life. This proposed disorder requires that the depressive symptoms be present for most of the day nearly every day for at least 2 weeks. In addition, the depressive symptoms must cause clinically significant distress or impairment. Depressive symptoms occurring in response to the loss of a loved one are considered **Bereavement** (unless they meet the criteria for a Major Depressive Episode; see p. 349). **Substance-Induced Mood Disorder** is distinguished from this disturbance in that the depressive symptoms are due to the direct physiological effects of a drug of abuse (e.g., alcohol or cocaine) or the side effects of a medication (e.g., steroids) (see p. 405). **Mood Disorder Due to a General Medical Condition** is distinguished from this disturbance in that the depressive symptoms are due to the direct physiological effects of a general medical condition (e.g., hypothyroidism) (see p. 401). Because depressive symptoms are common associated features of psychotic disorders, they do not receive a separate diagnosis if they occur exclusively during **Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder,** or **Psychotic Disorder Not Otherwise Specified.** The relationship between this proposed disorder and several other proposed categories included in this appendix (i.e., recurrent brief depressive disorder, depressive personality disorder, and mixed anxiety-depressive disorder) and with other Personality Disorders is not known, but substantial overlap may exist among them.

Research criteria for minor depressive disorder

A. A mood disturbance, defined as follows:

(1) at least two (but less than five) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (a) or (b):

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

(b) 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 made by others)

(c) 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 gains.

(d) insomnia or hypersomnia nearly every day

(e) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(f) fatigue or loss of energy nearly every day

(g) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(h) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(i) 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

(2) the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

(3) the symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)

(4) the symptoms are not better accounted for by Bereavement (i.e., a normal reaction to the death of a loved one)

B. There has never been a Major Depressive Episode (see p. 356), and criteria are not met for Dysthymic Disorder.

C. There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368), and criteria are not met for Cyclothymic Disorder. **Note:** This exclusion does not apply if all of the manic-, mixed-, or hypomanic-like episodes are substance or treatment induced.

D. The mood disturbance does not occur exclusively during Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Recurrent Brief Depressive Disorder

Features

The essential feature is the recurrence of brief episodes of depressive symptoms that are identical to Major Depressive Episodes in the number and severity of symptoms but that do not meet the 2-week duration requirement. See the text for a Major Depressive Episode (p. 349) for a more detailed description of the characteristic symptoms. The episodes last at least 2 days but less than 2 weeks and most typically have a duration of between 2 and 4 days. Episodes must recur at least once a month for a period of 12 consecutive months, and they must not be associated exclusively with the menstrual cycle. The brief depressive episodes must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In some individuals, there may be near-normal functioning, but this is accomplished with significantly increased effort.

A number of disorders exclude consideration of this proposed disorder. There has never been a Major Depressive, Manic, Mixed, or Hypomanic Episode, and criteria are not met for Dysthymic or Cyclothymic Disorder. The mood disturbance does not occur exclusively during Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Associated Features

The pattern of lifetime or current comorbidity appears to be similar to that of Major Depressive Disorder. Associated disorders may include Substance-Related Disorders and Anxiety Disorders. The episodes may follow a seasonal pattern. The 1-year prevalence of this proposed disorder has been reported to be about 7% (although this was often in association with other established mental disorders). Males and females appear equally likely to experience recurrent brief depressive episodes, and the most typical age at onset appears to be in adolescence. Suicide attempts are the most serious complication. The rate of depressive disorders is increased in the first-degree biological relatives of individuals who have recurrent brief depressive episodes.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Depressive Disorder Not Otherwise Specified.**

An episode of recurrent brief depressive disorder is distinguished from a **Major Depressive Episode** by the duration of the episode (2–13 days for a brief depressive episode and 2 weeks or longer for a Major Depressive Episode). Recurrent brief depressive disorder is considered to be a residual category and is not to be used if there is a history of a **Major Depressive Episode, Manic Episode, Mixed Episode,** or **Hypomanic Episode,** or if criteria are met for **Cyclothymic Disorder** or **Dysthymic Disorder. Substance-Induced Mood Disorder** is distinguished from this disturbance in that the depressive symptoms are due to the direct physiological effects of a drug of abuse (e.g., alcohol or cocaine) or the side effects of a medication (e.g., steroids) (see

p. 405). **Mood Disorder Due to a General Medical Condition** is distinguished from this disturbance in that the depressive symptoms are due to the direct physiological effects of a general medical condition (e.g., hypothyroidism) (see p. 401). Because depressive symptoms are common associated features of psychotic disorders, they do not receive a separate diagnosis if they occur exclusively during **Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder,** or **Psychotic Disorder Not Otherwise Specified.** Recurrent brief depressive disorder shares some clinical features with **Borderline Personality Disorder** (i.e., both disorders manifest brief and episodic depressive symptoms such as suicidal ideation or sadness). In cases where a Personality Disorder and this proposed disorder are both present, both may be noted (with recurrent brief depressive disorder noted as Depressive Disorder Not Otherwise Specified). The relationship between this proposed disorder and several other proposed categories included in this appendix (i.e., minor depressive disorder, depressive personality disorder, and mixed anxiety-depressive disorder) and with other Personality Disorders is not known, but substantial overlap may exist among them.

Research criteria for recurrent brief depressive disorder

A. Criteria, except for duration, are met for a Major Depressive Episode (see p. 356).

B. The depressive periods in Criterion A last at least 2 days but less than 2 weeks.

C. The depressive periods occur at least once a month for 12 consecutive months and are not associated with the menstrual cycle.

D. The periods of depressed mood cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

F. There has never been a Major Depressive Episode (see p. 356), and criteria are not met for Dysthymic Disorder.

G. There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368), and criteria are not met for Cyclothymic Disorder. **Note:** This exclusion does not apply if all of the manic-, mixed-, or hypomanic-like episodes are substance or treatment induced.

H. The mood disturbance does not occur exclusively during Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Mixed Anxiety-Depressive Disorder

Features

The essential feature is a persistent or recurrent dysphoric mood lasting at least 1 month. The dysphoric mood is accompanied by additional symptoms that also must persist for at least 1 month and include at least four of the following: concentration or memory difficulties, sleep disturbance, fatigue or low energy, irritability, worry, being easily moved to tears, hypervigilance, anticipating the worst, hopelessness or pessimism about the future, and low self-esteem or feelings of worthlessness. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. This proposed disorder should not be considered if the symptoms are due to the direct physiological effects of a substance or a general medical condition or if the criteria for Major Depressive Disorder, Dysthymic Disorder, Panic Disorder, or Generalized Anxiety Disorder have ever been met. The diagnosis is also not made if the criteria for any other Anxiety or Mood Disorder are currently met, even if the Anxiety or Mood Disorder is in partial remission. The symptoms must also not be better accounted for by any other mental disorder. Importantly, the longitudinal relationship between this proposed disorder and other Depressive and Anxiety Disorders is also unknown. Thus, it is not clear in what proportion of individuals this pattern of symptoms (i.e., mixed anxiety-depressive disorder) may be a risk factor for another mental disorder such as Major Depressive Disorder, Generalized Anxiety Disorder, or Panic Disorder.

Current prevalence rates range from 1.3% to 2% in primary care settings. In community samples, the current prevalence rate has been estimated to be 0.8%. Mixed anxiety-depressive disorder has also been found to be quite common in the few mental health settings in which it has been studied.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Anxiety Disorder Not Otherwise Specified.**

Substance-Induced Anxiety Disorder is distinguished from this disturbance in that the symptoms of dysphoria are due to the direct physiological effects of a drug of abuse (e.g., alcohol or cocaine) or the side effects of a medication (e.g., steroids) (see p. 479). **Anxiety Disorder Due to a General Medical Condition** is distinguished from this disturbance in that the symptoms of dysphoria are due to the direct physiological effects of a general medical condition (e.g., pheochromocytoma, hyperthyroidism) (see p. 476). The symptoms described in this presentation are a frequent **associated feature of many mental disorders** and therefore should not be diagnosed separately if better accounted for by any other mental disorder. This condition should also not be considered in individuals with a current or past history of **Major Depressive Disorder, Dysthymic Disorder, Panic Disorder,** or **Generalized Anxiety Disorder** or with any other current Mood or Anxiety Disorder (including those in partial remission). This presentation is also distinguished from **no mental disorder** by the facts that the symptoms are persistent or recurrent and that they cause clinically significant

distress or impairment in social, occupational, or other important areas of functioning.

The relationship between this proposed disorder and several other proposed categories included in this appendix (i.e., minor depressive disorder, recurrent brief depressive disorder, and depressive personality disorder) and with other Personality Disorders is not known, but substantial overlap may exist among them.

Research criteria for mixed anxiety-depressive disorder

A. Persistent or recurrent dysphoric mood lasting at least 1 month.

B. The dysphoric mood is accompanied by at least 1 month of four (or more) of the following symptoms:

(1) difficulty concentrating or mind going blank
(2) sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)
(3) fatigue or low energy
(4) irritability
(5) worry
(6) being easily moved to tears
(7) hypervigilance
(8) anticipating the worst
(9) hopelessness (pervasive pessimism about the future)
(10) low self-esteem or feelings of worthlessness

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

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

E. All of the following:

(1) criteria have never been met for Major Depressive Disorder, Dysthymic Disorder, Panic Disorder, or Generalized Anxiety Disorder
(2) criteria are not currently met for any other Anxiety or Mood Disorder (including an Anxiety or Mood Disorder, In Partial Remission)
(3) the symptoms are not better accounted for by any other mental disorder

Factitious Disorder by Proxy

Features

The essential feature is the deliberate production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care. Typically the victim is a young child and the perpetrator is the child's mother. The motivation for the perpetrator's behavior is presumed to be a psychological need to assume the sick role by proxy. External incentives for the behavior, such as economic

gain, are absent. The behavior is not better accounted for by another mental disorder. The perpetrator induces or simulates the illness or disease process in the victim and then presents the victim for medical care while disclaiming any knowledge about the actual etiology of the problem. The most common induced and simulated conditions include persistent vomiting or diarrhea, respiratory arrest, asthma, central nervous system dysfunction (e.g., seizures, uncoordination, loss of consciousness), fever, infection, bleeding, failure to thrive, hypoglycemia, electrolyte disturbances, and rash. The simulation of mental disorders in the victim is much less frequently reported. The type and severity of signs and symptoms are limited only by the medical sophistication and opportunities of the perpetrator. Cases are often characterized by an atypical clinical course in the victim and inconsistent laboratory test results that are at variance with the seeming health of the victim.

The victim is usually a preschool child, although newborns, adolescents, and adults may be used as victims. With older children, consideration should be given to the possibility of collaboration with the perpetrator in the production of signs and symptoms. The perpetrator receives a diagnosis of factitious disorder by proxy. For the victim, Physical Abuse of Child (995.54) or Physical Abuse of Adult (995.81) may be noted if appropriate. In the event of voluntary collaboration, an additional diagnosis of Factitious Disorder may be appropriate for the collaborator.

Associated Features

Life stressors, such as chronic family dysfunction, may be present. Perpetrators may exhibit pathological lying (or pseudologia fantastica) in describing everyday experiences and when presenting the victim for medical care. They commonly have considerable experience in health-related areas and seem to thrive in a medical environment. They are often unresponsive to their children when they are unaware of being observed. Victims may suffer a significant morbidity and mortality rate as a consequence of the induced conditions or associated problems, such as iatrogenic complications from medications, diagnostic tests, and surgical procedures. As they mature, they are at increased risk of developing Factitious Disorder themselves or of emotional and behavioral problems that may include difficulties in attention and concentration, impaired school performance, or symptoms of Posttraumatic Stress Disorder. The perpetrator is usually the mother, and the father usually appears uninvolved. Sometimes, however, the father or husband may collaborate with the mother or may act alone. The perpetrator may also be another caregiver (e.g., a baby-sitter, grandmother, or stepmother). Perpetrators may have a history of having been abused. Somatoform Disorders and Personality Disorders may be present.

This proposed disorder often coexists with Factitious Disorder, which is usually quiescent as long as the perpetrator can induce or simulate a factitious illness in the victim. When confronted with the consequences of their behavior, perpetrators may become depressed and suicidal. Some become angry with the health care providers, deny the accusations, attempt to remove the victim from the hospital against medical advice, and seek care from other providers even at a considerable distance. Perpetrators may face criminal charges ranging from abuse to murder. Typically the perpetrator focuses on only one victim at a time, although other siblings or individuals may have been or might become victims.

Differential Diagnosis

In DSM-IV, an individual (i.e., the perpetrator) whose presentation meets these research criteria would be diagnosed as having **Factitious Disorder Not Otherwise Specified.**

Factitious disorder by proxy must be distinguished from a **general medical condition** or a **mental disorder** in the individual being brought for treatment. Factitious disorder by proxy must also be distinguished from **physical or sexual abuse** that is not motivated by the goal of indirectly assuming the sick role. **Malingering** differs from factitious disorder by proxy in that the motivation for the symptom production in Malingering is an external incentive, whereas in Factitious Disorder external incentives are absent. Individuals with Malingering may seek hospitalization for an individual under their care by producing symptoms in an attempt to obtain compensation.

Research criteria for factitious disorder by proxy

A. Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care.

B. The motivation for the perpetrator's behavior is to assume the sick role by proxy.

C. External incentives for the behavior (such as economic gain) are absent.

D. The behavior is not better accounted for by another mental disorder.

Dissociative Trance Disorder

Features

The essential feature is an involuntary state of trance that is not accepted by the person's culture as a normal part of a collective cultural or religious practice and that causes clinically significant distress or functional impairment. This proposed disorder should not be considered in individuals who enter trance or possession states voluntarily and without distress in the context of cultural and religious practices that are broadly accepted by the person's cultural group. Such voluntary and nonpathological states are common and constitute the overwhelming majority of trance and possession trance states encountered cross-culturally. However, some individuals undergoing culturally normative trance or possession trance states may develop symptoms that cause distress or impairment and thus could be considered for this proposed disorder. Specific local instances of dissociative trance disorder show considerable variation cross-culturally with regard to the precise nature of the behaviors performed during the altered state, the presence or absence of dissociative sensory alterations (e.g., blindness), the identity assumed during these states, and the degree of amnesia experienced following the altered state (for examples, see Appendix I's Glossary of Culture-Bound Syndromes, p. 897).

In trance, the loss of customary identity is not associated with the appearance of alternate identities, and the actions performed during a trance state are generally not

complex (e.g., convulsive movements, falling, running). In possession trance, there is the appearance of one (or several) distinct alternate identities with characteristic behaviors, memories, and attitudes, and the activities performed by the person tend to be more complex (e.g., coherent conversations, characteristic gestures, facial expressions, and specific verbalizations that are culturally established as belonging to a particular possessing agent). Full or partial amnesia is more regularly reported after an episode of possession trance than after an episode of trance (although reports of amnesia after trance are not uncommon). Many individuals with this proposed disorder exhibit features of only one type of trance, but some present with mixed symptomatology or fluctuate between types of trance over time according to local cultural parameters.

Associated Features

Variants of these conditions have been described in nearly every traditional society on every continent. The prevalence appears to decrease with increasing industrialization but remains elevated among traditional ethnic minorities in industrialized societies. There are considerable local variations in age and mode of onset. The course is typically episodic, with variable duration of acute episodes from minutes to hours. It has been reported that during a trance state, individuals may have an increased pain threshold, may consume inedible materials (e.g., glass), and may experience increased muscular strength. The symptoms of a pathological trance may be heightened or reduced in response to environmental cues and the ministrations of others. Presumed possessing agents are usually spiritual in nature (e.g., spirits of the dead, supernatural entities, gods, demons) and are often experienced as making demands or expressing animosity. Individuals with pathological possession trance typically experience a limited number of agents (one to five) in a sequential, not simultaneous, fashion. Complications include suicide attempts, self-mutilation, and accidents. Sudden deaths have been reported as a possible outcome, perhaps due to cardiac arrhythmias.

Differential Diagnosis

In DSM-IV, individuals whose presentation meets these research criteria would be diagnosed as having **Dissociative Disorder Not Otherwise Specified.**

This diagnosis should not be made if the trance state is judged to be due to the direct physiological effects of a general medical condition (in which case the diagnosis would be **Mental Disorder Not Otherwise Specified Due to a General Medical Condition,** see p. 190) or a substance (in which case the diagnosis would be **Substance-Related Disorder Not Otherwise Specified**).

The symptoms of the trance state (e.g., hearing or seeing spiritual beings and being controlled or influenced by others) may be confused with the hallucinations and delusions of **Schizophrenia, Mood Disorder With Psychotic Features,** or **Brief Psychotic Disorder.** The trance state may be distinguished by its cultural congruency, its briefer duration, and the absence of the characteristic symptoms of these other disorders.

Individuals with **Dissociative Identity Disorder** can be distinguished from those with trance and possession symptoms by the fact that those with trance and possession symptoms typically describe external spirits or entities that have entered their bodies and taken over.