Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition  (DSM-5 TM)
Overview
(2 CEU’s)

Course Objectives:
At the completion of this course, participants will be able to:

➢ Explain the importance of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders.

➢ Detail a brief history of the Diagnostic and Statistical Manual of Mental Disorders, as well as its usage and its significance within multiple professions.

➢ Identify the organizational and diagnostic changes within the DSM-5.

➢ Describe the DSM-5’s diagnostic changes for children.

➢ Explain the controversy about the removal of Asperger’s as a distinct classification.

➢ Discuss the ongoing debates regarding changes within the DSM-5.

DSM-5
Introduction

The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association (APA), is the classification and diagnostic tool universally recognized as an authority for psychiatric diagnoses. It is often referred to as the psychiatrist’s “Bible” and has been translated into over twenty languages worldwide. It is the source that has been widely referenced - from those in private practice to insurance companies and criminal courts (Kawa & Giordano, 2012).

The newest version, The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) was published on May 18, 2013. The DSM-5 has brought some major changes to its organization and diagnostic classifications; these changes have elicited controversy from some within the industry. The Coalition for DSM-5 Reform stated in an open letter that “the DSM–5 proposals appear to lower diagnostic thresholds, expanding the purview of mental disorder to include normative reactions to life events. Some new proposals (e.g., “Disruptive Mood Dysregulation Disorder” and “Attenuated Psychosis Syndrome”) seem to lack the empirical grounding necessary for inclusion in a scientific taxonomy.”
The letter continued that “newly proposed disorders are particularly likely to be diagnosed in vulnerable populations, such as children and the elderly, for whom the over-prescription of powerful psychiatric drugs is already a growing nationwide problem; and the increased emphasis on medico-biological theories for mental disorder despite the fact that recent research strongly points to multifactorial etiologies.”

The DSM-5 has also been criticized for removing the Asperger syndrome as a distinct classification, removing subtype classifications within different forms of schizophrenia, removing the “bereavement exclusion” for depressive disorders, revising the treatment and the naming of “gender identity disorder” to “gender dysphoria,” and dropping the A2 criterion for post-traumatic stress disorder (PTSD) because its requirement for specific emotional reactions to trauma did not apply to combat veterans and first responders with PTSD.

Among the diagnostic and content dissent about the DSM-5, discussions regarding the financial ties of its panel members to pharmaceutical companies were initiated. Sixty-nine percent of the DSM-5 task force members reported ties to the pharmaceutical industry. These ties represented a relative increase of 21 percent over the proportion of DSM-IV task force members with such ties - 57 percent of DSM-IV task force members had such ties (Crosgrove & Krimsky, 2012).

These findings prompted a 2009 response as written about in the Psychiatric Times from Nada Stotland, MD, MPH - the American Psychiatric Association’s president at the time. “We are in the midst of a revolution caused by public and legislative concern about the influence of the for-profit sector on the entire field of medicine,” said Stotland.

“We have anticipated and addressed questions about conflicts of interest in the DSM process. The abolition of conflict is a myth. . . . what we can do is to be very clear what those interests are” (Kaplan, 2009).

The following course will provide an overview of these changes in the order in which the volume was written. Additionally, this course will present a realistic view of the manual’s strengths as well as its purported weaknesses.

The DSM-5’s definition of mental disorder is essentially the same as the DSM-IV:

“A mental disorder is a condition characterized by dysfunction in thought, mood, or behaviors, which usually causes distress. The condition should not be primarily a result of social deviance or conflicts with society.”

The newest edition of the DSM presented intent to “harmonize” the World Health Organization’s (WHO) ICD-11 (International Classification of Disease) with the DSM-5, due to the fact that two classifications can complicate scientific results across countries. Two classifications can confuse collection and use of national statistics, design of clinical trials, and global applicability.
of results by regulatory organizations. In the past, the DSM-IV and ICD-10 diagnoses were not always congruent.

The ICD had generally been used for reimbursement purposes and compiling national health statistics. Historically, it contained only a brief definition of each disorder. Having similar, but separate, research criteria resulted in a major international convergence of clinical practice communication and research on mental disorders- although the seemingly slight differences in diagnostic criteria for research did produce some difference in prevalence rates and correlates of mental disorders (Regier, Kuhl & Kupfer, 2013).

According to Regier, Kuhl & Kupfer (2013), based on these experiences, the latest DSM-5 and ICD-11 development processes offered “a further opportunity to not only advance the field in terms of diagnostic utility and validity, but to also increase compatibility with ICD-11 clinical guidelines and the global psychiatric community at large.”

A Brief History

The DSM was first created to enable mental health professionals to communicate using a common diagnostic language. Its forerunner was a plan developed in 1917 by the American Medico-Psychological Association, together with the National Commission on Mental Hygiene. This was used primarily for gathering statistics across mental hospitals, and was essentially an administrative classification. It was entitled “Statistical Manual for the Use of Institutions for the Insane,” and included 22 diagnoses.

The American Medico-Psychological Association changed its name to the American Psychiatric Association (APA) in 1921. At the time, it worked with the New York Academy of Medicine to create a nationally accepted psychiatric classification. This would be incorporated within the first edition of the American Medical Association’s Standard Classified Nomenclature of Disease. This system would be designed for diagnosing in patients with severe psychiatric and neurological disorders, according to the American Psychiatric Association’s “History of the DSM.”

A broader system for classifying diagnoses was later developed by the United States Army then was modified by the Veterans Administration. It was first used to better incorporate the diagnoses of World War II servicemen and veterans.

The first edition of the DSM was published in 1952. The first version had many concepts and suggestions that would be shocking to today’s mental health professionals. For example, homosexuality was listed as a “sociopathic personality disorder,” and remained so until 1973. Autistic spectrum disorders were also thought to be a type of childhood schizophrenia.

The DSM is periodically updated because the profession’s understanding of mental health grows. In each revision, mental health conditions that are no longer considered valid are removed, while newly defined conditions are added. The DSM-II was introduced in 1968. The DSM-III,
introduced in 1980, provided “criteria sets” and operationalized diagnosis, becoming a reference guide for insurance coverage. The DSM-III-R (1987), DSM-IV (1994), and the DSM-IV-TR (2000) also emphasized empirical evidence to justify diagnosis. By design, the DSM is primarily concerned with the signs and the symptoms of mental disorders, rather than the underlying causes of these disorders.

The updates from the third edition on have mainly been concerned with diagnostic reliability, or the degree to which different diagnosticians agree on a diagnosis. It has been argued that “a science of psychiatry can only advance if diagnosis is reliable. If clinicians and researchers frequently disagree about a diagnosis with a patient, then research into the causes and effective treatments of those disorders cannot advance (Fadul, 2014).

The DSM-IV had some drawbacks. For example, it:

- Promoted increase use of NOS, or not-other-wise specified disorders, when there are no criteria for this category.
- There were many comorbidities.
- There were more discrete categories as opposed to spectrum disorders.

The New DSM-5 Organizing System

The organization in the new DSM-5 differs from DSM-IV in order to correspond more closely to the ICD and to reflect a developmental perspective. The coordination most closely resembles the ICD-11 which is proposed to be published in a few years, although the actual time remains uncertain. The new organization reflects:

1. Developmental perspective in each category of disorder.
2. Clustering of disorders into internalizing and externalizing. (Research indicates that each of these two clusters reflect genetic and environmental risk factors.

The DSM-5 is divided into three sections:

- **Section I** - Introduction and Instructions. Section I of DSM-5 contains a description of changes pertaining to the chapter organization in DSM-5, the multiaxial system, and the introduction of dimensional assessments (in Section III). In addition, the phrase “general medical condition” is replaced in DSM-5 with “another medical condition” where relevant across all disorders.

- **Section II** - Mental Health Disorders.

- **Section III** - Other Conditions that require further research, cultural considerations, and dimensional scales. It includes cross-cutting assessment, scales, psychosis symptom severity, WHO or World Health Organization Disability Assessment Schedule, Cultural
formulations that include an interview guide, notes on mental illness, and conditions for further study.

The DSM-5 organization parallels ICD-11 and reflects a developmental perspective. It also clusters disorders into:

- Internalizing – anxiety, depression, somatic symptoms.
- Externalizing – impulsive, disruptive, substance related.

**Major Changes in the DSM-5**

Major changes in the new DSM-5 manual include:

1. Merging or renaming various diagnoses.
2. Some disorders now have a dimensional scale, spanning a spectrum from typical to pathological. Some scales cut across diagnosis. For example:

**Severity Scales**

The following diagnoses have severity scales:

- Intellectual Disability
- Autism Spectrum
- ADHD
- Specific Learning Disorder
- Stereotypic Movement Disorder
- Psychotic Disorders (in Section III)
- Bipolar Disorder
- Major Depression, Persistent Depressive Disorder
- Attachment Disorders
- Somatic Symptom Disorder
- Anorexia, Bulimia, Binge Eating
- Various Sleep Disorders
- Various Sexual Dysfunctions
- Oppositional Defiant Disorder
- Conduct Disorder
- Substance Use Disorders
- Neurocognitive Disorders

**Cross-Cutting Assessments**

An optional Cross-cutting Symptom Measure in Section III looks at:

- Depression
- Anger
- Mania
- Anxiety
- Somatic symptoms
- Suicidal ideation
- Psychosis
- Sleep problems
- Memory
- Repetitive thoughts and behaviors
- Dissociation
- Personality functioning
- Substance use

**Additional Cross-Cutting**

Many specifiers use symptoms in a cross-cutting way and include:

- Panic attacks
- Anxious distress
- Mixed features for all mood disorders

**Suicide**

There are 22 disorders in DSM-5 that have a suicide risk comment section. In Section III suicidal ideation is listed in the Optional Cross-cutting Symptom Measure.
Back to DSM-IV Changes…….

Changes are further identified here.

3. Axial System

The Axial system has changed due to the fact that Disorders are no longer clustered as major mental illnesses, personality disorders, and medical problems related to mental illness. – (Axis I, Axis II, Axis III, Axis IV, Axis V)

☐ Axis I, II, III Disorders are listed as independent diagnosis.

☐ Axis IV – psychological, environmental problems are listed as ICD-9 V codes.

☐ Axis V(GAF) will no longer be used since there are severity scales for each diagnosis.

For Example: The newer system would look something like this:

Major Depression
Alcohol Use - Severe
Antisocial Personality Disorder
Cirrhosis
Relationship (V-61.10)

No GAF

NOS

Instead of NOS, mental health professionals are asked to:

☐ Indicate the disorder as mild on a severity scale.

☐ Use the classification “Other Specified” and explain what is it that keeps the client from meeting standard criteria. For example, short episodes, insufficient symptoms, etc.

☐ Use the classification “Unspecified” if the clinician chooses not to specify the reason that the diagnosis cannot be made. For example, there may be insufficient information. No reason need be given.

WHODAS

A self-administered World Health Organization Disability Assessment Schedule, Version 2, (WHODAS) is provided in Section III in order to capture the degree of disability. Instructions for using this measure are given.

4. Asperger’s Syndrome
The diagnosis of Asperger’s syndrome has been removed from the DSM-5 and is now part of one umbrella, "Autism Spectrum Disorder". This is controversial because, according to the ICD-10, those suffering from Asperger’s syndrome have “no general delay or retardation in language or in cognitive development”.

5. **DMDD**

Disruptive mood dysregulation disorder (DMDD) is defined by DSM-5 as severe and recurrent temper outbursts (three or more times a week). Critics say that this is grossly out of proportion in intensity or duration in children up to the age of 18. Critics point out that this diagnosis may “exacerbate, not relieve, the already excessive and inappropriate use of medication in young children.”

6. **MCD**

Mild cognitive disorder (MCD) is defined as “a level of cognitive decline that requires compensatory strategies to help maintain independence and perform activities of daily living.” The DSM-5 is clear that this decline goes beyond that usually associated with ageing. Despite this, the concept of mild cognitive disorder has been criticized. The main criticism is that there is little in the way of effective treatment for MCD, but if people are diagnosed with the condition it may cause needless stress and anxiety.

7. **GAD**

The “diagnostic threshold" for Generalized anxiety disorder (GAD) was lowered in the new version. In previous versions, GAD was defined as having any three of six symptoms (such as restlessness, a sense of dread, and feeling constantly on edge) for at least three months. In DSM-5, this has been revised to having just one to four symptoms for at least one month.

8. **MDD**

With Major depressive disorder (MDD), previous definitions described MDD as a persistent low mood, loss of enjoyment and pleasure, and a disruption to everyday activity. However, these definitions also specifically excluded a diagnosis of MDD if the person was recently bereaved. This exception has been removed in DSM-5.

9. ‘Dependence’ to ‘addiction,’ cannabis withdrawal and gambling disorders

The DSM’s chapter on substance abuse is now called the Substance Use Disorders chapter. The diagnostic criteria for these conditions have been expanded, but one of the biggest changes deals with the swapping of two seemingly similar words when describing these disorders: the term “dependence” is out and the term “addiction” is in. For example, patients being prescribed pain medication may become addicted to the drug, but they are still taking the medication under the guidance of a physician. They aren’t necessarily seeking out the medication by themselves, but if they are taken off the drug they may still
have psychological withdrawal. In this case, they aren’t dependent on the drug, but they are addicted - according to the new guidelines.

New categories of gambling disorders and cannabis withdrawal have been created in the DSM-5. Research discloses there are more people that meet the criteria for abuse of cannabis than any other illicit drug.

Similar to the changes made to the autism spectrum disorders, substance use disorders will also be categorized more on a sliding scale, depending on the severity of each person’s symptoms.

10. PTSD
DSM-5 also refines the criteria for post-traumatic stress disorders (PTSD), including a subtype for PTSD in preschool children. (The diagnosis for attention deficit hyperactivity disorder also eliminates previously required symptom and the changing of the required age of onset from age 7 to age 12.)

11. OCD
Obsessive compulsive disorder (OCD), once categorized under anxiety disorders, is now getting its own category of Obsessive-compulsive and related disorders. Along with OCD, this category includes Body Dysmorphic Disorder (BDD), Trichotillomania (TTM, or hair pulling) and a brand new disorder called Hoarding Disorder.

Diagnostic Changes
Changes made to the DSM-5 diagnostic criteria and texts are described further, in the same order in which they appear in the manual.

Neurodevelopmental Disorders

- Intellectual Disability (Intellectual Developmental Disorder)
  Diagnostic criteria for intellectual disability (intellectual developmental disorder) stress the need for an assessment of both cognitive capacity (IQ) and adaptive functioning. Severity is determined by adaptive functioning rather than IQ score.

  *Intellectual disability* replaces the term “mental retardation with intellectual disability” with a severity scale to reflect function, not IQ... The term *intellectual developmental disorder* was placed in parentheses to reflect the World Health Organization’s classification system, which lists “disorders” in the International Classification of Diseases (ICD) and bases all “disabilities” on the International Classification of Functioning, Disability, and Health (ICF).
Communication Disorders
The DSM-5 communication disorders include language disorder (which combines DSM-IV expressive and mixed receptive-expressive language disorders), speech sound disorder (a new name for phonological disorder), and childhood-onset fluency disorder (a new name for stuttering). Also included is social (pragmatic) communication disorder, a new condition for persistent difficulties in the social uses of verbal and nonverbal communication. Social (pragmatic) communication disorder cannot be diagnosed in the presence of restricted repetitive behaviors, interests, and activities (the other component of ASD). The symptoms of some persons diagnosed with DSM-IV pervasive developmental disorder not otherwise specified may meet the DSM-5 criteria for social communication disorder.

Autism Spectrum Disorder (ASD)
Autism spectrum disorder is a new DSM-5 name. ASD now encompasses the previous DSM-IV autistic disorder (autism), Asperger’s disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. A large controversy has surrounded this decision and will further be explained later in this course. However some of the comments have to do with:
1. Some persons fear that Asperger’s will not meet the criteria for ASD and they will lose benefits such as education, treatment, etc.
2. Some persons with Asperger’s do not want to be seen in the same light or category as people with autism.
3. Many mental health professionals believe that Asperger’s is different as an illness than autism.

DSM-IV Asperger’s Disorder included:
1. Impairment in social interaction (2 of the following): nonverbal behaviors, no peer relationships, lack of shared activities, lack of social reciprocity.
2. No delay in language.
3. No cognitive delay.
4. Repetitive activities of behavior (1 of the following): pattern of activity, rituals, motor mannerisms, fixation on parts of objects.

Autism Spectrum Disorders (symptoms present in early childhood, 3 levels of severity). Deficits in communication and interaction – include reciprocity, nonverbal interaction, having relationships; repetitive and/or restrictive behaviors; and expanded list of specifiers (for example- intellectual, language impairment, catatonic).

Attention-Deficit/Hyperactivity Disorder
The diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD) in DSM-5 are similar to those in DSM-IV. The same 18 symptoms are used as in DSM-IV, and continue to be divided into two symptom domains (inattention and
hyperactivity/impulsivity), of which at least six symptoms in one domain are required for diagnosis.

In addition:
1. Examples have been added to the criterion items to facilitate application across the life span.
2. The cross-situational requirement has been strengthened to “several” symptoms in each setting.
3. The onset criterion has been changed from “symptoms that caused impairment were present before age 7 years” to “several inattentive or hyperactive-impulsive symptoms were present prior to age 12”.
4. Subtypes have been replaced with presentation specifiers that map directly to the prior subtypes.
5. A comorbid diagnosis with autism spectrum disorder is now allowed.
6. A symptom threshold change has been made for adults, to reflect substantial evidence of clinically significant ADHD impairment, with the cutoff for ADHD of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity.

ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the DSM-5 decision to eliminate the DSM-IV chapter that includes all diagnoses usually first made in infancy, childhood, or adolescence.

- **Specific Learning Disorder**
  Specific learning disorder combines the DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified. Because learning deficits in the areas of reading, written expression, and mathematics commonly occur together, coded specifiers for the deficit types in each area are included. The DSM-5 recognizes that specific types of reading deficits are described internationally in different ways such as dyslexia and specific types of mathematics deficits as dyscalculia.

- **Motor Disorders**
  The following motor disorders are included in the DSM-5 neurodevelopmental disorders chapter:
  1. Developmental coordination disorder, stereotypic movement disorder.
2. Tourette’s disorder, persistent (chronic) motor or vocal tic disorder.
3. Provisional tic disorder, other specified tic disorder, and unspecified tic disorder.

The tic criteria have been standardized across all of these disorders in this chapter. Stereotypic movement disorder has been more clearly differentiated from body-focused repetitive behavior disorders that are in the DSM-5 obsessive-compulsive disorder chapter.

**Schizophrenia Spectrum and Other Psychotic Disorders**

- **Schizophrenia**
  Two changes were made to DSM-IV Criterion A for schizophrenia. The first change is the elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing). In DSM-IV, only one symptom was needed to meet the diagnostic requirement for Criterion A, instead of two of the other listed symptoms. This special attribution was removed. Within the DSM-5, two Criterion A symptoms are required for any diagnosis of schizophrenia. The second change is the addition of a requirement in Criterion A that the individual must have at least one of these three symptoms:
  1. Delusions.
  2. Hallucinations.
  3. Disorganized speech.

At least one of these core “positive symptoms” is necessary for a reliable diagnosis of schizophrenia.

- **Schizophrenia subtypes**
  The DSM-IV subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) are eliminated. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia is included in Section III.

- **Schizoaffective Disorder**
  The primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder’s total duration after Criterion A has been met.

- **Delusional Disorder**
  Criterion A for delusional disorder no longer has the requirement that the delusions must be non-bizarre. A specifier for bizarre type delusions provides continuity with DSM-IV. A new exclusion criterion, states that the symptoms must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs.
DSM-5 no longer separates delusional disorder from shared delusional disorder. If criteria are met for delusional disorder then that diagnosis is made. If the diagnosis cannot be made but shared beliefs are present, then the diagnosis “other specified schizophrenia spectrum and other psychotic disorder” is used.

## Catatonia
The same criteria are used to diagnose catatonia whether the context is a psychotic, bipolar, depressive, or other medical disorder, or an unidentified medical condition. In DSM-5, all contexts require three catatonic symptoms (from a total of 12 characteristic symptoms). In DSM-5, catatonia may be diagnosed as a specifier for depressive, bipolar, and psychotic disorders; as a separate diagnosis in the context of another medical condition; or as another specified diagnosis.

### Bipolar and Related Disorders

#### Bipolar Disorders
Criterion A for manic and hypomanic episodes now includes an emphasis on changes in activity and energy as well as mood. The DSM-IV diagnosis of bipolar I disorder, mixed episode, requiring that the individual simultaneously meet full criteria for both mania and major depressive episode, has been removed. A new specifier, “with mixed features,” has been added that can be applied to episodes of mania or hypomania when depressive features are present and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present.

#### Other Specified Bipolar and Related Disorder
DSM-5 allows the specification of particular conditions for other specified bipolar and related disorder, including categorization for individuals with a past history of a major depressive disorder who meet all criteria for hypomania except the duration criterion (i.e., at least 4 consecutive days).

#### Anxious Distress Specifier
In the chapter on bipolar and related disorders and the chapter on depressive disorders, a specifier for anxious distress is delineated. This specifier is intended to identify patients with anxiety symptoms that are not part of the bipolar diagnostic criteria.

### Depressive Disorders

DSM-5 contains several new depressive disorders, including disruptive mood dysregulation disorder and premenstrual dysphoric disorder. A new diagnosis, disruptive mood dysregulation...
disorder, is included for children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol.

Premenstrual dysphoric disorder has been moved to the main body of DSM-5. In addition, what was referred to as dysthymia in DSM-IV is now under the category of persistent depressive disorder, which includes both chronic major depressive disorder and the previous dysthymic disorder.

- **Major Depressive Disorder**
  Neither the core criterion symptoms applied to the diagnosis of major depressive episode nor the requisite duration of at least 2 weeks has changed from DSM-IV. Criterion A for a major depressive episode in DSM-5 is identical to that of DSM-IV, in addition to the requirement for clinically significant distress or impairment in social, occupational, or other important areas of life, although this is now listed as Criterion B rather than Criterion C.

  The coexistence within a major depressive episode of at least three manic symptoms (insufficient to satisfy criteria for a manic episode) is now acknowledged by the specifier “with mixed features.” The presence of mixed features in an episode of major depressive disorder increases the likelihood that the illness exists in a bipolar spectrum; however, if the individual has never met criteria for a manic or hypomaniac episode, the diagnosis of major depressive disorder is retained.

- **Bereavement Exclusion**
  In DSM-IV, there was an exclusion criterion for a major depressive episode that was applied to depressive symptoms lasting less than 2 months following the death of a loved one (i.e., the bereavement exclusion). This exclusion is omitted in DSM-5.

**Specifiers for Depressive Disorders**

The clinician is given guidance on assessment of suicidal thinking, plans, and the presence of other risk factors in order to make a determination of the prominence of suicide prevention in treatment planning for a given individual. A new specifier to indicate the presence of mixed symptoms has been added across both the bipolar and the depressive disorders, allowing for the possibility of manic features in individuals with a diagnosis of unipolar depression. The “with anxious distress” specifier gives the clinician an opportunity to rate the severity of anxious distress in all individuals with bipolar or depressive disorders.

**Anxiety Disorders**

The DSM-5 chapter on anxiety disorder no longer includes obsessive-compulsive disorder (which is included with the obsessive-compulsive and related disorders) or posttraumatic stress
disorder and acute stress disorder (which is included with the trauma and stressor-related disorders).

- **Agoraphobia, Specific Phobia, and Social Anxiety Disorder (Social Phobia)**
  Changes in criteria for agoraphobia, specific phobia, and social anxiety disorder (social phobia) include deletion of the requirement that individuals over age 18 years recognize that their anxiety is excessive or unreasonable. The anxiety must be out of proportion to the actual danger or threat in the situation, after taking cultural contextual factors into account. In addition, the 6-month duration, which was limited to individuals under age 18 in DSM-IV, is now extended to all ages. This change is intended to minimize over-diagnosis of transient fears.

- **Panic Attack**
  The essential features of panic attacks remain unchanged. Panic attack can be listed as a specifier that is applicable to all DSM-5 disorders.

- **Panic Disorder and Agoraphobia**
  Panic disorder and agoraphobia are unlinked in DSM-5. The former DSM-IV diagnoses of panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder are now replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria. The co-occurrence of panic disorder and agoraphobia is now coded with two diagnoses. The endorsement of fears from two or more agoraphobia situations is now required, because this is a means for distinguishing agoraphobia from specific phobias. The criteria for agoraphobia are extended to be consistent with criteria sets for other anxiety disorders.

- **Specific Phobia**
  Core features of specific phobia remain the same, but there is no longer a requirement that individuals over age 18 years must recognize that their fear and anxiety are excessive or unreasonable, and the duration requirement (“typically lasting for 6 months or more”) now applies to all ages. Although they are now referred to as specifiers, the different types of specific phobia have essentially remained unchanged.

- **Social Anxiety Disorder (Social Phobia)**
  The essential features of social anxiety disorder (social phobia) (formerly called social phobia) are the same. However, a number of changes have been made, including deletion of the requirement that individuals over age 18 years must recognize that their fear or anxiety is excessive or unreasonable, and duration criterion of “typically lasting for 6 months or more” is now required for all ages. Another change is that the “generalized” specifier has been deleted and replaced with a “performance only” specifier.
Separation Anxiety Disorder
Separation anxiety disorder is now classified as an anxiety disorder. The core features remain mostly unchanged, although the wording of the criteria has been modified to more adequately represent the expression of separation anxiety symptoms in adulthood. For example, attachment figures may include the children of adults with separation anxiety disorder, and avoidance behaviors may occur in the workplace as well as at school. Also, the diagnostic criteria no longer specify that age at onset must be before 18 years. Also, a duration criterion—“typically lasting for 6 months or more”—has been added for adults to minimize over-diagnosis of transient fears.

Selective Mutism
In DSM-IV, selective mutism was classified in the section “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.” It is now classified as an anxiety disorder, given that a large majority of children with selective mutism are anxious. The diagnostic criteria are largely unchanged.

Obsessive-Compulsive and Related Disorders
The chapter on obsessive-compulsive and related disorders is new in DSM-5. New disorders include hoarding disorder, excoriation (skin-picking) disorder, substance-/medication-induced obsessive-compulsive and related disorder, and obsessive-compulsive and related disorder due to another medical condition. The DSM-IV diagnosis of trichotillomania is now termed trichotillomania (hair-pulling disorder) and has been moved from a DSM-IV classification of impulse-control disorders not elsewhere classified to obsessive-compulsive and related disorders in DSM-5.

Specifiers for Obsessive-Compulsive and Related Disorders
The “with poor insight” specifier for obsessive-compulsive disorder has been refined in DSM-5 to allow for a distinction between individuals with good or fair insight, poor insight, and “absent insight/delusional” obsessive-compulsive disorder beliefs.

Similar to “insight” specifiers have been included for body dysmorphic disorder and hoarding disorder. The change emphasizes that the presence of absent insight/delusional beliefs; a diagnosis of the relevant obsessive-compulsive or related disorder, rather than a schizophrenia spectrum and other psychotic disorder.

The “tic-related” specifier for obsessive-compulsive disorder reflects a growing literature on the diagnostic validity and clinical utility of identifying individuals with a current or past comorbid tic disorder.
Body Dysmorphic Disorder
For DSM-5 body dysmorphic disorder, a diagnostic criterion describing repetitive behaviors or mental acts in response to preoccupations with perceived defects or flaws in physical appearance has been added. A “with muscle dysmorphia” specifier has been added. The delusional variant of body dysmorphic disorder (which identifies individuals who are completely convinced that their perceived defects or flaws are truly abnormal appearing) is no longer coded as both delusional disorder, somatic type, and body dysmorphic disorder; in DSM-5 this is designated only as body dysmorphic disorder with the absent insight/delusional beliefs specifier.

Hoarding Disorder
Hoarding disorder is a new diagnosis in DSM-5. Hoarding disorder reflects persistent difficulty discarding or parting with possessions due to a perceived need to save the items and distress associated with discarding them.

Trichotillomania (Hair-Pulling Disorder)
Trichotillomania was included in DSM-IV, although “hair-pulling disorder” has been added parenthetically to the disorder’s name in DSM-5.

Excoriation (Skin-Picking) Disorder
Excoriation (skin-picking) disorder is newly added to DSM-5.

Substance/Medication-Induced Obsessive-Compulsive and Related Disorder and Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
DSM-IV included a specifier “with obsessive-compulsive symptoms” in the diagnoses of anxiety disorders due to a general medical condition and substance-induced anxiety disorders. Because obsessive-compulsive and related disorders are now a distinct category, DSM-5 includes new categories for substance-/medication-induced obsessive-compulsive and related disorder and for obsessive-compulsive and related disorder due to another medical condition. Substances, medications, and medical conditions can be present with symptoms similar to primary obsessive-compulsive and related disorders.

Other Specified and Unspecified Obsessive-Compulsive and Related Disorders
DSM-5 includes the diagnoses other specified obsessive-compulsive and related disorder, which can include conditions such as body-focused repetitive behavior disorder and obsessional jealousy, or unspecified obsessive-compulsive and related disorder.

Body-focused repetitive behavior disorder is characterized by recurrent behaviors other than hair pulling and skin picking (e.g., nail biting, lip biting, cheek chewing) and repeated attempts to decrease or stop the behaviors. Obsessional jealousy is characterized by non-delusional preoccupation with a partner’s perceived infidelity.
Trauma- and Stressor-Related Disorders

Acute Stress Disorder

The stressor criterion (Criterion A) for acute stress disorder is changed from DSM-IV. The criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly. The DSM-IV Criterion A2 regarding the subjective reaction to the traumatic event (e.g., “the person’s response involved intense fear, helplessness, or horror”) has been eliminated. Individuals may meet diagnostic criteria in DSM-5 for acute stress disorder if they exhibit any 9 of 14 listed symptoms in these categories: intrusion, negative mood, dissociation, avoidance, and arousal.

□ Adjustment Disorders

In DSM-5, adjustment disorders are re-conceptualized as a heterogeneous array of stress-response syndromes that occur after exposure to a distressing (traumatic or non-traumatic) event, rather than as a residual category for individuals who exhibit clinically significant distress without meeting criteria for a more discrete disorder (as in DSM-IV). DSM-IV subtypes marked by depressed mood, anxious symptoms, or disturbances in conduct are unchanged.

□ Post-traumatic Stress Disorder

DSM-5 criteria for posttraumatic stress disorder have changed. For example:

1. Trauma does not include witnessing events on TV or other electronic media.

2. Where there were three major symptom clusters in DSM-IV—re-experiencing, avoidance/numbing, and arousal—there are now four symptom clusters in DSM-5, because the avoidance/numbing cluster is divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood. This latter category, which retains most of the DSM-IV numbing symptoms, also includes new or re-conceptualized symptoms, such as persistent negative emotional states.

3. The cluster alterations in arousal and reactivity retains most of the DSM-IV arousal symptoms. It also includes irritable or aggressive behavior and reckless or self-destructive behavior.

4. Diagnostic thresholds have been lowered for children and adolescents. In addition, separate criteria have been added for children age 6 years or younger.

5. PTSD no longer requires that an individual have a subjective experience of fear or horror.
6. There is no distinction between acute and chronic symptoms.

According to Dr. David Mays, significant research has indicated that PTSD is not a fear and anxiety-based disorder. PTSD is one of a range of disorders that surface in response to traumatic events. The disorders are characterized by symptoms of avoidance and negative alterations of mood, not fear. They are more than simply anxiety disorders.

- **Reactive Attachment Disorder**
  The DSM-IV childhood diagnosis reactive attachment disorder had two subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. In DSM-5, these subtypes are defined as distinct disorders: reactive attachment disorder of infancy and disinhibited social engagement disorder. Both of these disorders are the result of social neglect or other situations that limit a young child’s opportunity to form selective attachments.

  The two disorders differ in important ways. Because of dampened positive affect, reactive attachment disorder more closely resembles internalizing disorders; it is equivalent to a lack of or incompletely formed preferred attachments to caregiving adults. In contrast, disinhibited social engagement disorder more closely resembles ADHD; it may occur in children who do not necessarily lack attachments and may have established or even secure attachments. The two disorders differ in other ways, including correlates, course, and response to intervention.

**Dissociative Disorders**

Major changes in dissociative disorders in DSM-5 include the following:

1. Derealization is included in the name and symptom structure of what previously was called depersonalization disorder and is now called *depersonalization/derealization disorder*.
2. Dissociative fugue is now a specifier of dissociative amnesia rather than a separate diagnosis.
3. The criteria for dissociative identity disorder have been changed to indicate that symptoms of disruption of identity may be reported as well as observed, and that gaps in the recall of events may occur for everyday and not just traumatic events. Also, experiences of pathological possession in some cultures are included in the description of identity disruption.

**Dissociative Identity Disorder**

Changes to the criteria for dissociative identity disorder include:
1. Criterion A has been expanded to include certain possession-form phenomena and functional neurological symptoms to account for more diverse presentations of the disorder.

2. Criterion A now specifically states that transitions in identity may be observable by others or self-reported.

3. According to Criterion B, individuals with dissociative identity disorder may have recurrent gaps in recall for everyday events, not just for traumatic experiences.

4. Other text modifications clarify the nature and course of identity disruptions.

**Somatic Symptom and Related Disorders**

In DSM-5, somatoform disorders are now referred to as somatic symptom and related disorders. These disorders are primarily seen in medical settings. The DSM-5 classification reduces the number of these disorders and subcategories to avoid overlap. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed.

- **Somatic Symptom Disorder**
  Individuals with somatic symptoms plus abnormal thoughts, feelings, and behaviors *may or may not* have a diagnosed medical condition. The relationship between somatic symptoms and psychopathology exists along a spectrum. Persons previously diagnosed with somatization disorder can meet DSM-5 criteria for somatic symptom disorder, but only if they have the maladaptive thoughts, feelings, and behaviors that define the disorder, in addition to their somatic symptoms.

  Somatization disorder and undifferentiated somatoform disorder are merged in DSM-5 under somatic symptom disorder, and no specific number of somatic symptoms is required.

- **Medically Unexplained Symptoms**
  The DSM-5 classification defines disorders on the basis of positive symptoms (i.e., distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms). Medically unexplained symptoms do remain an important feature in conversion disorder and pseudocyesis.

- **Hypochondriasis and Illness Anxiety Disorder**
Hypochondriasis has been eliminated as a disorder. Most individuals who would previously have been diagnosed with hypochondriasis have significant somatic symptoms in addition to high health anxiety, and now receive a DSM-5 diagnosis of somatic symptom disorder. In DSM-5, individuals with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder).

- **Pain Disorder**
  Most individuals with chronic pain attribute their pain to a combination of factors, including somatic, psychological, and environmental influences. In DSM-5, some individuals with chronic pain would be diagnosed as having somatic symptom disorder, with predominant pain. For others, psychological factors affecting other medical conditions or an adjustment disorder is more appropriate.

- **Psychological Factors Affecting Other Medical Conditions and Factitious Disorder**
  Psychological factors affecting other medical conditions is a new mental disorder in DSM-5. This disorder and factitious disorder are placed among the somatic symptom and related disorders.

- **Conversion Disorder (Functional Neurological Symptom Disorder)**
  Criteria for conversion disorder (functional neurological symptom disorder) are modified to emphasize the importance of the neurological examination, and awareness that relevant psychological factors may not be transparent at the time of diagnosis.

**Feeding and Eating Disorders**

In DSM-5, the feeding and eating disorders include several disorders included in DSM-IV as feeding and eating disorders of infancy or early childhood in the chapter “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.”

- **Pica and Rumination Disorder**
  The DSM-IV criteria for pica and for rumination disorder have been revised to say that the diagnoses can be made for individuals of any age.

- **Avoidant/Restrictive Food Intake Disorder**
  DSM-IV feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder, and the criteria have been significantly expanded. Avoidant/restrictive food intake disorder is a broad category intended to
capture a range of presentations.

- **Anorexia Nervosa**
  The core diagnostic criteria for anorexia nervosa are conceptually unchanged from DSM-IV with one exception: the requirement for amenorrhea has been eliminated. As in DSM-IV, individuals with this disorder are required by Criterion A to be at a significantly low body weight for their developmental stage. In DSM-5, Criterion B is expanded to include not only overtly expressed fear of weight gain but also persistent behavior that interferes with weight gain.

- **Bulimia Nervosa**
  The only change to the DSM-IV criteria for bulimia nervosa is a reduction in the required minimum average frequency of binge eating and inappropriate compensatory behavior frequency from twice to once weekly.

- **Binge-Eating Disorder**
  DSM-IV criteria is that the minimum average frequency of binge eating required for diagnosis has been changed from at least twice weekly for 6 months to at least once weekly over the last 3 months, which is identical to the DSM-5 frequency criterion for bulimia nervosa.

**Elimination Disorders**

No major changes have been made to the elimination disorders diagnostic class. The disorders in this chapter were previously classified under disorders usually first diagnosed in infancy, childhood, or adolescence in DSM-IV and exist now as an independent classification in DSM-5.

**Sleep-Wake Disorders**

Because the DSM-5 mandate for concurrent specification of coexisting conditions (medical and mental), sleep disorders related to another mental disorder and sleep disorder related to a general medical condition have been removed from DSM-5, and greater specification of coexisting conditions is provided for each sleep-wake disorder.

The diagnosis of primary insomnia has been renamed insomnia disorder. DSM-5 also distinguishes narcolepsy, which is now known to be associated with hypocretin deficiency, from other forms of hypersomnolence. The developmental perspective encompasses age-dependent variations.
Breathing-Related Sleep Disorders
In DSM-5, breathing-related sleep disorders are divided into three relatively distinct disorders:
1. Obstructive sleep apnea hypopnea.
2. Central sleep apnea.
3. Sleep-related hypoventilation.

Circadian Rhythm Sleep-Wake Disorders
The subtypes of circadian rhythm sleep-wake disorders have been expanded to include advanced sleep phase syndrome, irregular sleep-wake type, and non-24-hour sleep-wake type, whereas the jet lag type has been removed.

Rapid Eye Movement Sleep Behavior Disorder and Restless Legs Syndrome
The use of DSM-IV “not otherwise specified” diagnoses has been reduced by designating rapid eye movement sleep behavior disorder and restless legs syndrome as independent disorders.

Sexual Dysfunctions
In DSM-5, gender-specific sexual dysfunctions have been added, and, for females, sexual desire and arousal disorders have been combined into one disorder: female sexual interest/arousal disorder. All of the DSM-5 sexual dysfunctions (except substance-/medication-induced sexual dysfunction) now require a minimum duration of approximately 6 months and more precise severity criteria.

New Categories
Genito-Pelvic Pain/Penetration Disorder
Genito-pelvic pain/penetration disorder is new in DSM-5 and represents a merging of the DSM-IV categories of vaginismus and dyspareunia, which were highly comorbid and difficult to distinguish. The diagnosis of sexual aversion disorder has been removed.

Delayed Ejaculation – Male orgasmic disorder
Female Sexual Interest/Arousal Disorder – Hypoactive sexual desire disorder- Female sexual arousal disorder
Male Hypoactive Sexual Desire Disorder – Hypoactive sexual disorder.
Premature (early) Ejaculation

Subtypes
DSM-5 includes only lifelong versus acquired and generalized versus situational subtypes. Sexual dysfunction due to a general medical condition and the subtype have been deleted To indicate the presence and degree of medical and other nonmedical correlates, the following associated features are described in the accompanying text:
partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, and medical factors.

**Gender Dysphoria**

Gender dysphoria is a new diagnostic class in DSM-5 reflecting a change in conceptualization of the disorder’s defining features by emphasizing the phenomenon of “gender incongruence” rather than cross-gender identification per se.

Separate criteria sets are provided for gender dysphoria in children and in adolescents and adults. The adolescent and adult criteria include a more detailed and specific set of polythetic symptoms. The previous Criterion A (cross-gender identification) and Criterion B (aversion toward one’s gender) have been merged.

In the wording of the criteria, “the other sex” is replaced by “some alternative gender.” Gender instead of sex is used systematically because the concept “sex” is inadequate when referring to individuals with a disorder of sex development.

In the child criteria, “strong desire to be of the other gender” replaces the previous “repeatedly stated desire” to capture the situation of some children who, in a coercive environment, may not verbalize the desire to be of another gender. For children, Criterion A1 (“a strong desire to be of the other gender or an insistence that he or she is the other gender . . .”) is now necessary (but not sufficient), which makes the diagnosis more restrictive and conservative.

- **Subtypes and Specifiers**
  The subtyping on the basis of sexual orientation has been removed. A post-transition specifier has been added.

**Disruptive, Impulse-Control, and Conduct Disorders**

The chapter on disruptive, impulse-control, and conduct disorders is new to DSM-5. It merges disorders that were previously included in the chapter “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence” (i.e., oppositional defiant disorder; conduct disorder; and disruptive behavior disorder not otherwise specified, now categorized as other specified and unspecified disruptive, impulse-control, and conduct disorders) and the chapter “Impulse-Control Disorders Not Otherwise Specified” (i.e., intermittent explosive disorder, pyromania, and kleptomania). Because of its close association with conduct disorder, antisocial personality disorder has dual listing in both this chapter and in the chapter on personality disorders.

- **Oppositional Defiant Disorder**
  Four changes have been made to the criteria for oppositional defiant disorder.
1. Symptoms are now grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness.

2. The exclusion criterion for conduct disorder has been removed.

3. A note has been added to the criteria to provide guidance on the frequency typically needed for a behavior to be considered symptomatic of the disorder.

4. A severity rating has been added to the criteria.

☐ **Conduct Disorder**

The criteria for conduct disorder are largely unchanged from DSM-IV. A descriptive features specifier has been added for individuals who meet full criteria for the disorder but also present with limited prosocial emotions. This specifier applies to those with conduct disorder who show a callous and unemotional interpersonal style across multiple settings and relationships.

☐ **Intermittent Explosive Disorder**

A major change in DSM-5 intermittent explosive disorder is the type of aggressive outbursts that should be considered. Physical aggression was required in DSM-IV, whereas verbal aggression and nondestructive/non-injurious physical aggression also meet criteria in DSM-5. DSM-5 provides more specific criteria defining frequency needed to meet criteria and specifies that the aggressive outbursts are impulsive and/or anger based in nature, and must cause marked distress, cause impairment in occupational or interpersonal functioning, or be associated with negative financial or legal consequences.

A minimum age of 6 years (or equivalent developmental level) is now required. Finally, especially for youth, the relationship of this disorder to other disorders (e.g., ADHD, disruptive mood dysregulation disorder) has been further clarified.

**Substance-Related and Addictive Disorders**

☐ **Gambling Disorder**

The substance-related disorders chapter has been expanded to include gambling disorder.

☐ **Criteria and Terminology**

DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Criteria are provided for substance use disorder, accompanied by criteria for
Neurocognitive environment without disorder has criteria Severity

The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5, and a new criterion, craving or a strong desire or urge to use a substance, has been added. The threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria, in contrast to a threshold of one or more criteria for a diagnosis of DSM-IV substance abuse and three or more for DSM-IV substance dependence.

Cannabis withdrawal is new for DSM-5, as is caffeine. The criteria for DSM-5 tobacco use disorder are the same as those for other substance use disorders. The criteria in DSM-5 that are from DSM-IV abuse are new for tobacco in DSM-5.

Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed: 2–3 criteria indicate a mild disorder; 4–5 criteria, a moderate disorder; and 6 or more, a severe disorder. The DSM-IV specifier for a physiological subtype has been eliminated in DSM-5, as has the DSM-IV diagnosis of polysubstance dependence. Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without criteria (except craving). Additional new DSM-5 specifiers include “in a controlled environment” and “on maintenance therapy” as warranted.

Neurocognitive Disorders

- **Delirium**
  The criteria for delirium have been updated and clarified on the basis of currently available evidence.

- **Major and Mild Neurocognitive Disorder**
  The DSM-IV diagnoses of dementia and amnestic disorder are subsumed under the newly named entity major neurocognitive disorder (NCD). The term dementia is not precluded from use in the etiological subtypes where that term is standard. DSM-5 now recognizes a less severe level of cognitive impairment, mild NCD, which is a new disorder that permits the diagnosis of less disabling syndromes. Diagnostic criteria are provided for both major NCD and mild NCD, followed by diagnostic criteria for the different etiological subtypes. An updated listing of neurocognitive domains is also provided in DSM-5. Although the threshold between mild NCD and major NCD is inherently
arbitrary, there are important reasons to consider these two levels of impairment separately.

- **Etiological Subtypes**
  In DSM-5, major or mild vascular NCD and major or mild NCD due to Alzheimer’s disease have been retained, whereas new separate criteria are now presented for major or mild NCD due to frontotemporal NCD, Lewy bodies, traumatic brain injury, Parkinson’s disease, HIV infection, Huntington’s disease, prion disease, another medical condition, and multiple etiologies. Substance/medication-induced NCD and unspecified NCD are also included as diagnoses.

**Personality Disorders**

The criteria for personality disorders in Section II of DSM-5 have not changed from those in DSM-IV.

**Paraphilic Disorders**

- **Specifiers**
  A major change from DSM-IV is the addition of the course specifiers “in a controlled environment” and “in remission” to the diagnostic criteria sets for all the paraphilic disorders. These specifiers are added to indicate important changes in an individual’s status.

  The “in remission” specifier has been added to indicate remission from a paraphilic disorder. The specifier is silent with regard to changes in the presence of the paraphilic interest per se. The other course specifier, “in a controlled environment,” is included.

**Change to Diagnostic Names**

In DSM-5 there is a distinction between paraphilias and paraphilic disorders. A paraphilic disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not automatically justify or require clinical intervention.

The distinction between paraphilias and paraphilic disorders was implemented without making any changes to the basic structure of the diagnostic criteria as they had existed since DSM-III-R. In the diagnostic criteria set for each of the listed paraphilic disorders, Criterion A specifies the qualitative nature of the paraphilia (e.g., an erotic focus on children or on exposing the genitals to strangers), and Criterion B specifies the negative consequences of the paraphilia (distress, impairment, or harm—or risk of harm—to others). The change for DSM-5 is that individuals
who meet both Criterion A and Criterion B would now be diagnosed as having a paraphilic disorder. A diagnosis would not be given to individuals whose symptoms meet Criterion A but not Criterion B—that is, to those individuals who have a paraphilia but not a paraphilic disorder.

The distinction between paraphilias and paraphilic disorders is one of the changes from DSM-IV that applies to all atypical erotic interests. This change is reflected in the diagnostic criteria sets by the addition of the word disorder to all the paraphilias. For example, DSM-IV pedophilia has become DSM-5 pedophilic disorder. DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders.

DSM-5 Controversy Overview

Controversy and debate have partnered with the DSM-5, to the extent that it has been rejected by The National Institute of Mental Health (NIMH). The government agency announced it will no longer fund research based on DSM symptom clusters giving the reason that the DSM is irrelevant to determining the cause and treatment of psychological problems.

Thomas Insel, the director of NIMH, wrote in a statement in May 2013 that the NIMH felt the proposed definitions for psychiatric disorders were too broad and ignored smaller disorders that were lumped in with a larger diagnosis.

"The weakness is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever," said Insel.

In addition, he remarked that the final product is a modest alteration of the previous edition. And in response to the DSM-5, NIMH has launched the Research Domain Criteria project to transform diagnosis by incorporating genetics, imagine, cognitive science, etc.

For various reasons, NIMH said it would use a different classification system, the Research Domain Criteria (RDoC) project, instead for its studies. Various criticisms are reported here:

1. Critics have emphasized a disconnect exists between DSM categories and treatment. They state that some diagnoses have no viable treatments, some have the same treatment, and some have multiple evidence-based treatments. They’ve commented that if DSM diagnosis doesn't inform treatment, the intention is to facilitate the exchange of money between payers and providers, and create silos for focused research.
2. The DSM is a topographical symptom map that doesn't point to the actual causes underlying mechanisms that drive and maintain disorders. Treatments must be aimed at these causative mechanisms rather than outdated symptom clusters.

3. DSM categories are not discrete. The same symptom can show up in many different diagnoses. Sadness/dysphoria is listed as a criterion symptom in more than a dozen disorders. According to critics, if the DSM categories were useful and distinct, symptoms across diagnoses would not occur. It forces clinicians, who observe anger symptoms for example, to rule out attention deficit hyperactivity disorder, bipolar disorder, borderline personality disorder, narcissistic personality disorder, post-traumatic stress disorder, substance use disorder, grief, intermittent explosive disorder, and six other DSM categories. If one successfully wades through all these choices, there is still no understanding of why the disorder exists or what to do about it.

4. The DSM fails to account for comorbidity.

5. Combination of autism spectrum disorders into single category. One of the most publicized changes in the DSM-5 involves grouping all of the subcategories of autism into a single category as autism spectrum disorder (ASD). This move eliminates previously separate diagnoses of autism – including autistic disorder, Asperger’s disorder, childhood disintegrative disorder and pervasive development disorder “not otherwise specified,” or PDD-NOS (Grush, 2013).

This merging of categories creates a “sliding scale” for autism, meaning individuals will be diagnosed somewhere along the autism spectrum, given the personal severity of their symptoms. Many parents and health care providers have speculated that this transformation may end up excluding some of those already diagnosed with an autism disorder, like Asperger’s or PDD-NOS (Grush, 2013).

Dr. Alexander Kolevzon, the associate professor of psychiatry and pediatrics and Mount Sinai Hospital in New York City stated, “The specificity is going to go up, meaning the false positives are going to be less likely. This universe of people with PDD-NOS; it’s possible that some of those patients may no longer meet those criteria. Some of the debate revolves around Asperger’s, but it seems to me that most people diagnosed with Asperger’s will still be on the autism spectrum.”

Over the past decade, the United States has seen a striking increase in the amount of autism diagnoses, with the Centers for Disease Control and Prevention estimating that one in 88 children suffers from an autism spectrum disorder. According to Kolvezon, numerous epidemiological studies have found that the majority of children accounting for this incidence are those with PDD-NOS; a diagnosis given to those with communication issues and pattern behavior but who do not meet the full criteria for autism or another pervasive developmental
disorder. Kolevzon said it’s possible that over-diagnosis of PDD-NOS has led to this increase in autism spectrum disorder cases.

“What happens in the community is that the diagnosis of autism spectrum disorder virtually guarantees a whole host of therapies such as speech therapy, occupational therapy, behavioral therapy, and potentially physical therapy,” Kolevzon said. “Theoretically, it’s possible that community providers and clinicians are incentivized to label kids with PDD-NOS, because it would make it more likely to receive appropriate services.”

The autism spectrum disorder scale will further refine the way providers diagnose autism, Kolevzon said, by recognizing differences from person to person rather than trying to generalize them into one of four categories.

6. The creation of disruptive mood dysregulation disorder. Within the past decade, more children as young as 2 years old have been diagnosed with bipolar disorder, leading to the prescription of powerful antipsychotic medication that can be quite intense for children at such a young age.

According to the Agency for Healthcare Research and Quality, hospital stays for childhood bipolar disorder have increased by 434 percent from 1997 to 2010. The trend began in the mid-1990s, when doctors from Harvard University stated that bipolar disorder presented differently in children than that of adults. However, recent studies have found that many of these diagnoses were false, causing what many have described as the “false epidemic.” To combat this trend, the DSM-5 is eliminating the diagnosis of pediatric bipolar disorder and creating a brand new category called disruptive mood dysregulation disorder (DMDD), described as intense outbursts and irritability beyond normal temper tantrums in young children.

While the move is meant to address an established problem, many are worried that the category will be applied too liberally. Dr. Max Wiznitzer, a pediatric neurologist for UH Rainbow Babies & Children’s Hospital in Cleveland, Ohio states, “My concern is this category will be applied to individuals where the reason for these blow ups is for something else. You can see it in kids with anxiety disorders and ADHD; even the head of the DSM committee asked, ‘Are we going to label kids with temper tantrums?’”

“The thing is, we have to make sure people are going to be rigorous in application and not just apply to any kid with temper tantrums or sleep deprivation.”

7. What is an illness and what is normal variation is not always clear and frequently changes over time and by culture.
Other criticism

One vocal critic, Dr. Allen Frances, who co-authored the DSM-IV, stated that clinicians are over-treating people in this country who are "basically well" and are "shamefully neglecting" people with mental disorders who are really sick, including one million people in prison with psychiatric disorders. The new manual, he said, is too loose for its diagnoses.

Some proposed diagnoses in DSM-5 were criticized as potentially medicalizing patterns of behavior and mood. These criticisms came to public attention when an open letter was published by the Society for Humanistic Psychology.

This was followed by a number of high-profile articles by Dr. Frances. In an article he highlighted changes to the manual that he argued were examples of over-medicalization of mental health. For example, the manual appears not to have taken into consideration that the average diagnosis is being given by a primary care doctor in a seven minute visit. "People who are basically normal are getting all kinds of medicine that they don't need that makes them worse and it is a terrible drain on the economy,"

"I'm very curious to see what happens because as you know there's kind of this tension between the DSM and some of the new NIMH initiatives," Dr. James Murrough, an assistant professor of psychiatry and neuroscience at Mount Sinai Hospital in New York City, stated in an interview.

He said by now, some psychiatrists had hoped the new DSM would contain more information about scientific tests or scans for licensed mental health professionals to help aid their diagnoses. But, he added the new version doesn't appear to look very different from the last one.

Additional DSM-5 Information

☐ The DSM-5 is compatible with the ICD-9. ICD-10 is expected to be implemented by October of 2014. ICD-11 is scheduled for release in the U.S. in a few more years.

☐ Licensed mental health professionals are encouraged to check with their professional licensing boards to learn how long the DSM-IV will be used for licensing exams.

☐ A DSM-5 mobile app is expected to be available in June of 2014.

☐ Additional assessments can be accessed on the APA website.

☐ There is a good chance insurance will determine payment based on severity scales.

Summary

In section III conditions for further study include:

☐ Attenuated Psychosis Syndrome
Depressive Episodes with Short Duration Hypomania.

Persistent Complex Bereavement Disorder

Caffeine Use Disorders

Internet Gaming Disorder

Neurobehavioral Disorder due to Prenatal Alcohol Exposure

Suicidal Behavior Disorder

Non-suicidal Self-Injury

Conclusion

The DSM-5 represents hundreds of thousands of discussions, hours of research, writing and editing, as well as many good intentions in the attempt to define and categorize the multitude of afflictions that human beings may possess, to ultimately initiate healing through knowledge. As any evolving document, it will continue to raise debate throughout the mental health community and beyond. The APA’s Diagnostic and Statistical Manual of Mental Disorders is, in the end, a textbook. Perhaps, rather than seeing the DSM-5 as the “Psychiatric Bible,” the publication may be better thought of as a basic travel guide within a landscape we just begun to explore.
References


Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition  (DSM-5 TM)
Overview
(2 CEU’s)

Test

1. There was a clear intention to __________ ICD-11 (International Classification of Disease) with the DSM-5.
   a. “disconnect”
   b. “measure”
   c. “familiarize”
   d. “harmonize”

2. The DSM was created to enable mental health professionals to communicate using a common __________.
   a. Plan.
   b. Criteria set.
   c. Professional overview.
   d. Diagnostic language.

3. A major change in the new DSM-5 manual includes merging or renaming various __________.
   a. Age groups
   b. Diagnoses.
   c. Outcomes
   d. Symptoms

4. There are 22 disorders in DSM-5 that have a ___________ comment section.
   a. Suicide risk
   b. Diagnostic.
   c. Future study.
   d. Disorder.

5. __________ will no longer be used since there are severity scales for each diagnosis.
   a. Criteria.
   b. Common criteria.
   c. Axis VI.
   d. Axis V(GAF).

6. Instead of NOS mental health professionals are asked to indicate the disorder as _______ on a severity scale.
   a. Singular.
   b. Simple.
   c. Mild.
   d. Moderate.
7. The diagnosis of ____________ has been removed from the DSM-5 and is now part of one umbrella, "Autism Spectrum Disorder".
   a. Mental retardation.
   b. Intellectual disability.
   c. Cognitive separation.
   d. Asperger’s syndrome.

8. The DSM’s chapter on substance abuse is now called the ____________.
   a. Substance Addiction Disorders chapter.
   b. Dependence and Addictions Disorders chapter.
   c. Addictions Use Disorders chapter.
   d. Substance Use Disorders chapter.

9. __________ was placed in the neurodevelopmental disorders chapter.
   a. Asperger’s syndrome.
   b. Dysthymia.
   c. ADHD.
   d. Feeding Disorder.

10. Premenstrual dysphoric disorder has __________________________.
    a. Been removed altogether.
    b. Been moved to the main body of DSM-5.
    c. Has been selected for further study.
    d. Been changed to Premenstrual syndrome.

11. The DSM-5 chapter on anxiety disorder no longer includes ____________.
    a. Hoarding disorder.
    b. Asperger’s syndrome.
    c. Substance use disorder.
    d. Obsessive-compulsive disorder.

12. The chapter on __________________________ is new in DSM-5.
    a. Substance Dependence.
    b. Asperger’s Syndrome
    c. Obsessive-compulsive and related disorders.
    d. Acute Stress.

13. ________________ is a new diagnosis in DSM-5.
    a. Personality Disorder.
    b. Hoarding Disorder.
    c. Bulimia Nervosa.
    d. Intermittent Explosive Disorder.
14. Trauma does not include_____________________.
   a. Witnessing actual events in person.
   b. Witnessing events on TV or other electronic media.
   c. Witnessing another person harmed.
   d. Near death experiences.

15. DSM-IV feeding disorder of infancy or early childhood has been renamed_______________.
   a. Avoidant/restrictive food intake disorder.
   b. Feeding disorder of early childhood.
   c. Early childhood discretionary disorder.
   d. Early childhood feeding restrictive disorder.