

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE ARMED FORCES**

---

**UNITED STATES,**  
*Appellee*

v.

**Wendell E. MELLETTE**  
Electrician's Mate (Nuclear) First Class (E-6)  
United States Navy,  
*Appellant*

---

USCA Dkt. No. 21-0312/NA

Crim. App. No. 201900305

---

**PATIENT/VICTIM S.S.'S AMICUS CURIAE BRIEF  
IN SUPPORT OF APPELLEE**

---

Peter Coote  
Pennoni Associates Inc.  
1900 Market Street, 3rd Floor  
Philadelphia, PA 19103  
(215) 254-7857  
pcoote@pennoni.com

**Table of Contents**

ISSUES PRESENTED.....1

INTEREST OF AMICUS CURIAE .....1

FACTS NOT RAISED BY THE PARTIES .....2

ARGUMENT .....4

    I.    Standard of Review .....4

    II.   A Borderline Personality Disorder Diagnosis Is Irrelevant .....4

    III.  Diagnoses and Treatments Are Privileged Communications .....11

    IV.  The NMCCA did not depart from Supreme Court and CAAF ..  
        Precedent by Not Reviewing In Camera Patient/Victim S.S.’s  
        Diagnoses and Treatments .....13

    V.   Patient/Victim S.S. Did Not Waive Her Privilege .....16

CONCLUSION .....17

CERTIFICATES OF FILING AND SERVICE AND COMPLIANCE .....18

## Table of Authorities

### Cases

<i>Brady v. Maryland</i> , 373 U.S. 83 (1963) .....	16
<i>H.V. v. Kitchen</i> , 75 M.J. 717, 721 (C.G. Ct. Crim. App. 2016) .....	8
<i>Pennsylvania v. Ritchie</i> , 480 U.S. 39 (1987) .....	13, 16
<i>States v. Chisum</i> , 77 M.J. 176 (C.A.A.F. 2018) .....	4
<i>United States v. Commisso</i> , 76 M.J. 315 (C.A.A.F. 2017) .....	4
<i>United States v. Hendrix</i> , 76 M.J. 283 (C.A.A.F. 2016) .....	4
<i>United States v. Jacinto</i> , 81 M.J. 350 (C.A.A.F. 2021) .....	13, 14, 15
<i>United States v. Mellette</i> , 81 M.J. 681, 688 (N-M. Ct. Crim. App. 2021) .....	passim
<i>United States v. Reece</i> , 25 M.J. 93 (C.M.A. 1987) .....	13
<i>United States v. Rodriguez</i> , 60 M.J. 239 (C.A.A.F. 2004) .....	4
<i>United States v. Tinsley</i> , No. 20200337, 2021 CCA LEXIS 679 (A. Ct. Crim. App. Dec. 15, 2021) .....	15, 16

### Statutes

10 U.S.C. § 806b – Rights of the Victim .....	1
10 U.S.C. 912a - Wrongful Use, Possession, etc. of a Controlled Substance .....	13
10 U.S.C. 920b - Rape and Sexual Assault of a Child .....	12
10 U.S.C. 920c - Other Sexual Misconduct .....	12
10 U.S.C. 928 - Assault .....	13

### Other Authorities

Diagnostic and Statistical Manual of Mental Disorders (DSM-5®), Fifth Edition,   Jesse H. Wright, Gregory K. Brown, Michael E. Thase and Monica Ramirez Basco, <a href="https://ebooks.appi.org/epubreader/diagnostic-statistical-manual-mental-disorders-dsm5">https://ebooks.appi.org/epubreader/diagnostic-statistical-manual-mental-disorders-dsm5</a> .....	passim
--	--------

### Rules

M.R.E. 401 - Test for Relevant Evidence .....	5, 7, 12
M.R.E. 403 - Excluding Relevant Evidence .....	5, 8, 12
M.R.E. 513 – Psychotherapist-Patient Privilege .....	passim
M.R.E. 701 through 705 – Opinions and Expert Testimony .....	10
R.C.M. 703 – Production of Witnesses and Evidence .....	14

### **ISSUES PRESENTED**

1. Whether diagnoses and treatments are privileged under M.R.E. 513.
2. Whether the NMCCA departed from Supreme Court and CAAF precedent by not reviewing Patient/Victim S.S.'s diagnoses and treatments.
3. Whether a diagnosis and treatment of borderline personality disorder is relevant to a witness's memory or ability to perceive or tell the truth.

### **INTEREST OF AMICUS CURIAE**

Appellant Mellette was convicted of sexually abusing Amicus Curiae Patient/Victim S.S., his fifteen-year-old sister-in-law. Appellant is asking this Court to reverse his conviction because he asserts the military judge and lower court erred when it determined S.S.'s diagnoses and treatments were privileged under M.R.E. 513. If this Court grants Appellant relief, S.S.'s diagnoses and treatments will be disclosed to the Appellant and the government. S.S. has a legal interest in the Court's decision concerning her psychotherapist privilege.

## FACTS NOT RAISED BY THE PARTIES

The American Psychiatric Association’s Diagnostic and Statistical Manual, Fifth Edition (“DSM-5”)<sup>1</sup> lists nine criteria used to diagnose borderline personality disorder. DSM-5, at 663. One criterium includes self-mutilating behavior. *Id.* A diagnosis of borderline personality disorder requires the examining psychotherapist to find the existence of at least five of the nine diagnostic criteria. *Id.*

There is no evidence in the record that Patient/Victim S.S. has ever been diagnosed with borderline personality disorder. The record of trial and briefs of the parties include evidence that S.S. was treated for “depression, anxiety and self-harm” or “cutting.” *United States v. Mellette*, 81 M.J. 681, 688 (N-M. Ct. Crim. App. 2021), Supplement at 3, Brief at 7, Answer at 7. The Appellant’s expert testified that “cutting behavior discussed by S.S. is a common feature of someone with Borderline Personality Disorder *or someone who has traits of Borderline Personality Disorder.*” Supplement at 27, Brief at 39 (emphasis added). The Appellant’s expert further opined that S.S. “*could* have Borderline Personality

---

<sup>1</sup> Diagnostic and Statistical Manual of Mental Disorders (DSM-5®), Fifth Edition, | Jesse H. Wright, Gregory K. Brown, Michael E. Thase and Monica Ramirez Basco, <https://ebooks.appi.org/epubreader/diagnostic-statistical-manual-mental-disorders-dsm5>

Relevant excerpts of DSM-5 are submitted to assist the Court in understanding the limits of psychotherapy and diagnoses. The entire DSM-5 is worthy of review.

Disorder, which *could* further manifest in attention-seeking and manipulative behaviors, particularly when associated with fear of abandonment.” *Mellette*, 81 M.J. at 691 (emphasis added). The expert did not identify any attention-seeking or manipulative behavior by S.S. but based this possibility solely upon S.S.’s cutting. He relied on no other evidence.<sup>2</sup> The Appellant’s expert notably did not testify that borderline personality disorder affects a person’s memory or ability to perceive or tell the truth. *Id.* (“The Defense argued that information about Stacy’s diagnoses and treatment was relevant to the issues of suggestion, memory, and truthfulness, which all impacted her credibility . . .”).

The DSM-5 diagnostic criteria identify disorders that affect memory<sup>3</sup> or ability to perceive<sup>4</sup> or tell<sup>5</sup> the truth. The DSM-5 diagnostic criteria for borderline

---

<sup>2</sup> As the Court has denied Patient/Victim S.S.’s motions to examine sealed records, counsel has reviewed only the opinion below, the redacted briefs filed by the parties and the unsealed portion of the joint appendix. Counsel reasonably believes in the accuracy of his assertion the expert relied upon no other evidence because the lower court and parties would have identified such relevant evidence in their opinion or briefs. If counsel is incorrect in his assertion, counsel respectfully requests the opportunity to examine sealed materials and to address the facts in the record.

<sup>3</sup> For example, neurocognitive disorders. DSM-5 at 602-05

<sup>4</sup> For example, delusional disorder. DSM-5 at 90-91.

<sup>5</sup> For example, antisocial personality disorder. DSM-5 at 659.

personality disorder do not identify any effects on memory or the ability to perceive or tell the truth.

## **ARGUMENT**

### **I. Standard of Review.**

A military judge's ruling on an in camera review and production of mental health diagnoses, treatments, and medications are reviewed for an abuse of discretion. *Mellette*, 81 M.J. at 690; citing *United States v. Chisum*, 77 M.J. 176, 179 (C.A.A.F. 2018). A military judge abuses his discretion when he (1) predicates his ruling on findings of fact that are not supported by the evidence of record; (2) uses incorrect legal principles; (3) applies correct legal principles to the facts in a way that is clearly unreasonable, or (4) fails to consider important facts. *Id.* at 690-91, citing *United States v. Comisso*, 76 M.J. 315, 321 (C.A.A.F. 2017). A military judge's conclusions of law are reviewed de novo. *Id.* citing *United States v. Rodriguez*, 60 M.J. 239, 246 (C.A.A.F. 2004).

### **II. A Borderline Personality Disorder Diagnosis Is Irrelevant.**

The Court does not need to reach the granted issues because the diagnoses and treatments sought by the Appellant are irrelevant. *United States v. Hendrix*, 76 M.J. 283, 289 (C.A.A.F. 2016) ("Evidence that has no probative value is irrelevant and is therefore inadmissible at trial."). Even if admissible under the lenient

relevancy standard of M.R.E. 401, the materiality of S.S.'s diagnoses and treatments is substantially outweighed by the M.R.E. 403 considerations.

The military judge found that the Appellant failed to show why S.S.'s diagnoses and treatments were relevant. *Mellette*, 81 M.J. at 691 (characterizing Appellant's motion as a "a mere 'fishing expedition'"). The NMCCA disagreed and found the military judge's conclusion that the requested information was not relevant were "clearly unreasonable." *Id.* at 693.

The NMCCA explained that the Appellant sought to confirm S.S.'s stated diagnoses<sup>6</sup> and ascertain whether there were any "other related diagnoses that could impact [S.S.'s] credibility." *Id.* The Appellant also sought S.S.'s medications to assess any adverse effect on memory. *Id.*

The NMCCA had no evidence in the record that the speculated diagnosis of borderline personality disorder could have affected S.S.'s memory or ability to perceive or tell the truth. The NMCCA had no evidence in the record that the Prozac S.S. admitted to taking or any other drug, alone or with Prozac, typically prescribed for anxiety, depression or borderline personality disorder could have affected S.S.'s memory or ability to perceive or tell the truth.

---

<sup>6</sup> The briefs and joint appendix indicate S.S. sought psychotherapy to address depression, anxiety and self-harm.

The NMCCA does not analyze or discuss how the diagnoses or treatments were relevant to S.S.'s credibility. The NMCCA reasoned that S.S. had a strong motive to fabricate the allegations against the Appellant because she initially denied the allegations and belatedly reported them only after they were relevant to the child custody battle between Appellant and S.S.'s sister. *Mellette*, 81 M.J. at 693.

The NMCCA's finding that S.S. had a strong motive to fabricate is not tied in anyway to S.S.'s diagnoses or medications. If the Appellant's expert offered expert testimony that anxiety, depression, or borderline personality disorder could have affected memory or truthfulness, there would be at least a modicum of relevancy. In this case there is none. If the expert offered expert testimony that Prozac or other medications used to treat S.S.'s potential diagnoses could have affected S.S.'s memory or truthfulness, there would be a modicum of relevancy. In this case there is none.

The NMCCA's finding that the trial judge's conclusion was clearly unreasonable is based upon the stigma that persists against those who seek mental health treatment. If S.S. had been diagnosed with and treated for diabetes, her diagnosis and medications would be irrelevant to her strong motive to fabricate.<sup>7</sup>

---

<sup>7</sup> Diagnosis of and treatment for diabetes may be relevant for other purposes such as the likelihood of losing consciousness, it would not make a person more or  
(continued...)

S.S.'s potential diagnosis and treatment should be treated no differently unless there were evidence to establish their relevancy to credibility.

Under M.R.E. 401, evidence is relevant if it has any tendency to make a fact more or less probable than it would be without the evidence, and the fact is of consequence in determining the action. In this case, there is no evidence that S.S.'s diagnoses or treatments are relevant. Under the DSM-5, memory and truthfulness are not implicated in any way by a diagnosis of borderline personality disorder. DSM-5 at 663-66. The Appellant's expert presented no testimony of the diagnosis's relevancy to credibility. There was no evidence or expert testimony of the relevancy of S.S.'s potential medications. The Appellant's arguments that borderline personality disorder and its medications were relevant to the issues of suggestion, memory and truthfulness were arguments and not evidence.

Based upon the evidence in the record if S.S. were diagnosed with borderline personality disorder the diagnosis would not make her more or less credible. Her potential diagnosis and medications are of no consequence to this case.

Even if there were a scintilla of relevancy, such relevancy would be substantially outweighed by its unfair prejudice, confusing the issues, misleading

---

less credible. Still, its relevancy would need to be established by expert testimony or other evidence.

the members, and wasting time, and would be inadmissible under M.R.E. 403. The military judge recognized that S.S.'s diagnoses and treatments were irrelevant and that the Appellant was conducting a mere fishing expedition. The Appellant's expert did not opine that S.S. likely had borderline personality disorder. He simply testified that her cutting behavior was a "common feature of someone with Border Personality Disorder *or someone who has traits of Borderline Personality Disorder.*" Brief at 39 (emphasis added).<sup>8</sup> Although a diagnosis of borderline personality disorder requires a therapist to identify at least five of nine diagnostic criteria, the Appellant's expert identified only one criterium - cutting or self-mutilation. Based solely upon the cutting evidence, the expert opines that S.S. could have borderline personality disorder and could further exhibit "attention-seeking and manipulative behaviors" and fear of abandonment. Brief at 39. This is purely speculative of both the diagnosis and the resulting behavior.

The dissenting opinion in *H.V. v. Kitchen*, 75 M.J. 717, 721 (C.G. Ct. Crim. App. 2016) (Bruce dissenting) does not understand the fundamental nature of psychotherapy. In his dissent, Judge Bruce states that diagnoses, medications, and

---

<sup>8</sup> The speculative nature of the expert's testimony is clear because he assures the accuracy of this statement by including "or someone with traits . . ." The significance of this testimony is that the expert implicitly acknowledges that many (most?) people who do not have borderline personality disorder nevertheless have traits of the disorder.

other treatments are “matters of fact that exist independent of any communications between the patient and a psychotherapist.” *Id.* Diagnoses are not facts.

Diagnoses are opinions held by the psychotherapist after the examination of (through confidential communications with) a patient. It is an opinion subject to change as the therapist shares the proposed diagnosis with the patient and continues the examination through further communications and dialogue.

Diagnostic criteria are guidelines for making a diagnosis and their use should be informed by the psychologist’s professional judgment. DSM-5 at 21. The purpose or utility of a diagnosis is to help psychologists “determine prognosis, treatment plans, and potential treatment outcomes for their patients.” *Id.* at 20. Diagnosis requires clinical training, judgment and experience requiring the psychotherapist to consider many factors. *Id.*, at 5, 19.

The DSM-5 has a cautionary statement on using the manual in court proceedings. DSM-5 at 25. The criteria for disorders were developed to meet the needs of clinicians and not the technical needs of courts. *Id.* Use of DSM-5 should be “informed by an awareness of the risks and limitations of its use in forensic settings” because of the risk that diagnostic information will be misunderstood. *Id.* Diagnosis of a disorder does not imply that the patient meets the legal criteria for the presence of a mental disorder. *Id.* Impairments, abilities, and disabilities vary widely for each assignment of a particular diagnosis. *Id.* The

use of the DSM-5 to determine the presence of a mental disorder by untrained individuals is not advised, and such untrained decision makers should be cautioned that a diagnosis does not imply the etiology or causes of the patient's ability to control other behaviors associated with the disorder. *Id.* Any court that considers diagnoses as facts that are independent of privileged communications is unaware of the nature of psychotherapy and the risks of using diagnoses for any purpose other than treatment.

Since diagnoses are not facts but professional opinions, the military judge would be required to follow the requirements for opinions and expert testimony in R.C.M. 701 through 705. If the military judge were to allow the speculative evidence that S.S. had borderline personality disorder, the judge would be required to allow examination of the diagnosing psychotherapist and the Appellant's expert. The psychotherapists would be subject to voir dire examinations to evaluate their training, experience, and judgment. Members would be confused or misled if the experts' opinions were admitted without disclosure of the underlying privileged communications used to form the opinions. This trial within a trial to determine whether S.S. has borderline personality disorders substantially outweighs any relevance of a borderline personality disorder diagnosis.

Whether S.S. has borderline personality disorder is speculative and irrelevant evidence that is not admissible regardless of whether it is privileged. The military judge's finding that this evidence is irrelevant is not unreasonable.

### **III. Diagnoses and Treatments Are Privileged Communications.**

Diagnoses and treatments are privileged communications under M.R.E. 513. Patient/Victim S.S. concurs with the arguments on this issue presented by the Appellee in its Answer and the Navy, Marine Corps, and Coast Guard Victim's Legal Counsel and Special Victims' Counsel Programs in their amicus curiae brief. S.S. will not repeat those arguments.<sup>9</sup>

Patient/Victim S.S. will address how the military justice system will be fundamentally affected by any decision that holds diagnoses and treatments are not privileged communications under M.R.E. 513. If diagnoses and treatments are not privileged because they are not within the plain language of M.R.E. 513, then the

---

<sup>9</sup> S.S. disagrees with the assertion in Appellee's Answer that there is a split among the service courts of criminal appeals on this issue. Answer at 13 n.1. The two courts of criminal appeals that addressed this issue in published opinions have agreed that diagnoses and treatments are confidential communications that are privileged under M.R.E. 513. *H.V. v. Kitchen*, 75 M.J. 717, 719 (C. G. Ct. Crim. App. 2016); and *Mellette*, 81 M.J. at 692.

In an unpublished and nonprecedential opinion, the Army Court of Criminal Appeals ("ACCA") opined in dictum that diagnoses and treatments are not privileged communications. *United States v. Rodriguez*. No. ARMY 20180138, 2019 CCA LEXIS 387, at \*8 (A. Ct. Crim. App. Oct. 1, 2019). The dictum was not necessary for deciding the case.

Court's decision would be based upon the language of the rule and not any constitutional requirement. Diagnoses and treatments of all patients would be disclosable and admissible in every court-martial regardless of whether the patient is a victim or an accused.

As discussed above, in this case a diagnosis of borderline personality disorder is irrelevant and would not be admissible under either M.R.E. 401 or 403. In other cases, the diagnosis or treatments may be relevant for evaluating the credibility of a patient-witness, but usually it would not be relevant.<sup>10</sup> There would be no constitutional or statutory interpretation basis to apply a different rule if the patient is an accused.

Unlike the low relevance of most diagnoses for determining the credibility of a victim or other witness, many DSM-5 diagnoses would be extremely relevant to whether an accused committed the charged crime. A pedophilic disorder diagnosis would be extremely relevant to an accused charged with sexual assault of a child (10 U.S.C. 920b). A voyeuristic disorder diagnosis would be relevant to an accused charged with indecent viewing (10 U.S.C. 920c). An opioid use disorder diagnosis would be relevant to an accused charged with wrongful use of controlled

---

<sup>10</sup> As discussed above, certain diagnoses within the DSM-5 have criteria relating to memory and the ability to perceive or tell the truth. Only in those cases where there is evidence of relevancy would the diagnoses or treatments be discoverable and admissible.

substances (10 U.S.C. 912a). A conduct disorder diagnosis would be relevant to an accused charged with assault (10 U.S.C. 928). The potential uses of diagnoses against an accused are limitless. If diagnoses and treatments are not privileged, in each of these cases an accused's diagnosis would be disclosed and admitted to prove guilt.

This result would defeat the purpose of the psychotherapist privilege and would discourage service members struggling with psychological disorders from seeking help. Many times, the arrest or charge for these crimes is the event that triggers an accused to recognize the need to seek help. If diagnoses and treatments are not privileged, defense counsel will advise their clients to forego needed psychological treatment.

Diagnoses and treatments are privileged communications under M.R.E. 513.

**IV. The NMCCA did not depart from Supreme Court and CAAF precedent by not reviewing in camera Patient/Victim S.S.'s diagnoses and treatments.**

The second granted issue is whether the NMCCA departed from this Court's and the Supreme Court's precedents regarding prejudice and harmlessness. The Appellant's brief relies only on this Court's precedents in *United States v. Reece*, 25 M.J. 93 (C.M.A. 1987) and *United States v. Jacinto*, 81 M.J. 350 (C.A.A.F. 2021); and the Supreme Court's precedent in *Pennsylvania v. Ritchie*, 480 U.S. 39 (1987).

These precedents have nothing to do with prejudice, harmlessness, or any other issue before the Court. These precedents are being misused by the Appellant.

The Appellant notes the similarities between *Reece* and *Ritchie*. Both involved sexual abuse of minors, and both involve counseling records. Appellant then discusses *Reece*'s R.C.M. 703 analysis that emotional or mental defects have high probative value on the issue of credibility. Brief at 36-37.

What the Appellant omits from his argument is that at the time *Reece* was decided there was no psychotherapist privilege in the military justice system. Psychotherapy records were treated as medical records and subject to the usual relevancy analysis under R.C.M. 703 because they were not privileged.

Applying *Reece* today ignores the implementation of M.R.E. 513 in 1997 and its changes since. *Reece* has no precedential value in this case.

The Appellant then discusses *Jacinto*. Patient/Victim S.S. concurs with the Appellee's arguments on *Jacinto*. This Court remanded *Jacinto* back to the NMCCA because five pages were omitted from the record and additional information ordered to be produced by the military judge was not received. *Jacinto*, 81 M.J. at 354. This missing information "likely would have resolved the questions surrounding [the patient/victim's] diagnosis." *Id.* The in camera review directed by the Court applied to this missing information and no more. In the same sentence that the Appellant's brief partially quotes ("to conduct an in camera

review”), the Court specifically stated, “M.R.E. 513 and other privileges will apply . . .” Brief at 38; *Jacinto*, 81 M.J. at 355. The Court specifically stated that it was not deciding whether there is a constitutionally required exception to M.R.E. 513 and its sole focus was on where the Appellant establish a basis for a continuance and an in camera review. *Id.* at 354 n.10. An in camera review of all of the psychotherapy records in *Jacinto* would be prohibited under M.R.E. 513 if there is no constitutionally required exception.

The record is complete in this case. *Jacinto* does not support the Appellant’s argument that the military judge should have ordered an in camera review.

Finally, the Appellant argues that the Supreme Court’s decision in *Ritchie* required the military judge to at conduct an in camera review of the confidential records. Brief at 35-36. Patient/Victim S.S. concurs with the Appellee’s analysis of *Ritchie*. Answer at 24-25.

In *United States v. Tinsley*, No. 20200337, 2021 CCA LEXIS 679 (A. Ct. Crim. App. Dec. 15, 2021), the ACCA squarely addressed the constitutionality of the psychotherapist privilege under M.R.E. 513. To the extent the Appellant is asking this Court to rule upon the constitutionality of M.R.E. 513 by citing *Ritchie*, this Court has not yet ruled upon this issue. *Jacinto*, 81 M.J. at 354 n.10. The granted issue does not involve the constitutionality of M.R.E. 513, and this case is

not a good vehicle to decide the issue. If *Tinsley* reaches this Court, the issue should be decided then.

*Tinsley* explains why *Ritchie* is not applicable, and it alludes to a key fact distinguishing *Ritchie* from cases in which there is an absolute privilege. *Tinsley*, 2021 CCA LEXIS 679 at \*34 n.5. *Ritchie* did not involve the psychotherapist privilege. In *Ritchie* the confidential records at issue were investigatory files of the state agency charged with investigating child abuse and thus material required to be disclosed under *Brady v. Maryland*, 373 U.S. 83 (1963). *Ritchie*, 480 U.S. at 42-44. As explained in *Tinsley*, privileged psychotherapy records are not *Brady* material. *Tinsley*, 2021 CCA LEXIS at \*35-43.

**V. Patient/Victim S.S. Did Not Waive Her Privilege.**

Patient/Victim S.S. did not waive her M.R.E. 513 privilege. S.S. has not disclosed a significant part of her privileged communications under circumstances where it would be inappropriate to allow her claim of privilege.

The NMCCA found that S.S. waived her privilege by discussing her diagnoses and treatment during a civil deposition and with family and law enforcement. *Mellette*, 81 M.J. at 690. In their briefs, the parties discuss waiver even though waiver is not included in the granted issues.

S.S. was not represented by special victim counsel at the court-martial, and upon information and belief, she was not notified of the M.R.E. 513 hearing or

given the opportunity to be heard. Upon information and belief, she was not notified of the proceedings at the NMCCA and did not participate in them.

Counsel for S.S. has not had the opportunity to examine the sealed records. If S.S.'s waiver becomes relevant as a result of this Court's decision on the granted issues, S.S. respectfully joins the Appellee's request that the Court require supplemental briefing on the waiver issue. Appellee Answer at 15 n.3. S.S. should be given the opportunity to examine the factual basis of the NMCCA's holding and to make argument on those facts before this Court upholds the NMCCA's waiver finding.

### CONCLUSION

Patient/Victim S.S. respectfully requests that this Court affirm the findings and sentence as adjudged and approved below.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Peter Coote', with a stylized flourish extending to the right.

Peter Coote, Esq.  
Attorney for Patient/Victim S.S.  
Court Bar No. 35957

Pennoni Associates Inc.  
1900 Market Street  
Third Floor  
Philadelphia, PA 19103  
[pcoote@pennoni.com](mailto:pcoote@pennoni.com)  
Phone: (215) 254-7857

## CERTIFICATE OF FILING AND SERVICE

I certify that on December 30, 2021 a copy of the foregoing was transmitted by electronic means to the following:

- (1) This Court: [efiling@armfor.uscourts.gov](mailto:efiling@armfor.uscourts.gov)
- (2) Counsel for Appellant: LCDR Michael W. Wester, JAGC, USN
- (3) Counsel for Appellee: LCDR Jeffrey S. Marden, JAGC, USN

I further certify that after a January 4, 2021 notice from the Court, on January 5, 2021 a copy of the foregoing amicus curiae brief was retransmitted to each of the above recipients.

## CERTIFICATE OF COMPLIANCE

1. This Brief complies with the type-volume limitation of Rule 24(c)(1) of this Court's Rules of Appellate Procedure because it contains fewer than 7,000 words.
2. This Brief complies with the typeface and type style requirements of Rule 37(a) of this Court's Rules of Appellate Procedure because it uses proportional, 14-point, Times New Roman font with one-inch margins on all four sides.

Respectfully submitted,



Peter Coote, Esq.  
Attorney for Patient/Victim S.S.  
Court Bar No. 35957

Pennoni Associates Inc.  
1900 Market Street  
Third Floor  
Philadelphia, PA 19103  
[pcoote@pennoni.com](mailto:pcoote@pennoni.com)  
Phone: (215) 254-7857

**RELEVANT EXCERPTS FROM DSM-5  
AMICUS CURIAE BRIEF OF PATIENT/VICTIM S.S.  
United States v. Mellette  
USCA Dkt. No. 21-0312/NA**

**PREFACE**

**Pages xli through xliv**

xli

**Preface**

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

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

disorders as well as for seasoned professionals encountering rare disorders for the first time. Fortunately, all of these uses are mutually compatible.

These diverse needs and interests were taken into consideration in planning DSM-5. The classification of disorders is harmonized with the World Health Organization's International Classification of Diseases (ICD), the official coding system used in the United States, so that the DSM criteria define disorders identified by ICD diagnostic names and code numbers. In DSM-5, both ICD-9-CM and ICD-10-CM codes (the latter scheduled for adoption in October 2015) are attached to the relevant disorders in the classification.

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

xlii

- **Representation of developmental issues related to diagnosis.** The change in chapter organization better reflects a lifespan approach, with disorders more frequently diagnosed in childhood (e.g., neurodevelopmental disorders) at the beginning of the manual and disorders more applicable to older adulthood (e.g., neurocognitive disorders) at the end of the manual. Also, within the text, subheadings on development and course provide descriptions of how disorder presentations may change across the lifespan. Age-related factors specific to diagnosis (e.g., symptom presentation and prevalence differences in certain age groups) are also included in the text. For added emphasis, these age-related factors have been added to the criteria themselves where applicable (e.g., in the criteria sets for insomnia disorder and posttraumatic stress disorder, specific criteria describe how symptoms might be expressed in children). Likewise, gender and cultural issues have been integrated into the disorders where applicable.
- **Integration of scientific findings from the latest research in genetics and neuroimaging.** The revised chapter structure was informed by recent research in neuroscience and by emerging genetic linkages between diagnostic groups. Genetic and physiological risk factors, prognostic indicators, and some putative diagnostic markers are highlighted in the text. This new structure should improve clinicians' ability to identify diagnoses in a disorder spectrum based on common neurocircuitry, genetic vulnerability, and environmental exposures.

- **Consolidation of autistic disorder, Asperger’s disorder, and pervasive developmental disorder into autism spectrum disorder.** Symptoms of these disorders represent a single continuum of mild to severe impairments in the two domains of social communication and restrictive repetitive behaviors/interests rather than being distinct disorders. This change is designed to improve the sensitivity and specificity of the criteria for the diagnosis of autism spectrum disorder and to identify more focused treatment targets for the specific impairments identified.
- **Streamlined classification of bipolar and depressive disorders.** Bipolar and depressive disorders are the most commonly diagnosed conditions in psychiatry. It was therefore important to streamline the presentation of these disorders to enhance both clinical and educational use. Rather than separating the definition of manic, hypomanic, and major depressive episodes from the definition of bipolar I disorder, bipolar II disorder, and major depressive disorder as in the previous edition, we included all of the component criteria within the respective criteria for each disorder. This approach will facilitate bedside diagnosis and treatment of these important disorders. Likewise, the explanatory notes for differentiating bereavement and major depressive disorders will provide far greater clinical guidance than was previously provided in the simple bereavement exclusion criterion. The new specifiers of anxious distress and mixed features are now fully described in the narrative on specifier variations that accompanies the criteria for these disorders.
- **Restructuring of substance use disorders for consistency and clarity.** The categories of substance abuse and substance dependence have been eliminated and replaced with an overarching new category of substance use disorders—with the specific substance used defining the specific disorders. “Dependence” has been easily confused with the term “addiction” when, in fact, the tolerance and withdrawal that previously defined dependence are actually very normal responses to prescribed medications that affect the central nervous system and do not necessarily indicate the presence of an addiction. By revising and clarifying these criteria in DSM-5, we hope to alleviate some of the widespread misunderstanding about these issues.
- **Enhanced specificity for major and mild neurocognitive disorders.** Given the explosion in neuroscience, neuropsychology, and brain imaging over the past 20 years, it was critical to convey the current state-of-the-art in the diagnosis of specific types of disorders that were previously referred to as the “dementias” or organic brain diseases. Biological markers identified by imaging for vascular and traumatic brain disorders and specific molecular genetic findings for rare variants of Alzheimer’s disease and Huntington’s disease have greatly advanced clinical diagnoses, and these disorders and others have now been separated into specific subtypes.
- **Transition in conceptualizing personality disorders.** Although the benefits of a more dimensional approach to personality disorders have been identified in previous editions,

the transition from a categorical diagnostic system of individual disorders to one based on the relative distribution of personality traits has not been widely accepted. In DSM-5, the categorical personality disorders are virtually unchanged from the previous edition. However, an alternative “hybrid” model has been proposed in Section III to guide future research that separates interpersonal functioning assessments and the expression of pathological personality traits for six specific disorders. A more dimensional profile of personality trait expression is also proposed for a trait-specified approach.

- **Section III: new disorders and features.** A new section (Section III) has been added to highlight disorders that require further study but are not sufficiently well established to be a part of the official classification of mental disorders for routine clinical use. Dimensional measures of symptom severity in 13 symptom domains have also been incorporated to allow for the measurement of symptom levels of varying severity across all diagnostic groups. Likewise, the WHO Disability Assessment Schedule (WHODAS), a standard method for assessing global disability levels for mental disorders that is based on the International Classification of Functioning, Disability and Health (ICF) and is applicable in all of medicine, has been provided to replace the more limited Global Assessment of Functioning scale. It is our hope that as these measures are implemented over time, they will provide greater accuracy and flexibility in the clinical description of individual symptomatic presentations and associated disability during diagnostic assessments.
- **Online enhancements.** DSM-5 features online supplemental information. Additional cross-cutting and diagnostic severity measures are available online ([www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5)), linked to the relevant disorders. In addition, the Cultural Formulation Interview, Cultural Formulation Interview—Informant Version, and supplementary modules to the core Cultural Formulation Interview are also included online at [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5).

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

We would especially like to acknowledge the chairs, text coordinators, and members of the 13 work groups, listed in the front of the manual, who spent many hours in this volunteer effort to improve the scientific basis of clinical practice over a sustained 6-year period. Susan K. Schultz, M.D., who served as text editor, worked tirelessly with Emily A. Kuhl, Ph.D., senior science

writer and DSM-5 staff text editor, to coordinate the efforts of the work groups into a cohesive whole. William E. Narrow, M.D., M.P.H., led the research group that developed the overall research strategy for DSM-5, including the field trials, that greatly enhanced the evidence base for this revision. In addition, we are grateful to those who contributed so much time to the independent review of the revision proposals, including Kenneth S. Kendler, M.D., and Robert Freedman, M.D., co-chairs of the Scientific Review Committee; John S. McIntyre, M.D., and Joel Yager, M.D., co-chairs of the Clinical and Public Health Committee; and Glenn Martin, M.D., chair of the APA Assembly

xliv

review process. Special thanks go to Helena C. Kraemer, Ph.D., for her expert statistical consultation; Michael B. First, M.D., for his valuable input on the coding and review of criteria; and Paul S. Appelbaum, M.D., for feedback on forensic issues. Maria N. Ward, M.Ed., RHIT, CCS-P, also helped in verifying all ICD coding. The Summit Group, which included these consultants, the chairs of all review groups, the task force chairs, and the APA executive officers, chaired by Dilip V. Jeste, M.D., provided leadership and vision in helping to achieve compromise and consensus. This level of commitment has contributed to the balance and objectivity that we feel are hallmarks of DSM-5.

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

*David J. Kupfer, M.D.*  
DSM-5 Task Force Chair

*Darrel A. Regier, M.D., M.P.H.*  
DSM-5 Task Force Vice-Chair

December 19, 2012

**SECTION I DSM-5 BASICS**  
**Pages 1 through 25 of DSM-5**

1

**SECTION I**  
**DSM-5 Basics**

Introduction

Use of the Manual

Cautionary Statement for Forensic Use of DSM-5

2

3

This section is a basic orientation to the purpose, structure, content, and use of DSM-5. It is not intended to provide an exhaustive account of the evolution of DSM-5, but rather to give readers a succinct overview of its key elements. The introductory section describes the public, professional, and expert review process that was used to extensively evaluate the diagnostic criteria presented in Section II. A summary of the DSM-5 structure, harmonization with ICD-11, and the transition to a non-axial system with a new approach to assessing disability is also presented. "Use of the Manual" includes "Definition of a Mental Disorder," forensic considerations, and a brief overview of the diagnostic process and use of coding and recording procedures.

4

5

**Introduction**

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

Reliable diagnoses are essential for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic

research, and documenting important public health information such as morbidity and mortality rates. As the understanding of mental disorders and their treatments has evolved, medical, scientific, and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research.

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

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

examination of the range of symptoms present, DSM can serve clinicians as a guide to identify the most prominent symptoms that should be assessed when diagnosing a disorder. Although

some mental disorders may have well-defined boundaries around symptom clusters, scientific evidence now places many, if not most, disorders on a spectrum with closely related disorders that have shared symptoms, shared genetic and environmental risk factors, and possibly shared neural substrates (perhaps most strongly established for a subset of anxiety disorders by neuroimaging and animal models). In short, we have come to recognize that the boundaries between disorders are more porous than originally perceived.

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

#### A Brief History

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

#### DSM-5 Revision Process

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

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

7

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

### **Proposals for Revisions**

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

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

Building on the initial literature reviews, work groups identified key issues within their diagnostic areas. Work groups also examined broader methodological concerns, such as the presence of contradictory findings within the literature; development of a refined definition of

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

### **DSM-5 Field Trials**

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

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

The medical-academic field trials were conducted at 11 North American medical-academic sites and assessed the reliability, feasibility, and clinical utility of select revisions, with priority given to those that represented the greatest degree of change from DSM-IV or those potentially having the greatest public health impact. The full clinical patient populations coming to each site were screened for DSM-IV diagnoses or qualifying symptoms likely to predict several specific DSM-5 disorders of interest. Stratified samples of four to seven specific disorders, plus a stratum containing a representative sample of all other diagnoses, were identified for each site. Patients consented to the study and were randomly assigned for a clinical interview by a clinician blind to the diagnosis, followed by a second interview with a clinician blind to previous diagnoses. Patients first filled out a computer-assisted inventory of cross-cutting symptoms in

more than a dozen psychological domains. These inventories were scored by a central server, and results were provided to clinicians before they conducted a typical clinical interview (with no structured protocol). Clinicians were required to score the presence of qualifying criteria on a computer-assisted DSM-5 diagnostic checklist, determine diagnoses, score the severity of the diagnosis, and submit all data to the central Web-based server. This study design allowed the calculation of the degree to which two independent clinicians could agree on a diagnosis (using the intraclass kappa statistic) and the agreement of a single patient or two different clinicians on two separate ratings of cross-cutting symptoms, personality traits, disability, and diagnostic severity measures (using intraclass correlation coefficients) along with information on the precision of these estimates of reliability. It was also possible to assess the prevalence rates of both DSM-IV and DSM-5 conditions in the respective clinical populations.

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

### **Public and Professional Review**

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

### **Expert Review**

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

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

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

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

The work groups themselves were charged with the responsibility to review the entire research literature surrounding a diagnostic area, including old, revised, and new diagnostic criteria, in an intensive 6-year review process to assess the pros and cons of making either small iterative changes or major conceptual changes to address the inevitable reification that occurs with diagnostic conceptual approaches that persist over several decades. Such changes included the merger of previously separate diagnostic areas into more dimensional spectra, such as that which occurred with autism spectrum disorder, substance use disorders, sexual dysfunctions,

and somatic symptom and related disorders. Other changes included correcting flaws that had become apparent over time in the choice of operational criteria for some disorders. These types of changes posed particular challenges to the SRC and CPHC review processes, which were not constructed to evaluate the validity of DSM-IV diagnostic criteria. However, the DSM-5 Task Force, which had reviewed proposed changes and had responsibility for reviewing the text describing each disorder contemporaneously with the work groups during this period, was in a unique position to render an informed judgment on the scientific merits of such revisions. Furthermore, many of these major changes were subject to field trial testing, although comprehensive testing of all proposed changes could not be accommodated by such testing because of time limitations and availability of resources.

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

10

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

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

#### Organizational Structure

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

DSM is a medical classification of disorders and as such serves as a historically determined cognitive schema imposed on clinical and scientific information to increase its comprehensibility and utility. Not surprisingly, as the foundational science that ultimately led to

DSM-III has approached a half-century in age, challenges have begun to emerge for clinicians and scientists alike that are inherent in the DSM structure rather than in the description of any single disorder. These challenges include high rates of comorbidity within and across DSM chapters, an excessive use of and need to rely on “not otherwise specified” (NOS) criteria, and a growing inability to integrate DSM disorders with the results of genetic studies and other scientific findings.

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

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

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

With any ongoing review process, especially one of this complexity, different viewpoints emerge, and an effort was made to consider various viewpoints and, when warranted, accommodate them. For example, personality disorders are included in both Sections II and III. Section II represents an update of the text associated with the same criteria found in DSM-IV-TR, whereas Section III includes the proposed research model for personality disorder diagnosis

and conceptualization developed by the DSM-5 Personality and Personality Disorders Work Group. As this field evolves, it is hoped that both versions will serve clinical practice and research initiatives.

### **Harmonization With ICD-11**

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

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

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

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

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

well as the contours of individual disorders and, furthermore, that the simple and linear organization that best supports clinical practice

12

may not fully capture the complexity and heterogeneity of mental disorders. The revised organization is coordinated with the mental and behavioral disorders chapter (Chapter V) of ICD-11, which will utilize an expanded numeric–alphanumeric coding system. However, the official coding system in use in the United States at the time of publication of this manual is that of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)—the U.S. adaptation of ICD-9. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), adapted from ICD-10, is scheduled for implementation in the United States in October 2015. Given the impending release of ICD-11, it was decided that this iteration, and not ICD-10, would be the most relevant on which to focus harmonization. However, given that adoption of the ICD-9-CM coding system will remain at the time of the DSM-5 release, it will be necessary to use the ICD-9-CM codes. Furthermore, given that DSM-5's organizational structure reflects the anticipated structure of ICD-11, the eventual ICD-11 codes will follow the sequential order of diagnoses in the DSM-5 chapter structure more closely. At present, both the ICD-9-CM and the ICD-10-CM codes have been indicated for each disorder. These codes will not be in sequential order throughout the manual because they were assigned to complement earlier organizational structures.

### **Dimensional Approach to Diagnosis**

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

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

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

13

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

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

Despite the problem posed by categorical diagnoses, the DSM-5 Task Force recognized that it is premature scientifically to propose alternative definitions for most disorders. The organizational structure is meant to serve as a bridge to new diagnostic approaches without disrupting current clinical practice or research. With support from DSM-associated training materials, the National Institutes of Health other funding agencies, and scientific publications,

the more dimensional DSM-5 approach and organizational structure can facilitate research across current diagnostic categories by encouraging broad investigations within the proposed chapters and across adjacent chapters. Such a reformulation of research goals should also keep DSM-5 central to the development of dimensional approaches to diagnosis that will likely supplement or supersede current categorical approaches in coming years.

### **Developmental and Lifespan Considerations**

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

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

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

Cultural Issues

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

In Section III, the "Cultural Formulation" contains a detailed discussion of culture and diagnosis in DSM-5, including tools for in-depth cultural assessment. In the Appendix, the "Glossary of

Cultural Concepts of Distress” provides a description of some common cultural syndromes, idioms of distress, and causal explanations relevant to clinical practice.

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

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

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

illness, or distress (e.g., maladi moun). Causal explanations may be salient features of folk classifications of disease used by laypersons or healers.

15

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

### Gender Differences

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

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

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

The manual is configured to include information on gender at multiple levels. If there are gender-specific symptoms, they have been added to the diagnostic criteria. A gender-related

specifier, such as perinatal onset of a mood episode, provides additional information on gender and diagnosis. Finally, other issues that are pertinent to diagnosis and gender considerations can be found in the section “Gender-Related Diagnostic Issues.”

#### Use of Other Specified and Unspecified Disorders

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

#### 16

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

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

#### The Multiaxial System

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

individual's functional status separately from his or her diagnoses or symptom status. In DSM-5, Axis III has been combined with Axes I and II. Clinicians should continue to list medical conditions that are important to the understanding or management of an individual's mental disorder(s).

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

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

It was challenging to determine what to include in the print version of DSM-5 to be most clinically relevant and useful and at the same time maintain a manageable size. For this reason, the inclusion of clinical rating scales and measures in the print edition is limited to those considered most relevant. Additional assessment measures used in the field trials are available online ([www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5)), linked to the relevant disorders. The Cultural Formulation Interview, Cultural Formulation Interview—Informant Version, and supplementary modules to the core Cultural Formulation Interview are also available online at [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5). DSM-5 is available as an online subscription at [PsychiatryOnline.org](http://PsychiatryOnline.org) as well as an e-book. The online component contains modules and assessment tools to enhance the diagnostic criteria and text. Also available online is a complete set of supportive references as well as additional helpful information. The organizational structure of DSM-5, its use of dimensional measures, and compatibility with ICD codes will allow it to be readily adaptable to future scientific discoveries and refinements in its clinical utility. DSM-5 will be analyzed over time to continually assess its validity and enhance its value to clinicians.

## Use of the Manual

The introduction contains much of the history and developmental process of the DSM-5 revision. This section is designed to provide a practical guide to using DSM-5, particularly in clinical practice. The primary purpose of DSM-5 is to assist trained clinicians in the diagnosis of their patients' mental disorders as part of a case formulation assessment that leads to a fully informed treatment plan for each individual. The symptoms contained in the respective diagnostic criteria sets do not constitute comprehensive definitions of underlying disorders, which encompass cognitive, emotional, behavioral, and physiological processes that are far more complex than can be described in these brief summaries. Rather, they are intended to summarize characteristic syndromes of signs and symptoms that point to an underlying disorder with a characteristic developmental history, biological and environmental risk factors, neuropsychological and physiological correlates, and typical clinical course.

### Approach to Clinical Case Formulation

The case formulation for any given patient must involve a careful clinical history and concise summary of the social, psychological, and biological factors that may have contributed to developing a given mental disorder. Hence, it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis. Although a systematic check for the presence of these criteria as they apply to each patient will assure a more reliable assessment, the relative severity and valence of individual criteria and their contribution to a diagnosis require clinical judgment. The symptoms in our diagnostic criteria are part of the relatively limited repertoire of human emotional responses to internal and external stresses that are generally maintained in a homeostatic balance without a disruption in normal functioning. It requires clinical training to recognize when the combination of predisposing, precipitating, perpetuating, and protective factors has resulted in a psychopathological condition in which physical signs and symptoms exceed normal ranges. The ultimate goal of a clinical case formulation is to use the available contextual and diagnostic information in developing a comprehensive treatment plan that is informed by the individual's cultural and social context. However, recommendations for the selection and use of the most appropriate evidence-based treatment options for each disorder are beyond the scope of this manual.

Although decades of scientific effort have gone into developing the diagnostic criteria sets for the disorders included in Section II, it is well recognized that this set of categorical diagnoses does not fully describe the full range of mental disorders that individuals experience and present to clinicians on a daily basis throughout the world. As noted previously in the introduction, the range of genetic/environmental interactions over the course of human development affecting cognitive, emotional and behavioral function is virtually limitless. As a

result, it is impossible to capture the full range of psychopathology in the categorical diagnostic categories that we are now using. Hence, it is also necessary to include “other specified/unspecified” disorder options for presentations that do not fit exactly into the diagnostic boundaries of disorders in each chapter. In an emergency department setting, it may be possible to identify only the most prominent symptom expressions associated with a particular chapter—for example, delusions, hallucinations,

20

mania, depression, anxiety, substance intoxication, or neurocognitive symptoms—so that an “unspecified” disorder in that category is identified until a fuller differential diagnosis is possible.

#### Definition of a Mental Disorder

Each disorder identified in Section II of the manual (excluding those in the chapters entitled “Medication-Induced Movement Disorders and Other Adverse Effects of Medication” and “Other Conditions That May Be a Focus of Clinical Attention”) must meet the definition of a mental disorder. Although no definition can capture all aspects of all disorders in the range contained in DSM-5, the following elements are required:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

The diagnosis of a mental disorder should have clinical utility: it should help clinicians to determine prognosis, treatment plans, and potential treatment outcomes for their patients. However, the diagnosis of a mental disorder is not equivalent to a need for treatment. Need for treatment is a complex clinical decision that takes into consideration symptom severity, symptom salience (e.g., the presence of suicidal ideation), the patient’s distress (mental pain) associated with the symptom(s), disability related to the patient’s symptoms, risks and benefits of available treatments, and other factors (e.g., psychiatric symptoms complicating other illness). Clinicians may thus encounter individuals whose symptoms do not meet full criteria for a mental disorder but who demonstrate a clear need for treatment or care. The fact that some individuals do not show all symptoms indicative of a diagnosis should not be used to justify limiting their access to appropriate care.

Approaches to validating diagnostic criteria for discrete categorical mental disorders have included the following types of evidence: antecedent validators (similar genetic markers, family traits, temperament, and environmental exposure), concurrent validators (similar neural substrates, biomarkers, emotional and cognitive processing, and symptom similarity), and predictive validators (similar clinical course and treatment response). In DSM-5, we recognize that the current diagnostic criteria for any single disorder will not necessarily identify a homogeneous group of patients who can be characterized reliably with all of these validators. Available evidence shows that these validators cross existing diagnostic boundaries but tend to congregate more frequently within and across adjacent DSM-5 chapter groups. Until incontrovertible etiological or pathophysiological mechanisms are identified to fully validate specific disorders or disorder spectra, the most important standard for the DSM-5 disorder criteria will be their clinical utility for the assessment of clinical course and treatment response of individuals grouped by a given set of diagnostic criteria.

This definition of mental disorder was developed for clinical, public health, and research purposes. Additional information is usually required beyond that contained in the DSM-5 diagnostic criteria in order to make legal judgments on such issues as criminal responsibility, eligibility for disability compensation, and competency (see “Cautionary Statement for Forensic Use of DSM-5” elsewhere in this manual).

### **Criterion for Clinical Significance**

There have been substantial efforts by the DSM-5 Task Force and the World Health Organization (WHO) to separate the concepts of mental disorder and disability (impairment in social, occupational, or other important areas of functioning). In the WHO system, the International Classification of Diseases (ICD) covers all diseases and disorders, while the International Classification of Functioning, Disability and Health (ICF) provides a separate classification of global disability. The WHO Disability Assessment Schedule (WHODAS) is based on the ICF and has proven useful as a standardized measure of disability for mental disorders. However, in the absence of clear biological markers or clinically useful measurements of severity for many mental disorders, it has not been possible to completely separate normal and pathological symptom expressions contained in diagnostic criteria. This gap in information is particularly problematic in clinical situations in which the patient’s symptom presentation by itself (particularly in mild forms) is not inherently pathological and may be encountered in individuals for whom a diagnosis of “mental disorder” would be inappropriate. Therefore, a generic diagnostic criterion requiring distress or disability has been used to establish disorder thresholds, usually worded “the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.” The text following the revised definition of a mental disorder acknowledges that this criterion may be especially helpful in determining a patient’s need for treatment. Use of information from family members and other

third parties (in addition to the individual) regarding the individual's performance is recommended when necessary.

## Elements of a Diagnosis

### **Diagnostic Criteria and Descriptors**

Diagnostic criteria are offered as guidelines for making diagnoses, and their use should be informed by clinical judgment. Text descriptions, including introductory sections of each diagnostic chapter, can help support diagnosis (e.g., providing differential diagnoses; describing the criteria more fully under "Diagnostic Features").

Following the assessment of diagnostic criteria, clinicians should consider the application of disorder subtypes and/or specifiers as appropriate. Severity and course specifiers should be applied to denote the individual's current presentation, but only when the full criteria are met. When full criteria are not met, clinicians should consider whether the symptom presentation meets criteria for an "other specified" or "unspecified" designation. Where applicable, specific criteria for defining disorder severity (e.g., mild, moderate, severe, extreme), descriptive features (e.g., with good to fair insight; in a controlled environment), and course (e.g., in partial remission, in full remission, recurrent) are provided with each diagnosis. On the basis of the clinical interview, text descriptions, criteria, and clinician judgment, a final diagnosis is made.

The general convention in DSM-5 is to allow multiple diagnoses to be assigned for those presentations that meet criteria for more than one DSM-5 disorder.

### **Subtypes and Specifiers**

Subtypes and specifiers (some of which are coded in the fourth, fifth, or sixth digit) are provided for increased specificity. Subtypes define mutually exclusive and jointly exhaustive phenomenological subgroupings within a diagnosis and are indicated by the instruction "Specify whether" in the criteria set. In contrast, specifiers are not intended to be mutually exclusive or jointly exhaustive, and as a consequence, more than one specifier may be given. Specifiers are indicated by the instruction "Specify" or "Specify if" in the criteria set. Specifiers provide an opportunity to define a more homogeneous subgrouping of

individuals with the disorder who share certain features (e.g., major depressive disorder, with mixed features) and to convey information that is relevant to the management of the individual's disorder, such as the "with other medical comorbidity" specifier in sleep-wake disorders. Although a fifth digit is sometimes assigned to code a subtype or specifier (e.g., 294.11 [F02.81] major neurocognitive disorder due to Alzheimer's disease, with behavioral disturbance) or severity (296.21 [F32.0] major depressive disorder, single episode, mild), the majority of subtypes and specifiers included in DSM-5 cannot be coded within the ICD-9-CM and ICD-10-CM systems and are indicated only by including the subtype or specifier after the

name of the disorder (e.g., social anxiety disorder [social phobia], performance type). Note that in some cases, a specifier or subtype is codable in ICD-10-CM but not in ICD-9-CM. Accordingly, in some cases the 4th or 5th character codes for the subtypes or specifiers are provided only for the ICD-10-CM coding designations.

A DSM-5 diagnosis is usually applied to the individual's current presentation; previous diagnoses from which the individual has recovered should be clearly noted as such. Specifiers indicating course (e.g., in partial remission, in full remission) may be listed after the diagnosis and are indicated in a number of criteria sets. Where available, severity specifiers are provided to guide clinicians in rating the intensity, frequency, duration, symptom count, or other severity indicator of a disorder. Severity specifiers are indicated by the instruction "Specify current severity" in the criteria set and include disorder-specific definitions. Descriptive features specifiers have also been provided in the criteria set and convey additional information that can inform treatment planning (e.g., obsessive-compulsive disorder, with poor insight). Not all disorders include course, severity, and/or descriptive features specifiers.

### **Medication-Induced Movement Disorders and Other Conditions That May Be a Focus of Clinical Attention**

In addition to important psychosocial and environmental factors (see "The Multiaxial System" in the "Introduction" elsewhere in this manual), these chapters in Section II also contain other conditions that are not mental disorders but may be encountered by mental health clinicians. These conditions may be listed as a reason for clinical visit in addition to, or in place of, the mental disorders listed in Section II. A separate chapter is devoted to medication-induced disorders and other adverse effects of medication that may be assessed and treated by clinicians in mental health practice such as akathisia, tardive dyskinesia, and dystonia. The description of neuroleptic malignant syndrome is expanded from that provided in DSM-IV-TR to highlight the emergent and potentially life-threatening nature of this condition, and a new entry on antidepressant discontinuation syndrome is provided. An additional chapter discusses other conditions that may be a focus of clinical attention. These include relational problems, problems related to abuse and neglect, problems with adherence to treatment regimens, obesity, antisocial behavior, and malingering.

### **Principal Diagnosis**

When more than one diagnosis for an individual is given in an inpatient setting, the principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission of the individual. When more than one diagnosis is given for an individual in an outpatient setting, the reason for visit is the condition that is chiefly responsible for the ambulatory care medical services received during the visit. In most cases, the principal diagnosis or the reason for visit is also the main focus of attention or treatment. It is often difficult (and somewhat arbitrary) to determine which diagnosis is the principal diagnosis or the reason for visit, especially when, for example, a substance-related diagnosis such as alcohol use

disorder is accompanied by a non-substance-related diagnosis such as schizophrenia. For example, it may be unclear which diagnosis should

23

be considered “principal” for an individual hospitalized with both schizophrenia and alcohol use disorder, because each condition may have contributed equally to the need for admission and treatment. The principal diagnosis is indicated by listing it first, and the remaining disorders are listed in order of focus of attention and treatment. When the principal diagnosis or reason for visit is a mental disorder due to another medical condition (e.g., major neurocognitive disorder due to Alzheimer’s disease, psychotic disorder due to malignant lung neoplasm), ICD coding rules require that the etiological medical condition be listed first. In that case, the principal diagnosis or reason for visit would be the mental disorder due to the medical condition, the second listed diagnosis. In most cases, the disorder listed as the principal diagnosis or the reason for visit is followed by the qualifying phrase “(principal diagnosis)” or “(reason for visit).”

### **Provisional Diagnosis**

The specifier “provisional” can be used when there is a strong presumption that the full criteria will ultimately be met for a disorder but not enough information is available to make a firm diagnosis. The clinician can indicate the diagnostic uncertainty by recording “(provisional)” following the diagnosis. For example, this diagnosis might be used when an individual who appears to have a major depressive disorder is unable to give an adequate history, and thus it cannot be established that the full criteria are met. Another use of the term provisional is for those situations in which differential diagnosis depends exclusively on the duration of illness. For example, a diagnosis of schizophreniform disorder requires a duration of less than 6 months but of at least 1 month and can only be given provisionally if assigned before remission has occurred.

### **Coding and Reporting Procedures**

Each disorder is accompanied by an identifying diagnostic and statistical code, which is typically used by institutions and agencies for data collection and billing purposes. There are specific recording protocols for these diagnostic codes (identified as coding notes in the text) that were established by WHO, the U.S. Centers for Medicare and Medicaid Services (CMS), and the Centers for Disease Control and Prevention’s National Center for Health Statistics to ensure consistent international recording of prevalence and mortality rates for identified health conditions. For most clinicians, the codes are used to identify the diagnosis or reason for visit for CMS and private insurance service claims. The official coding system in use in the United States as of publication of this manual is ICD-9-CM. Official adoption of ICD-10-CM is scheduled to take place on October 1, 2015, and these codes, which are shown parenthetically in this manual, should not be used until the official implementation occurs. Both ICD-9-CM and ICD-10-CM codes have been listed 1) preceding the name of the disorder in the classification and 2) accompanying the criteria set for each disorder. For some diagnoses (e.g., neurocognitive and

substance/medication-induced disorders), the appropriate code depends on further specification and is listed within the criteria set for the disorder, as coding notes, and, in some cases, further clarified in a section on recording procedures. The names of some disorders are followed by alternative terms enclosed in parentheses, which, in most cases, were the DSM-IV names for the disorders.

#### Looking to the Future: Assessment and Monitoring Tools

The various components of DSM-5 are provided to facilitate patient assessment and to aid in developing a comprehensive case formulation. Whereas the diagnostic criteria in Section II are well-established measures that have undergone extensive review, the assessment tools,

24

a cultural formulation interview, and conditions for further study included in Section III are those for which we determined that the scientific evidence is not yet available to support widespread clinical use. These diagnostic aids and criteria are included to highlight the evolution and direction of scientific advances in these areas and to stimulate further research.

Each of the measures in Section III is provided to aid in a comprehensive assessment of individuals that will contribute to a diagnosis and treatment plan tailored to the individual presentation and clinical context. Where cultural dynamics are particularly important for diagnostic assessment, the cultural formulation interview should be considered as a useful aid to communication with the individual. Cross-cutting symptom and diagnosis-specific severity measures provide quantitative ratings of important clinical areas that are designed to be used at the initial evaluation to establish a baseline for comparison with ratings on subsequent encounters to monitor changes and inform treatment planning.

The use of such measures will undoubtedly be facilitated by digital applications, and the measures are included in Section III to provide for further evaluation and development. As with each DSM edition, the diagnostic criteria and the DSM-5 classification of mental disorders reflect the current consensus on the evolving knowledge in our field.

25

#### **Cautionary Statement for Forensic Use of DSM-5**

Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning, DSM-5 is also used as a reference for the courts and attorneys in assessing the forensic consequences of mental disorders. As a result, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals. It is also important to note that DSM-5 does not provide treatment guidelines for any given disorder.

When used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, DSM-5 may facilitate legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information about longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time.

However, the use of DSM-5 should be informed by an awareness of the risks and limitations of its use in forensic settings. When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder such as intellectual disability (intellectual developmental disorder), schizophrenia, major neurocognitive disorder, gambling disorder, or pedophilic disorder does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is usually required beyond that contained in the DSM-5 diagnosis, which might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.

Use of DSM-5 to assess for the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised. Nonclinical decision makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the etiology or causes of the individual's mental disorder or the individual's degree of control over behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.

**SECTION II DSM-5 DIAGNOSTIC CRITERIA AND CODES**  
**PERSONALITY DISORDERS CHAPTER**  
**BORDERLINE PERSONALITY DISORDER**  
**Pages 663 through 666 of DSM-5**

663

**Borderline Personality Disorder**

**Diagnostic Criteria**

**01.83 (F60.3)**

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

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

**Diagnostic Features**

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

Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense

abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician's announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this "abandonment" implies they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic

664

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

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

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

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

increased responsibility. Self-mutilation may occur during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual's sense of being evil.

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

665

### **Associated Features Supporting Diagnosis**

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

## **Prevalence**

The median population prevalence of borderline personality disorder is estimated to be 1.6% Torgersen 2009 but may be as high as 5.9% Grant et al. 2008. The prevalence of borderline personality disorder is about 6% in primary care settings, about 10% among individuals seen in outpatient mental health clinics, and about 20% among psychiatric inpatients Gunderson 2011; Gunderson and Links 2008. The prevalence of borderline personality disorder may decrease in older age groups Oltmanns and Balsis 2011.

## **Development and Course**

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

## **Risk and Prognostic Factors**

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

## **Culture-Related Diagnostic Issues**

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

666

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

## **Gender-Related Diagnostic Issues**

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

## Differential Diagnosis

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

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

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

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

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

## **References**

Grant BF, Chou SP, Goldstein RB, et al: Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *J Clin Psychiatry* 69(4):533–545, 2008 18426259

Gunderson JG: Clinical practice: borderline personality disorder. *N Engl J Med* 364(21):2037–2042, 2011 21612472

Gunderson JG, Links P: *Borderline Personality Disorder: A Clinical Guide*, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2008

Oltmanns TF, Balsis S: Personality disorders in later life: questions about the measurement, course, and impact of disorders. *Annu Rev Clin Psychol* 7:321–349, 2011 21219195

Torgersen S: The nature (and nurture) of personality disorders. *Scand J Psychol* 50(6):624–632, 2009 19930262