The Diagnostic and Statistical Manual of Mental Disorders (DSM) has been the industry standard for clinicians, researchers, pharmaceutical companies, insurance companies, and policymakers since the original draft was published in 1952. The DSM-5, which is the fifth edition of the manual, was published in May 2013. While the DSM has been a valuable guide to diagnose and treat mental illness for decades, it is not without controversy. Nonetheless, clinicians are advised to refer to the DSM-5 to diagnose and to plan treatment of patients with mental illness.
Continuing Nursing Education Course Planners

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Policy Statement
This activity has been planned and implemented in accordance with the policies of NurseCe4Less.com and the continuing nursing education requirements of the American Nurses Credentialing Center's Commission on Accreditation for registered nurses. It is the policy of NurseCe4Less.com to ensure objectivity, transparency, and best practice in clinical education for all continuing nursing education (CNE) activities.

Continuing Education Credit Designation
This educational activity is credited for 5.5 hours. Nurses may only claim credit commensurate with the credit awarded for completion of this course activity.

Statement of Learning Need
The DSM-5 takes a different approach in several broad categories to diagnose mental disorders. Critics of newer versions of the DSM argue more scientific methods are needed to diagnose mental health conditions. Use of the DSM-5 requires clinicians to be aware of the latest changes and need for future research to improve psychiatric diagnosis and treatment.
Course Purpose
To provide professional nurses with knowledge of the DSM-5 for psychiatric diagnosis and treatment.

Target Audience
Advanced Practice Registered Nurses and Registered Nurses
(Interdisciplinary Health Team Members, including Vocational Nurses and Medical Assistants may obtain a Certificate of Completion)

Course Author & Planning Team Conflict of Interest Disclosures
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Susan DePasquale, MSN, FPMHNP-BC – all have no disclosures

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There is no commercial support for this course.

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Please take time to complete a self-assessment of knowledge, on page 4, sample questions before reading the article.

Opportunity to complete a self-assessment of knowledge learned will be provided at the end of the course.
1. According to the American Psychiatric Association ("APA"), the purpose of the DSM was

a. to serve as an educational tool for teaching psychopathology.
b. to provide a helpful guide to clinical practice.
c. facilitate research and improve communication among clinicians and researchers.
d. All of the above

2. It was the _____ that truly established the manual as the standard for identifying and diagnosing mental disorders.

a. DSM-I 
b. DSM-III-R 
c. DSM-III 
d. DSM-II

3. A new section in the DSM-5 includes the role of __________ in diagnosing mental illness.

a. behavior disorders of childhood 
b. culture 
c. dementia 
d. gender

4. Some conditions listed in DSM-5 for further study are:

a. Persistent Complex Bereavement Disorder 
b. Internet Gaming Disorder 
c. Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure 
d. All of the above

5. True or False: The section on personality disorders changed significantly in the DSM-5 because of a new model to classify personality disorders.

a. True 
b. False
Introduction

The American Psychiatric Association’s (APA) publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM) has been the industry standard for clinicians, researchers, pharmaceutical companies, insurance companies, and policymakers since the original draft was published in 1952. The fifth revision of the DSM manual, DSM-5, was published on May 22, 2013, after receiving approval at the annual APA conference. Although the manual has been considered the standard for the diagnosis of mental disorders, each revision has been met with criticism due to the changes in diagnostic categories and the removal or inclusion of specific disorders.

The publication of the DSM-5 has been controversial and has received a great deal of criticism throughout the entire revision process. Concern regarding proposed changes to specific disorders, along with the inclusion of those that many argue are not truly mental disorders, led to negative press and direct appeals to the APA to seriously consider the impact the revisions would have in the identification and diagnosis of mental disorders. This course will offer an overview of the new DSM-5, with emphasis placed on the manual’s changes and transitions from the DSM 4th edition.

DSM-5: Historical Trends And Development

Revisions to the DSM-5 began in 1999. Over the past years, a number of task forces and working groups were established to examine current trends in mental health and utilize research findings to make the appropriate revisions to the diagnostic categories. Throughout the process, the APA solicited feedback from experts in the field of mental health and ensured that each discipline and diagnostic category was represented. Once the working groups established focused-work criteria, the manual was used in
field tests at select hospitals and clinics and data received from those trials were used to modify the criteria. During the revision process, there was much speculation about which disorders would be included in the new edition of the manual, and the availability of information spurred controversy as various groups and individuals began to weigh in on the potential changes.

When the DSM-5 was released many groups had already denounced the manual due to concern about the reliability and validity of the manual. In fact, these concerns have prompted the National Institute of Mental Health to develop an alternate framework for diagnosis and treatment. How these two standards will co-exist remains to be seen. This course will offer a general overview of the DSM-5, and emphasis is placed on the manual’s changes and transitions from the 4th edition.

**American Psychiatric Association**

The American Psychiatric Association (APA) was founded in 1844 and serves as the world’s largest psychiatric organization. The APA is comprised of more than 33,000 psychiatric physicians from the United States and worldwide. The mission of the APA is to carry forward the following values and services to the public.

- Promote the highest quality care for individuals with mental disorders (including intellectual disabilities and substance use disorders) and their families.
- Promote psychiatric education and research.
- Advance and represent the profession of psychiatry.
- Serve the professional needs of its membership.
The APA serves psychiatrists throughout the world through a variety of mechanisms. The four areas of focus are outlined below:

1. Education and Training
2. Publications
3. Research
4. Charitable contributions and public education

**Education and Training**

A primary goal of the APA is to provide education, training and career development opportunities for psychiatrists and other physicians. The APA is accredited through the Accreditation Council for Continuing Medical Education and is recognized as a leader in educational training. Educational opportunities are diverse to meet the varying needs of the constituents and include annual scientific meetings, online training, published journals and other publications, and other relevant offerings. The goal is to meet the professional development needs of psychiatrists and physicians worldwide and assist with professional performance improvement through the various initiatives and offerings. In addition to psychiatrists and other physicians, educational support is provided to psychiatric educators, residents and medical students and other health associates, such as therapists and nurses. Along with regular educational offerings, the APA also offers two educational conferences each year: the APA Annual Meeting and the Institute on Psychiatric Services (IPS). The conferences provide an opportunity for individuals to learn about new research and advances related to patient care strategies and treatment options.

**Publications**

An important aspect of the American Psychiatric Association is the numerous publications the organization produces each year. In fact, the APA is...
considered the world’s premier publisher of books, multimedia, and journals on psychiatry, mental health and behavioral science. Utilizing the expertise of a broad network of mental health professionals, the APA produces a variety of publications that provide up-to-date information for mental health professionals. The APA is most known for the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is used as the standard for diagnosis of psychiatric conditions. In addition to the DSM, the APA also produces a number of journals, including the American Journal of Psychiatry, as well as numerous papers relevant to psychiatric care and a bimonthly newspaper, *Psychiatric News*.6

Research

The APA is one of the leading psychiatric research organizations in the world. The goal of research is to improve the quality of psychiatric care and expand the knowledge base of mental health professionals. Specific research programs include the Practice Research Network, clinical and health services research, producing evidence-based practice guidelines, and oversight of development of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Research is also used to develop educational programs that disseminate new and emerging research findings and to help translate those findings into clinical practice.6

Charitable Contributions and Public Education

The APA is committed to advancing public understanding of mental health issues and the need to effectively treat them. To accomplish this, the APA created the American Psychiatric Foundation (APF), which is the charitable and educational affiliate of the APA. The goal of APF is to promote awareness of mental health and the effectiveness of treatment, the importance of early
intervention and access to care through grants, programs, research and awards.\textsuperscript{7}

**Purpose**

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is used by healthcare professionals throughout the world as a guide for the recognition and diagnosis of mental disorders. The DSM provides a comprehensive list of identified mental disorders by classification category and includes a description and symptoms, as well as clearly established criteria for the diagnosis of each disorder. The DSM also includes numerical codes for each disorder to assist with effective medical coding and record keeping.\textsuperscript{1} The DSM is considered by practitioners in the mental health field to be the authoritative guide to mental health disorders. According to the American Psychiatric Association, the purpose of the DSM is:\textsuperscript{8}

- To provide a helpful guide to clinical practice.
- To facilitate research and improve communication among clinicians and researchers.
- To serve as an educational tool for teaching psychopathology.

The DSM is intended to assess and diagnose mental disorders. It does not include guidelines for the treatment of identified disorders.\textsuperscript{9} However, the DSM is a valuable asset in the treatment of patients as it provides the first step of treatment, which is proper identification. In addition, the DSM helps measure the effectiveness of treatment as initial diagnosis requires the practitioner to carefully assess and determine the severity of the symptoms. This baseline data is helpful in assessing response to treatment, as long-term monitoring will include assessments of changes in severity of symptoms.\textsuperscript{1}
History

The DSM-5 has an extensive history that dates back to the period before the publication of the initial edition of the DSM-I in 1952. Prior to the publication of the DSM, there was no standard system to identify and diagnose mental disorders. The creation of the DSM provided a consistent means for practitioners to diagnose patients who presented with mental disorders, which changed psychiatric care. Over the years, the DSM has undergone a number of changes and the utility of the manual and diagnostic system has been questioned. However, while the manual may not be viewed as favorably as in years previously, it must be recognized for the structure it brought to the mental health field.

The following fact sheet, distributed by the American Psychiatric Association provides a concise history and development of the DSM.

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American Psychiatric Association: Fact Sheet
DSM: History of the Manual

Overview
The need for a classification of mental disorders has been clear throughout the history of medicine, but until recently there was little agreement on which disorders should be included and the optimal method for their organization. The many different classification systems that were developed over the past two millennia have differed in their relative emphasis on phenomenology, etiology, and course as defining features. Some systems included only a handful of diagnostic categories; others included thousands. Moreover, the various systems for categorizing mental disorders have differed with respect to whether their principle objective was for use in clinical, research, or statistical settings. Because the history of classification is too extensive to be summarized here, this summary focuses briefly only on those aspects that have led directly to the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and to the "Mental Disorders" sections in the various editions of the International Classification of Diseases.
Pre-World War II

In the United States, the initial stimulus for developing a classification of mental disorders was the need to collect statistical information. What might be considered the first official attempt to gather information about mental health was the recording of the frequency of "idiocy/insanity" in the 1840 census. By the 1880 census, seven categories of mental health were distinguished: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy.

In 1917, the American Medico-Psychological Association, together with the National Commission on Mental Hygiene, formulated a plan that was adopted by the Bureau of the Census for gathering uniform statistics across mental hospitals. Although this system devoted more attention to clinical utility than did previous systems, it was still primarily a statistical classification. The American Psychiatric Association subsequently collaborated with the New York Academy of Medicine to develop a nationally acceptable psychiatric nomenclature that would be incorporated within the first edition of the American Medical Association's Standard Classified Nomenclature of Disease. This nomenclature was designed primarily for diagnosing inpatients with severe psychiatric and neurological disorders.

In 1921, the American Medico-Psychological Association changed its name to the Committee on Statistics of the American Psychiatric Association.

Post-World War II

A much broader nomenclature was later developed by the U.S. Army (and modified by the Veterans Administration) in order to better incorporate the outpatient presentations of World War II servicemen and veterans (i.e., psychophysiological, personality, and acute disorders). Concurrently, the World Health Organization (WHO) published the sixth edition of International Classification of Diseases (ICD), which, for the first time, included a section for mental disorders. ICD-6 was heavily influenced by the Veterans Administration nomenclature and included 10 categories for psychoses and psychoneuroses and seven categories for disorders of character, behavior, and intelligence.

The American Psychiatric Association Committee on Nomenclature and Statistics developed a variant of the ICD-6 that was published in 1952 as the first edition of
Diagnostic and Statistical Manual: Mental Disorders (DSM-I). DSM-I contained a glossary of descriptions of the diagnostic categories and was the first official manual of mental disorders to focus on clinical utility. The use of the term “reaction” throughout DSM-I reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors.

In part because of the lack of widespread acceptance of the mental disorder taxonomy contained in ICD-6 and ICD-7, WHO sponsored a comprehensive review of diagnostic issues, which was conducted by the British psychiatrist Erwin Stengel. His report can be credited with having inspired many advances in diagnostic methodology - most especially the need for explicit definitions of disorders as a means of promoting reliable clinical diagnoses. However, the next round of diagnostic revisions, which led to DSM-II and ICD-8, did not follow Stengel's recommendations to any great degree. DSM-II was similar to DSM-I but eliminated the term “reaction.”

**Development of DSM-III**

As had been the case for the Diagnostic and Statistical Manual of Mental Disorders, First Edition and Second Edition (DSM-I) and (DSM-II), the development of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) was coordinated with the development of the next version of the International Classification of Diseases (ICD), ICD-9, which was published in 1975 and implemented in 1978. Work began on DSM-III in 1974, with publication in 1980. DSM-III introduced a number of important methodological innovations, including explicit diagnostic criteria, a multiaxial system, and a descriptive approach that attempted to be neutral with respect to theories of etiology. This effort was facilitated by extensive empirical work on the construction and validation of explicit diagnostic criteria and the development of semi-structured interviews.

ICD-9 did not include diagnostic criteria or a multiaxial system largely because the primary function of this international system was to outline categories for the collection of basic health statistics. In contrast, DSM-III was developed with the additional goal of providing a medical nomenclature for clinicians and researchers. Because of dissatisfaction across all of medicine with the lack of specificity in ICD-9, a decision was made to modify it for use in the United States, resulting in ICD-9-CM (for Clinical Modification). The ICD-9-CM is still in use today.
**DSM-III-R and DSM-IV**

Experience with Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) revealed a number of inconsistencies in the system and a number of instances in which the criteria were not entirely clear. Therefore, the American Psychiatric Association appointed a work group to revise DSM-III, which developed the revisions and corrections that led to the publication of DSM-III-R in 1987.

Several years later, in 1994, the last major revision of DSM, DSM-IV, was published. It was the culmination of a six-year effort that involved more than 1000 individuals and numerous professional organizations. Much of the effort involved conducting a comprehensive review of the literature to establish a firm empirical basis for making modifications. Numerous changes were made to the classification (*i.e.*, disorders were added, deleted, and reorganized), to the diagnostic criteria sets, and to the descriptive text based on a careful consideration of the available research about the various mental disorders. Developers of DSM-IV and the 10th Edition of the International Classification of Diseases (ICD-10) worked closely to coordinate their efforts, resulting in increased congruence between the two systems and fewer meaningless differences in wording. ICD-10 was published in 1992.

**Previous Revisions**

The DSM has gone through four major revisions and two minor revisions since it was first published. This does not include the initial publication of the manual. There have been seven separate editions of the manual published. However, two of the editions were minor revisions and did not receive a new edition number. Instead, the APA added a qualifier to the primary edition.¹² Prior to the DSM-5, the APA used roman numerals to indicate the number of the edition. However, the use of roman numerals was discontinued with the DSM-5, as the publishers opted for standard numbering instead. The use of standard numbering will enable the APA to easily identify new versions of the current edition, as it allows for the use of a decimal system.¹³ For
example, a new version of the DSM-5 will be noted as DSM-5.2. The following is a list of all of the editions of the DSM:

- DSM-I
- DSM-II
- DSM-III
- DSM-III-R
- DSM-IV
- DSM-IV-TR
- DSM-5


dsm-i

The DSM-I, which was approved in 1952, was the first version of the DSM and it was based primarily on the Medical 203 classification system. The DSM-I was 145 pages long and included a total of 106 disorders. In the first DSM, all disorders were described in paragraph form and it was expected that psychiatrists would use the descriptions to assess patients. Since the DSM-I was based on the Medical 203, many of the descriptions used were taken directly from the previous manual.

During the development of the DSM-I, the APA distributed questionnaires to 10% of the membership asking for feedback on the potential categories. As a result of the feedback, the final version of the manual assigned categories based on symptoms rather than disorder types. The three main categories of psychopathology were organic brain syndromes, functional disorders, and mental deficiency. The DSM-I also included a category for somatization reactions. Within the categories were 106 diagnoses. In addition to the standard categories and descriptions, the DSM-I also provided nondiagnostic terms that could be used for coding test results and other significant observations. The DSM-I did not include a section for childhood disorders.
DSM-II

The DSM-II was published in 1968 and, while it followed the same basic format of the DSM-I, it included a number of significant changes. Rather than three categories, the DSM-II contained eleven major diagnostic categories which included 182 specific diagnoses. The manual was 136 pages. The DSM-II also included a section focused on problems prevalent in children and adolescents. The section devoted to children and adolescents was called Behavior Disorders of Childhood-Adolescence and it included the following disorders:

- Hyperkinetic Reaction
- Overanxious Reaction
- Runaway Reaction
- Withdrawing Reaction
- Unsocialized Aggressive Reaction
- Group Delinquent Reaction

The DSM-II also included a section on sexual deviations and included specific disorders, such as:

- Homosexuality
- Fetishism
- Pedophilia
- Transophilia
- Transvestism
- Exhibitionism
- Voyeurism
- Sadism
- Machoism
While the original version of the DSM-II listed homosexuality as a diagnosable disorder, there was a great deal of controversy surrounding that decision. Many individuals opposed the inclusion of homosexuality. Eventually, the movement gained enough momentum, and a large group of protesters demonstrated at the 1970 APA conference, arguing that homosexuality was not a mental disorder, but rather a normal variant of human sexuality. As a result, the APA, which was divided, sent the issue to committee for consideration. The committee produced a final report, which outlined the following tenets.¹⁸

1. Some experts believed homosexuality was pathological while other experts considered it to be a normal variant.
2. Many homosexuals are satisfied with their sexual orientation.
3. Significant portions of homosexuals wish to change their orientation.
4. Modern treatment allows a significant proportion of homosexuals who wish to change their orientation to do so.

As a result of the committee’s findings, it was determined that homosexuality did not fit the criteria for a mental disorder and it was removed from the DSM-II.¹⁶

*DSM-III*

The DSM-III was published in 1980 and was considered a radical shift from previous versions of the manual.¹⁹ Unlike earlier versions, the DSM-III was quite large. It included 265 diagnoses over 494 pages.²⁰ In addition, the DSM-III utilized a new classification system that was vastly different from that used in the DSM-I and the DSM-II.¹² The DSM-III was published at a time when psychiatric medicine was advancing and gaining credibility as a true medical field. Individuals were taking mental disorders more seriously
and reliance on psychiatric care for individuals was increasing. Therefore, the DSM-III became widely recognized as the authoritative source on mental disorders and was used by professionals in the mental health field, including social workers, therapists, mental health counselors, psychologists and psychiatrists.  

Although two previous versions of the DSM had been published, it was the DSM-III that truly established the manual as the standard for identifying and diagnosing mental disorders. The success of the DSM-III can be attributed to the change in psychiatric medicine at the time it was published, but it is also because the third edition of the manual differed greatly from the first two versions, especially in the way it was developed. Unlike previous versions of the DSM, the DSM-III was considered a reliable source for the diagnosis of mental disorders. During the development phase, the APA utilized field trials and empirical data to determine the categorization system for mental disorders, thereby increasing its validity.

Another major change with the DSM-III is that it utilized a multiaxial system of assessment to examine the patient as an individual, as well as a family and community member. This altered the classification system and made the criteria for diagnosing a patient more consistent and reliable, therefore increasing the credibility of the manual and establishing a defined system for the identification and diagnosis of mental disorders. The multiaxial system of evaluation and classification provided guidelines that ensured that every patient was evaluated in a number of specific domains. The multiaxial system included the following domains.

- **Axis I:** Clinical Disorders of Mental Illness
- **Axis II:** Personality Disorders and Mental Retardation
- **Axis III:** General Medical Conditions
Axis IV: Psychosocial and Environmental Problems (homelessness, legal issues, etc.)

Axis V: Global Assessment of Functioning: A single number from 0 to 100

**DSM-III-R**

Shortly after the DSM-III was released in 1980, it became apparent that some changes would need to be made. While the DSM-III provided a reliable set of criteria for diagnosing mental disorders, many practitioners found the wording of the criteria difficult to comprehend. In fact, practitioners regularly criticized the manual for its lack of clarity and inconsistency. In addition, the criteria for the diagnosis of mental disorders included an arbitrary number of symptoms and were not based on empirical evidence. This led to over diagnosis of disorders as individuals who presented with more than the minimal number of symptoms were automatically diagnosed with the associated disorder. On the other hand, individuals who presented with fewer than the required number of symptoms, even if that number was just one below the minimum, were not able to receive a diagnosis.

As the result of the emergence of research findings, the outcomes of field trials, and issues with the coding system, the APA published a modified version of the DSM-III in 1987. The new version was identified as the DSM-III-R and was originally intended to be a brief update to the original DSM-III. However, it quickly became apparent that there were significant differences between the two versions. The DSM-III-R included significant changes to the criteria as well as the renaming and reorganization of categories. Six of the new categories were removed and others were
added. The DSM-III-R also utilized data from field trials and diagnostic interviews in the revision process.

**DSM-IV**

The DSM-IV was published in 1994 and was the first manual to use the classification system that is still used today. The DSM-IV was developed in response to feedback received regarding the DSM-III and the DSM-III-R. To improve the reliability and credibility of the manual, a committee was convened to ensure that research and development included empirical evidence and data-based decisions. To prevent the negative feedback that occurred with the publication of the DSM-III, the committee took a strict approach to researching and developing the DSM-IV. Using empirical evidence, the committee required every change to go through three specific phases:

1. Systematic literature review
2. Secondary data reanalysis
3. Focused field trials

After the initial review was complete, the changes were then reviewed and critiqued by other work group members and members of the larger advisory group. The advisory group was charged with identifying inaccuracies, biases and gaps in the proposed changes. To further reduce the chance of criticism, a four-volume companion to the DSM-IV was published, which outlined the rationale and empirical evidence used for each change. The DSM-IV was significantly different than previous versions of the DSM. Many of the categories were restructured and more detailed information about each disorder was included. The manual grew to include 365 diagnoses over 886 pages.
While the DSM-IV was considered a reliable manual for the identification and diagnosis of mental disorders, it still required some revisions a few years after it was published. In 2000, the APA produced a text revision of the DSM-IV and it was renamed the DSM-IV-TR to differentiate it from the original edition. The DSM-IV-TR was not significantly different from the DSM-IV, as it only contained minor changes. The committee focused on the following four areas during the revision process.

1. Correct minor errors found in the original DSM-IV edition.
2. Make changes based on new research.
3. Enhance the educational value of the document by adding more text.
4. Update the coding scheme to match international standards.

Update Process

Each edition of the DSM required a number of years for the update process. In the case of the DSM-5, the update process began in 1999. It took approximately fourteen years to complete the updates and produce a new manual. The process is lengthy and involved and requires the input of an extensive network of practitioners and researchers. The following DSM facts, made available on the APA website, explained the lengthy process to develop the DSM-5.

DSM-5 Overview: The Future Manual

The process for revising Diagnostic and Statistical Manual of Mental Disorders (DSM) began with a brief discussion between Steven Hyman, M.D., (then-director of the National Institute of Mental Health [NIMH]), Steven M. Mirin, M.D. (then-medical director of the American
Psychiatric Association [APA]), and David J. Kupfer, M.D., (then-chair of the American Psychiatric Association Committee on Psychiatric Diagnosis and Assessment) at the NIMH in 1999. They believed it was important for the APA and NIMH to work together on an agenda to expand the scientific basis for psychiatric diagnosis and classification.

Under the joint sponsorship of the two organizations, an initial DSM-5 Research Planning Conference was convened in 1999 to set research priorities. Participants included experts in family and twin studies, molecular genetics, basic and clinical neuroscience, cognitive and behavioral science, development throughout the life-span, and disability. To encourage thinking beyond the current DSM-IV framework, many participants closely involved in the development of DSM-IV were not included at this conference. Through this process, participants recognized the need for a series of white papers that could guide future research and promote further discussion, covering overarching topic areas that cut across many psychiatric disorders. Planning work groups were created, including groups covering developmental issues, gaps in the current system, disability and impairment, neuroscience, nomenclature, and cross-cultural issues.

In early 2000, Darrel A. Regier, M.D., M.P.H., was recruited from the NIMH to serve as the research director for the APA and to coordinate the development of DSM-5. Additional conferences were held later in July and October of 2000 to set the DSM-5 research agenda, propose planning the work groups’ membership, and to hold the first face-to-face meetings. These groups, which included liaisons from the National Institutes of Health (NIH) and the international psychiatric community, developed the series of white papers, published in "A Research Agenda

Leaders from the APA, the World Health Organization (WHO), and the World Psychiatric Association (WPA) determined that additional information and research planning was needed for specific diagnostic areas. Hence, in 2002, the American Psychiatric Institute for Research and Education (APIRE), with Executive Director Darrel A. Regier, M.D., M.P.H., as the Principal Investigator, applied for a grant from the NIMH to implement a series of research planning conferences that would focus on the scientific evidence for revisions of specific diagnostic areas. A $1.1 million cooperative agreement grant was approved with support provided by NIMH, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcoholism and Alcohol Abuse (NIAAA).

Under the guidance of a steering committee comprised of representatives from APIRE, the three NIH institutes, and the WHO, 13 conferences were held from 2004 to 2008. Expertise represented at these conferences spanned the globe: each conference had co-chairs from both the U.S. and another nation, and approximately half of the 397 participants were from outside the U.S. In each conference, participants wrote papers addressing specific diagnostic questions, based on a review of the literature, and from these papers and the conference proceedings, a research agenda was developed on the topic. The results of 11 of these conferences have been published to date in peer-reviewed journals or American Psychiatric Publishing, Inc. (APPI) monographs, with the remainder of the publications anticipated
in 2011 and 2012. Findings from all 13 conferences are available to serve as a substantial contribution to the research base for the DSM-5 Task Force and Work Groups and for the WHO as it develops revisions of the International Classification of Diseases.

In 2006, APA President Dr. Steven Sharfstein announced Dr. Kupfer as chair and Dr. Regier as vice-chair of the task force to oversee the development of DSM-5. Along with other leaders at the APA, they nominated additional members to the task force, which includes the chairs of the diagnostic work groups that will review the research and literature base to form the content for DSM-5. These task force nominees were reviewed for potential conflicts of interest, approved by the APA Board of Trustees, and announced in 2007. In turn, the work group chairs, together with the task force chair and vice-chair, recommended to the successive APA Presidents, Drs. Pedro Ruiz and Carolyn Robinowitz, nominees widely viewed as leading experts in their field who were then formally nominated as members of the work groups. All work group members were also reviewed for potential conflicts of interest, approved by the APA Board, and were announced in 2008.

From 2007 until the end of 2012, each work group met regularly in person and on conference calls. They reviewed DSM-IV’s strengths and problems, from which research questions and hypotheses were developed, followed by thorough investigations of literature reviews and analyses of existing data. Based on their comprehensive review of scientific advancements, targeted research analyses, and clinical expertise, the work groups developed draft DSM-5 diagnostic criteria.
The final, approved DSM-5 was released in May 2013 at APA's Annual Meeting.

**DSM-5: Overview Of Revisions**

Since the APA began revising the DSM in 1999, the process has been mired with controversy. The revision process was extensive and included significant changes that baffled many practitioners and individuals living with mental disorders. As the public followed the revision process, there were many discussions regarding the appropriateness and relevance of some of the decisions that were made. There was an abundance of criticism against the APA and the process that was used, and even before the manual was released the internet was abuzz with reviews of the new text.

When the DSM-5 was officially released on May 22, 2013, it was met with concern from various groups representing cross sections of those afflicted with mental disorders. In fact, the manual received so much negative publicity prior to its release that most editorials focused on the controversy surrounding the manual rather than the actual release of the manual.

**Background**

During the time that the DSM-5 was being developed, great advances were made in the field of psychiatry, all of which contributed to the changes in the manual. Most significant were changes in medical technology, which allowed for advances in brain imaging techniques and improved methods for analyzing research results. These new technologies have enabled practitioners to better understand and diagnose mental disorders. As a result, the classification system and the scientific basis for mental health
diagnosis evolved in the new manual to reflect the emerging trends in mental health diagnosis and treatment.\textsuperscript{27}

The process to revise the DSM began in 1999 with a conference for research planning. At the conference, a DSM-5 task force was established. The task force was comprised of the thirteen chairs of each diagnostic work group. The diagnostic work groups included representation from global experts in diverse areas of diagnosis and represented the different classifications of disorders that were present in the DSM-IV.\textsuperscript{8} However, there were a number of participants who were directly involved in the development of the DSM-IV that were not included in the work groups as the goal was to expand the scope and depth of the development process.\textsuperscript{28}

The original development phase of the DSM-5 relied on participation in a number of planning conferences that focused on organizing and analyzing the available scientific evidence, as well as identifying missing information and additional research goals. Members from all of the diagnostic work groups were present at these planning conferences.\textsuperscript{8} Eventually, the number of individuals working on the DSM-5 expanded to include over 500 clinicians and experts in the field. Their input was used to develop a framework for the new manual and to establish a scientific basis for the proposed changes. The work groups spent over ten years establishing new criteria and identifying areas of expansion for the manual.\textsuperscript{13}

Throughout the fourteen years that the manual was being developed, the members of the work groups attended numerous planning meetings and posted the results and full proceedings of each meeting on the DSM-5 website.\textsuperscript{8} Unlike with previous revisions, which occurred with limited or no internet availability, all of the actions of the revision process were broadcast
electronically and were made readily available to constituents for immediate review. This availability of information both helped and hampered the revision process. While the immediate availability of information enabled all constituents to be aware of potential changes, it also provided an opportunity for them to critique potential changes. This resulted in extensive criticism of the manual well before it was officially released.29

Development Timeline

Throughout the DSM revision process, the APA relied on the work of a DSM-5 task force, various work groups and the input of numerous mental health practitioners. The following is the timeline and outline of development, which had been provided by the APA.4

1999-2007:

Development of DSM-5 Pre-Planning white papers, including “A Research Agenda for the DSM-5” (2002, American Psychiatric Association) and “Age and Gender Considerations in Psychiatric Diagnosis: A Research Agenda for the DSM-5” (2007, American Psychiatric Association) and a white paper on cultural and spiritual issues that can affect diagnosis; “Phase 1: A Research Agenda for DSM-5: White Paper Monographs.”

2004-2007:

2006-2008:
Drs. David Kupfer and Darrel Regier were appointed as chair and vice-chair, respectively, of the DSM-5 Task Force. Another key appointment included that of Dr. William Narrow, Research Director. DSM-5 Work Group Chairs and Members were appointed and announced.

2008–2010:
The DSM-5 Task Force and Work Group members spent much of 2008-2010 formulating their proposed draft criteria. This included conducting extensive literature reviews, performing secondary data analyses, and soliciting feedback from colleagues and professionals.

April 2010–December 2011:
Field Trial Testing in Large, Academic Medical Centers. Proposed revisions were examined in a variety of populations (i.e., child, older adults) and in diverse settings.

December 2010–October 2011:
Data collection for DSM-5 Field Trials was among 11 large, academic-medical centers.

October 2010–February 2012:
Field Trial Testing in Routine Clinical Practices (RCPs). DSM-5 Field Trials were also conducted in RCPs, such as solo and small group practices.
November 2010–May 2011:
Recruitment of a representative sample of psychiatrists, consisting of randomly sampled general psychiatrists, plus a representative stratified sample of additional geriatric, addiction, consultation and liaison, and child psychiatrists, all selected from the AMA Masterfile of Physicians.

November 2010–October 2011:
Recruitment of volunteer sample of clinicians, consisting of psychiatrists, psychologists, licensed clinical social workers, licensed counselors, licensed marriage and family therapists, and advanced practice psychiatric-mental health nurses.

July 2011–February 2012:
Data collection for DSM-5 Field Trials was in RCPs.

March 2011–November 2012:
Drafting Text for DSM-5. Members of the DSM-5 Task Force and Work Group began drafting their initial text for DSM-5, including possible revisions to text descriptions within each diagnostic chapter.

March 2011–October 2012:
Text for disorders not included in the DSM-5 Field Trials were drafted first. Texts for disorders under examination in the field trials were completed after the work groups had received data from each of the field trials. Work groups submitted initial drafts, and DSM leadership and work groups revised and resubmitted as needed, providing comments and suggestions. The DSM-5 Task Force had the opportunity to review all drafts before they were submitted to APA publishing in December 2012.
November 30, 2012:

Final draft text of DSM-5 due to APA publishing for preparation for publication; the entire draft manual was due to publishing by December 31, 2012.

October 2011-April 2012:

Data analysis of results from both types of field trials started in October 2011. Data analysis from the large academic field trials began first, while data analysis from the RCP field trials continued until after enrollment ended in February 2012. Work groups were provided with results from both field trials and updated their draft criteria as needed.

Spring 2012:

Revised draft diagnostic criteria were posted on www.dsm5.org and open to a third public feedback period for 2 months. Feedback was shared directly with work group members, and further edits to proposals were made as needed.

March-December 2012:

Presentation of penultimate DSM-5 proposals to APA Board of Trustees; Task Force review of feedback from APA Governance bodies; Final revisions by the APA Task Force; Final approval by APA Board of Trustees; Submission to American Psychiatric Publishing, Inc.

May 18-22, 2013:

The release of DSM-5 took place during the APA’s 2013 Annual Meeting in San Francisco, CA.
Changes from Previous Versions

Each version of the DSM differs from its predecessor. Using data analysis and feedback from professionals in the field, the APA makes revisions to the manual that best reflect the emerging trends in psychiatry. In addition, each revision of the DSM is intended to best outline the criteria for mental disorders in a way that is useful for those working in the mental health field. Therefore, the DSM-5, like previous versions, contains some significant changes from the previous versions of the manual. This section will provide a general overview of the changes, and subsequent sections will cover the changes more in depth. The changes can be broken down in the following ways.

Organization of the Manual

The DSM-5 contains approximately the same number of disorders as the DSM-IV, but the specific disorders have changed. These changes will be covered briefly in this section and more in depth in future sections. The structure of the manual has changed as well.\textsuperscript{30}

The DSM-5 is organized into the following three sections:

Section 1:
Introduction to the Introduction to the DSM-5 and information on how to navigate the updated manual

Section II:
Diagnoses and Disorders – This section provides revised chapter organization and includes 20 disorders, which is an increase from the 16 included in the DSM-IV-TR.
Section III:
This is a new section in the manual. It includes a number of conditions that cannot be classified as official disorders until they undergo further research and analysis. This section also includes cultural concepts of distress and the names of individuals who were involved in the development of the DSM-5.

Coding of Disorders
The coding system used in the DSM-5 was consistent with the ICD-9. However, it included changes as well that would be consistent once the ICD-10 released in October 2013. The ICD-10 requires the use of a seven-digit code instead of the five-digit code previously in use. It was anticipated that the codes would change again in 2015 or beyond relative to release of the ICD-11.31

Diagnostic Recording Procedures
One of the most significant changes in the DSM-5 is the shift from a multiaxial coding system to a non-axial documentation system. The multiaxial system included axes I, II, and III, IV and V. In the DSM-5, axes I, II and III have been combined into one category. The DSM-5 also includes separate psychosocial and contextual factors as well as disability factors. These were axes IV and V in previous versions.30 The goal is to have precise measures that ensure the appropriate identification and diagnosis of mental disorders.

Other Changes
In addition to the major organizational changes, the DSM-5 includes other changes to the manual, specific disorders and other categories. One such change is the title. In previous versions, as mentioned earlier, a roman
numeral was used to indicate the edition. However, this version uses a standard number 5 to indicate the edition. This change was instituted so that future versions of the same edition will include a version number after the decimal point. Under this system, the next revision of the DSM will be DSM 5.1.\(^\text{13}\)

There have been a number of changes made to specific disorders. These changes will be discussed in full detail in later sections of this course. However, a brief overview of each of the changes, which is provided by the APA, is listed below.\(^\text{32}\)

*Neurodevelopmental Disorders*

Communication Disorders:

Restructured to now include Social Communication Disorder plus two diagnostic categories: Language Disorders and Speech Disorders. These categories each contain appropriate subtypes to cover all seven of the disorders previously proposed for this diagnostic category (Language Emergence, Specific Language Impairment, Social Communication Disorder, Voice Disorder, Speech-Sound Disorder, Motor Speech Disorder, Child Onset Fluency Disorder).

Learning Disorder:

Learning Disorder has been changed to Specific Learning Disorder and the previous types of Learning Disorder (Dyslexia, Dyscalculia, and Disorder of Written Expression) are no longer being recommended. The type of Learning Disorder will instead be *specified* as noted in the diagnosis.
Social Communication Disorder:

Social Communication Disorder has undergone some moderate wording changes for consistency with wording of DSM-5.

Neurodevelopmental Disorders

Attention-Deficit/Hyperactivity Disorder (ADHD):  
- ADHD involved minor wording changes.
- Chronic Tic Disorder, Tic Disorder Not Elsewhere Classified, and Tic Disorder Associated With Another Medical Condition:
  - This section included minor wording changes.
  - Addition of criteria for Attention-Deficit/Hyperactivity Disorder Not Elsewhere Classified.

Schizophrenia Spectrum and Other Psychotic Disorders

Attenuated Psychosis Syndrome:  
Proposed for Section III, a section of DSM-5 in which conditions that require further study will be included.

Schizoaffective Disorder:  
- Updated rationale for proposed changes to this disorder.
- Reorganization of the disorders within this category to reflect a gradient of psychopathology, from least to most severe.
- Psychotic Disorder Not Elsewhere Classified renamed from Psychotic Disorder Not Otherwise Specified.
• Psychotic Disorder Associated with Another Medical Condition renamed from Psychotic Disorder Associated With a Known General Medical Condition.
• Updated severity dimensions for these disorders.

Bipolar and Related Disorders:
• Hypomanic Episode - Criterion A revised to include increased energy/activity as a core symptom.
• Manic Episode - Criterion A revised to include increased energy/activity as a core symptom.
• Major Depressive Episode - proposed removal of the bereavement exclusion and addition of a footnote to clarify for clinicians how to differentiate bereavement and other loss reactions from Major Depression.

Depressive Disorders:
• Mixed Anxiety/Depression - proposed for Section III, a section in DSM-5 in which conditions that require further research will be included.
• Major Depressive Episode - proposed removal of the bereavement exclusion and addition of a footnote to clarify for clinicians how to differentiate bereavement and other loss reactions from Major Depression.
• Disruptive Mood Dysregulation Disorder - additional information provided to assist in differentiation from Oppositional Defiant Disorder.
Anxiety Disorders:

- **Adjustment Disorder** – addition of a 6-month requirement for children for the bereavement related subtype and minor wording changes, including changes to the bereavement related subtype.

- **Specific Phobia** - duration criterion changed from “The duration is at least 6 months” to “The fear, anxiety, or avoidance is persistent, typically lasting 6 or more months”; and, minor wording changes.

- **Social Anxiety Disorder (Social Phobia)** – duration criterion changed from “The duration is at least 6 months” to “The fear, anxiety, or avoidance is persistent, typically lasting 6 or more months”; and minor wording changes.

- **Generalized Anxiety Disorder** – the number of associated physical symptoms has been reduced from six to two; minor wording changes.

- **Panic Attack** - minor wording changes.

- **Panic Disorder** - minor wording changes.

- **Agoraphobia** - duration criterion changed from “The duration is at least 6 months” to “The fear, anxiety, or avoidance is persistent, typically lasting 6 or more months”; and minor wording changes.

- **Separation Anxiety Disorder** - duration criterion changed from “The duration is at least 6 months” to “The fear, anxiety, or avoidance is persistent, typically lasting 6 or more months”; and, age of onset requirement has been dropped and includes minor wording changes.

- **Addition of criteria for Substance-Induced Anxiety Disorder.**

- **Addition of criteria for Anxiety Disorder Attributable to Another Medical Condition.**

- **Addition of criteria for Anxiety Disorder Not Elsewhere Classified.**
Obsessive-Compulsive and Related Disorders:

- Obsessive Compulsive Disorder - minor wording changes
- Hoarding Disorder - minor wording changes
- Olfactory Reference Syndrome - minor wording changes
- Skin Picking Disorder - addition of a new criterion that addresses attempts to resist skin picking
- Hair-Pulling Disorder (Trichotillomania) - addition of a new criterion that addresses attempts to resist hair pulling
- Body Dysmorphic Disorder - minor wording changes
- Addition of criteria for Substance-Induced Obsessive-Compulsive or Related Disorders
- Addition of criteria for Obsessive-Compulsive or Related Disorder Attributable to Another Medical Condition
- Addition of criteria for Obsessive-Compulsive or Related Disorder Not Elsewhere Classified

Trauma and Stressor Related Disorders:

- Posttraumatic Stress Disorder - wording changes (*i.e.*, adding “directly” in criterion A1); and, PTSD in preschool children proposed as a subtype of PTSD instead of a separate diagnosis, and proposal of a dissociative symptoms subtype
- Acute Stress Disorder - minor wording changes
- Addition of criteria for Persistent Complex Bereavement Disorder - this is being proposed for Section III, a section of DSM-5 in which conditions that require further research will be included
- Addition of criteria for Trauma - or Stressor - Related Disorder Not Elsewhere Classified
Dissociative Disorders:

- Dissociative Amnesia - minor wording changes and revisions to the subtype
- Depersonalization/Derealization Disorder - minor wording changes
- Dissociative Identity Disorder - minor wording changes and revisions to the specifiers

Somatic Symptom Disorders:

- Somatic Symptom Disorder - formerly proposed as a singular disorder that combines the previously proposed diagnoses Complex Somatic Symptom Disorder and Simple Somatic Symptom Disorder
- Conversion Disorder (renamed Functional Neurological Symptoms) – renamed Conversion Disorder (Functional Neurological Symptom Disorder)
- Factitious Disorder - proposed for removal from the section Other Disorders and instead be placed in the section Somatic Symptom Disorders

Feeding and Eating Disorders:

- Avoidant/Restrictive Food Intake Disorder - minor wording changes

Sleep-Wake Disorders:

- Reclassification of Hypersomnia Disorders to include subtypes of Narcolepsy/Hypocretin Deficiency Syndrome, Narcolepsy Without Cataplexy/Hypocretin Deficiency Syndrome, Periodic Hypersomnia, Kleine-Levin Subtype, Major Somnolence Disorder, and Hypersomnia Not Elsewhere Classified
- Circadian Rhythm Sleep - Wake Disorders renamed from Circadian Rhythm Sleep Disorders
- Rationales have now been provided for all of these disorders

Gender Dysphoria:
- Gender Incongruence renamed Gender Dysphoria

Disruptive, Impulse Control, and Conduct Disorders:
- Oppositional Defiant Disorder – frequency will be addressed via a coding note, rather than in Criterion B
- Intermittent Explosive Disorder criteria were added (one of the major changes is that the age at which the diagnosis can be made is now 18)
- Conduct Disorder had minor wording changes
- The Callous and Unemotional Specifier has clarified wording and some additional guidance on use
- Pyromania and Kleptomania were removed, as there is insufficient evidence to retain them as distinct disorders. The behaviors are better accounted for by other disorders, such as fire-starting in Conduct Disorder, or compulsive stealing as a symptom of a depressive disorder or impulse control disorder

Substance Use and Addictive Disorders:
- Chapter order and numbering designations have been reorganized according to substance (whereas, these were previously organized according to the diagnosis, i.e., use, intoxication, withdrawal)
- Hallucinogen Disorders have now subsumed Phencyclidine Disorders
- Sedative/Hypnotic-Related Disorders renamed from Sedative, Hypnotic, or Anxiolytic Disorders
• Stimulant Disorders renamed from Amphetamine and Cocaine Disorders
• Updated the Severity Specifiers
• Updated the Remission Specifiers
• Removal of Substance-Induced Dissociative Disorder
• Minor wording changes to most of the criteria
• Addition of criteria for Hallucinogen Persisting Perception Disorder
• Addition of criteria for Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure - proposed for Section III, a section of DSM-5 in which conditions that require further research will be included
• Addition of criteria for Caffeine Use Disorder - proposed for Section III, a section of DSM-5 in which conditions that require further research will be included.
• Addition of criteria for Internet Use Disorder - proposed for Section III, a section of DSM-5 in which conditions that require further research will be included.
• Addition of criteria for Drug Specific "Not Elsewhere Classified" diagnoses

Neurocognitive Disorders:

• Major and Mild Neurocognitive Disorder – diagnostic criteria are now added for each of the following subtypes of Major and Mild Neurocognitive Disorder: 1) Vascular Neurocognitive Disorder, 2) Frontotemporal Neurocognitive Disorder, 3) Neurocognitive Disorder due to Lewy Body Dementia, 4) Neurocognitive Disorder due to Parkinson’s Disease, 5) Neurocognitive Disorder due to HIV Infection, 6) Substance-Induced Neurocognitive Disorder, 7) Neurocognitive Disorder due to Huntington’s Disease, 8) Neurocognitive Disorder due...
to Prion Disease, 9) Neurocognitive Disorder due to Another Medical Condition

- Neurocognitive Disorder due to Alzheimer’s Disease was modified to maintain consistency with newly published consensus criteria
- Addition of criteria for Neurocognitive Disorder Not Elsewhere Classified

Personality Disorders:

- Addition of more extensive rationale for proposed changes in the diagnosis and classification of Personality Disorders
- Minor wording changes to all diagnostic criteria

Paraphilic Disorders:

- All Paraphilic Disorders now include two new specifiers: In a Controlled Environment and In Remission
- Paraphilies chapter renamed Paraphilic Disorders
- Pedophilic Disorder - addition of a Hebephilic Subtype
- Hypersexual Disorder - proposed for Section III, a section of DSM-5 in which conditions that require further research will be included
- Paraphilic Coercive Disorder - proposed for Section III, a section of DSM-5 in which conditions that require further research will be included

Other Disorders:

- Addition of criteria for Suicidal Behavior Disorder
**Culture and DSM-5**

The DSM-IV included a brief section on the role of culture in diagnosing mental illness. This section was part of the appendix and included a Glossary of Cultural Bound Syndromes and an Outline of Cultural Formulation. While the appendix provided a means for understanding cultural implications in mental disorders, it did not align well with many of the DSM disorders. In the DSM-5, Cultural Formulation is included in the section entitled *Emerging Measures and Models* and includes descriptive information as well as the Cultural Formation Interview (CFI), which is a sixteen-question tool that is administered during a patient’s initial visit.

Within the preface of the manual, the APA highlights a number of improvements that they feel are important to note. The following is a list of the improvements as indicated in the preface of the manual, along with summarized justifications for each modification.

*Representation of Developmental Issues Related to Diagnosis*

This change enables the manual to examine a disorder over an individual’s lifespan, rather than at one specific point in time. The manual is now organized to reflect this, with typical childhood disorders listed in the beginning of the manual and later age disorders included later on. Each description also includes information on how the disorder will evolve over the patient’s lifetime. Each description also includes any relevant age-related factors.
Integration of Scientific Findings from the Latest Research in Genetics and Neuroimaging

The chapter structure has been revised to best reflect current research findings and emerging trends in diagnostic criteria. The revised chapter structure utilizes information regarding genetic linkages between diagnostic groups.

Consolidation of Autistic Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder into Autism Spectrum Disorder

Many of the symptoms of these individual disorders are part of a continuum of symptoms that actually make up one disorder. The individual diagnoses represent mild to severe symptoms along the same continuum and grouping all of them into one disorder will ensure appropriate diagnosis and effective treatment of patients.

Streamlined Classification of Bipolar and Depressive Disorders

Changes in this category include changes to the way both disorders are presented. In previous editions of the manual, the definition of manic, hypomanic and major depressive episodes were separated from the definition of bipolar I, bipolar II and major depressive disorder. In the DSM-5, all of the component criteria are included with the respective criteria for each disorder. This should provide greater guidance and more effective and efficient diagnosis of the disorders.

Restructuring of Substance Use Disorders for Consistency and Clarity

Previous versions of the manual have separated “substance abuse” and “substance dependence” into separate categories. In this manual, the two
categories have been combined into one category of substance use disorders.

Enhanced Specificity for Major and Mild Neurocognitive Disorders

Changes to this category provide differentiation between the various neurocognitive disorders that were once grouped into the category known as dementia. Using scientific data regarding the different disorders in this category, the manual now includes criteria for diagnosing each type of neurocognitive disorder.

Transition in Conceptualizing Personality Disorders

The section providing criteria for individual personality disorders is ultimately unchanged in this manual. However, section three provides updated information regarding the future implications and potential changes to the classification of personality disorders.30

Section III: New Disorders and Features

This section is new in the DSM-5. It provides information regarding disorders that are not yet recognized as classifiable disorders. These disorders are still being researched and analyzed to determine where and how they will fit into the classification system in the future.13

Controversy

In the months before the DSM-5 was approved at the APA annual meeting, there was a great deal of controversy surrounding its release. Various mental health organizations, as well as individual practitioners and those living with mental disorders, found fault in the proposed revisions.3 As mentioned previously, before the manual was even released, many had
already denounced it based on speculation regarding the changes that were being made to the manual and the potential impact these changes would have on the mental health community. Initial criticism focused on the review and revision process. Of particular concern were the perceived lack of scientific rigor in the review process and the exclusion of key individuals in the mental health field.

While members from the various mental health organizations, such as the American Psychological Association, American Counseling Association, American Mental Health Counselors Association, and others provided initial suggestions and feedback on the proposed changes, there was little representation from social workers. This was considered problematic, as clinical social workers are responsible for providing a significant portion of the mental health services in the United States. A number of participants submitted responses and comments about their concerns and the content revisions.

Much of the controversy surrounding the release of the DSM-5 centers around changes to specific disorders. The removal of Asperger’s from the manual as an individual condition has been especially controversial. In the DSM-5, Asperger’s is included within the diagnostic criteria for Autism Spectrum Disorder. This change caused outrage among many child development specialists and the parents of children previously diagnosed with Asperger’s. Along with Asperger’s, child disintegrative disorder and pervasive developmental disorder (PDD) were also eliminated as individual conditions and were grouped into the autism spectrum diagnosis. The concern was that it would become difficult for children with Asperger’s and these other conditions to receive the appropriate services.
Revisions to other disorders have also caused a great deal of controversy, especially the changes made to schizophrenia, bipolar disorder, dissociative identity disorder, and depressive disorder. The criteria for diagnosis of these disorders were changed in the DSM-5, which affects how patients are identified and diagnosed. For example, in previous versions of the manual, there was a bereavement exclusion in the major depressive disorder category that eliminated grief that occurred as the result of the death of a loved one as a diagnostic category. However, in the DSM-5, the new criteria indicate that an individual who suffers from grief as the result of the death of a loved one can be classified as depressed, as long as that grief lasts for longer than two weeks. This has caused a great deal of controversy, as many mental health professionals do not consider grief from bereavement to be a mental disorder.

The bereavement issue is indicative of a greater issue with the manual. There are many disorders listed within the text that mental health practitioners do not consider diagnosable disorders. Common complaints against the manual have focused on the broad range of criteria and the ease with which some individuals can be diagnosed with a disorder. For example, previous behaviors, which were considered general behavior problems such as temper tantrums in children and general forgetfulness, are now considered diagnosable conditions with names like “disruptive mood dysregulation disorder” and “neurocognitive disorder.” The criticism against this is that not every behavior problem is a diagnosable mental disorder and by establishing criteria in the DSM-5, the APA is going to increase the number of relatively “normal” individuals who are diagnosed with a mental disorder.
Other critics have expressed the opposite view of the criteria, complaining that they are too narrow to adequately diagnose those who actually have a mental disorder.³ For example, disruptive mood dysregulation disorder requires a number of qualifiers for a child to be diagnosed, and some critics argue that the strict criteria exclude a number of children who actually have disruptive mood dysregulation disorder.³⁴ Other critics have expressed similar sentiments regarding other disorders in the manual.

Another criticism against the DSM-5 is the change from a multiaxial coding system to a nonaxial coding system. The APA promotes the new coding system as making the diagnostic process more streamlined and comprehensive.⁸ In the new manual, the first three DSM-IV-TR axes have been combined into one list. This list contains all mental disorders, including personality disorders and intellectual disability, as well as other medical diagnoses.³² Critics of the new coding system argue that it does not allow for the identification of individual disorders and symptoms as it removes the separate axes and combines them into one broad category.³⁴ Critics also argue that the removal of axes IV and V eliminate the opportunity to specify relevant psychosocial and contextual factors (Axis IV) and disability status (Axis V) within the diagnosis.²⁵ Meanwhile, supporters of the new nonaxial coding system argue that the removal of individual axes allows for patients to be diagnosed on a broad spectrum that focuses more on severity level than individual symptoms.³

The controversy surrounding the release of the DSM-5 caused problems between the APA and other mental health organizations, including the National Institute of Mental Health and the American Psychological Association. These other groups have expressed concerns similar to those listed above and have criticized the APA for expanding the breadth of the
manual to a point that it will result in the over diagnosis of numerous individuals who do not actually have a mental disorder.\textsuperscript{33} These organizations were hopeful that the new DSM would utilize scientific information and data to better outline the mental disorders plaguing individuals in society. However, according to them, the manual is not based on substantial scientific evidence and will be detrimental to the mental health community as a whole. They are concerned that the manual lacks validity.\textsuperscript{26}

**Organization Of The DSM-5**

The DSM-5 is organized differently than previous editions of the manual. While some of the sections have remained the same, new sections have been added and some mental disorders have been moved to new sections. To best understand the DSM-5, one must understand the overall organization of the manual and the implications this has on the classification system and criteria used to identify and diagnose mental disorders.

The DSM-5 is divided into four distinct sections, each of which contains an abundance of information that can be used by mental health professionals to diagnose and, subsequently, treat individuals with mental disorders. The following is a list of the sections included in the DSM-5:\textsuperscript{30}

- Section I: DSM-5 Basics
- Section II: Diagnostic Criteria and Codes
- Section III: Emerging Measures and Models

Each section of the manual contains extensive information that can be used in the diagnosis and care of patients. The following is the table of contents for the DSM-5.
DSM-5 Classification

Preface

Section I: DSM-5 Basics

Introduction

- Use of the Manual
- Cautionary Statement for Forensic Use of DSM-5

Section II: Diagnostic Criteria and Codes

Neurodevelopmental Disorders

Intellectual Disabilities:

- Intellectual Disability (Intellectual Developmental Disorder)
- Global Developmental Delay
- Unspecified Intellectual Disability (Intellectual Developmental Disorder)

Communication Disorders:

- Language Disorder
- Speech Sound Disorder (previously Phonological Disorder)
- Childhood-Onset Fluency Disorder (Stuttering)
- Social (Pragmatic) Communication Disorder
- Unspecified Communication Disorder

Autism Spectrum Disorder

- Autism Spectrum Disorder
Attention-Deficit/Hyperactivity Disorder

- Attention-Deficit/Hyperactivity Disorder
- Other Specified Attention-Deficit/Hyperactivity Disorder
- Unspecified Attention-Deficit/Hyperactivity Disorder

Specific Learning Disorder

- Specific Learning Disorder

Motor Disorders

- Developmental Coordination Disorder
- Stereotypic Movement Disorder

Tic Disorders

- Tourette’s Disorder
- Persistent (Chronic) Motor or Vocal Tic Disorder
- Provisional Tic Disorder
- Other Specified Tic Disorder
- Unspecified Tic Disorder

Other Neurodevelopmental Disorders

- Other Specified Neurodevelopmental Disorder
- Unspecified Neurodevelopmental Disorder

Schizophrenia Spectrum and Other Psychotic Disorders

- Schizotypal (Personality) Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Substance/Medication-Induced Psychotic Disorder
- Psychotic Disorder Due to Another Medical Condition

Catatonia:
- Catatonia Associated With Another Mental Disorder (Catatonia Specifier)
- Catatonic Disorder Due to Another Medical Condition
- Unspecified Catatonia
- Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

**Bipolar and Related Disorders**
- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder
- Substance/Medication-Induced Bipolar and Related Disorder
- Bipolar and Related Disorder Due to Another Medical Condition
- Other Specified Bipolar and Related Disorder
- Unspecified Bipolar and Related Disorder

**Depressive Disorders**
- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder, Single and Recurrent Episodes
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Substance/Medication-Induced Depressive Disorder
• Depressive Disorder Due to Another Medical Condition
• Other Specified Depressive Disorder
• Unspecified Depressive Disorder

**Anxiety Disorders**

• Separation Anxiety Disorder
• Selective Mutism
• Specific Phobia
• Social Anxiety Disorder (Social Phobia)
• Panic Disorder
• Panic Attack (Specifier)
• Agoraphobia
• Generalized Anxiety Disorder
• Substance/Medication-Induced Anxiety Disorder
• Anxiety Disorder Due to Another Medical Condition
• Other Specified Anxiety Disorder
• Unspecified Anxiety Disorder

**Obsessive-Compulsive and Related Disorders**

• Obsessive-Compulsive Disorder
• Body Dysmorphic Disorder
• Hoarding Disorder
• Trichotillomania (Hair-Pulling Disorder)
• Excoriation (Skin-Picking) Disorder
• Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
• Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
• Other Specified Obsessive-Compulsive and Related Disorder
- Unspecified Obsessive-Compulsive and Related Disorder

**Trauma- and Stressor-Related Disorders**

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders
- Other Specified Trauma- and Stressor-Related Disorder
- Unspecified Trauma- and Stressor-Related Disorder

**Dissociative Disorders**

- Dissociative Identity Disorder
- Dissociative Amnesia
- Depersonalization/Derealization Disorder
- Other Specified Dissociative Disorder
- Unspecified Dissociative Disorder

**Somatic Symptom and Related Disorders**

- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder (Functional Neurological Symptom Disorder)
- Psychological Factors Affecting Other Medical Conditions
- Factitious Disorder
- Other Specified Somatic Symptom and Related Disorder
- Unspecified Somatic Symptom and Related Disorder
Feeding and Eating Disorders

- Pica
- Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder
- Anorexia Nervosa
- Bulimia Nervosa
- Binge-Eating Disorder
- Other Specified Feeding or Eating Disorder
- Unspecified Feeding or Eating Disorder

Elimination Disorders

- Enuresis
- Encopresis
- Other Specified Elimination Disorder
- Unspecified Elimination Disorder

Sleep-Wake Disorders

- Insomnia Disorder
- Hypersomnolence Disorder
- Narcolepsy

Breathing-Related Sleep Disorders:

- Obstructive Sleep Apnea Hypopnea
- Central Sleep Apnea
- Sleep-Related Hypoventilation

Circadian Rhythm Sleep-Wake Disorders:

- Parasomnias
• Non–Rapid Eye Movement Sleep Arousal Disorders
• Sleepwalking
• Sleep Terrors
• Nightmare Disorder
• Rapid Eye Movement Sleep Behavior Disorder
• Restless Legs Syndrome
• Substance/Medication-Induced Sleep Disorder
• Other Specified Insomnia Disorder
• Unspecified Insomnia Disorder
• Other Specified Hypersomnolence Disorder
• Unspecified Hypersomnolence Disorder
• Other Specified Sleep-Wake Disorder
• Unspecified Sleep-Wake Disorder

**Sexual Dysfunctions**

• Delayed Ejaculation
• Erectile Disorder
• Female Orgasmic Disorder
• Female Sexual Interest/Arousal Disorder
• Genito-Pelvic Pain/Penetration Disorder
• Male Hypoactive Sexual Desire Disorder
• Premature (Early) Ejaculation
• Substance/Medication-Induced Sexual Dysfunction
• Other Specified Sexual Dysfunction
• Unspecified Sexual Dysfunction

**Gender Dysphoria**

• Gender Dysphoria
• Other Specified Gender Dysphoria
- Unspecified Gender Dysphoria

**Disruptive, Impulse-Control, and Conduct Disorders**
- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorder
- Pyromania
- Kleptomania
- Other Specified Disruptive, Impulse-Control, and Conduct Disorder
- Unspecified Disruptive, Impulse-Control, and Conduct Disorder

**Substance-Related and Addictive Disorders**
- Substance-Related Disorders
- Substance Use Disorders
- Substance-Induced Disorders
- Substance Intoxication and Withdrawal
- Substance/Medication-Induced Mental Disorders

**Alcohol-Related Disorders:**
- Alcohol Use Disorder
- Alcohol Intoxication
- Alcohol Withdrawal
- Other Alcohol-Induced Disorders
- Unspecified Alcohol-Related Disorder

**Caffeine-Related Disorders:**
- Caffeine Intoxication
• Caffeine Withdrawal
• Other Caffeine-Induced Disorders
• Unspecified Caffeine-Related Disorder

Cannabis-Related Disorders:
• Cannabis Use Disorder
• Cannabis Intoxication
• Cannabis Withdrawal
• Other Cannabis-Induced Disorders
• Unspecified Cannabis-Related Disorder

Hallucinogen-Related Disorders:
• Phencyclidine Use Disorder
• Other Hallucinogen Use Disorder
• Phencyclidine Intoxication
• Other Hallucinogen Intoxication
• Hallucinogen Persisting Perception Disorder
• Other Phencyclidine-Induced Disorders
• Other Hallucinogen-Induced Disorders
• Unspecified Phencyclidine-Related Disorder
• Unspecified Hallucinogen-Related Disorder

Inhalant-Related Disorders:
• Inhalant Use Disorder
• Inhalant Intoxication
• Other Inhalant-Induced Disorders
• Unspecified Inhalant-Related Disorder
Opioid-Related Disorders:

- Opioid Use Disorder
- Opioid Intoxication
- Opioid Withdrawal
- Other Opioid-Induced Disorders
- Unspecified Opioid-Related Disorder

Sedative-, Hypnotic-, or Anxiolytic-Related Disorders:

- Sedative, Hypnotic, or Anxiolytic Use Disorder
- Sedative, Hypnotic, or Anxiolytic Intoxication
- Sedative, Hypnotic, or Anxiolytic Withdrawal
- Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders
- Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder

Stimulant-Related Disorders:

- Stimulant Use Disorder
- Stimulant Intoxication
- Stimulant Withdrawal
- Other Stimulant-Induced Disorders
- Unspecified Stimulant-Related Disorder

Tobacco-Related Disorders:

- Tobacco Use Disorder
- Tobacco Withdrawal
- Other Tobacco-Induced Disorders
- Unspecified Tobacco-Related Disorder
- Other (or Unknown) Substance-Related Disorders
- Other (or Unknown) Substance Use Disorder
• Other (or Unknown) Substance Intoxication
• Other (or Unknown) Substance Withdrawal
• Other (or Unknown) Substance–Induced Disorders
• Unspecified Other (or Unknown) Substance–Related Disorder

Non-Substance-Related Disorders:

• Gambling Disorder

Neurocognitive Disorders

• Delirium
• Other Specified Delirium
• Unspecified Delirium
• Major and Mild Neurocognitive Disorders
• Major Neurocognitive Disorder
• Mild Neurocognitive Disorder
• Major or Mild Neurocognitive Disorder Due to Alzheimer’s Disease
• Major or Mild Frontotemporal Neurocognitive Disorder
• Major or Mild Neurocognitive Disorder With Lewy Bodies
• Major or Mild Vascular Neurocognitive Disorder
• Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury
• Substance/Medication-Induced Major or Mild Neurocognitive Disorder
• Major or Mild Neurocognitive Disorder Due to HIV Infection
• Major or Mild Neurocognitive Disorder Due to Prion Disease
• Major or Mild Neurocognitive Disorder Due to Parkinson’s Disease
• Major or Mild Neurocognitive Disorder Due to Huntington’s Disease
• Major or Mild Neurocognitive Disorder Due to Another Medical Condition
• Major or Mild Neurocognitive Disorder Due to Multiple Etiologies
• Unspecified Neurocognitive Disorder
Personality Disorders

- General Personality Disorder
- Cluster A Personality Disorders
- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Cluster B Personality Disorders
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Cluster C Personality Disorders
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder

Other Personality Disorders:

- Personality Change Due to Another Medical Condition
- Other Specified Personality Disorder
- Unspecified Personality Disorder

Paraphilic Disorders

- Voyeuristic Disorder
- Exhibitionistic Disorder
- Frotteuristic Disorder
- Sexual Masochism Disorder
- Sexual Sadism Disorder
- Pedophilic Disorder
• Fetishistic Disorder
• Transvestic Disorder
• Other Specified Paraphilic Disorder
• Unspecified Paraphilic Disorder

Other Mental Disorders

• Other Specified Mental Disorder Due to Another Medical Condition
• Unspecified Mental Disorder Due to Another Medical Condition
• Other Specified Mental Disorder
• Unspecified Mental Disorder
• Medication-Induced Movement Disorders and Other Adverse Effects of Medication
• Other Conditions That May Be a Focus of Clinical Attention

Section III: Emerging Measures and Models

Assessment Measures

Cross-Cutting Symptom Measures:

• DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure — Adult
• Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure—Child Age 6–17
• Clinician-Rated Dimensions of Psychosis Symptom Severity
• World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)

Cultural Formulation:

• Cultural Formulation Interview (CFI)
• Cultural Formulation Interview (CFI)—Informant Version
Alternative DSM-5 Model for Personality Disorders

Conditions for Further Study:

- Attenuated Psychosis Syndrome
- Depressive Episodes With Short-Duration Hypomania
- Persistent Complex Bereavement Disorder
- Caffeine Use Disorder
- Internet Gaming Disorder
- Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure
- Suicidal Behavior Disorder
- Nonsuicidal Self-Injury

Appendix:

- Highlights of Changes From DSM-IV to DSM-5
- Glossary of Technical Terms
- Glossary of Cultural Concepts of Distress
- Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)
- Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)
- Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM)
- DSM-5 Advisors and Other Contributors (30)

Section 1: DSM-5 Basics

The first section of the DSM-5 provides information on the basics of the manual. This section provides an introduction to the manual as well as instructions for how to use the manual. The APA also included a cautionary statement for forensic use of the DSM-5. This is a new section in the DSM. Previous editions of the manual did not include a section with instructions for use and a statement providing cautions for forensic use.8
The APA includes the following descriptive statement at the beginning of section 1, to give readers an understanding of the purpose of the section:  

>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.

First Part of Section 1: Purpose of the Manual

The first part of section 1 is the introduction. In this section, the APA provides an overview of the purpose of the manual as a tool for the identification, understanding and diagnosis of mental disorders. The introduction also provides an overview of the history of the DSM as well as an outline of the revision process. The final section of the introduction provides information on the organization of the manual, and includes information on the following components:

- Organizational Structure
  - Harmonization with ICD-11
  - Dimensional Approach to Diagnosis
- Developmental and Lifespan Considerations
- Cultural Issues
- Gender Differences
- Use of Other Specified and Unspecified Disorders
- The Multiaxial System
- Online Enhancements

*Use of the Manual*

The second section of section 1 provides an overview of how to use the manual. In this section, the APA indicates that the primary purpose of the 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 APA also stresses that the symptoms included in the manual are not comprehensive definitions of underlying disorders, but rather they summarize characteristic syndromes of signs and syndromes that indicate an underlying disorder. This section is broken into the following categories:

- Approach to Clinical Case Formulation
- Definition of a Mental Disorder
  - Criterion for Clinical Significance
- Elements of a Diagnosis
  - Diagnostic Criteria and Descriptors
  - Subtypes and Specifiers
  - Medication Induced Movement Disorders and Other Conditions That May Be a Focus of Clinical Attention
  - Principal Diagnosis
  - Provisional Diagnosis
  - Coding and Reporting Procedures
Looking to the Future: Assessment and Monitoring Tools

Cautionary Statement for Forensic Use of DSM-5

The final section of section 1 provides information on how the manual can, and should, be used as part of forensics. In the beginning of this section, the APA clearly states that the DSM-5 criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning. However, the APA also recognizes that courts and attorneys will also use the manual as a reference in assessing the forensic consequences of mental disorders. Therefore, this section stresses that the definition of mental disorder as used in the 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 court and legal professionals.” Individuals in these fields are cautioned against using the DSM-5 in any way other than to inform the investigation and/or decision making process. The DSM-5 should not be used by “nonclinical, nonmedical, or otherwise insufficiently trained individuals” to assess or diagnose an individual.

Section II: Diagnostic Criteria and Codes

The second section of the DSM-5 provides the descriptions and criteria for each of the diagnosable disorders. This section also provides coding information. The statement at the beginning of the section provides the following information:

This section contains the diagnostic criteria approved for routine clinical use along with the ICD-9-CM codes (ICD-10 codes are shown parenthetically). For each mental disorder, the diagnostic criteria are followed by descriptive text to
assist in diagnostic decision-making. Where needed, specific recording procedures are presented with the diagnostic criteria to provide guidance in selecting the most appropriate code. In some cases, separate recording procedures for ICD-9-CM and ICD-10-CM are provided. Although not considered as official DSM-5 disorders, medication induced movement disorders and other adverse affects of medication, as well as other conditions that may be a focus of clinical attention (including additional ICD-9-CM V codes and forthcoming ICD-10-CM Z codes), are provided to indicate other reasons for a clinical visit such as environmental factors and relational problems. These codes are adapted from ICD-9-CM and ICD-10-CM and were neither reviewed nor approved as official DSM-5 diagnoses, but can provide additional context for a clinical formulation and treatment plan. These three components – the criteria and their descriptive text, the medication induced movement disorders and other adverse effects of medication, and the descriptions of other conditions that may be a focus of clinical attention – represent key elements of the clinical diagnostic process and thus are presented together.

The diagnostic criteria and codes are broken into categories based on the type of disorder. The following is a list of the different diagnostic categories as well as the individual medical disorders:

**Neurodevelopmental Disorders**

- Intellectual Disabilities:
- Intellectual Disability (Intellectual Developmental Disorder)
- Global Developmental Delay
- Unspecified Intellectual Disability (Intellectual Developmental Disorder)

- Communication Disorders:
  - Language Disorder
  - Speech Sound Disorder (previously Phonological Disorder)
  - Childhood-Onset Fluency Disorder (Stuttering)
  - Social (Pragmatic) Communication Disorder
  - Unspecified Communication Disorder

- Autism Spectrum Disorder:
  - Autism Spectrum Disorder

- Attention-Deficit/Hyperactivity Disorder:
  - Attention-Deficit/Hyperactivity Disorder
  - Other Specified Attention-Deficit/Hyperactivity Disorder
  - Unspecified Attention-Deficit/Hyperactivity Disorder

- Specific Learning Disorder:
  - Specific Learning Disorder

- Motor Disorders:
  - Developmental Coordination Disorder
  - Stereotypic Movement Disorder
  - Tic Disorders:
    - Tourette’s Disorder
    - Persistent (Chronic) Motor or Vocal Tic Disorder
    - Provisional Tic Disorder
    - Other Specified Tic Disorder
    - Unspecified Tic Disorder

- Other Neurodevelopmental Disorders:
  - Other Specified Neurodevelopmental Disorder
- Unspecified Neurodevelopmental Disorder

Schizophrenia Spectrum and Other Psychotic Disorders

- Schizotypal (Personality) Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Substance/Medication-Induced Psychotic Disorder
- Psychotic Disorder Due to Another Medical Condition
- Catatonia:
  - Catatonia Associated With Another Mental Disorder (Catatonia Specifier)
  - Catatonic Disorder Due to Another Medical Condition
  - Unspecified Catatonia

- Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Bipolar and Related Disorders

- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder
- Substance/Medication-Induced Bipolar and Related Disorder
- Bipolar and Related Disorder Due to Another Medical Condition
- Other Specified Bipolar and Related Disorder
- Unspecified Bipolar and Related Disorder
Depressive Disorders

- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder, Single and Recurrent Episodes
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Substance/Medication-Induced Depressive Disorder
- Depressive Disorder Due to Another Medical Condition
- Other Specified Depressive Disorder
- Unspecified Depressive Disorder

Anxiety Disorders

- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder
- Panic Attack (Specifier)
- Agoraphobia
- Generalized Anxiety Disorder
- Substance/Medication-Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition
- Other Specified Anxiety Disorder
- Unspecified Anxiety Disorder

Obsessive-Compulsive and Related Disorders

- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania (Hair-Pulling Disorder)
- Excoriation (Skin-Picking) Disorder
- Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
- Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
- Other Specified Obsessive-Compulsive and Related Disorder
- Unspecified Obsessive-Compulsive and Related Disorder

**Trauma- and Stressor-Related Disorders**

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders
- Other Specified Trauma- and Stressor-Related Disorder
- Unspecified Trauma- and Stressor-Related Disorder

**Dissociative Disorders**

- Dissociative Identity Disorder
- Dissociative Amnesia
- Depersonalization/Derealization Disorder
- Other Specified Dissociative Disorder
- Unspecified Dissociative Disorder

**Somatic Symptom and Related Disorders**

- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder (Functional Neurological Symptom Disorder)
- Psychological Factors Affecting Other Medical Conditions
- Factitious Disorder
- Other Specified Somatic Symptom and Related Disorder
- Unspecified Somatic Symptom and Related Disorder

**Feeding and Eating Disorders**

- Pica
- Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder
- Anorexia Nervosa
- Bulimia Nervosa
- Binge-Eating Disorder
- Other Specified Feeding or Eating Disorder
- Unspecified Feeding or Eating Disorder

**Elimination Disorders**

- Enuresis
- Encopresis
- Other Specified Elimination Disorder
- Unspecified Elimination Disorder

**Sleep-Wake Disorders**

- Insomnia Disorder
- Hypersomnolence Disorder
- Narcolepsy
- Breathing-Related Sleep Disorders:
  - Obstructive Sleep Apnea Hypopnea
- Central Sleep Apnea
- Sleep-Related Hypoventilation
- Circadian Rhythm Sleep-Wake Disorders
- Parasomnias
- Non-Rapid Eye Movement Sleep Arousal Disorders
  - Sleepwalking
  - Sleep Terrors
- Nightmare Disorder
- Rapid Eye Movement Sleep Behavior Disorder
- Restless Legs Syndrome
- Substance/Medication-Induced Sleep Disorder
- Other Specified Insomnia Disorder
- Unspecified Insomnia Disorder
- Other Specified Hypersomnolence Disorder
- Unspecified Hypersomnolence Disorder
- Other Specified Sleep-Wake Disorder
- Unspecified Sleep-Wake Disorder

**Sexual Dysfunctions**

- Delayed Ejaculation
- Erectile Disorder
- Female Orgasmic Disorder
- Female Sexual Interest/Arousal Disorder
- Genito-Pelvic Pain/Penetration Disorder
- Male Hypoactive Sexual Desire Disorder
- Premature (Early) Ejaculation
- Substance/Medication-Induced Sexual Dysfunction
- Other Specified Sexual Dysfunction
- Unspecified Sexual Dysfunction
Gender Dysphoria

- Gender Dysphoria
- Other Specified Gender Dysphoria
- Unspecified Gender Dysphoria

Disruptive, Impulse-Control, and Conduct Disorders

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorder
- Pyromania
- Kleptomania
- Other Specified Disruptive, Impulse-Control, and Conduct Disorder
- Unspecified Disruptive, Impulse-Control, and Conduct Disorder

Substance-Related and Addictive Disorders

- Substance-Related Disorders
- Substance Use Disorders
- Substance-Induced Disorders
  - Substance Intoxication and Withdrawal
  - Substance/Medication-Induced Mental Disorders
- Alcohol-Related Disorders:
  - Alcohol Use Disorder
  - Alcohol Intoxication
  - Alcohol Withdrawal
  - Other Alcohol-Induced Disorders
  - Unspecified Alcohol-Related Disorder
- Caffeine-Related Disorders:
- Caffeine Intoxication
- Caffeine Withdrawal
- Other Caffeine-Induced Disorders
- Unspecified Caffeine-Related Disorder

- Cannabis-Related Disorders:
  - Cannabis Use Disorder
  - Cannabis Intoxication
  - Cannabis Withdrawal
  - Other Cannabis-Induced Disorders
  - Unspecified Cannabis-Related Disorder

- Hallucinogen-Related Disorders:
  - Phencyclidine Use Disorder
  - Other Hallucinogen Use Disorder
  - Phencyclidine Intoxication
  - Other Hallucinogen Intoxication
  - Hallucinogen Persisting Perception Disorder
  - Other Phencyclidine-Induced Disorders
  - Other Hallucinogen-Induced Disorders
  - Unspecified Phencyclidine-Related Disorder
  - Unspecified Hallucinogen-Related Disorder

- Inhalant-Related Disorders:
  - Inhalant Use Disorder
  - Inhalant Intoxication
  - Other Inhalant-Induced Disorders
  - Unspecified Inhalant-Related Disorder

- Opioid-Related Disorders:
  - Opioid Use Disorder
  - Opioid Intoxication
  - Opioid Withdrawal
- Other Opioid-Induced Disorders
- Unspecified Opioid-Related Disorder

**Sedative-, Hypnotic-, or Anxiolytic-Related Disorders:**
- Sedative, Hypnotic, or Anxiolytic Use Disorder
- Sedative, Hypnotic, or Anxiolytic Intoxication
- Sedative, Hypnotic, or Anxiolytic Withdrawal
- Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders
- Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder

**Stimulant-Related Disorders:**
- Stimulant Use Disorder
- Stimulant Intoxication
- Stimulant Withdrawal
- Other Stimulant-Induced Disorders
- Unspecified Stimulant-Related Disorder

**Tobacco-Related Disorders:**
- Tobacco Use Disorder
- Tobacco Withdrawal
- Other Tobacco-Induced Disorders
- Unspecified Tobacco-Related Disorder

**Other (or Unknown) Substance–Related Disorders**

**Other (or Unknown) Substance Use Disorder**
**Other (or Unknown) Substance Intoxication**
**Other (or Unknown) Substance Withdrawal**
**Other (or Unknown) Substance–Induced Disorders**
**Unspecified Other (or Unknown) Substance–Related Disorder**

**Non-Substance-Related Disorders:**
- Gambling Disorder
Neurocognitive Disorders

- Delirium
- Other Specified Delirium
- Unspecified Delirium
- Major and Mild Neurocognitive Disorders
- Major Neurocognitive Disorder
- Mild Neurocognitive Disorder
- Major or Mild Neurocognitive Disorder Due to Alzheimer’s Disease
- Major or Mild Frontotemporal Neurocognitive Disorder
- Major or Mild Neurocognitive Disorder With Lewy Bodies
- Major or Mild Vascular Neurocognitive Disorder
- Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury
- Substance/Medication-Induced Major or Mild Neurocognitive Disorder
- Major or Mild Neurocognitive Disorder Due to HIV Infection
- Major or Mild Neurocognitive Disorder Due to Prion Disease
- Major or Mild Neurocognitive Disorder Due to Parkinson’s Disease
- Major or Mild Neurocognitive Disorder Due to Huntington’s Disease
- Major or Mild Neurocognitive Disorder Due to Another Medical Condition
- Major or Mild Neurocognitive Disorder Due to Multiple Etiologies
- Unspecified Neurocognitive Disorder

Personality Disorders

- General Personality Disorder
- Cluster A Personality Disorders
- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Cluster B Personality Disorders
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Cluster C Personality Disorders
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Other Personality Disorders:
  - Personality Change Due to Another Medical Condition
  - Other Specified Personality Disorder
  - Unspecified Personality Disorder

**Paraphilic Disorders**

- Voyeuristic Disorder
- Exhibitionistic Disorder
- Frotteuristic Disorder
- Sexual Masochism Disorder
- Sexual Sadism Disorder
- Pedophilic Disorder
- Fetishistic Disorder
- Transvestic Disorder
- Other Specified Paraphilic Disorder
- Unspecified Paraphilic Disorder

**Other Mental Disorders**

- Other Specified Mental Disorder Due to Another Medical Condition
- Unspecified Mental Disorder Due to Another Medical Condition
- Other Specified Mental Disorder
• Unspecified Mental Disorder

_Medication-Induced Movement Disorders and Other Adverse Effects of Medication_

• Neuroleptic Induced Parkinsonism
• Other Medication Induced Parkinsonism
• Neuroleptic Malignant Syndrome
• Medication Induced Acute Dystonia
• Medication Induced Acute Akathisia
• Tardive Dyskinesia
• Tardive Dystonia
• Tardive Akathisia
• Medication Induced Postural Tremor
• Other Medication Induced Movement Disorder
• Antidepressant Discontinuation Syndrome
• Other Adverse Effect of Medication

_Other Conditions That May Be a Focus of Clinical Attention_

• Relational Problems
• Problems Related to Family Upbringing:
  – Parent Child Relational Problem
  – Sibling Relational Problem
  – Upbringing Away From Parents
  – Child Affected by Parental Relationship Distress
• Other Problems Related to Primary Support Group:
  – Relationship Distress With Spouse or Intimate Partner
  – Disruption of Family by Separation or Divorce
  – High Expressed Emotion Level Within Family
- Uncomplicated Bereavement

- Abuse and Neglect
  - Child Maltreatment and Neglect Problems:
    - Child Physical Abuse
    - Child Sexual Abuse
    - Child Neglect
    - Child Psychological Abuse
  - Adult Maltreatment and Neglect Problems:
    - Spouse or Partner Violence, Physical
    - Spouse or Partner Violence, Sexual
    - Spouse or Partner Neglect
    - Spouse or Partner Abuse, Psychological
    - Adult Abuse by Nonspouse or Nonpartner

- Educational and Occupational Problems
  - Educational Problems
  - Occupational Problems

- Housing and Economic Problems
  - Housing Problems
  - Economic Problems

- Other Problems Related to the Social Environment
- Problems Related to Crime or Interaction with the Legal System
- Other Health Service Encounters for Counseling and Medical Advice
- Problems Related to Other Psychosocial, Personal, and Environmental Circumstances
- Other Circumstances of Personal History
- Problems Related to Access to Medical and Other Health Care
- Nonadherence to Medical Treatment
Each category includes a basic overview of the type of disorder and the common attributes for the category. This descriptive section provides information regarding how these disorders typically manifest and the impact they have on the individual. This general overview also includes information on the specific disorders that make up the category. After the general overview, each disorder specific to the category is listed with the diagnostic criteria and other factors associated with each disorder. For each disorder, the following information is provided:\(^{30}\)

- Diagnostic Criteria
- Specifiers
- Diagnostic Features
- Associated Features Supporting Diagnosis
- Prevalence
- Development and Course
- Risk and Prognostic Factors
- Culture Related Diagnostic Issues
- Gender Related Diagnostic Issues
- Diagnostic Markers
- Differential Diagnosis
- Comorbidity
- Relationship to Other Classifications

While each disorder includes the same categories, the information included within these categories is unique to the specific disorder. Some disorders have different levels of severity, while others have different diagnostic categories within the general diagnosis. Therefore, the individual diagnostic section is tailored to the specific attributes of the disorder.
This section also includes a number of tables that provide information specific to various disorders. For example, one table provides a breakdown of the severity levels for intellectual disability across the conceptual domain, social domain and practical domain. There is also a table that differentiates the severity levels for autism spectrum disorder based on level 1, level 2, and level 3. The table included in the section on neurocognitive disorders includes information on the different neurocognitive domains and provides examples of symptoms or observations for each as well as examples of assessments for each. The tables throughout section two are used to provide additional information about specific disorders that does not fit within the pre-established sections.

**Section III: Emerging Measures and Models**

This is a new section in the DSM-5. Previous editions of the manual did not contain a section on emerging measures and models. The APA uses this section to provide information on the types of assessments available as well as potential future revisions and conditions for further study. The APA provides the following section description:

This section contains tools and techniques to enhance the clinical decision making process, understand the cultural context of mental disorders, and recognize emerging diagnoses for further study. It provides strategies to enhance clinical practice and new criteria to stimulate future research, representing a dynamic DSM-5 that will evolve with advances in the field.
Among the tools in Section III is a Level I cross-cutting self/informant-rated measure that serves as a review of systems across mental disorders. Clinician-rated severity scale for schizophrenia and other psychotic disorders also is provided, as well as the World Health Organization Disability Assessment Schedule, Version 2 (WHODAS 2.0). Level 2 severity measures are available online (www.psychiatry.org/dsm5) and may be used to explore significant responses to the Level 1 screen. A comprehensive review of the cultural context of mental disorders, and the Cultural Formation Interview (CFI) for clinical use, are provided.

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

Section III includes the following topical categories:

Assessment Measures:

- Cross Cutting Symptom Measures
  - DSM-5 Self Rated Level 1 Cross Cutting Symptom Measures – Adult
- Parent Guardian Rated DSM-5 Level 1 Cross Cutting Symptom Measure – Child Age 6 – 17
  - Clinician Rated Dimensions of Psychosis Symptom Severity
  - World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)

Cultural Formation:
  - Cultural Formation Interview (CFI)
  - Cultural Formation Interview (CFI) – Informant Version

Alternative DSM-5 Model for Personality Disorders:

Conditions for Further Study -
  - Attenuated Psychosis Syndrome
  - Depressive Episodes With Short Duration Hypomnina
  - Persistent Complex Bereavement Disorder
  - Caffeine Use Disorder
  - Internet Gaming Disorder
  - Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure
  - Suicidal Behavior Disorder
  - Nonsuicidal Self Injury

Assessment Measures

The first category in section III of the DSM-5 focuses on assessment and includes Cross Cutting Symptom Measures, Clinician Rated Dimensions of Psychosis Symptom Severity and the WHO Disability Assessment Schedule 2.0. All of these assessments are intended to provide a more dimensional approach to the diagnosis of mental
disorders that allows for combinations with the DSM-5 categorical diagnoses.

The assessment measures enable practitioners to better identify and diagnose different aspects of mental disorders, including the level of severity, symptom intensity and type and duration of the symptoms.

Cross Cutting Symptom Measures Provide Two Levels for Diagnosis:

Level I and Level II -

The first level provides a general assessment and includes 13 symptom domains for adult patients and 12 domains for children. The second level is a more in-depth assessment of the domains. The Cross Cutting symptom measures are intended for use during an initial screening as well as throughout the duration of treatment.

The following two tables are provided for use to understand the differences between disorders and severity of symptoms. The first table is used when diagnosing adults and the second is used when diagnosing children and adolescents.
Table 1: Adult DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: domains, thresholds for further inquiry, and associated Level 2 measures for adults ages 18 and over

<table>
<thead>
<tr>
<th>Domain</th>
<th>Domain Name</th>
<th>Threshold to guide further inquiry</th>
<th>DSM-5 Level 2 Cross-Cutting Symptom Measure available online</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Depression</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Depression — Adult (PROMIS Emotional Distress—Depression—Short Form)</td>
</tr>
<tr>
<td>II.</td>
<td>Anger</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Anger — Adult (PROMIS Emotional Distress — Anger — Short Form)</td>
</tr>
<tr>
<td>III.</td>
<td>Mania</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Mania — Adult (Altman Self-Rating Mania Scale)</td>
</tr>
<tr>
<td>IV.</td>
<td>Anxiety</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Anxiety — Adult (PROMIS Emotional Distress — Anxiety — Short Form)</td>
</tr>
<tr>
<td>V.</td>
<td>Somatic Symptoms</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Somatic Symptom — Adult (Patient Health Questionnaire 15 Somatic Symptom Severity [PHQ-15])</td>
</tr>
<tr>
<td>VI.</td>
<td>Suicidal Ideation</td>
<td>Slight or greater</td>
<td>None</td>
</tr>
<tr>
<td>VII.</td>
<td>Psychosis</td>
<td>Slight or greater</td>
<td>None</td>
</tr>
<tr>
<td>VIII.</td>
<td>Sleep Problems</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Sleep Disturbance — Adult (PROMIS — Sleep Disturbance — Short Form)</td>
</tr>
<tr>
<td>IX.</td>
<td>Memory</td>
<td>Mild or greater</td>
<td>None</td>
</tr>
<tr>
<td>X.</td>
<td>Repetitive Thoughts and Behaviors</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Repetitive Thoughts and Behaviors — Adult (adapted from the Florida Obsessive - Compulsive Inventory [FOCI] Severity Scale [Part B])</td>
</tr>
<tr>
<td>XI.</td>
<td>Dissociation</td>
<td>Mild or greater</td>
<td>None</td>
</tr>
<tr>
<td>XII.</td>
<td>Personality Functioning</td>
<td>Mild or greater</td>
<td>None</td>
</tr>
<tr>
<td>XIII.</td>
<td>Substance Use</td>
<td>Slight or greater</td>
<td>LEVEL 2 — Substance Abuse — Adult (adapted from the NIDA - modified ASSIST)</td>
</tr>
</tbody>
</table>
### Table 2: DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17: domains, thresholds for further inquiry, and associated Level 2 measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Domain Name</th>
<th>Threshold to guide further inquiry</th>
<th>DSM-5 Level 2 Cross-Cutting Symptom Measure available online</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Somatic Symptoms</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Somatic Symptom — Parent/Guardian of Child Age 6–17 (Patient Health Questionnaire 15 Somatic Symptom Severity (PHQ-15))</td>
<td></td>
</tr>
<tr>
<td>II. Sleep Problems</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Sleep Disturbance — Parent/Guardian of Child Age 6–17 (PROMIS — Sleep Disturbance — Short Form)</td>
<td></td>
</tr>
<tr>
<td>III. Inattention</td>
<td>Slight or greater</td>
<td>LEVEL 2 — Inattention — Parent/Guardian of Child Age 6–17 (SNAP-IV)</td>
<td></td>
</tr>
<tr>
<td>IV. Depression</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Depression— Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress — Depression — Parent Item Bank)</td>
<td></td>
</tr>
<tr>
<td>V. Anger</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Anger — Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress — Calibrated Anger Measure — Parent)</td>
<td></td>
</tr>
<tr>
<td>VI. Irritability</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Irritability — Parent/Guardian of Child Age 6–17 (Affective Reactivity Index)</td>
<td></td>
</tr>
<tr>
<td>VII. Mania</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Mania — Parent/Guardian of Child Age 6–17 (adapted from the Altman Self-Rating Mania Scale)</td>
<td></td>
</tr>
<tr>
<td>VIII. Anxiety</td>
<td>Mild or greater</td>
<td>LEVEL 2 — Anxiety — Parent/Guardian of Child Age 6–17 (adapted from PROMIS Emotional Distress — Anxiety — Parent Item Bank)</td>
<td></td>
</tr>
<tr>
<td>IX. Psychosis</td>
<td>Slight or greater</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>X. Repetitive Thoughts and Behaviors</td>
<td>Mild or greater</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>XI. Substance Use</td>
<td>Yes/Don’t Know</td>
<td>LEVEL 2 — Substance Use — Parent/Guardian of Child Age 6–17 (adapted from the NIDA-modified ASSIST)/LEVEL 2 — Substance Use — Child Age 11–17 (adapted from the NIDA-modified ASSIST)</td>
<td></td>
</tr>
<tr>
<td>XII. Suicidal Ideation/Attempts</td>
<td>Yes/Don’t Know</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
The Clinician Rated Dimensions of Psychosis Symptom Severity is intended for use when diagnosing individuals with psychotic disorders. According to the DSM-5, the Clinician Rated Dimensions of Psychosis Severity “provides scales for the dimensional assessment of the primary symptoms of psychosis, including hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, and negative symptoms.” This assessment evaluates the severity of symptoms in individuals with psychotic disorders to ensure proper diagnosis and assist with the development of an appropriate treatment plan. The assessment tool is used during the initial consult and throughout the duration of treatment to monitor progress and identify any changes in the patient’s status.

The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) is a 36-item measure that assesses disabilities in adults. The scale, which is completed by the patient or caregiver, corresponds to concepts contained in the WHO International Classification of Functioning, Disability and Health. It uses six domains to determine the type and level of disability. The six domains are:

- Understanding and communicating
- Getting around
- Self care
- Getting along with people
- Life activities (i.e., household, work, school)
- Participation in society
The WHODAS is administered during an initial consult with the patient, as well as throughout the patient’s life to monitor changes in status.

The DSM-5 website provides electronic links to all of the assessment forms that are used during patient diagnosis and treatment. The forms can be accessed at the following website: http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level1.

**Cultural Formulation**

The addition of a section on culture formulation to the DSM-5 is an important revision that will enable practitioners to better assess and address cultural issues related to patient diagnosis and care. Earlier editions of the DSM did not take cultural issues into account. While the DSM-IV did include a brief section on the role of culture in diagnosing mental illness, it was not extensive and did not provide the same amount of consideration as the section in the DSM-5. In the DSM-IV, cultural formulation was included in the appendix and provided a Glossary of Cultural Bound Syndromes and an Outline of Cultural Formulation. While the appendix provided a means for understanding cultural implications in mental disorders, it did not align well with many of the DSM disorders. Therefore, it was removed from the appendix.

In the DSM-5, Cultural Formulation is included in the section entitled *Emerging Measures and Models* and includes descriptive information as well as the Cultural Formulation Interview (CFI), which is a sixteen-question tool that is administered during a patient’s initial visit. It is imperative to understand the cultural impact and context of mental disorders in the...
diagnosis and treatment process. Therefore, practitioners are encouraged to use this section of the manual, as well as the Cultural Formulation Interview to better understand the cultural implications of mental disorders. In this section, the APA provides a definition for culture to establish a context from which to work.

According to the APA, the definition for culture is as follows:\textsuperscript{30}

\textit{Culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience.}

This definition provides a foundation for understanding how culture impacts an individual’s experience with a mental disorder and can be used to better understand the role it plays in diagnosis and treatment. Once a definition for culture has been established, the APA provides an explanation of race and ethnicity and how the two fit in with culture to impact the patient’s experience, especially in the areas of economic inequalities, racism and discrimination, which “result in health disparities.”\textsuperscript{30}

\textit{Outline for Cultural Formulation}

The Cultural Formulation section continues with an Outline for Cultural Formulation, which was originally introduced in the DSM-IV. This outline
provides guidelines to assess the cultural features related to a patient’s mental disorder. The Outline for Cultural Formulation is broken into the following categories:30

- Cultural Identity of the Individual
- Cultural conceptualization of distress
- Psychosocial stressors and cultural features of vulnerability and resilience
- Cultural features of the relationship between the individual and the clinician
- Overall cultural assessment

Cultural Formulation Interview

The Cultural Formulation Interview (CFI) is a new addition to this edition of the DSM. The Cultural Formulation Interview is a sixteen-question document that can be used by practitioners to gather cultural information about a patient during an initial assessment. The CFI is intended to assess the impact of culture on key aspects of an individuals’ mental disorder and subsequent treatment.32 The CFI is administered by the practitioner and focuses on the patient’s individual experiences and views.30

The CFI is very patient-centered and relies on the patient’s individual perspective to assess the cultural factors that influence participation in care. While the CFI is primarily intended for use during an initial assessment, it can also be helpful in later stages of care when the patient is showing resistance to treatment or changes in the care plan.8 According to the APA, the CFI is especially useful when the following exists.32

- Difficulty in diagnostic assessment owning to significant differences in the cultural, religious, or socioeconomic backgrounds of clinicians and the individual.
• Uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria.
• Difficulty in judging illness severity or impairment.
• Disagreement between the individual and the clinician on the course of care.
• Limited engagement in and adherence to treatment by the individual.

The CFI assesses the patient across the following four domains:

• Cultural Definition of the Problem
• Cultural Perceptions of Cause, Context and Support
• Cultural Factors Affecting Self-Coping and Past Help Seeking
• Cultural Factors Affecting Current Help Seeking

The following is the Cultural Formulation Interview sheet that is used during patient assessment. The left side is intended as a guide for the interviewer and includes notes regarding how to frame specific questions, the things the interviewer should focus on, and other appropriate factors. The right side of the form provides specific questions to ask to identify issues and concerns within the four domains listed above.

Cultural Formulation Interview (CFI)—Patient Version

<table>
<thead>
<tr>
<th>GUIDE TO INTERVIEWER</th>
<th>INSTRUCTIONS TO INTERVIEWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual’s social network (i.e., family, friends, or others involved in current problem). This includes the problem’s meaning, potential sources of help, and expectations for services.</td>
<td>Try to understand the problems that bring the person in for help to help them more effectively. Try to know their experience and ideas. Ask some questions about what is going on and how they are dealing with it. Let them know that there are no right or wrong answers.</td>
</tr>
</tbody>
</table>
## CULTURAL DEFINITION OF THE PROBLEM

### Cultural Definition Of The Problem

| Elicit the individual’s view of core problems and key concerns. Focus on the individual’s own way of understanding the problem. Use terms, expressions, to identify the problem in subsequent questions (i.e., “your conflict with your son”). Ask how the individual frames the problem for members of the social network. Focus on the aspects of the problem that matter most to the individual. | Ask what brings them in for help. *If few details are provided or few symptoms mentioned or medical diagnosis, probe further.* People often understand their problems in their own way, which may be similar to or different from how a medical describes the problem. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. What troubles the person most about their problem? |

## CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

### Causes

| This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. Note that individuals may identify multiple causes, depending on the facet of the problem they are considering. Focus on the views of members of the individual’s social network. These may be diverse and vary from the individual’s. | Why does the person think this is happening to them? What do they think are the causes of their problem? *Prompt if further explanation need.* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes. What do others in their family, friends, or others in community think is causing their problem? |

### STRESSORS AND SUPPORTS

<table>
<thead>
<tr>
<th>Elicit information on the individual’s life context, focusing on resources, social supports, and resilience. May also probe other supports (i.e., from co-workers, from participation in religion or spirituality).</th>
<th>Are there any kinds of support that make their problem better, such as support from family, friends, or others?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on stressful aspects of the individual’s environment. Can also probe, i.e., relationship problems, difficulties at work/school, or discrimination.</td>
<td>Are there any kinds of stresses that make the person’s problem worse, such as difficulties with money, or family problems?</td>
</tr>
</tbody>
</table>
### ROLE OF CULTURAL IDENTITY
(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

<table>
<thead>
<tr>
<th>Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.</th>
<th>Sometimes, aspects of people’s background or identity can make their mental health issue better or worse. The terms <strong>background</strong> or <strong>identity</strong> refers to the communities a person belongs to, the languages spoken, where the person or family are from, and race or ethnic background, gender or sexual orientation, or faith or religion. What are the most important aspects of the person’s background or identity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elicit aspects of identity that make the problem better or worse. Probe as needed, <em>i.e.</em>, clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation.</td>
<td>Are there any aspects of the person’s background or identity that make a difference to their problem?</td>
</tr>
<tr>
<td>Probe as needed (<em>i.e.</em>, migration-related problems; conflict across generations or due to gender roles).</td>
<td>Are there any aspects of the person’s background or identity that are causing other concerns or difficulties for them?</td>
</tr>
</tbody>
</table>

### CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

#### Self-Coping
(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)

| Clarify self-coping for the problem. | Sometimes people have various ways of dealing with problems. What the person done on your own to cope with their problem? |

### PAST HELP SEEKING
(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

<table>
<thead>
<tr>
<th>Elicit various sources of help (<em>i.e.</em>, medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing).</th>
<th>Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have they sought for their problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probe as needed (<em>i.e.</em>, “What other sources of help have you used?”). Clarify the individual’s experience and regard for previous help.</td>
<td><em>Probe if does not describe problem or help received:</em> What types of help or treatment were most useful? Not useful?</td>
</tr>
</tbody>
</table>
### BARRIERS
(Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

| Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. Probe details as needed (i.e., “What got in the way?”). | Has anything prevented the person from getting the help needed? *Probe as needed:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand their language or background? |

### CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING
(Social Network, Caregivers, Religion/Spirituality, Older Adults, Coping/Help Seeking)

| Clarify individual’s current perceived needs and expectations of help, broadly defined. Probe if individual lists only one source of help, i.e., “What other kinds of help would be useful to you at this time?”). Focus on the views of the social network regarding help seeking. | Talk some more about the help needed. What kinds of help do they think would be most useful to them for their problem? Are there other kinds of help that family, friends, or other people have suggested would be helpful for them? |

### CLINICIAN-PATIENT RELATIONSHIP
(Clinician-Patient Relationship, Older Adults)

| Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. Probe details as needed i.e., “In what way?”). Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously. | Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Has the person been concerned about this and is there anything that can be done to provide the person with the care needed? |

In many instances, the patient is unable to participate in the interview process. This can occur for a variety of reasons, including but not limited to, the patient’s age, ability to speak, mental capacity, and other factors that may limit communication abilities. In those instances, an informant is used to gather information about the patient. The informant is typically a family member or an individual.
who is very familiar with the patient. To ensure that cultural information is still gathered and assessed, the APA provides a separate CFI intended for the informant. The Informant CFI is structured the same way as the CFI that is used with the patient. However, the questions and guidelines are different to accommodate the informant’s participation. The following is the CFI that is used with informants.³⁹

### Cultural Formulation Interview (CFI)—Informant Version

<table>
<thead>
<tr>
<th>GUIDE TO INTERVIEWER</th>
<th>INSTRUCTIONS TO INTERVIEWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions aim to clarify key aspects of the presenting clinical problem from the informant’s point of view. This includes the problem’s meaning, potential sources of help, and expectations for services.</td>
<td>Aim to understand the problems that bring a family member/friend to seek help. Seek to know the patient’s experience and ideas. Ask some questions about what is going on and how the patient and family member/friend are dealing with it. There are no right or wrong answers.</td>
</tr>
</tbody>
</table>

#### RELATIONSHIP WITH THE PATIENT

<table>
<thead>
<tr>
<th>Questions</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarify the informant’s relationship with the individual and/or the individual’s family.</td>
<td>How would the person describe the relationship to another individual or family? <em>Probe if not clear:</em> How often does the person see the individual or family?</td>
</tr>
</tbody>
</table>

#### CULTURAL DEFINITION OF THE PROBLEM

<table>
<thead>
<tr>
<th>Questions</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elicit the informant’s view of core problems and key concerns. Focus on the informant’s way of understanding the individual’s problem. Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (i.e., “her conflict with her son”). Ask how informant frames the problem for members of the social network.</td>
<td>Ask why the family member/friend seeks help. <em>Probe if informant gives few details/only mentions symptoms/medical diagnosis.</em> People often understand problems in their own way, which may be similar or different from how medical providers describe the problem. How would the person describe a problem? Sometimes people have different ways of describing the problem to family, friends, or others in their community. How would the person describe a problem to them? Focus on the aspects of the problem that matter most to the informant. What troubles the person most about a problem?</td>
</tr>
</tbody>
</table>
### CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

<table>
<thead>
<tr>
<th>Causes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>This question indicates the meaning of the condition for the informant, which may be relevant for clinical care.</td>
<td>What does the individual think is happening? What do they think are the causes of his/her problem?</td>
</tr>
<tr>
<td>Note that informants may identify multiple causes depending on the facet of the problem they are considering.</td>
<td>Prompt further if required: Some people may explain the problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.</td>
</tr>
<tr>
<td>Focus on the views of members of the individual’s social network. These may be diverse and vary from the informant’s.</td>
<td>What do others in the individual’s family, his/her friends, or others in the community think is causing the individual’s problem?</td>
</tr>
</tbody>
</table>

### STRESSORS AND SUPPORTS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Elicit information on the individual’s life context, focusing on resources, social supports, and resilience. May also probe other supports (i.e., from co-workers, from participation in religion or spirituality).</td>
<td>Are there any kinds of supports that make his/her problem better, such as from family, friends, or others?</td>
</tr>
<tr>
<td>Focus on stressful aspects of the individual’s environment. Can also probe, i.e., relationship problems, difficulties at work or school, or discrimination.</td>
<td>Are there any kinds of stresses that make his/her problem worse, such as difficulties with money, or family problems?</td>
</tr>
</tbody>
</table>

### ROLE OF CULTURAL IDENTITY

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask the informant to reflect on the most salient elements of the individual’s cultural identity. Use this information to tailor questions 10–11 as needed.</td>
<td>Sometimes, aspects of people’s background or identity can make the problem better or worse. Background or identity, mean the communities the person belongs to, languages spoken, where the person or family are from, race or ethnic background, gender or sexual orientation, and faith or religion. For the individual, what are the most important aspects of their background or identity?</td>
</tr>
<tr>
<td>Elicit aspects of identify that make the problem better or worse. Probe as needed, i.e., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation.</td>
<td>Are there any aspects of the individual’s background or identity that make a difference to his/her problem?</td>
</tr>
<tr>
<td>Probe as needed, i.e., migration-related problems; conflict across generations or due to gender roles.</td>
<td>Are there any aspects of the individual’s background or identity that are causing concerns or difficulties for him/her?</td>
</tr>
</tbody>
</table>
## CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

<table>
<thead>
<tr>
<th>Self-Coping</th>
<th>Past Help-Seeking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarify individual’s self-coping for the problem.</td>
<td>Sometimes people have various ways of dealing with problems. What has the individual done on his/her own to cope with a problem?</td>
</tr>
<tr>
<td>Elicit various sources of help (<em>i.e.</em>, medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other alternative healing). Probe as needed (<em>i.e.</em>, “What other sources of help has he/she used?”). Clarify the individual’s experience and regard for previous help.</td>
<td>Often, people also look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing has the individual sought for his/her problem? Prove if does not probe usefulness of help received: What types of help or treatment were most useful? Not useful?</td>
</tr>
</tbody>
</table>

## BARRIERS

| Clarify the role of social barriers to help-seeking, access to care, and problems engaging in previous treatment. Probe details as needed, *i.e.*, “What got in the way?”). | Has anything prevented the individual from getting the help he/she needs? Prove as needed: For example, money, work or family commitments, stigma or discrimination, or lack of services that understand his/her language or background? |

## CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

| Preferences | |
|-------------| Talk about the help the individual needs. What kinds of help would be most useful to him/her at this time for his/her problem? Are there other kinds of help that the individual’s family, friends, or other people have suggested would be helpful for him/her now? |
| Clarify individual’s current perceived needs and expectations of help, broadly defined, from the point of view of the informant. Probe if informant lists only one source of help (*i.e.*, what other kinds of help would be useful to the individual). Focus on the views of the social network regarding help seeking. | |
**CLINICIAN-PATIENT RELATIONSHIP**

| Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. Probe details as needed (i.e., “In what way?”). Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously. | Sometimes medical providers and patients misunderstand each other because they come from different backgrounds or have different expectations. Has the individual been concerned about this, and is there anything that can be done to provide the individual with the care he/she needs? |

In addition to the CFI forms included above, the APA also provides supplemental modules for the CFI. According to the APA:

> These modules supplement the core Cultural Formulation Interview and can help clinicians conduct a more comprehensive cultural assessment. The first eight supplementary modules explore the domains of the core CFI in greater depth. The next three modules focus on populations with specific needs, such as children and adolescents, older adults, and immigrants and refugees. The last module explores the experiences and views of individuals who perform caregiving functions, in order to clarify the nature and cultural context of caregiving and how they affect social support in the immediate environment of the individual receiving care. In addition to these supplementary modules, an Informant version of the core CFI collects collateral information on the CFI domains from family members or caregivers.

Clinicians may use these supplementary modules in two ways:

- As adjuncts to the core CFI for additional information about various aspects of illness affecting diverse populations. The
core CFI refers to pertinent modules under each subheading to facilitate such use of the modules.

- As tools for in-depth cultural assessment independent of the core CFI. Clinicians may administer one, several, or all modules depending on what areas of an individual’s problems they would like to elaborate.

The Cultural Formulation Interview Supplemental Modules can be found at the following website:
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level1

**Cultural Concepts of Distress**

The final component of the Cultural Formulation section focuses on cultural concepts of distress. According to the APA, cultural concepts of distress "refers to ways that cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions." There are three main types of cultural concepts:

- Cultural syndromes
- Cultural idioms of distress
- Cultural explanations or perceived causes

The DSM-5 provides a list of the reasons that cultural concepts are important to psychiatric diagnosis. The following is the list of reasons provided in the manual:

- To avoid misdiagnosis
- To obtain useful clinical information
- To improve clinical rapport and engagement
To improve therapeutic efficacy
To guide clinical research
To clarify the cultural epidemiology

Alternative DSM-5 Model for Personality Disorders

Section II of the DSM-5 provides information on the current criteria for the diagnosis of personality disorders. However, during the revision process, an alternative model was developed. While this model was not officially adopted and included in section II, the APA chose to include it in section III to “preserve continuity with current clinical practice, while also introducing a new approach that aims to address numerous shortcomings of the current approach to personality disorders.”

The alternative model that is included in section III provides a different model for diagnosing personality disorders. Under this model, “personality disorders are characterized by impairments in personality functioning and pathological personality traits.”

According to the APA, this model is especially useful in diagnosing the following personality disorders:

- Antisocial
- Avoidant
- Borderline
- Narcissistic
- Obsessive Compulsive
- Schizotypal personality disorder
General Personality Disorder

The section on the alternative model for diagnosis then provides the general criteria for personality disorder, which originally appears in section II. After providing the general criteria, the section continues with the criteria for diagnosis under the alternative model. With this model, patients are diagnosed and described using criteria sets. The following is a list of the criteria sets that are used in this model:30

- Criterion A: Level of Personality Functioning
- Criterion B: Pathological Personality Traits
- Criteria C and D: Pervasiveness and Stability
- Criteria E, F, and G: Alternative Explanations for Personality Pathology (Differential Diagnosis)

Specific Personality Disorder

In addition to providing criteria for the diagnosis of general personality disorder, section III also provides criteria for diagnosing the personality disorders listed above. The criteria for each disorder are included and an explanation of how the patient presents symptoms is provided. The description of each disorder includes information on different levels of severity, as well as specific symptoms and criteria for each disorder.30

This section also includes information on the following components of the alternative model for diagnosing personality disorder:

- Personality Disorder Scoring Algorithms
- Personality Disorder Diagnosis
- Level of Personality Functioning
  - Self and Interpersonal Functioning: Dimensional Definition
- Rating Level of Personality Functioning
  - Personality Traits
    - Definition and Description
      - Dimensionality of personality traits
      - Hierarchical structure of personality
    - The Personality Trait Model
    - Distinguishing Traits, Symptoms, and Specific Behaviors
    - Assessment of the DSM-5 Section III Personality Trait Model
  - Clinical Utility of the Multidimensional Personality Functioning and Trait Model

Included in this section is the *Level of Personality Functioning Scale*, which examines the level of impairment based on the following four categories:
  - Identity
  - Self Direction
  - Empathy
  - Intimacy

The categories listed above are broken down by the following two categories:
  - Self
  - Interpersonal

This section also includes a table that provides definitions of DSM-5 personality disorder trait domains and facets. The following domains are included in the table: 30
• Negative Affectivity
• Emotional liability
• Anxiousness
• Separation insecurity
• Submissiveness
• Hostility
• Perseveration
• Depressivity
• Suspiciousness
• Restricted affectivity
• Detachment
• Withdrawal
• Intimacy avoidance
• Anhedonia
• Depressivity
• Restricted affectivity
• Antagonism
• Manipulativeness
• Deceitfulness
• Grandiosity
• Attention Seeking
• Callousness
• Hostility
• Disinhibition
• Irresponsibility
• Impulsivity
• Distractibility
• Risk taking
• Rigid perfectionism
- Psychoticism
- Unusual beliefs and experiences
- Eccentricity
- Cognitive and perceptual dysregulation

**Conditions for Further Study**

The final component of section III provides information on conditions for further study. In this section, the APA provides information about disorders that has not been researched or developed enough to include in section III, but that warrant further study. These conditions are currently being studied and will, most likely, be included in future editions of the manual. There are eight conditions included in this section, and the APA cautions that the criteria sets provided are not intended as a diagnostic tool. At this point, these conditions cannot be diagnosed, as they are not officially recognized as mental disorders. They are not intended for clinical purposes.

The eight conditions included in the conditions for further study section are:

- Attenuated Psychosis Syndrome
- Depressive Episodes With Short Duration Hypomania
- Persistent Complex Bereavement Disorder
- Caffeine Use Disorder
- Internet Gaming Disorder
- Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure
- Suicidal Behavior Disorder
- Non-suicidal Self Injury
Appendix

The appendix is the final section of the DSM-5 and includes important information for the reader. The appendix is broken down into the following sections:

- Highlights of Changes from DSM-IV to DSM-5
- Glossary of Technical Terms
- Glossary of Cultural Concepts of Distress
- Alphabetical Listing of DSM Diagnoses and Codes (ICD-9-CM and ICD-10-CM)
- Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)
- Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM)
- DSM-5 Advisors and Other Contributors

Highlights of Changes from DSM-IV to DSM-5

The first section of the appendix provides thorough information on all of the disorder-specific changes that appear in the new manual. The introduction of the manual covered organizational changes, so this section focuses entirely on changes to specific disorders. The APA also published a fact sheet that is available electronically, which provides the same information. This section is organized by disorder category and follows the structure of section II so that practitioners can easily apply the changes to the previous section.

Glossary of Technical Terms

The glossary of technical terms provides a list of terms used throughout the DSM-5. It is intended to help the reader better understand the specific language used, especially when referring to specific disorders.
Glossary of Cultural Concepts of Distress

The focus on culture and the impact it has on an individual’s mental health experience, diagnosis and treatment extends throughout the DSM-5. In the appendix, a glossary is provided with specific terms that refer to cultural concepts of distress. Each term is defined and then related conditions in other cultural contexts, as well as related conditions in the DSM-5, are provided.

The glossary is intended to be a guide by practitioners who are working with individuals from various cultures. When an individual presents with one of these cultural concepts of distress, the practitioner can refer to the manual and determine the cultural context of the disorder and then identify an appropriate equivalent DSM-5 recognized mental disorder. In most instances, there is not a direct connection between the cultural concept and a specific psychiatric disorder. However, an understanding of the similarities between the two is important when working with and diagnosing a patient.

Alphabetical Listing of DSM-5 Diagnosis and Codes (ICD-9-CM and ICD-10-CM)

This section provides a comprehensive listing of all of the ICD-9-CM and ICD-10-CM codes for each disorder, condition or problem included in the manual. The DSM-5 included both the ICD-9-CM codes as well as the ICD-10-CM codes because of the previously planned transition to the ICD-10 coding system. Practitioners were expected to use the ICD-9-CM codes for coding purposes through September 30, 2014. Practitioners were expected to use the ICD-10-
CM codes for coding purposes starting on October 1, 2014.\(^{31}\) For ease of use, the manual has listed the ICD-9-CM code next to the ICD-10-CM code for each disorder, condition, or problem. The list is organized alphabetically by condition.

**Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)**

This section provided a full listing of the ICD-9-CM codes for DSM-5 disorders, conditions and problems. The codes are listed numerically rather than alphabetically.

**Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM)**

This section provided a full listing of the ICD-10-CM codes for DSM-5 disorders, conditions and problems. The codes are listed numerically, rather than alphabetically.

**DSM-5 Advisors and Other Contributors**

This section is a comprehensive listing of all of the individuals who were involved with the DSM revision process. The following categories are included: \(^{30}\)

- APA Board of Trustees DSM-5 Review Committee
- Past DSM-5 APA Staff
- Work Group Advisors
- DSM-5 Study Group and Other DSM-5 Group Advisors
- Other Contributors/Consultants
- CPHC Peer Reviewers
- DSM-5 Field Trials in Academic Clinical Centers: Adult Samples
- DSM-5 Field Trials Pilot Study, Johns Hopkins Medical Institution, Baltimore, Maryland
Insurance Implications

As the DSM-5 was developed, the APA wanted to be sure that the manual would be able to be used immediately by clinicians and insurers without disrupting patient care or impacting insurance coding. To accomplish this, the APA sought input from clinicians and insurers to ensure that the diagnostic and coding system would be compatible with the ICD-9-CM and, eventually, the ICD-10-CM. The DSM-5 uses the statistical codes that are contained in the U.S. Clinical Modifications (CM) of the World Health Organization’s (WHO’s) International Classification System (ICD). The ICD-9-CM provided the statistical codes used for all medical conditions, diseases, and disorders. While the ICD-9-CM provided statistical codes, it did not include descriptive information regarding the diagnosis of these conditions.

With the transition to the ICD-10-CM after October 2014, the APA included coding information for both versions of ICD coding structures. This was expected to ensure a smooth transition from one system to the other without having to make major revisions to the manual.

HIPAA Approved Coding

The DSM codes are used to diagnose mental disorders, but they cannot be used for medical billing purposes, as they are not HIPAA compliant. ICD codes (the World Health Organization’s International Classification of Diseases and Related Health Problems) have been required, as per HIPAA, for all medical billing and reimbursement activities since 2003. The DSM codes are accepted as HIPAA compliant diagnostic codes, but they are not
considered HIPAA compliant from a billing standpoint.\textsuperscript{31} Therefore, DSM codes are used by mental health professionals to identify and diagnose mental disorders, while ICD codes are used by billing professionals to code mental disorders and submit them for billing.\textsuperscript{42}

The DSM-5 includes both the DSM diagnostic codes, as well as ICD-9-CM and ICD-10-CM codes for billing purposes. This ensures that the DSM-5 is fully HIPAA compliant. By including both the ICD-9-CM codes and the ICD-10-CM codes, the DSM-5 can be used seamlessly during the transition from one system to the other without being out of compliance with HIPAA. According to the APA, “\textit{DSM-5 and the ICD should be thought of as companion publications. DSM-5 contains the most up-to-date criteria for diagnosing mental disorders, along with extensive descriptive text, providing a common language for clinicians to communicate about their patients. The ICD contains the code numbers used in DSM-5 and all of medicine, needed for insurance reimbursement and for monitoring of morbidity and mortality statistics by national and international health agencies. The APA works closely with staff from the WHO, CMS, and CDC-NCHS to ensure that the two systems are maximally compatible.}”\textsuperscript{31}

While the DSM codes and ICD codes often mirror each other, there are instances when the names of the DSM-5 disorders do not match the names of the ICD disorders, even though they have the same code.\textsuperscript{31} This occurs because “the DSM-5 diagnostic codes are limited to those contained in the ICD,” therefore, new DSM-5 disorders were “assigned the best available ICD codes.”\textsuperscript{31} In these instances, the name associated with the ICD codes will not match the DSM-5 names. The APA provides guidelines for these instances, indicating that the DSM-5 disorder should be recorded by name in the medical record along with the listing code.
The APA provides a table with specific examples of coding and name differences. The table that follows is intended to serve as an example and does not provide a complete listing.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Social (pragmatic) communication disorder</td>
<td>315.39</td>
<td>Other developmental speech or language disorder</td>
<td>F80.89</td>
<td>Other developmental disorders of speech and language</td>
</tr>
<tr>
<td>Disruptive mood dysregulation disorder</td>
<td>296.99</td>
<td>Other specified episodic mood disorder</td>
<td>F34.8</td>
<td>Other persistent mood [affective] disorders</td>
</tr>
<tr>
<td>Premenstrual dysphoric disorder</td>
<td>625.4</td>
<td>Premenstrual tension syndromes</td>
<td>N94.3</td>
<td>Premenstrual tension syndrome</td>
</tr>
<tr>
<td>Hoarding disorder</td>
<td>300.3</td>
<td>Obsessive-compulsive disorders</td>
<td>F42</td>
<td>Obsessive-compulsive disorder</td>
</tr>
<tr>
<td>Other specified obsessive compulsive and related disorder</td>
<td>300.3</td>
<td>Obsessive-compulsive disorders</td>
<td>F42</td>
<td>Obsessive-compulsive disorder</td>
</tr>
<tr>
<td>Unspecified obsessive compulsive and related disorder</td>
<td>300.3</td>
<td>Obsessive-compulsive disorders</td>
<td>F42</td>
<td>Obsessive-compulsive disorder</td>
</tr>
<tr>
<td>Excoriation (skin picking) disorder</td>
<td>698.4</td>
<td>Dermatitis factitia [artefacta]</td>
<td>L98.1</td>
<td>Factitial dermatitis</td>
</tr>
<tr>
<td>Binge eating disorder</td>
<td>307.51</td>
<td>Bulimia nervosa</td>
<td>F50.8</td>
<td>Other eating disorders</td>
</tr>
</tbody>
</table>
ICD-9-CM and ICD-10-CM

The ICD-9-CM was the prior coding system used within the medical system. The ICD-10-CM was released and became immediately effective in October of 2014. Therefore, medical practitioners, coders and billers were required to be familiar with both systems as the change occurred. To ensure a smooth transition, the DSM-5 was developed with both coding systems in mind. According to the American Medical Association:

*The ICD-10-CM is intended to correct some of the problems that occur with the ICD-9-CM. Especially important is the lack of adequate diagnostic and procedure code sets. A specific concern in this area is the lack of specificity of the information that is described through the codes. The ICD-9-CM does not distinguish specific features of an illness or disorder. Therefore, the ICD-9-CM diagnostic code does not differentiate between the same type of injury or illness on different parts of the body or in different stages. This can be problematic when submitting multiple disorders, all occurring on different days, for reimbursement.*

*Unlike the ICD-9-CM, the ICD-10-CM diagnosis code set uses more in-depth identifying characters, which allow for differentiation between parts of the body and specific symptoms. This reduces problems with insurance companies rejecting claims for similar conditions, which are reported on different days.*

*Another issue with the ICD-9-CM is that the available codes for some chapters have been exhausted, which means that new codes cannot be added as there is nothing to assign them to. Therefore, the new codes are added to different, unrelated, chapters. This causes problems*
when trying to locate all available codes during diagnosis. In the ICD-10-CM, the codes have increased character length, which increases the number of available codes in each chapter.\textsuperscript{43}

The following is a breakdown of the differences between the ICD-9-CM codes and the ICD-10-CM codes.\textsuperscript{44}

ICD-9 codes consist of 3-5 digits:
- Chapters 1-7 are numeric
- Supplemental chapters: the first digit is alpha (E or V) and the rest are numeric

ICD-10-CM codes consist of 3-7 alphanumeric characters:
- Digit 1 is alpha
- Digit 2 is numeric
- Digits 3-7 are alpha or numeric

The expanded number of characters of the ICD-10 diagnosis codes provides greater specificity to identify disease etiology, anatomic site, and severity.\textsuperscript{44}

ICD-10 Code Structure:

Characters 1-3 – Category
Characters 4-6 – Etiology, anatomic site, severity, or other clinical detail
Characters 7 – Extension
**ICD-9-CM Diagnosis Codes** | **ICD-10-CM Diagnosis Codes**
--- | ---
3 – 5 Characters in length | 3 – 7 characters in length
Approximately 13,000 codes | Approximately 68,000 available codes
First digit may be alpha (E or V) or numeric; Digits 2 – 5 are numeric | First digit is alpha; Digits 2 and 3 are numeric; Digits 4 – 7 are alpha or numeric
Limited space for adding new codes | Flexible for adding new codes
Lacks detail | Very specific
Lacks laterality | Allows laterality and bi-laterality
Difficult to analyze data due to non-specific codes | Specificity improves coding accuracy and richness of data for analysis
Codes are non-specific and do not adequately define diagnoses needed for medical research | Detail improves the accuracy of data used for medical research
Does not support interoperability | Supports interoperability and the exchange of health data between the United States and other countries

The DSM-5 included the ICD-9-CM codes to be used immediately, as well as the ICD-10-CM codes as they became required for use in 2014. The ICD-10-CM codes are provided in parentheses after the ICD-9-CM codes.

According to the APA, the “inclusion of ICD-10-CM codes facilitates a crosswalk to the new coding system” that became implemented in 2014 for all U.S. health care providers and systems. This coding system was also recommended by the Centers for Disease Control and Prevention’s National Center for Health Statistics (CDC-NCHS) and the Centers for Medicare and Medicaid Services (CMS). Providing both sets of codes ensured consistency during the transition process and reduced the need for training on the ICD-10-CM codes. Individuals were able to begin learning the system in order to transition immediately during 2014.

**DSM-IV-TR Coding**

The DSM-IV-TR used the ICD-9-CM coding system to provide HIPAA approved codes for medical billing. While the DSM codes in the DSM-IV-TR manual are used for diagnosing mental disorders, medical coders and billers
when submitting claims to insurance companies for reimbursement use the accompanying ICD codes. While the diagnostic codes are extremely important, the ICD codes are also necessary as they ensure that practitioners receive payment.

The DSM-IV and DSM-IV-TR were the first editions of the DSM to use ICD-9-CM codes to accompany the DSM codes. The DSM-IV-TR was developed with ICD compliance in mind. The diagnostic codes and the ICD codes are used together to diagnose, treat and bill a patient. However, there are some discrepancies between the two systems, which required the development of the *DSM-IV Crosswalk: Guidelines for Coding Mental Health Information*. The American Health Information Management Association published the crosswalk in 1999. The crosswalk addressed differences with the coding order. The codes were listed differently in each system on the medical record. The crosswalk also helped medical coders better understand the coding system. Medical coders follow the ICD-9-CM, which lists codes alphabetically. The crosswalk was developed to help them locate the equivalent DSM codes.

The process to select the appropriate diagnostic codes to use in the DSM-IV-TR involved carefully examining the ICD-9-CM codes and selecting those that best corresponded to each DSM-IV-TR category. All of the DSM-IV-TR codes represented valid ICD-9-CM codes, which enabled clinicians to switch between the DSM-IV-TR codes and the ICD-9-CM codes in any situation. This made insurance billing easier and also ensured compliance with HIPAA. In fact, the addition of ICD-9-CM codes in the DSM-IV and DSM-IV-TR was in direct response to issues with HIPAA. To be HIPAA compliant, the DSM was required to include the ICD-9-CM codes.
In the DSM-IV-TR, some of the DSM disorders share the same ICD-9-CM code. This is due to the fact that the DSM-IV-TR was developed with greater diagnostic specificity in the area of mental disorders than the ICD-9-CM. The ICD-9-CM only recognizes a limited range of disorders, especially for those that have a range of symptoms and severity. The DSM, on the other hand, recognizes each of the subtle differences within a specific disorder. To address this issue, some DSM disorders were given the same ICD code. The APA provided the following information to explain the two caveats that existed with coding compatibility issues between the DSM-IV-TR and the ICD-9-CM:45

1) Updates were made to the entire ICD-9-CM diagnostic coding system by the U.S. government on a yearly basis, with changes becoming mandatory each January 1st. When DSM-IV-TR was initially printed in May 2000, all diagnostic codes were updated to insure that they were up-to-date (to reflect coding changes effective the following October 2000). Since May 2000, there have been four cycles of coding changes (October 2001, October 2002, October 2003, and October 2004).

2) Although all codes in DSM-IV-TR are valid ICD-9-CM codes, technical differences in ICD-9-CM coding rules can result in slightly different results when looking up codes in DSM-IV-TR versus the ICD-9-CM, mainly in the order that the codes are listed. This was of interest primarily to coders.

The DSM-IV-TR used the same basic coding system that the DSM-5 uses. However, there are some differences between the two. The DSM-5 is based on the ICD-9-CM as was the DSM-IV-TR. However, the DSM-5 also incorporated the new ICD-10-CM codes in preparation for the shift in October 2014. During the development process, the APA used the coding
system from the DSM-IV-TR and made the necessary modifications to ensure proper diagnostic capabilities and HIPAA compliance.\(^{32}\)

**Changes to Coding in the DSM-5**

After the first printing of the DSM-5, the APA recognized some errors in coding information. Therefore, the APA provided the following table with important changes.\(^{46}\) This table accompanies the first printing of the manual. All of these changes will be included in future editions and printings of the DSM-5.

<table>
<thead>
<tr>
<th>Name of Disorder</th>
<th>Incorrectly Listed As</th>
<th>Corrected Code</th>
<th>IN DSM-5: Corrections should be made on the following pages</th>
<th>IN DSM-5 DESK REFERENCE: Corrections should be made on the following pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual Disability (Intellectual Developmental Disorder)</td>
<td>319 (70) Mild 319 (71) Moderate 319 (72) Severe 319 (73) Profound</td>
<td>317 (70) Mild 318.0 (71) Moderate 318.1 (72) Severe 318.2 (73) Profound</td>
<td>xiii, 33, 848, 872 (also delete coding note on page 33)</td>
<td>Ix, 18 (also delete coding note on page 33)</td>
</tr>
<tr>
<td>Trichotillomania (Hair-Pulling Disorder)</td>
<td>312.39 (F63.2)</td>
<td>312.39 (F63.3)</td>
<td>xxix, 251, 861, 890</td>
<td>xviii, 133</td>
</tr>
<tr>
<td>Conduct Disorder, Adolescent Onset Type</td>
<td>312.32 (F91.2)</td>
<td>312.82 (F91.2)</td>
<td>xxiv, 846, 871</td>
<td>xxv</td>
</tr>
<tr>
<td>Kleptomania</td>
<td>312.32 (F63.3)</td>
<td>312.32 (F63.2)</td>
<td>xxiv, 478, 848, 890</td>
<td>xxvi, 225</td>
</tr>
</tbody>
</table>
Diagnostic Recording Changes

One of the most significant changes in the DSM-5 is in the area of diagnostic recording. In previous versions of the DSM, the diagnostic system relied on a multiaxial diagnostic process. However, the DSM-5 eliminated the multiaxial system and replaced it with a nonaxial system. This change sparked a great deal of controversy amongst professionals in the field and resulted in a considerable amount of negative feedback. To best understand the impact this change had on the medical community, it is important to understand the how the multiaxial and nonaxial coding systems work. The APA fact sheet on the changes to the diagnostic coding system provides the following explanation for the changes from a multiaxial to nonaxial system.

*DSM-5 combines the first three DSM-IV-TR axes into one list that contains all mental disorders, including personality disorders and intellectual disability, as well as other medical diagnoses. Although a single axis recording procedure was previously used for Medicare and Medicaid reporting, some insurance companies required clinicians to report on the status of all five DSM-IV-TR axes.*

*Contributing psychosocial and environmental factors or other reasons for visits are now represented through an expanded selected set of ICD-9-CM V-codes and, from the forthcoming ICD-10-CM, Z-codes. These codes provide ways for clinicians to indicate other conditions or problems that may be a focus of clinical attention or otherwise affect the diagnosis, course, prognosis, or treatment of a mental disorder (such as relationship problems between patients and their intimate partners). These conditions may be coded along with the patient’s mental and other medical disorders if they are a focus of the current visit or help to explain the need for a treatment or test. Alternatively,*
they may be entered into the patient’s clinical record as useful information on circumstances that may affect the patient’s care.

The DSM-5 includes separate measures of symptom severity and disability for individual disorders, rather than the Global Assessment of Functioning (GAF) scale that combined assessment of symptom severity, suicide risk, and social functioning into a single global assessment. This change is consistent with WHO recommendations to move toward a clear conceptual distinction between the disorders contained in the ICD and the disabilities resulting from disorders, which are described in the International Classification of Functioning, Disability, and Health (ICF).

The World Health Organization Disability Assessment Schedule (WHO-DAS 2.0) is provided in Section III of DSM-5 as the best current alternative for measuring disability, and various disorder-specific severity scales are included in Section III and online. The WHO-DAS 2.0 is based on the ICF and is applicable to patients with any health condition, thereby bringing DSM-5 into greater alignment with other medical disciplines. While the WHO-DAS was tested in the DSM-5 field trials and found to be reliable, it is not yet being recommended by APA until more data are available to evaluate its utility in assessing disability status for treatment planning and monitoring purposes.

Multiaxial
The DSM Multiaxial system used five axes to categorize and diagnose mental disorders. Practitioners used the multiaxial system to assess, identify and diagnose mental disorders based on specific criteria.
DSM IV Multiaxial System

- Axis I Clinical Syndromes. Conditions not attributable to a mental disorder
- Axis II Personality Disorders. Specific Developmental Disorders
- Axis III Physical Disorders
- Axis IV Psychosocial Stressors
- Axis V Global Functioning

Axis I:
Axis I was defined as the top level of the multiaxial system. This axis included all of the acute symptoms that a patient needs to be treated for, and often considered the patient’s primary problem. The diagnoses included in Axis I are considered the most familiar of the disorders and are often the most recognized. The terms included in this axis are classified according to V-codes in the medical industry. Axis I Disorders are grouped into categories listed below with examples of each.

Adjustment Disorders
- With Anxiety
- With Depressed Mood
- With Disturbance of Conduct
- With Mixed Anxiety and Depressed Mood
- With Mixed Disturbance of Emotions and Conduct
- Unspecified

Anxiety Disorders
- Acute Stress Disorder
- Agoraphobia
- Agoraphobia Without History of Panic Disorder
• Anxiety Disorder Due to a General Medical Condition
• Anxiety Disorder Not Otherwise Specified (Anxiety Disorder NOS)
• Generalized Anxiety Disorder (GAD)
• Obsessive-Compulsive Disorder (OCD)
• Panic Attack
• Panic Disorder With Agoraphobia
• Panic Disorder Without Agoraphobia
• Posttraumatic Stress Disorder
• Social Phobia
• Specific Phobia
• Substance-Induced Anxiety Disorder

*Cognitive Disorders (Delirium, Dementia, and Amnestic)*

• Amnestic
• Delirium
• Dementia

*Dissociative Disorders*

• Depersonalization Disorder
• Dissociative Amnesia
• Dissociative Fugue
• Dissociative Identity Disorder
• Dissociative Disorder Not Otherwise Specified (NOS)

*Eating Disorders*

• Anorexia Nervosa
• Bulimia Nervosa
• Eating Disorder Not Otherwise Specified (NOS)
Factitious Disorders
- With Combined Psychological and Physical Signs and Symptoms
- With Predominantly Physical Signs and Symptoms
- With Predominantly Psychological Signs and Symptoms

Impulse-Control Disorders (Not Classified Elsewhere)
- Impulse-Control Disorder Not Otherwise Specified (NOS)
- Intermittent Explosive Disorder
- Kleptomania
- Pathological Gambling
- Pyromania
- Trichotillomania

Mental Disorders Due to a General Medical Condition
- Catatonic Disorder Due to a General Medical Condition
- Personality Change Due to a General Medical Condition

Mood Disorders
- Bipolar I Disorder
- Bipolar II Disorder
- Bipolar Disorder Not Otherwise Specified (NOS)
- Cyclothymic Disorder
- Depressive Disorder Not Otherwise Specified (NOS)
- Depression (General Overview)
- Dysthymic Disorder
- Major Depressive Disorder
- Mood Disorder Due to a General Medical Condition
- Mood Disorder Not Otherwise Specified (NOS)
- Substance-Induced Mood Disorder
Schizophrenia and other Psychotic Disorders

- Paranoid Type
- Disorganized Type
- Catatonic Type
- Undifferentiated Type
- Residual Type
- Brief Psychotic Disorder
- Delusional Disorder
- Psychotic Disorder Due to a General Medical Condition
- Psychotic Disorder Not Otherwise Specified
- Schizoaffective Disorder
- Schizophreniform Disorder
- Substance-Induced Psychotic Disorder

Sexual and Gender Identity Disorders

- Paraphilias:
  - Exhibitionism
  - Fetishism
  - Frotteurism
  - Pedophilia
  - Sexual Masochism
  - Sexual Sadism
  - Transvestic Fetishism
  - Voyeurism
  - Paraphilia Not otherwise Specified

- Sexual Dysfunction:
  - Hypoactive Sexual Desire Disorder
  - Female Orgasmic Disorder (Inhibited Female Orgasm)
- Female Sexual Arousal Disorder
- Male Erectile Disorder
- Male Orgasmic Disorder (Inhibited Male Orgasm)
- Premature Ejaculation
- Sexual Aversion Disorder
- Sexual Dysfunction Due to a General Medical Condition
- Substance-Induced Sexual Dysfunction
- Sexual Dysfunction Not Otherwise Specified (NOS)

- Sexual Pain Disorders:
  - Dyspareunia (Not Due to a General Medical Condition)
  - Vaginismus (Not Due to a General Medical Condition)

**Sleep Disorders**

- Breathing-Related Sleep Disorder
- Circadian Rhythm Sleep Disorder
- Dyssomnias Not Otherwise Specified (NOS)
- Insomnia Related to Another Mental Disorder
- Nightmare Disorder (Dream Anxiety Disorder)
- Primary Sleep Disorders:
  - Primary Insomnia
  - Primary Hypersomnia
  - Narcolepsy
  - Sleep Disorder Due to a General Medical Condition
  - Sleep Disorder Related to Another Mental Disorder
  - Sleep Terror Disorder
  - Sleepwalking Disorder
  - Substance-Induced Sleep Disorder
**Somatoform Disorders**
- Somatization Disorder
- Undifferentiated Somatoform Disorder
- Conversion Disorder
- Pain Disorder
- Hypochondriasis. Body Dysmorphic Disorder
- Somatoform Disorder not Otherwise Specified (NOS)

**Substance-Related Disorders**
- Substance-Induced Anxiety Disorder
- Substance-Induced Mood Disorder
- Substance-Induced Psychotic Disorder
- Substance-Induced Sleep Disorder

**Axis II:**

Axis II included many of the disorders that are considered life-long problems, as they typically begin in childhood. The disorders in Axis II are distinct from Axis I. However, many of the conditions included in Axis I can be symptomatic of Axis II. Axis II is primarily used to diagnose personality disorders and intellectual disabilities. Therefore, a patient may present with an Axis I disorder such as depression, which may actually be a result of Borderline Personality Disorder.\(^{50}\)

The disorders included in Axis II are those that directly impact an individual’s ability to adapt well to society. Therefore, they often result in social stigma. Many of the Axis II disorders are difficult to treat and can often be difficult to distinguish from each other.\(^{49}\) The following includes a list of some more commonly diagnosed Axis II disorders: \(^{50}\)
• Antisocial Personality Disorder
• Avoidant Personality Disorder
• Borderline Personality Disorder
• Dependent Personality Disorder
• Histrionic Personality Disorder
• Mental Retardation
• Narcissistic Personality Disorder
• Obsessive-Compulsive Personality Disorder
• Paranoid Personality Disorder
• Personality Disorder Not Otherwise Specified
• Schizoid Personality Disorder
• Schizotypal Personality Disorder

Ultimately, Axes I and II comprise all of the mental disorders, as well as many associated conditions.

Axis III:
Axis III is used to identify any physical disorders and conditions that can impact treatment. Axis III is also used to record those physical conditions that are relevant to, or caused by, one of the disorders included in Axis I or Axis II.  

Axis IV:
Axis IV is used to track a patient’s psychosocial and environmental problems. Typically, only those problems that may affect the diagnosis, treatment and prognosis of the mental disorder(s) are included. These problems typically include negative life events, environmental difficulties, deficiencies, family or interpersonal stress, inadequacy of social support, lack of personal resources, or other relevant problems.
Examples of psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders include:\(^5\)

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system/crime
- Other psychosocial and environmental problems

**Axis V:**

Axis V is used to report the clinician’s judgment of the individual’s overall level of functioning. The information included in this section is used to assist with treatment planning and monitoring. Axis V uses the Global Assessment Functioning (GAF) scale to report functioning. Using a single measure, the GAF tracks clinical progress on a global scale.\(^4\)

**Usefulness of the DSM IV Multiaxial System:**\(^5\)

- Provides a framework for interdisciplinary communication
- Bases subsequent revisions on a series of formative evaluations
- Represents progress toward a more holistic view of mind-body relations
- Represents a collaborative achievement
- Makes a provision for diagnostic uncertainty
- Incorporates, at least in part, biological, psychological and social variables
• Has achieved positive results in extensive field testing of validity and reliability
• Considers adaptive strength as well as problems
• Provides for a comprehensive biological-psychological-social approach
• Reflects a descriptive phenomenological perspective rather than any particular psychiatric theoretical orientation

An example of a multiaxial diagnosis (obtained from Edward Pierce, LCSW):\textsuperscript{51}

Axis I: Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
Axis II: Dependent Personality Disorder Frequent use of denial
Axis III: None
Axis IV: Threat of job loss
Axis V: GAF = 35 (last year)

**Nonaxial**

The revised recording system that is used in the DSM-5 is a “nonaxial,” or single axis system. This is a major change from the multiaxial recording system that was used in previous versions of the DSM. In the new nonaxial system, Axes I, II and III have been combined to create one broad diagnostic group that includes all of the disorders listed separately under Axes I and II, and the physical conditions listed under Axis III. Instead of using Axes IV and V to indicate any relevant psychosocial and contextual factors (Axis IV) and disability status (Axis V), the nonaxial system utilizes separate notations for these factors.\textsuperscript{31}
The nonaxial system allows for a dimensional approach to diagnosis that expands the categorical approach used previously. The new system provides an opportunity for clinicians to rate disorders along a continuum of severity, rather than just as part of individual categories. This will eliminate commonly used “not otherwise specified (NOS)” conditions often reported by clinicians. The new system also allows for better treatment development and management.¹

**Coding Differences between a Multiaxial System and a Nonaxial System**

<table>
<thead>
<tr>
<th>Multiaxial</th>
<th>Nonaxial</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example 1:</strong></td>
<td></td>
</tr>
<tr>
<td>Axis I 296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features</td>
<td>296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features</td>
</tr>
<tr>
<td>305.00 Alcohol Abuse</td>
<td>305.00 Alcohol Abuse</td>
</tr>
<tr>
<td>Axis II 301.6 Dependent Personality Disorder</td>
<td>301.6 Dependent Personality Disorder</td>
</tr>
<tr>
<td>Frequent use of denial</td>
<td></td>
</tr>
<tr>
<td>Axis III None</td>
<td></td>
</tr>
<tr>
<td>Axis IV Threat of job loss</td>
<td></td>
</tr>
<tr>
<td>Axis V GAF = 35 (current)</td>
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</tbody>
</table>

<table>
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<tr>
<th>Example 2:</th>
<th></th>
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<tbody>
<tr>
<td>Axis I 300.4 Dysthymic Disorder</td>
<td>300.4 Dysthymic Disorder</td>
</tr>
<tr>
<td>315.00 Reading Disorder</td>
<td>315.00 Reading Disorder</td>
</tr>
<tr>
<td>Axis II V71.09 No diagnosis</td>
<td>382.9 Otitis media, recurrent</td>
</tr>
<tr>
<td>Axis III 382.9 Otitis media, recurrent</td>
<td></td>
</tr>
<tr>
<td>Axis IV Victim of child neglect</td>
<td></td>
</tr>
<tr>
<td>Axis V GAF = 53 (current)</td>
<td></td>
</tr>
</tbody>
</table>
Example 3:
Axis I 293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features
Axis II V71.09 No diagnosis, histrionic personality features
Axis III 244.9 Hypothyroidism
Axis IV None
Axis V GAF = 45 (on admission)
GAF = 65 (at discharge)

Example 4:
Axis I V61.10 Partner Relational Problem
Axis II V71.09 No diagnosis
Axis III None
Axis IV Unemployment
Axis V GAF = 83 (highest level past year)

Example 3:
293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features
244.9 Hypothyroidism
365.23 Chronic angle-closure glaucoma

Example 4:
V61.10 Partner Relational Problem

**Controversial Changes**

The DSM revision process was controversial for a number of reasons. As already discussed, much of the controversy centered on the way the revision process was conducted, how the recording system was changed, and the changes and additions that were made to the specific disorders. The APA received a great deal of backlash regarding its decision to modify some disorders. In addition, the reorganization and elimination of other disorders sparked criticism from individuals in the mental health field, both consumers and practitioners.
While the entire manual was mired in controversy, some changes were more controversial than others and received more backlash. The APA received the most criticism for changes it made to specific disorders, including Grief as a Major Depression, Disruptive Mood Dysregulation Disorder, Mild Neurocognitive Disorder in Seniors, Somatic Symptom Disorder, Binge Eating, and Asperger’s. While the specific reasons differed for each disorder, critics argued against the changes made to these disorders because of the impact they had on the diagnosis and treatment of patients.

**Grief as a Major Depression**

In previous editions of the DSM, the depression category specifically excluded grief as one of the categories of depression. In fact, previous versions included a bereavement exclusion that explained that grief that occurred for less than two months as the result of the loss of a loved one was not considered depression. However, in the DSM-5, the depression category has been revised to include grief. The bereavement exclusion has been eliminated.

The DSM-5 provides the following explanation of the addition of grief to the Major Depression category:

> As part of the ongoing study of major depression, the bereavement exclusion has been removed from DSM. This change from DSM-IV, would be replaced by notes in the criteria and text that caution clinicians to differentiate between normal grieving associated with a significant loss and a diagnosis of a mental disorder. Removing the bereavement exclusion helps prevent major depression from being overlooked and facilitates the possibility of appropriate treatment including therapy or other interventions.
While the grieving process is natural and unique to each individual and shares some of the same features of depression like intense sadness and withdrawal from customary activities, grief and depression are also different in important aspects:

- In grief, painful feelings come in waves, often intermixed with positive memories of the deceased; in depression, mood and ideation are almost constantly negative.
- In grief, self-esteem is usually preserved; in MDD, corrosive feelings of worthlessness and self-loathing are common.
- While many believe that some form of depression is a normal consequence of bereavement, MDD should not be diagnosed in the context of bereavement since diagnosis would incorrectly label a normal process as a disorder.

Research and clinical evidence have demonstrated that, for some people, the death of a loved one can precipitate major depression, as can other stressors, like losing a job or being a victim of a physical assault or a major disaster. However, unlike those stressors, bereavement is the only life event and stressor specifically excluded from a diagnosis of major depression in DSM-IV.

While bereavement may precipitate major depression in people who are especially vulnerable (i.e., they have already suffered a significant loss or have other mental disorders), when grief and depression co-exist, the grief is more severe and prolonged than grief without major depression. Despite some overlap between grief and MDD, they are different in important ways, and therefore they should be distinguished separately to enable people to benefit from the most appropriate treatment.
The diagnostic criteria for a Major Depressive Episode in the DSM-5 is as follows:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) Depressed mood or (2) Loss of interest or pleasure.

*Note:* Do not include symptoms that are clearly due to a general medical condition.

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

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

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

4) Insomnia or Hypersomnia nearly every day

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

6) Fatigue or loss of energy nearly every day

7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

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

C. The episode is not attributable to the direct physiological effects of a substance (i.e., a drug of abuse, a medication) or a general medical condition (i.e., hypothyroidism).

Note: Criteria A – C represent a major depressive episode.

Note: Responses to significant loss (i.e., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual’s history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional
disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

*Note*: This exclusion does not apply if all the manic-like or hypomanic-like episodes are substance induced or are attributable to the physiological effects of another medical condition.30

The criteria for a Major Depressive Episode were almost identical in the DSM-IV, except that the DSM-IV included the following exclusion under bullet E:24

> The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Section E in the DSM-IV specifically states that symptoms caused by the loss of a loved one are not considered symptoms of a major depressive episode and should not be used when diagnosing a patient. This qualifying statement was removed from the DSM-5, which allows for grief from the loss of a loved one to be used when diagnosing a major depressive episode.

This removal of the bereavement exclusion in the DSM-5 received a great deal of backlash from the mental health community. The most common criticism of the removal of the exclusion is that it would encourage clinicians to diagnose major depression in patients who are experiencing sadness as the result of normal bereavement.55 Since the DSM-5 requires that patients
have only experienced mild depressive symptoms for a minimum of two weeks, critics fear that too many individuals will be diagnosed with depression, even though they are not actually depressed.\textsuperscript{56} The argument against this was that the diagnosis of major depression in these patients will medicalize normal grief, thereby increasing the number of healthy individuals who are labeled with a psychiatric diagnosis.\textsuperscript{38} The fear is that these individuals will then be unnecessarily prescribed antidepressants and antipsychotics to treat a condition that does not traditionally require pharmaceutical intervention.\textsuperscript{37}

According to many professionals in the mental health field, the overdiagnosis of major depression as a result of the elimination of the bereavement exclusion is problematic and unnecessary. Especially since grief is a natural human experience in response to the loss of a loved one.\textsuperscript{55} Medical professionals recognize the normalcy of grief and do not consider it a major depressive episode. Clinicians and researchers have long known that, for the vast majority of people, grief typically runs its course within 2 to 6 months and requires no treatment.\textsuperscript{56}

**Disruptive Mood Dysregulation Disorder**

A new, and very controversial, addition to the DSM-5 is Disruptive Mood Dysregulation Disorder, which is a condition specific to children who are prone to severe and recurrent temper outbursts. These outbursts are not typical outbursts and are characterized as being out of proportion in intensity and duration to the situation that they are in response to.\textsuperscript{57} Outbursts that are caused by DMDD occur frequently, which is defined as three or more times per week for one year or more. Children who are diagnosed with DMDD also consistently display irritability and anger during the periods between outbursts. To be diagnosed with DMDD, a child must
display these behaviors in at least two different settings, such as at home, at school, during organized activities, or with peers. The typical onset of symptoms occurs prior to age ten.30

The APA provides the following explanation for the inclusion of Disruptive Mood Dysregulation Disorder in the DSM-5. Specifically, the APA explains why DMDD is different than Oppositional Defiant Disorder and Bipolar Disorder:58

While DSM does include two diagnoses with related symptoms to DMDD, oppositional defiant disorder (ODD) and Bipolar Disorder (BD), the symptoms described in DMDD are significantly different than these two diagnoses.

ODD is an ongoing pattern of anger-guided disobedience, hostilely defiant behavior toward authority figures that goes beyond the bounds of normal childhood behavior.

While some of its symptoms may overlap with the criteria for DMDD, the symptom threshold for DMDD is higher since the condition is considered more severe. To avoid any artificial comorbidity of the two disorders, it is recommended that children who meet criteria for both ODD and DMDD should only be diagnosed with DMDD.

BD also has similar symptoms. And while clinicians may have been assigning a BD diagnosis to these severely irritable youth to ensure their access to treatment resources and services, these children’s behaviors may not present in an episodic way as is the case with BD. In an effort to address this issue, research was conducted comparing
youth with severe non-episodic symptoms to those with the classic presentations of BD as defined in DSM-IV.

Results of that extensive research showed that children diagnosed with BD who experience constant, rather than episodic, irritability often are at risk for major depressive disorder or generalized anxiety disorder later in life, but not life-long BD. This finding pointed to the need for a new diagnosis for children suffering from constant, debilitating irritability. The hope is that by defining this condition more accurately, clinicians will be able to improve diagnosis and care.

Defining this disorder as a distinct condition will likely have a considerable impact on clinical practice and thus treatment. For example, the medication and psychotherapy treatment recommended for BD is entirely different from that of other disorders, such as depressive and anxiety disorders.

The unique features of DMDD necessitated a new diagnosis to ensure that children affected by this disorder get the clinical help they need.

The following is the diagnostic criteria for Disruptive Mood Dysregulation Disorder:\(^{30}\)

A. The disorder is characterized by severe recurrent temper outbursts manifested verbally (i.e., verbal rages) and/or behaviorally (i.e., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.

B. The temper outbursts are inconsistent with developmental level.

C. The temper outbursts occur, on average, three or more times per week.
D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (i.e., parents, teachers, peers).

E. Criteria A - D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A - D.

F. Criteria A and D are present in at least two of three settings (at home, at school, or with peers) and are severe in at least one of those.

G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.

H. By history or observation, the age at onset of Criteria A through E is before 10 years.

I. There has never been a distinct period lasting more than one day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

J. The behaviors do not occur exclusively during an episode of Major Depressive Disorder and are not better explained by another mental disorder (i.e., Autism Spectrum Disorder, Posttraumatic Stress Disorder, Separation Anxiety Disorder, Persistent Depressive Disorder).

K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

The addition of Disruptive Mood Dysregulation Disorder to the DSM-5 has caused a great deal of controversy. The primary concern amongst critics is that the addition of the disorder to the manual will result in an increase in the number of relatively healthy children who are diagnosed and, subsequently, medicated. Critics argue that the inclusion of DMDD will cause more children to be labeled with a mental disorder when they are, in
fact, acting within the normal range of child behavior. Critics also argue that the definition of DMDD lacks an empirical basis.

Those who support the inclusion of Disruptive Mood Disregulation Disorder argue that the new diagnostic criteria will enable practitioners to help prevent the misdiagnosis of a number of children. Previously, children who displayed the symptoms and behaviors that are consistent with DMDD were diagnosed with bipolar disorder and/or oppositional defiant disorder. As a result, the number of children diagnosed with these disorders has increased rapidly. According to supporters of DMDD, the rapid increase of diagnoses is a direct result of misdiagnosing children who should be diagnosed with DMDD.

By including DMDD as a diagnosable disorder, the number of children diagnosed with bipolar disorder will decrease, which will result in fewer children prescribed antipsychotic and mood-stabilizing drugs. Proponents of DMDD argue that the new diagnostic category will provide an alternative to the more stigmatized and pharmacologically treated conditions such as bipolar and oppositional defiant disorder.

**Mild Neurocognitive Disorder**

The DSM-5 is the first edition of the manual to include Mild Neurocognitive Disorder as a fully recognized disorder in the chapter on neurocognitive disorders. In the DSM-IV, mild neurocognitive disorder was included in the appendix. In response to the growing need to find a way to classify patients who are clinically impaired but who do not meet the criteria for dementia, the APA decided to include mild neurocognitive disorder as part of the chapter on neurocognitive disorders.
Utilizing current research in the field of neurocognitive disorders, the APA examined the progression of cognitive impairment in patients who eventually developed Alzheimer’s and other neurocognitive disorders. This led to the understanding that individuals often showed signs of cognitive impairment many years before being diagnosed with these disorders, yet they were unable to obtain an official diagnosis and could not receive the appropriate services and treatment. In response, the APA created two major diagnostic categories in the chapter on neurocognitive disorders:

- Mild Neurocognitive Disorder
- Major Neurocognitive Disorder

Each category includes subtypes. The following is a list of the subtypes:

- Alzheimer’s Disease neurocognitive disorder (NCD)
- Vascular NCD
- Frontotemporal NCD
- Lewy Bodies NCD
- Traumatic Brain Injuries NCD
- Parkinson’s Disease NCD
- HIV Infection NCD
- Substance or Medication Induced NCD
- Huntington’s Disease NCD
- Prion Disease NCD
- NCD due to another medical condition
- Unspecified NCD

In DSM-5, a mild neurocognitive disorder is defined by the following:

A. Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains (complex attention,
executive function, learning and memory, language, perceptual motor, or social cognition) based on:

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a mild decline in cognitive function; and

2. A modest impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive deficits do not interfere with capacity for independence in everyday activities (i.e., complex instrumental activities of daily living such as paying bills or managing medications are preserved, but greater effort, compensatory strategies, or accommodation may be required).

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder (i.e., major depressive disorder, schizophrenia).

In DSM-5, a major neurocognitive disorder is defined by the following:

A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual motor, or social cognition) based on:

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive deficits interfere with independence in everyday activities (i.e., at minimums, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications).

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder (i.e., major depressive disorder, schizophrenia).

When diagnosing a minor neurocognitive disorder, one and two standard deviations below appropriate norms are required. In diagnosing a major neurocognitive disorder, two or more standard deviations below appropriate norms are required. Once it is determined whether a patient has a major or minor neurocognitive disorder, the healthcare professional making the diagnosis must then decide on the etiological subtype of the major or minor neurocognitive disorder.

The APA provides the following explanation for the addition of neurocognitive disorder:

The diagnosis of mild neurocognitive disorder in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) provides an opportunity for early detection and treatment of cognitive decline before patients’ deficits become more pronounced and
progress to major neurocognitive disorder (dementia) or other debilitating conditions. Its inclusion in the manual will help clinicians develop effective treatment plans as well as encourage researchers to evaluate diagnostic criteria and potential therapies.

Mild neurocognitive disorder goes beyond normal issues of aging. It describes a level of cognitive decline that requires compensatory strategies and accommodations to help maintain independence and perform activities of daily living. To be diagnosed with this disorder, there must be changes that impact cognitive functioning. The individual, a close relative, or other knowledgeable informant, such as a friend, colleague, or clinician, usually observes these symptoms or they are detected through objective testing.

Recent studies suggest that identifying mild neurocognitive disorder as early as possible may allow interventions to be more effective. Early intervention efforts may enable the use of treatments that are not effective at more severe levels of impairment and may prevent or slow progression. Researchers will evaluate how well the new diagnostic criteria address the symptoms, as well as potential therapies like educational or brain stimulation.

While the changes in the DSM-5 chapter on neurocognitive disorders are meant to better diagnose various stages of neurocognitive disorder, they were met with a great deal of controversy. Much of the controversy has involved patient response and confusion.62 One argument is that many elderly patients are already confused about dementia and do not understand how it is caused or what other diseases it is connected to, especially in the case of dementia and Alzheimer’s. These critics argue that the addition of
major and mild neurocognitive disorders will only result in additional confusion for the patients.\textsuperscript{63}

Another criticism against the addition of mild neurocognitive disorder is that patients who are diagnosed with the disorder will minimize the diagnosis due to the inclusion of the clarifier “mild.” As a result, the patient will not recognize the seriousness of the diagnosis and the potential for disease progression. In these cases, the patient may not be willing to undergo treatment or take necessary medications.\textsuperscript{64}

Critics also argue that there is too much room for confusion and misdiagnosis with the new categories.\textsuperscript{65} There is the potential that practitioners will not fully comprehend the new guidelines, which can lead to misdiagnosis. Many geriatric experts argue that the new criteria have the potential to cause a number of false positives as a result of misdiagnosis.\textsuperscript{64}

A final complaint is that there is a lack of consistency between the criteria developed by the DSM-5, the Alzheimer’s Association, and the National Institute on Aging. Due to inconsistent categories, practitioners can potentially diagnose patients who present with dementia symptoms differently. Depending on the criteria used, the patient has potential to be diagnosed with dementia rather than mild neurocognitive disorder.\textsuperscript{63}

**Somatic Symptom Disorder**

In previous versions of the DSM, the section on Somatoform Disorders included various disorders that were characterized by an unusual preoccupation with physical symptoms and/or a physical illness. Within this section, the different diagnoses were broken into four distinct disorders.\textsuperscript{53}
1. Somatization Disorder
2. Hypochondriasis
3. Pain Disorder
4. Undifferentiated Somatoform Disorder

Each of the four disorders listed above had distinct criteria that differentiated it from the others. The following is a list of the criteria for each disorder:\n
1. Somatization Disorder – Presence of at least 8 specific symptoms which occurred over a period of several years, during which time there was no valid medical explanation.
2. Hypochondriasis – A persistent fear and suspicion of illness based on the misinterpretation of symptoms, both real and perceived.
3. Pain Disorder – The presence of severe pain that is considered to be primarily psychological, not physical, in nature.
4. Undifferentiated Somatoform Disorder – Similar to somatization disorder. However, the patient presents fewer complaints and the duration of the occurrence is shorter.

The four disorders listed above were combined in the DSM-5 and are now part of the general disorder known as Somatic Symptom Disorder. According to the APA, there were too many similarities between the four disorders listed above, which caused some confusion when diagnosing a patient. Somatic Symptom Disorder combines the elements from each of the other disorders to create a general category that can be used to diagnose a patient who shows signs of preoccupation with somatic symptoms. The new category is broad enough to encompass a number of patients.
The criteria for Somatic Symptom Disorder are as follows:

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
   1. Disproportionate and persistent thoughts about the seriousness of one’s symptoms.
   2. Excessive time and energy devoted to these symptoms or health concerns.
   3. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than six months).

Specify if:
With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if:
Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than six months).

Specify current severity:
Mild: Only one of the symptoms specified in Criterion B is fulfilled.
Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.
Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).
The APA provides the following explanation of the changes to this section:

Somatic symptom disorder (SSD) is characterized by somatic symptoms that are either very distressing or result in significant disruption of functioning, as well as excessive and disproportionate thoughts, feelings and behaviors regarding those symptoms. To be diagnosed with SSD, the individual must be persistently symptomatic (typically at least for 6 months).

Several important changes have been made from previous editions of DSM. The DSM-IV disorders of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed, and many, but not all, of the individuals diagnosed with one of these disorders could now be diagnosed with SSD. The DSM-IV diagnosis of somatization disorder required a specific number of complaints from among four symptom groups. The SSD criteria no longer have such a requirement; however, somatic symptoms must be significantly distressing or disruptive to daily life and must be accompanied by excessive thoughts, feelings, or behaviors.

Another key change in the DSM-5 criteria is that while medically unexplained symptoms were a key feature for many of the disorders in DSM-IV, an SSD diagnosis does not require that the somatic symptoms are medically unexplained. In other words, symptoms may or may not be associated with another medical condition. DSM-5 narrative text description that accompanies the criteria for SSD cautions that it is not appropriate to diagnose individuals with a mental disorder solely because a medical cause cannot be demonstrated. Furthermore, whether or not the somatic symptoms are medically
explained, the individual would still have to meet the rest of the criteria in order to receive a diagnosis of SSD.

Somatic Symptom and Related Disorders

In DSM-5, somatoform disorders are now referred to as somatic symptom and related disorders. In DSM-IV, there was significant overlap across the somatoform disorders and a lack of clarity about their boundaries. These disorders are primarily seen in medical settings, and nonpsychiatric physicians found the DSM-IV somatoform diagnoses problematic to use. The DSM-5 classification reduces the number of these disorders and subcategories to avoid problematic overlap. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed.

Somatic Symptom Disorder

DSM-5 better recognizes the complexity of the interface between psychiatry and medicine. 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, and the arbitrarily high symptom count required for DSM-IV somatization disorder did not accommodate this spectrum. The diagnosis of somatization disorder was essentially based on a long and complex symptom count of medically unexplained symptoms. Individuals previously diagnosed with somatization disorder will usually 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.
In DSM-IV, the diagnosis undifferentiated somatoform disorder had been created in recognition that somatization disorder would only describe a small minority of “somatizing” individuals, but this disorder did not prove to be a useful clinical diagnosis. Because the distinction between somatization disorder and undifferentiated somatoform disorder was arbitrary, they are merged in DSM-5 under somatic symptom disorder, and no specific number of somatic symptoms is required.

The criticism against the creation and inclusion of Somatic Symptom Disorder is that it will increase the number of individuals who are labeled with a mental disorder even though they may not actually have one. Critics argue that it is difficult to determine the mental anguish caused by a physical illness, and that this new disorder will make it much easier for practitioners to diagnose someone with a mental disorder who may not actually have one. According to the critics, this increase will occur as a result of the reduction in criteria needed for a diagnosis. First, the APA has reduced the minimum number of symptoms necessary for a diagnosis from eight to “no minimum.” In addition, the APA reduced the criteria for the duration of symptoms to six months. Therefore, critics argue, it will be easier to diagnose someone with Somatic Symptom Disorder, even if that person is experiencing normal stress and anxiety about a real physical illness.

Proponents of the new disorder argue the opposite. According to supporters, the new diagnostic category will enable practitioners to better assist patients who would otherwise be denied treatment due to an inability to diagnose. According to the APA:
Comprehensive assessment of patients requires the recognition that psychiatric problems often co-occur in patients with medical problems. While DSM-IV was organized centrally around the concept of medically unexplained symptoms, DSM-5 criteria instead emphasize the degree to which a patient’s thoughts, feelings and behaviors about their somatic symptoms are disproportionate or excessive. The new narrative text for SSD notes that some patients with physical conditions such as heart disease or cancer will indeed experience disproportionate and excessive thoughts, feelings, and behaviors related to their illness, and that these individuals may qualify for a diagnosis of SSD. This in turn may enable them to access treatment for these symptoms. In this sense, SSD is like depression; it can occur in the context of a serious medical illness. It requires clinical training, experience and judgment based on guidance such as that contained in the DSM-5 text to recognize when a patient’s thoughts feelings and behaviors are indicative of a mental disorder that can benefit from focused treatment.

### Binge Eating

In previous editions of the DSM, binge eating was classified under the category “eating disorders not otherwise specified (EDNOS)” and was included in the appendix of the manual. However, the DSM-5 includes Binge Disorder as its own diagnosable mental disorder. Binge disorder is included in the section entitled “Feeding and Eating Disorders.”

The APA provides the following explanation of the changes made to the Binge Eating section of the manual:

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Extensive research followed the promulgation of preliminary criteria for binge eating disorder in Appendix B of DSM-IV, and findings supported the clinical utility and validity of binge-eating disorder. The only significant difference from the preliminary 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.

This change is intended to increase awareness of the substantial differences between binge eating disorder and the common phenomenon of overeating. While overeating is a challenge for many Americans, recurrent binge eating is much less common, far more severe, and is associated with significant physical and psychological problems.

The diagnostic criteria for Binge Eating Disorder is as follows:

A. Recurrent episodes of binge eating characterized by BOTH of the following:
   1. Eating in a discrete period of time (i.e., within any 2 hour period), an amount of food that is definitely larger than what most people would eat in a similar time period of time under similar circumstances.
   2. Sense of lack of control over eating during the episode (i.e., a feeling that one cannot stop eating or control what or how much one is eating).

B. Binge eating episodes are associated with three (or more) of the following:
1. Eating much more rapidly than normal.
2. Eating until feeling uncomfortably full.
3. Eating large amounts of food when not feeling physically hungry.
4. Eating alone because of being embarrassed by how much one is eating.
5. Feeling disgust with oneself, depressed, or very guilty after overeating.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for three months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Specify the Following:

In partial remission: After full criteria for binge eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.

In full remission: After full criteria for binge eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify Current Severity as Follows.
The minimum level of severity is based on the frequency of episodes of binge eating. The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- **Mild:** 1 – 3 binge eating episodes per week.
- **Moderate:** 4 – 7 binge eating episodes per week.
- **Severe:** 8 – 13 binge eating episodes per week.
- **Extreme:** 14 or more binge eating episodes per week.

Unlike some of the other controversial revisions and additions to the DSM-5, Binge Eating Disorder only received some negative feedback. For those who criticized the addition of Binge Eating Disorder, the concern is primarily regarding the potential to over diagnose individuals who do not actually have the disorder. Some critics argue that many people overeat on occasion, but that does not mean that they have an eating disorder. There is some concern that individuals who self-report on overeating may be diagnosed with Binge Eating Disorder even though their problem is just general overeating.

However, while there are some critics of the new disorder, there is a great deal more support. Eating disorder clinicians and organizations have embraced the addition of Binge Eating Disorder in the DSM-5 as it enables them to provide treatment to individuals who truly have an eating disorder. Supporters argue that the focus has primarily been on anorexia nervosa and bulimia nervosa, which has been detrimental to the subsection of the population that suffers from binge eating. According to supporters, the inclusion of Binge Eating Disorder will make it a recognized disorder, which will ensure that patient’s insurance will cover treatment expenses.
According to clinicians, the addition of Binge Eating Disorder (BED) to the DSM-5 is a positive step for the following reasons:74

- Official recognition legitimizes the disorder and gives new hope to those who have it.
- Nearly half of all states have parity laws that require insurers to cover officially recognized psychiatric disorders. While insurers have generally been receptive to providing coverage for binge-eating disorder, they may now provide more comprehensive coverage.
- DSM is used as a reference for psychiatrists and other healthcare professionals worldwide. Now, they will have common criteria for diagnosing binge-eating disorder.
- DSM provides healthcare professionals with the language they need to communicate effectively with patients, their families and insurance companies. Everyone affected by the disorder will now have consistent, shared language to use when discussing BED.
- By making BED a legitimate diagnosis, it helps those who have the disorder, from a psychiatric perspective, because they are more likely to accept it and to seek treatment.
- It should improve research funding. More research would lead to a better understanding of binge-eating disorder, and hopefully to improvements in treatment and recovery.
- Without the official designation, until now individuals with BED have been diagnosed as having “eating disorders not otherwise specified,” or EDNOS.

**Asperger’s**

Unlike previous versions of the manual, the DSM-5 incorporates the various autism spectrum associated disorders, which includes autistic disorder (autism), Asperger’s disorder, childhood disintegrative disorder, and
pervasive developmental disorder not otherwise specified, into one diagnosis. Rather than continue with the individual categories of diagnosis, the DSM-5 has combined all disorders into the one broad, singular category of Autism Spectrum Disorder. This change has sparked a great deal of controversy regarding the implications it will have on the autism community, especially for those with Asperger’s. In fact, the greatest criticism involves the elimination of a separate category for Asperger’s.36

In the DSM-5, the new diagnosis of Autism Spectrum Disorder includes a broad range of behaviors associated with the different disorders, such as social communication, restricted interests, and repetitive behaviors.30 In addition to including all of the disorders under one umbrella term, patients will now be evaluated on levels of severity, which are based on the amount of support the individual needs. The use of one umbrella term and different severity levels to diagnose a patient is expected to enable clinicians to better diagnose a patient and to ensure consistency among different doctors.8

The APA provides the following explanation for the changes made to the section on Autism Spectrum Disorder:76

*The revised diagnosis represents a new, more accurate, and medically and scientifically useful way of diagnosing individuals with autism-related disorders.*

*Using DSM-IV, patients could be diagnosed with four separate disorders: autistic disorder, Asperger’s disorder, childhood disintegrative disorder, or the catch-all diagnosis of pervasive developmental disorder not otherwise specified. Researchers found that these separate diagnoses were not consistently applied across different clinics and treatment centers. Anyone diagnosed with one of*
the four pervasive developmental disorders (PDD) from DSM-IV should still meet the criteria for ASD in DSM-5 or another, more accurate DSM-5 diagnosis. While DSM does not outline recommended treatment and services for mental disorders, determining an accurate diagnosis is a first step for a clinician in defining a treatment plan for a patient.

The criteria for Autism Spectrum Disorder in the DSM-5 is as follows:

Must meet criteria A, B, C, and D

A. Persistent deficits in social communication and social interaction across contexts, not accounted for by general developmental delays, and manifest by all 3 of the following:
   1. Deficits in social-emotional reciprocity; ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interaction.
   2. Deficits in nonverbal communicative behaviors used for social interaction; ranging from poorly integrated- verbal and nonverbal communication, through abnormalities in eye contact and body-language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures.
   3. Deficits in developing and maintaining relationships, appropriate to developmental level (beyond those with caregivers); ranging from difficulties adjusting behavior to suit different social contexts through difficulties in sharing imaginative play and in making friends to an apparent absence of interest in people.

B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following:30
1. Stereotyped or repetitive speech, motor movements, or use of objects; (such as simple motor stereotypies, echolalia, repetitive use of objects, or idiosyncratic phrases).

2. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change; (such as motoric rituals, insistence on same route or food, repetitive questioning or extreme distress at small changes).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (such as strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment; (such as apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects).

C. Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities).

D. Symptoms together limit and impair everyday functioning.

In addition to the above criteria, patients are evaluated using the following severity levels.\textsuperscript{30}
<table>
<thead>
<tr>
<th>Severity Level for ASD</th>
<th>Social Communication</th>
<th>Restricted Interests &amp; repetitive behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others.</td>
<td>Preoccupations, fixed rituals and/or repetitive behaviors markedly interfere with functioning in all spheres. Marked distress when rituals or routines are interrupted; very difficult to redirect from fixated interest or returns to it quickly.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others.</td>
<td>RRBs and/or preoccupations or fixated interests appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress or frustration is apparent when RRB’s are interrupted; difficult to redirect from fixated interest.</td>
</tr>
<tr>
<td>Level 1</td>
<td>Without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.</td>
<td>Rituals and repetitive behaviors (RRB’s) cause significant interference with functioning in one or more contexts. Resists attempts by others to interrupt RRB’s or to be redirected from fixated interest.</td>
</tr>
</tbody>
</table>
The change in the diagnostic criteria for Autism Spectrum Disorder and the elimination of a separate category for Asperger’s has sparked a great deal of controversy amongst those in the autism community. The removal of the formal diagnosis of Asperger’s Disorder is a significant change in the DSM-5, and it has not been done without the potential of impacting a large number of individuals. One fear is that those who are currently diagnosed with Asperger’s will no longer be recognized as having this disorder and will receive a different diagnosis instead. This has the potential to be very difficult for the families (and children) who have become familiar with the Asperger’s diagnosis.

While the APA believes that the changes will result in more specific diagnoses of children with autism spectrum disorders, many others fear that the opposite will happen. Autism spectrum disorder is complex and can be difficult to understand and categorize. Many clinicians argue that the DSM categories do not accurately diagnose many of the conditions under autism spectrum. As a result, critics fear that the umbrella diagnosis will cause a number of individuals to go undiagnosed because the category is too broad. In addition, there is some concern that those who are currently higher functioning will no longer meet the diagnostic criteria for Autism Spectrum Disorder, thereby losing access to valuable services.

An additional concern is that the use of an umbrella term to diagnose individuals with diverse disorders will result in the loss of diverse, varied services for these individuals. The use of distinct categories in the past enabled practitioners to provide a variety of services to patients based on the specific attributes of the individual disorders. For example, services could be tailored specifically to individuals with Asperger’s. These services would differ from those targeted to individuals with low-functioning autism.
Critics argue that these diverse services will no longer be available if the individual disorders are not recognized.\textsuperscript{36}

The final criticism against the combination of disorders is that there could be negative implications for insurance coverage.\textsuperscript{79} Under the previous system, various services were covered based on individual diagnoses. The concern is that insurance companies will no longer cover services for individuals with Asperger’s since the disorder will no longer be recognized, and that similar services may not be considered necessary under the new diagnosis.\textsuperscript{36}

Importantly, in keeping with the present DSM V focus on the heterogeneity of individuals diagnosed with an autism spectrum disorder (ASD) many treatment programs emphasize a highly \textit{individualized} approach to treatment. A child’s impairments and strengths across all levels of the ASD should be assessed as early as possible in treatment; and, should include family participation in treatment interventions and the ongoing assessment of a child’s progress.

\section*{Other Changes To The DSM}

The disorders listed in the section above were the most controversial of the revisions to the DSM. However, there were a number of other revisions that warrant special attention. Many of the revisions included in this section are disorders that were added to section II of the DSM after appearing as symptoms, subcategories or disorders in the appendix of other versions. Others are included because they underwent significant revisions to the diagnostic criteria or some other aspect of their description that will have an impact on identification, diagnosis and treatment. In addition, many of the revisions included in this section did receive a great deal of feedback, both
positive and negative. However, they were not considered as controversial as those included in the section above.

This section does not provide information on all of the other changes made to section II in the DSM, but it does include information on those considered most significant. For information on other changes made to the DSM, please see the *Overview of DSM-5* section.

**Excoriation Disorder**

To best understand the addition of excoriation, as well as other categories of obsessive-compulsive disorder, it is important to understand obsessive-compulsive disorder as a whole. The APA provides the following information regarding obsessive-compulsive disorder:

*Obsessive-Compulsive and Related Disorders*

The chapter on obsessive-compulsive and related disorders, which is new in *DSM-5*, reflects the increasing evidence that these disorders are related to one another in terms of a range of diagnostic validators, as well as the clinical utility of grouping these disorders in the same chapter. 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 a distinction between individuals with good or fair insight, poor insight, and “absent insight/delusional” obsessive-compulsive disorder beliefs (i.e., complete conviction that obsessive-compulsive disorder beliefs are true). Analogous “insight” specifiers have been included for body dysmorphic disorder and hoarding disorder.

These specifiers are intended to improve differential diagnosis by emphasizing that individuals with these two disorders may present with a range of insight into their disorder-related beliefs, including absent insight/delusional symptoms. This change also emphasizes that the presence of absent insight/delusional beliefs warrants 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, because this comorbidity may have important clinical implications.30

Previous editions of the DSM did not include a separate diagnostic category for excoriation. In previous manuals, skin picking was included as part of stereotypic movement disorder. Skin picking is often a symptom of another disorder, such as autism and obsessive compulsive disorder.8 Therefore, it was never included as a separate diagnosis. Instead, it was recognized within these other categories. However, due to new research regarding excoriation, many regard skin picking as a primary disorder rather than a symptom of another issue.13
The APA provides the following information regarding the newly added condition to the spectrum of obsessive-compulsive disorders:\textsuperscript{80}

*Excoriation (skin-picking) disorder is characterized by recurrent skin picking resulting in skin lesions. Individuals with excoriation disorder must have made repeated attempts to decrease or stop the skin picking, which must cause clinically significant distress or impairment in social, occupational or other important areas of functioning. The symptoms must not be better explained by symptoms of another mental disorder.*

*This disorder is included in DSM-5 because of substantial scientific literature on excoriation’s prevalence, diagnostic validators and treatment. Studies show that the prevalence of excoriation is estimated at approximately two to four percent of the population. Resulting problems may include medical issues such as infections, skin lesions, scarring and physical disfigurement.*

Excoriation is most common among people with other disorders, such as autism. However, it does occur on its own.\textsuperscript{81} The disorder is often referred to as neurotic excoriation, dermatillomania, compulsive skin picking, and psychogenic skin picking. Excoriation is characterized by compulsive skin picking that causes injuries, wounds and stress to the patient.\textsuperscript{81} According to the DSM-5, skin picking is often “accompanied by a range of behaviors or rituals involving skin or scabs ... individuals may search for a particular kind of scab to pull, and they may examine, play with, or mouth or swallow the skin after it has been pulled.”\textsuperscript{30}
Not only has the categorization of excoriation changed in the DSM-5, but also so has the criteria for diagnosis. The new diagnostic criteria for excoriation is as follows:

A. Recurrent skin picking resulting in skin lesions.
B. Repeated attempts to decrease or stop skin picking.
C. The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The skin picking is not attributable to the physiological effects of a substance (i.e., cocaine) or another medical condition (i.e., scabies).
E. The skin picking is not better explained by symptoms of another mental disorder (i.e., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm oneself in nonsuicidal self injury).

While the addition of excoriation to the DSM-5 has not been as controversial as some other changes, the APA still received some criticism. The primary argument against the inclusion of excoriation as a separate disorder is that it does not actually meet the criteria for a mental disorder. Critics argue that skin picking is more of a habit than a mental disorder. The concern is that by adding skin picking, there may be pressure in the future to add other habits to the DSM.

Another argument is that skin picking is primarily a symptom of another disorder and, therefore, should not have its own diagnosis. However, the APA argues that enough individuals present with only excoriation, thereby justifying the addition of the disorder to the DSM.
**Hoarding Disorder**

In the DSM-IV-TR, hoarding is not included as an individual disorder. Instead, it is listed as one of the diagnostic criteria for obsessive-compulsive personality disorder (OCD). In DSM-IV, “the inability to discard worn-out or worthless objects even when they have no sentimental value” is one of the 8 criteria for Obsessive-Compulsive Personality Disorder (OCPD).\(^{24}\) In the text accompanying the OCPD criteria, DSM-IV states: “Despite the similarity in names, OCD is usually easily distinguished from OCPD by the presence of true obsessions and compulsions. A diagnosis of OCD should be considered especially when hoarding is extreme (i.e., accumulated stacks of worthless objects present a fire hazard and make it difficult for others to walk through the house). When criteria for both disorders are met, both diagnoses should be recorded.”\(^{24}\)

Therefore, using the DSM-IV or the DSM-IV-TR, patients who presented with extreme instances of hoarding were diagnosed with obsessive-compulsive personality disorder. However, since a number of patients who presented with compulsive hoarding did not have any other symptoms of neurological and physical disorders, the APA determined that Hoarding Disorder should be included in the DSM-5 as a separate diagnosis.\(^{13}\)

Since there was no official diagnosis for hoarding disorder prior to the DSM-5, Frost and Hart developed a set of diagnostic criteria to use when diagnosing hoarding disorder. The diagnostic criteria were accepted by clinicians and researchers in the field and were widely used to diagnose individuals with hoarding disorder.
The following are the diagnostic criteria developed by Frost and Hart:  

1) The acquisition of and failure to discard a large number of possessions that seem to be useless or of limited value;  
2) Living spaces sufficiently cluttered so as to preclude activities for which those spaces were designed;  
3) Significant distress or impairment in functioning caused by the hoarding.

The APA provides the following explanation for the addition of the hoarding disorder category:

*Hoarding disorder is a new diagnosis in DSM-5. DSM-IV lists hoarding as one of the possible symptoms of obsessive-compulsive personality disorder and notes that extreme hoarding may occur in obsessive-compulsive disorder. However, available data do not indicate that hoarding is a variant of obsessive-compulsive disorder or another mental disorder. Instead, there is evidence for the diagnostic validity and clinical utility of a separate diagnosis of hoarding disorder, which reflects persistent difficulty discarding or parting with possessions due to a perceived need to save the items and distress associated with discarding them. Hoarding disorder may have unique neurobiological correlates, is associated with significant impairment, and may respond to clinical intervention.*

While the criteria listed above were unofficially used as the diagnostic criteria for hoarding disorder, the new criteria in the DSM-5 is more detailed and thorough. These criteria focus on specific attributes of hoarding disorder and provide guidance for diagnosing levels of severity. The following is a list of the diagnostic criteria for Hoarding Disorder in the DSM-5:
A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.

B. This difficulty is due to a perceived need to save the items and to distress with discarding them.

C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (i.e., family members, cleaners, authorities).

D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).

E. The hoarding is not attributable to another medical condition (i.e., brain injury, cerebrovascular disease, Prader Willi syndrome).

F. The hoarding is not better explained by the symptoms of another mental disorder (i.e., obsession in obsessive compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder).

Specify if:

With excessive acquisition: If difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space.

Specify if:30
With good or fair insight: The individual recognizes that hoarding related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic.

With poor insight: The individual is mostly convinced that hoarding related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

With absent insight/delusional beliefs: The individual is completely convinced that hoarding related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

The addition of hoarding disorder as a separate diagnosis has caused some controversy. Critics argue that the creation of a separate disorder for individuals who show signs of hoarding will likely result in disease inflation. According to the critics, the addition of a separate category for hoarders is unnecessary since hoarding can be considered a subset of obsessive compulsive disorder. Supporters of the addition argue that hoarding disorder should be recognized and diagnosed separately from obsessive compulsive disorder as many individuals do not exhibit any other symptoms of obsessive compulsive disorder and should not be classified as having OCD. The creation of a separate hoarding disorder allows practitioners to accurately diagnose patients, rather then label them with a disorder that they do not actually have.

**Pedophilic Disorder**

The APA did not make any significant changes to pedophilia in the DSM-5 other than the name that is used. The disorder has been included in previous
versions of the manual and has provided similar diagnostic criteria to that used in the DSM-5. However, in previous editions of the DSM, the disorder characterized by erotic interest and arousal in children was known as pedophilia. In the DSM-5, the name was changed to pedophilic disorder.

The APA provides the following explanation for the changes to the diagnostic names in the paraphilic category, which includes pedophilic disorder:

*In DSM-5, paraphilia’s are not ipso facto mental disorders. There is a distinction between paraphilia’s 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 paraphilia’s 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 (i.e., 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 paraphilia’s and paraphilic disorders is one of the changes from DSM-IV that applies to all atypical erotic interests. This approach leaves intact the distinction between normative and nonnormative sexual behavior, which could be important to researchers or to persons who have nonnormative sexual preferences, but without automatically labeling nonnormative sexual behavior as psychopathological. This change in viewpoint is reflected in the diagnostic criteria sets by the addition of the word disorder to all the paraphilia’s. Thus, for example, DSM-IV pedophilia has become DSM-5 pedophilic disorder.

In addition, the APA provides the following explanation regarding specific revisions to pedophilia:87

In the case of pedophilic disorder, the notable detail is what wasn’t revised in the new manual. Although proposals were discussed throughout the DSM-5 development process, diagnostic criteria ultimately remained the same as in DSM-IV TR. Only the disorder name will be changed from pedophilia to pedophilic disorder to maintain consistency with the chapter’s other listings.

The diagnostic criteria for pedophilic disorder is as follows:30

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).
B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with 12- or 13-year-old children.

Specify the following categories:
- Exclusive Type (attracted only to children)
- Nonexclusive Type

Specify if:
- Sexually Attracted to Males
- Sexually Attracted to Females
- Sexually Attracted to Both

Specify if:
- Limited to Incest

While there has been little criticism against changing the name from pedophilia to pedophilic disorder, some are still concerned about the diagnostic category itself. This is not as controversial as other topics in the DSM-5, but there are some critics who argue that the diagnostic criteria is not broad enough as it does not account for the individuals who are attracted to pubescent children from the ages of 11 – 14. Other critics argue that pedophilic disorder should not be a separate diagnosis, but rather a “sexual preference” listed under general paraphilic disorder.
**Personality Disorders**

Personality Disorders is a relatively large category in section II of the DSM-5. The beginning of the chapter provides a general description and diagnostic criteria for general personality disorder, which applies to the individual personality disorders included in the chapter. Along with diagnostic criteria for general personality disorder, the category also includes the following ten distinct personality disorders:

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive Compulsive Personality Disorder
- Personality change due to another medical condition
- Other specified personality disorder and unspecified personality disorder

The section on personality disorders did not change significantly in the DSM-5. However, the focus on a new model of diagnosing and classifying personality disorders is discussed in section III of the manual. Initially, the DSM-5 work group recommended significant changes to the section on personality disorders. These changes would result in a hybrid categorical dimensional model that would provide diagnostic criteria for both core impairments in personality as well as combinations of pathological personality traits.
The goals of this new model included:

- Reducing overlap among personality disorder diagnoses
- Reducing heterogeneity among patients receiving the same diagnosis
- Eliminating arbitrary diagnostic thresholds with little or no research basis
- Addressing the widespread use of the vague "personality disorder not otherwise specified" diagnosis
- Providing diagnostic thresholds that are related to level of impairment in a meaningful way

Ultimately, the DSM task force determined that the proposed model had not been researched thoroughly enough to be included in section II. Although the proposal was endorsed by the DSM-5 Task Force, it was decided that the hybrid model required more research support before being fully adopted. Therefore, the hybrid model is referred to as an "alternative model" and is included in Section III of the DSM-5. Meanwhile, the main body of the DSM-5 will retain the DSM-IV criteria for personality disorders.

The APA provides the following thorough explanation of the specific revisions to the section on personality disorders:

The criteria for personality disorders in Section II of DSM-5 have not changed from those in DSM-IV. An alternative approach to the diagnosis of personality disorders was developed for DSM-5 for further study and can be found in Section III.

The diagnostic criteria for specific DSM-5 personality disorders in the alternative model are consistently defined across disorders by typical impairments in personality functioning and by characteristic pathological personality traits that have been empirically determined.
to be related to the personality disorders they represent. Diagnostic thresholds for both Criterion A and Criterion B have been set empirically to minimize change in disorder prevalence and overlap with other personality disorders and to maximize relations with psychosocial impairment. A diagnosis of personality disorder—trait specified, based on moderate or greater impairment in personality functioning and the presence of pathological personality traits, replaces personality disorder not otherwise specified and provides a much more informative diagnosis for patients who are not optimally described as having a specific personality disorder. A greater emphasis on personality functioning and trait-based criteria increases the stability and empirical bases of the disorders.

Personality functioning and personality traits also can be assessed whether or not an individual has a personality disorder, providing clinically useful information about all patients. The DSM-5 Section III approach provides a clear conceptual basis for all personality disorder pathology and an efficient assessment approach with considerable clinical utility.

The following are the approved diagnostic criteria for personality disorders:

A. An enduring pattern of inner experience and behavior the deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (i.e., ways of perceiving and interpreting self, other people and events)
2. Affectivity (i.e., the range, intensity, liability, and appropriateness of emotional response)
3. Interpersonal functioning
4. Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not due to the direct physiological effects of a substance (i.e., a drug abuse, a medication) or a general medical condition (i.e., head trauma).

While the section on personality disorders did not change, the APA still received some criticism regarding the diagnostic category. Most of the controversy involved the number of disorders included in the section. Some critics favored the inclusion of additional disorders (those that are included in the alternative model in section III), while others argued for the removal of some of the disorders.91 Ultimately, some critics feel that there are not enough specific disorders included to adequately capture all of the individuals with personality disorders, while others argue that there are too many personality disorders, which causes over diagnosis.92

**Post Traumatic Stress Disorder (PTSD)**

In the DSM-IV, Post Traumatic Stress Disorder was included in the chapter on anxiety disorders. However, in the DSM-5, Post Traumatic Stress Disorder is included in a new class of disorders called *Trauma and Stressor Related Disorders*. Unlike anxiety disorders, all of the disorders that make up
this new class are required to be caused by exposure to a traumatic or stressful event.\textsuperscript{8}

In addition to changes in the categorization for Post Traumatic Stress Disorder from the last version of the DSM, there have also been significant changes to the diagnostic criteria. The following bullets, provided by the U.S. Department of Veterans Affairs, provides highlights of the specific changes made to the diagnostic criteria:\textsuperscript{93}

- The 3 clusters of DSM-IV symptoms are divided into 4 clusters in DSM-5: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. DSM-IV Criterion C, avoidance and numbing, was separated into two criteria: Criteria C (avoidance) and Criteria D (negative alterations in cognitions and mood). The rationale for this change was based upon factor analytic studies, and now requires at least one avoidance symptom for PTSD diagnosis.

- Three new symptoms were added:
  - Criteria D (negative alterations in cognitions and mood):
    persistent and distorted blame of self or others; and, persistent negative emotional state
  - Criteria E (alterations in arousal and reactivity): reckless or destructive behavior

- Other symptoms were revised to clarify symptom expression.
• Criterion A2 (requiring fear, helplessness or horror happen right after the trauma) was removed in DSM-5. Research suggests that Criterion A2 did not improve diagnostic accuracy.

• A clinical subtype "with dissociative symptoms" was added. The dissociative subtype is applicable to individuals who meet the criteria for PTSD and experience additional depersonalization and derealization symptoms.

• Separate diagnostic criteria are included for children ages 6 years or younger (preschool subtype).

The diagnostic criteria for Post Traumatic Stress Disorder are extensive and have not been included in their entirety within this document. The highlighted changes above will serve as an overview of the changes made to the diagnostic criteria.

The following explanation, provided by the APA, describes the significant changes made to the definition and criteria for Post Traumatic Stress Disorder:

*Compared to DSM-IV, the diagnostic criteria for DSM-5 draw a clearer line when detailing what constitutes a traumatic event. Sexual assault is specifically included, for example, as is a recurring exposure that could apply to police officers or first responders. Language stipulating an individual’s response to the event—intense fear, helplessness or horror, according to DSM-IV—has been deleted because that criterion proved to have no utility in predicting the onset of PTSD.*
DSM-5 pays more attention to the behavioral symptoms that accompany PTSD and proposes four distinct diagnostic clusters instead of three. They are described as re-experiencing, avoidance, negative cognitions and mood, and arousal.

Re-experiencing covers spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress. Avoidance refers to distressing memories, thoughts, feelings or external reminders of the event.

Negative cognitions and mood represents myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.

Finally, arousal is marked by aggressive, reckless or self-destructive behavior, sleep disturbances, hyper-vigilance or related problems. The current manual emphasizes the “flight” aspect associated with PTSD; the criteria of DSM-5 also account for the “fight” reaction often seen.

The number of symptoms that must be identified depends on the cluster. DSM-5 would only require that a disturbance continue for more than a month and would eliminate the distinction between acute and chronic phases of PTSD.

While the changes to Post Traumatic Stress Disorder were not mired in controversy, there were minor concerns about the modifications made to the diagnostic criteria. Some critics were concerned that the new criteria reduce the type of events that qualify as a traumatic event, thereby reducing the
number of individuals who will be able to obtain treatment for the disorder. Moreover, critics are concerned about how some of the criteria were developed.

In addition to highlighting the changes to the diagnostic criteria, the US Department of Veterans Affairs also provides information about the potential implications of changes to the diagnostic criteria, which provide a solid explanation of the criticism regarding the revised criteria:

- The revision of Criterion A1 in DSM-5 narrowed qualifying traumatic events such that the unexpected death of family or a close friend due to natural causes is no longer included. Research suggests this is the greatest contributor (>50%) to discrepancy for meeting DSM-IV but not DSM-5 PTSD criteria.
- Splitting DSM-IV Criterion C into two criteria in DSM-5 now requires that a PTSD diagnosis must include at least one avoidance symptom.
- Criterion A2, response to traumatic event involved intense fear, hopelessness, or horror, was removed from DSM-5.

**Schizophrenia**

There have been significant changes to the definition and diagnostic criteria for schizophrenia in the DSM-5. These changes are meant to improve the ways in which patients are identified, diagnosed and treated. According to the APA, the criteria for schizophrenia diagnosis in previous versions of the manual were unclear and often confusing, which resulted in difficulty differentiating schizophrenia from other psychotic disorders. The changes in definition and criteria are expected to reduce and/or eliminate these issues.
The first change that the APA made to the diagnostic criteria for schizophrenia was the removal of the subtypes of the disorder. In previous versions, the definition included the following subtypes:  

- Paranoid  
- Disorganized  
- Catatonic  
- Undifferentiated  
- Residual

Subtypes were eliminated from the DSM-5 as a way to reduce confusion regarding diagnosis. According to the APA, "Subtypes had been defined by the predominant symptom at the time of evaluation. But these were not helpful to clinicians because patients’ symptoms often changed from one subtype to another and presented overlapping subtype symptoms, which blurred distinctions among the five subtypes and decreased their validity." 

In addition, some of the subtypes were not useful in developing and providing treatment to patients. Rather than include separate subtypes, the DSM-5 uses some of the previous subtypes as specifiers during diagnosis.

Rather than focus on subtypes to determine the patient’s specific diagnosis, the DSM-5 utilizes a dimensional approach. This approach relies on rating the severity level of the core symptoms and making a determination about the patient’s status based on the results. The assessments for determining severity are included in Section III of the manual.

Another change in the DSM-5 is specific to Criterion A symptoms. In the DSM-IV, only one Criterion A symptom ("Characteristic Symptoms") was required for diagnosis. Criterion A symptoms are: delusions, hallucinations, disorganized speech, catatonic behavior, and negative symptoms. In the
DSM-5, two Criterion A symptoms are required for diagnosis. In addition, the DSM-5 requires that at least one of the characteristic symptoms of schizophrenia (delusions, hallucinations, and disorganized thinking) must be present for a diagnosis.\(^96\)

The APA provides the following information regarding the changes to schizophrenia in the DSM-5:\(^{30}\)

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 (i.e., two or more voices conversing). In DSM-IV, only one such symptom was needed to meet the diagnostic requirement for Criterion A, instead of two of the other listed symptoms. This special attribution was removed due to the nonspecificity of Schneiderian symptoms and the poor reliability in distinguishing bizarre from nonbizarre delusions. Therefore, in 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: delusions, hallucinations, and 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 due to their limited diagnostic stability, low reliability, and poor validity. These subtypes also have not been shown to exhibit distinctive
patterns of treatment response or longitudinal course. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia is included in Section III to capture the important heterogeneity in symptom type and severity expressed across individuals with psychotic disorders.

The following is the diagnostic criteria for schizophrenia in the DSM-5:\textsuperscript{30}

A. Characteristic symptoms:
Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these should include 1-3:

1. Delusions
2. Hallucinations
3. Disorganized speech
4. Grossly abnormal psychomotor behavior, such as catatonia
5. Negative symptoms, \textit{i.e.}, restricted affect or avolition/asociality

B. Social/occupational dysfunction:
For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration:
Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (\textit{i.e.}, active-phase
symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (i.e., odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion:
Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive or Manic Episodes have occurred concurrently with the active phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion:
The disturbance is not due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder or other communication disorder of childhood onset, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

The changes to the diagnostic criteria for schizophrenia did not receive a great deal of criticism. As is often the case, there were some critics who argued against the changes. Specifically, these critics were concerned with
the removal of the subtypes and the requirement of meeting two Criterion A symptoms. However, most practitioners support the changes to the criteria for schizophrenia.

**Specific Learning Disorders**

In the DSM-5, the section on learning disorders has changed significantly. In previous editions of the manual, learning disorders were called “Academic Skills Disorders (DSM-III). However, in the DSM-IV, they became known as Learning Disorders. The DSM-5 has maintained the same term of learning disorders, but now calls them Specific Learning Disorders. This diagnostic category is included in the chapter on neurodevelopmental disorders. In addition to a slight name change, the diagnostic approach has changed as well.

In the DSM-5, the learning disorders category has been broadened as a means of ensuring diagnostic accuracy and improving treatment and care identification and development. Instead of creating separate diagnostic categories for difficulty in individual subjects, the DSM-5 utilizes a single diagnostic category, called Specific Learning Disorders, to capture all individuals who meet the diagnostic criteria. According to the APA, “broadening the diagnostic category reflects the latest scientific understanding of the condition. Specific symptoms, such as difficulty in reading, are just symptoms. And in many cases, one symptom points to a larger set of problems. These problems can have long-term impact on a person’s ability to function because so many activities of daily living require a mastery of number facts, written words, and written expression.”

The change in the diagnostic criteria for learning disorders will enable clinicians to use assessments to determine the patient’s academic
performance ability as it relates to their intelligence and age. This information will be used to determine the areas of deficit and the development of a treatment plan that will include academic accommodations. The APA argues that the “broader DSM-5 category of specific learning disorder ensures that fewer affected individuals will go unidentified, while the detailed specifiers will help clinicians effectively target services and treatment.”

The APA provides the following explanation for the changes to the diagnostic criteria for Specific Learning Disorders:

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 text acknowledges that specific types of reading deficits are described internationally in various ways as dyslexia and specific types of mathematics deficits as dyscalculia.

The following is the new diagnostic criteria for Specific Learning Disorders:

A. Difficulties learning and using academic skills, as indicated by the presence of at least one of the following symptoms that have presented for at least six months, despite the provision of interventions that target these difficulties:

1. Inaccurate or slow and effortful word reading (i.e., reads single words aloud incorrectly or slowly or and hesitantly, frequently guesses words, has difficulty sounding out words).
2. Difficulty understanding the meaning of what is read (i.e., may read text accurately but not understand the sequence, relationships, inferences, or deeper meanings of what is read).

3. Difficulties with spelling (i.e., may add, omit, or substitute vowels or consonants).

4. Difficulties with written expression (i.e., makes multiple grammatical or punctuation errors within sentences; employs poor paragraph organization; written expression of ideas lacks clarity).

5. Difficulties mastering number sense, number facts, or calculation (i.e., has poor understanding of numbers, their magnitude, and relationships; counts on fingers to add single-digit numbers instead of recalling the math fact as peers do; gets lost in the midst of arithmetic computation and may switch procedures).

6. Difficulties with mathematical reasoning (i.e., has severe difficulty applying mathematical concepts, facts, or procedures to solve quantitative problems).

B. The affected academic skills are substantially and quantifiably below those expected for the individual’s chronological age, and cause significant interference with academic or occupational performance, or with activities of daily living, as confirmed by individually administered standardized achievement measures and comprehensive clinical assessment. For individuals 17 years and older, a documented history of impairing learning difficulties may be substituted for the standardized assessment.

C. The learning difficulties begin during school-age years but may not become fully manifest until the demands for those affected academic
skills exceed the individual’s limited capacities (i.e., as in timed tests, reading or writing lengthy complex reports for a tight deadline, excessively heavy academic loads).

D. The learning difficulties are not better accounted for by intellectual disabilities, uncorrected visual or auditory acuity, other mental or neurological disorders, psychosocial adversity, lack of proficiency in the language of academic instruction, or inadequate educational instruction.

Note: The four diagnostic criteria are to be met based on a clinical synthesis of the individual’s history (developmental, medical, family, educational), school reports, and psycho-educational assessment.³⁰

Along with the comprehensive diagnostic criteria listed above, the DSM-5 includes specifiers that must be used to identify and diagnose specific categories of learning disorders. The following categories are to be specified during diagnosis and coding:³⁰

- With impairment in reading
- With impairment in written expression
- With impairment in mathematics

The diagnostic criteria also include the following severity measures:³⁰

- Mild
- Moderate
- Severe

During the diagnosis, the practitioner will determine the level of severity for each learning disorder.
The changes to the diagnostic criteria for Specific Learning Disorders have been met with mixed response. While clinicians are generally supportive of the changes and welcome the recognition of learning disorders as medically significant, there are still some concerns. Critics of the changes in the diagnostic criteria are concerned mostly with the elimination of individual, academically specific disorders. Many critics have recommended that Learning Disorders be used as an umbrella category that includes subtypes based on specific learning disorders. For example, many critics argue that dyslexia should be an individual diagnostic category, rather than one of the criteria in the Specific Learning Disabilities diagnosis. The National Center on Learning Disabilities recommends the following.

Learning Disabilities” be used as an overarching category with subtypes including disorders of:

- Word reading (”dyslexia”)
- Reading fluency
- Reading comprehension
- Written expression
- Mathematics calculation (”dyscalculia”)
- Mathematics problem solving
- ”Learning Disabilities Not Otherwise Specified” be retained to capture difficulties that do not meet criterion for other areas but that constitute significant obstacles to learning, daily living and social-emotional well-being

**Substance Use Disorder**

In the DSM-5, the substance abuse category has been modified to provide diagnostic options for individual substance use disorders. Unlike the DSM-IV, the criteria for substance abuse and dependence have been combined to
produce the category of Substance Use Disorder, which is included in the chapter called *Substance Related and Addictive Disorders*. Within this category, there are individual substance use disorders that are substance specific. In addition, the DSM-5 includes a new addictions and related disorders category.

The individual substance use disorders are broken into three subtypes: mild, moderate and severe. In addition to changes in the diagnostic categories, the DSM-5 also requires that patient meets more criteria than previous manuals. For a mild substance abuse disorder, the DSM-5 requires that at least two diagnostic criteria are met. This differs from the DSM-IV, which required that patients only meet one of the criteria.30

The APA provides the following explanation of the changes to the substance use disorder category:30

*DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Rather, criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant. 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 urges to use a substance, has been added. In addition, 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 withdrawal (which was in DSM-IV Appendix B, “Criteria Sets and Axes Provided for Further Study”). Of note, the criteria for DSM-5 tobacco use disorder are the same as those for other substance use disorders. By contrast, DSM-IV did not have a category for tobacco abuse, so 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 the situation warrants.

The most significant change to substance use disorder is the removal of the categories of “abuse and dependence”. In the DSM-IV, substance abuse was used to refer to mild or early phases of substance use, while dependence was considered a more severe form of substance use disorder. This posed problems during diagnosis as it often left things open to interpretation. The APA chose, instead, to create the single category with levels of mild, moderate and severe instead of using abuse and dependence.8

Each substance in the DSM-5 is addressed as an individual disorder and includes its own diagnostic criteria. The specific disorders are:30

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Alcohol Related Disorders:
- Alcohol use disorder
- Alcohol intoxication
- Alcohol withdrawal
- Unspecified alcohol related disorder

Caffeine Related Disorders:
- Caffeine intoxication
- Caffeine withdrawal
- Unspecified caffeine related disorder

Cannabis Related Disorders:
- Cannabis use disorder
- Cannabis intoxication
- Cannabis withdrawal
- Unspecified cannabis related disorder

Hallucinogen Related Disorders:
- Phencyclidine use disorder
- Phencyclidine intoxication
- Hallucinogen persisting perception disorder
- Unspecified phencyclidine related disorder
- Unspecified hallucinogen related disorder

Inhalant Related Disorders:
- Inhalant use disorder
- Inhalant intoxication
- Unspecified inhalant related disorder
• Opioid Related Disorders:
  – Opioid use disorder
  – Opioid intoxication
  – Opioid withdrawal
  – Unspecified opioid related disorder

• Sedative, Hypnotic, or Anxiolytic Disorders:
  – Sedative, Hypnotic, or Anxiolytic use disorder
  – Sedative, Hypnotic, or Anxiolytic intoxication
  – Sedative, Hypnotic, or Anxiolytic withdrawal
  – Unspecified Sedative, Hypnotic, or Anxiolytic related disorder

• Stimulant Related Disorders:
  – Stimulant use disorder
  – Stimulant intoxication
  – Stimulant withdrawal
  – Unspecified stimulant related disorder

• Tobacco Related Disorders:
  – Tobacco use disorder
  – Tobacco withdrawal
  – Unspecified tobacco related disorder

• Other (or Unknown) Substance Related Disorders:
  – Other (or Unknown) substance use disorder
  – Other (or Unknown) substance intoxication
  – Other (or Unknown) substance withdrawal
  – Unspecified other (or Unknown) substance related disorder
While there has been some negative feedback regarding the changes to the substance use disorder criteria and diagnostic categories, most of the response has been positive. Those who have concerns about the revisions argue that the potential for being diagnosed with a disorder under the new criteria is greater than it was before, which may result in unnecessary diagnosis.¹⁰³

Other critics argue that many individuals who are substance users may only exhibit minor symptoms, which can negatively impact their chances of being diagnosed with a substance use disorder and accessing treatment.¹⁰⁴ While there are some critics of the new diagnostic criteria, there are also many clinicians who have embraced the changes. Supporters praise the new scaled approach to substance use disorders and promote the benefits of the new criteria in the diagnosis and treatment of patients.¹⁰³

Non-Accepted Proposals

While many new disorders were included in the DSM-5, there were some disorders that were not accepted. These are not that same as the disorders that are included in Section III that are undergoing further research. These disorders were not accepted for inclusion in any part of the DSM-5. Ultimately, although clinicians treat these conditions, the APA could not justify their inclusion in any part of the manual, including section III, as there is not sufficient evidence that they are even potential diagnosable disorders.¹³ In addition, critics feared that the criteria would be loose for the disorders listed below, thereby resulting in the over diagnosis of individuals.³ The following is a list of the disorders that were not accepted, with a brief description of each.
**Anxious Depression**

Anxious depression is a combination of both depression and anxiety. Patients who suffer from anxious depression typically present with feelings of worthlessness, pessimism, excessive worrying, guilt, and an inability to experience joy while doing things. Patients who experience anxious depression often experience physical manifestations, including diminished appetite, poor sleep, frequent awakenings, restlessness, and psychomotor agitation.\(^{105}\)

Anxious depression can manifest in two ways. In some patients, the anxiety will precede a major depressive disorder. In other patients, it will present after the onset of the depression. It is often difficult to treat with medication as there are very few options available.\(^{106}\)

**Hypersexual Disorder**

Although hypersexual disorder was not accepted as a disorder in the DSM-5, the APA did develop an initial definition and diagnostic criteria for the disorder. It is as follows.

The symptoms of Hypersexual Disorder are:\(^{107}\)

- Over a period of at least six months, a person experiences recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria:
  1. Excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior.
  2. Repetitively engaging in these sexual fantasies, urges, and behavior in response to dysphoric mood states (i.e., anxiety, depression, boredom, irritability).
3. Repetitively engaging in sexual fantasies, urges, and behavior in response to stressful life events.
4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior.
5. Repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others.

- The person experiences clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behavior.

- These sexual fantasies, urges, and behavior are not due to direct physiological effects of drugs or medications, or to Manic Episodes.

Specify if:
- Masturbation
- Pornography
- Sexual Behavior With Consenting Adults
- Cybersex
- Telephone Sex
- Strip Clubs
- Other

While an initial set of criteria were developed, there was not enough support for the disorder to be included in the DSM-5. In addition, critics argue that there was not enough evidence to support the inclusion of hypersexual disorder in the DSM-5. Therefore, the disorder was not included in this edition of the manual.
Parental Alienation Syndrome

Parental Alienation Syndrome is a term that was developed and defined by Richard Gardner. According to Gardner, Parental Alienation Syndrome arises primarily in the context of child-custody disputes. Its primary manifestation is the child's campaign of denigration against the parent, a campaign that has no justification. The disorder results from the combination of indoctrinations by the alienating parent and the child's own contributions to the vilification of the alienated parent.109

The alienating process develops over time and the distancing between the children and the targeted that occurs includes some or all of the following features:110

- The alienating parent speaks badly or demeans the targeted parent directly to the children - the disparaging comments made by the alienating parent to their children about the targeted parent can be implicit ("I am not sure I will be able to afford to send you to camp because "Mom" or "Dad" does not realize how much you enjoy it") or explicit ("Mom/Dad" left us because he/she never cared enough about you to keep our family together").
- The alienating parent speaks badly or demeans the targeted parent to others in the presence (or within audible distance) of the children.
- The alienating parent discusses with the children the circumstances under which the marriage broke down and blames the targeted parent for its failure.
- The alienating parent exposes the children to the details of the parents' ongoing conflict, financial problems and legal proceedings.
- The alienating parent blames the targeted parent for changes in lifestyle, any current hardships; his/her negative emotional state and inability to function as before and conveys this to the children.
• Allegations of sexual, physical and emotional abuse of children are often made.
• Alienated children come to know that in order to please the alienating parent, they must turn against the targeted parent.

**Sensory Processing Disorder**

Sensory processing (sometimes called "sensory integration" or SI) is a term that refers to the way the nervous system receives messages from the senses and turns them into appropriate motor and behavioral responses.

Sensory Processing Disorder (SPD, formerly known as "sensory integration dysfunction") is a condition that exists when sensory signals don't get organized into appropriate responses. A person with SPD finds it difficult to process and act upon information received through the senses, which creates challenges in performing countless everyday tasks. Motor clumsiness, behavioral problems, anxiety, depression, school failure, and other impacts may result if the disorder is not treated effectively.¹¹¹

Sensory Processing Disorder affects individuals on a spectrum, meaning that there are different severity levels. Individuals are either hypersensitive or hyposensitive. In addition, sensory processing disorder affects individuals differently and can result in sensory difficulties in the following areas:¹¹²

- Tactile Dysfunction
- Vestibular Dysfunction
- Proprioceptive Dysfunction
- Auditory Dysfunction
- Oral Input Dysfunction
- Olfactory Dysfunction
- Visual Input Dysfunction
Auditory-Language Processing Dysfunction
Social, Emotional, Play, And Self-Regulation Dysfunction
Internal Regulation

Related Organizations

The American Psychiatric Association developed the DSM-5. However, there are a number of other organizations that have provided input on the revisions. Some of these organizations responded negatively to many of the revisions, while others assisted with the development of the manual. This section provides information on the other mental health organizations.

National Institute of Mental Health

The National Institute of Mental Health (NIMH) is one of the 27 institutes and centers that comprise the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services. Thomas R. Insel is the current Director of NIMH.

NIMH is a multi-billion dollar enterprise that supports research on mental health through grants to institutions and organizations throughout the United States, as well as through an internal research effort.¹¹³

Mission:
The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure.

For the Institute to continue fulfilling this vital public health mission, it must foster innovative thinking and ensure that a full array of novel scientific...
perspectives are used to further discovery in the evolving science of brain, behavior, and experience. In this way, breakthroughs in science can become breakthroughs for all people with mental illnesses.¹¹⁴

**NIMH and the DSM-5:**

At the beginning of May, approximately three weeks before the DSM-5 was accepted by the APA, Thomas Insel, director of the National Institute of Mental Health (NIMH), publicly stated that NIMH will no longer use the manual to guide its research. The National Institute for Mental Health is planning to develop its own set of diagnostic criteria and treatment protocol that is “based on genetic, physiologic, and cognitive data rather than symptoms alone.”⁵

In his blog post denouncing the DSM-5, Insel stated the following:

*While DSM has been described as a “Bible” for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been “reliability” – each edition has ensured that clinicians use the same terms in the same ways. 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. Indeed, symptom-based diagnosis, once common in other areas of medicine, has been largely replaced in the past half century as we have understood that symptoms alone rarely indicate the best choice of treatment.*⁵
The NIMH is moving forward with its new research strategy, which has been named the Research Domain Criteria Project (RDoC). In response to issues with the DSM, as well as advances in genetic research, neuroscience, and behavioral science, NIMH established this new strategy as part of an overall strategic plan. The goal is to develop a new classification system that will replace the DSM. Rather than rely on patient observation and symptom reporting, the RDoC is expected to result in a classification system that is scientifically based and relies on genetic and biological information.115

American Counseling Association

The American Counseling Association is a not-for-profit, professional and educational organization that is dedicated to the growth and enhancement of the counseling profession. Founded in 1952, ACA is the world's largest association exclusively representing professional counselors in various practice settings.

There are 20-chartered divisions within the American Counseling Association. These divisions provide leadership, resources and information unique to specialized areas and/or principles of counseling. ACA has four regions, which serves members in those regions. Lastly, ACA has 56-chartered branches in the U.S., Europe, and Latin America.116

Mission:
The mission of the American Counseling Association is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity.
The American Counselors Association is providing training sessions for counselors that are specific to the DSM-5. The focus is on using the new diagnostic criteria with patients.\(^\text{117}\)

**American Mental Health Counselors Association**

The American Mental Health Counselors Association (AMHCA) is a community of approximately 7,000 clinical mental health counselors. AMHCA strives to provide a voice to the mental health counseling profession at a national and state level.

Mission:
To enhance the profession of clinical mental health counseling through licensing, advocacy, education and professional development.

In addition to serving as a task force during the development of the DSM-5, the American Mental Health Counselors Association is providing a variety of professional development opportunities to its members that are specific to the DSM-5.\(^\text{118}\)

**American Psychological Association**

The American Psychological Association is the largest scientific and professional organization representing psychology in the United States. APA is the world's largest association of psychologists, with more than 134,000 researchers, educators, clinicians, consultants and students as its members.

Mission:
APA seeks to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives by:\(^\text{119}\)
- Encouraging the development and application of psychology in the broadest manner
- Promoting research in psychology, the improvement of research methods and conditions and the application of research findings
- Improving the qualifications and usefulness of psychologists by establishing high standards of ethics, conduct, education and achievement
- Increasing and disseminating psychological knowledge through meetings, professional contacts, reports, papers, discussions and publications.

Members of the APA were given the opportunity to provide feedback on sections of the DSM-5 prior to its publication. In addition, the APA has provided a number of professional development sessions specific to the DSM-5 as well as ICD 10.

**British Psychological Society**
The British Psychological Society (BPS) provides representation for psychologists in the United Kingdom.

Mission:
The Society and its members develop, promote and apply psychology for the public good. They enhance the efficiency and usefulness of psychologists by setting high standards of professional education and knowledge. They cover all areas of psychological research and practice.

Specifically, the BPS does this by the following:119
- Providing a Directory of Chartered Psychologists
- Providing information to the public
• Ensuring high standards of education, training and practice
• Increasing the awareness and influence of psychology
• Supporting our members’ professional development
• Providing conferences and events
• Publishing
• Setting standards in psychological testing
• Maintaining and developing the History of Psychology Centre

The British Psychological Association highly criticized the DSM-5. Specifically, they attacked the changes in diagnostic criteria, the broad approach the manual takes, and the inclusion of a number of disorders that they do not consider true mental disorders.¹²⁰

**National Alliance on Mental Illness**

The National Alliance on Mental Illness (NAMI) is the nation’s largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need. NAMI is the foundation for hundreds of NAMI State Organizations, NAMI Affiliates and volunteer leaders who work in local communities across the country to raise awareness and provide essential and free education, advocacy and support group programs.¹²¹

During the DSM revision process, NAMI provided feedback on specific revisions. In addition, NAMI provides information regarding the changes to the DSM on its website. The information is intended for practitioners and consumers.¹²¹
Summary

The DSM-5 revision process lasted fourteen years and culminated with the release of a comprehensive manual that is intended to be used to properly identify and diagnose mental disorders. The American Psychiatric Association utilized task forces and work groups comprised of experts in the field throughout the process and relied on current scientific knowledge and recent research findings to develop the diagnostic criteria for mental disorders. The result is a manual that is comprised of numerous new mental disorders, as well as many others that have been changed drastically. In addition, the manual features an expanded section focused on cultural awareness and assessment, as well as information regarding disorders that are still undergoing research.

The intent is for the DSM-5 to serve as the standard guidebook for mental health professionals to use in the identification and diagnosis of mental disorders. However, the revision process and the changes that have been made to the manual have received a great deal of criticism from professionals in the field. Critics argue that the manual was not developed using sound scientific research or empirical evidence. They are also concerned that the manual contains too many disorders that are not true mental disorders, thereby increasing the number of relatively healthy individual who will be diagnosed and labeled with a mental disorder. The criticism against the DSM-5 extends beyond professionals in the field. Many families and individuals with mental disorders are concerned with the changes made to the manual and the impact those changes will have on treatment options and insurance coverage.

The DSM has served as the standard guide for mental health diagnosis since the DSM-III was published. However, with the changes made to the DSM-5
and the criticism received from the mental health field, there is less support for the manual. Many critics have determined that they will no longer rely on the DSM as a guide in the diagnostic process. In fact, the National Institute on Mental Health has publicly stated that they will begin developing a new standard for the diagnosis of mental disorders rather than rely on the DSM-5.

The DSM will likely have to evolve to align with changes in psychiatry. The combination of psychiatric diagnosis with genetics and science, as well as developing knowledge based on the observation of human behavior, will require modifications to the current diagnostic criteria. In addition, the emergence of new pharmacological treatment options and changes in coding and billing systems will further complicate and impact the diagnostic process. The APA will need to take these factors into consideration if they want the manual to continue to be the standard diagnostic tool for mental health practitioners.

Please take time to help NurseCe4Less.com course planners evaluate the nursing knowledge needs met by completing the self-assessment of Knowledge Questions after reading the article, and providing feedback in the online course evaluation.

Completing the study questions is optional and is NOT a course requirement.
1. According to the American Psychiatric Association ("APA"), the purpose of the DSM was

   a. to serve as an educational tool for teaching psychopathology.
   b. to provide a helpful guide to clinical practice.
   c. facilitate research and improve communication among clinicians and researchers.
   d. All of the above

2. It was the _______ that truly established the manual as the standard for identifying and diagnosing mental disorders.

   a. DSM-I
   b. DSM-III-R
   c. DSM-III
   d. DSM-II

3. A new section in the DSM-5 includes the role of _____________ in diagnosing mental illness.

   a. behavior disorders of childhood
   b. culture
   c. dementia
   d. gender

4. Some conditions listed in DSM-5 for further study are:

   a. Persistent Complex Bereavement Disorder
   b. Internet Gaming Disorder
   c. Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure
   d. All of the above

5. True or False: The section on personality disorders changed significantly in the DSM-5 because of a new model to classify personality disorders.

   a. True
   b. False
6. Learning Disorder has been changed to
   a. Dyscalculia.
   b. Dyslexia.
   c. Specific Learning Disorder.
   d. Disorder of Written Expression.

7. True or False: DSM-5 utilizes a single diagnostic category, called Specific Learning Disorders, to capture all individuals who meet the diagnostic criteria.
   a. True
   b. False

8. DSM-5 consolidates autism and Asperger’s into
   a. Asperger’s Disorder.
   b. Autistic Disorder.
   c. Pervasive Developmental Disorder.

9. Many of the symptoms of autism, Asperger’s, and such disorders are now part of a continuum of symptoms that
   a. make up one disorder.
   b. apply to a spectrum of disorders.
   c. are considered a minor depressive disorder.
   d. are now classified under bipolar.

10. In this manual, DSM-5, “substance abuse” and “substance dependence” have been
    a. divided into separate categories.
    b. combined into one category: substance use disorders.
    c. dropped from the manual.
    d. reclassified because they are not disorders.

11. The DSM-5 differentiates between the various neurocognitive disorders that were once grouped into the category known as
    a. neurobehavioral disorder.
    b. minor depressive disorder.
    c. dementia.
    d. unclassified or “other.”
12. True or False: It was the intent of the APA that the DSM-5 would be simple enough that it could and should be used by nonclinical or nonmedical individual to assess or diagnose an individual.

a. True
b. False

13. The new “Section III: New Disorders and Features,” provides information regarding disorders that are

a. new neurobehavioral disorders.
b. not yet recognized as classifiable disorders.
c. recognized as classifiable disorders needing further researched.
d. recognized as classifiable disorders but also controversial.

14. One criticism of the DSM-5 was the perceived ____________ in the review process.

a. overrepresentation of social workers
b. lack of breadth
c. lack of scientific rigor
d. change to multiaxial coding system

15. Much of the controversy surrounding the release of the DSM-5 centers around changes to specific disorders, such as the removal of ____________ from the manual.

a. Asperger’s Disorder
b. autism spectrum diagnosis
c. major depressive disorder
d. neurocognitive disorder

16. True or False: Temper tantrums in children, which may have been considered a general behavior problem, may now (under DSM-5) be a diagnosable condition, “disruptive mood dysregulation disorder.”

a. True
b. False
17. The new ______________ coding system allows a patient to be diagnosed on a broad spectrum that focuses more on severity level than individual symptoms.

a. multiaxial  
b. spectrum diagnosis  
c. nonaxial  
d. measures and models

18. Although the DSM-5 was developed to help clinicians identify and diagnose mental disorders, it was not developed to meet all the technical needs of

a. professionals clinicians.  
b. public health professionals.  
c. research investigators.  
d. the courts and legal professionals.

19. Previous editions of the manual did not contain a section on ______________ but this was added to DSM-5.

a. clinical practice  
b. emerging measures and models  
c. the courts and legal processes  
d. dementia

20. True or False: The DSM codes are used to diagnose mental disorders and they may also be used for medical billing purposes, as they are HIPAA compliant.

a. True  
b. False

21. The “Clinician Rated Dimensions of Psychosis Symptom Severity” is intended for use when diagnosing individuals with

a. psychotic disorders.  
b. dementia.  
c. dyscalculia.  
d. All of the above
22. The Cultural Formulation Interview (“CFI”) is primarily intended for use

a. only when a patient is showing resistance to treatment.
b. in later stages of care.
c. during an initial assessment.
d. only when there is a change in the care plan.

23. The World Health Organization Disability Assessment Schedule 2.0 (“WHODAS 2.0”) is a 36-item measure that assesses

a. disabilities in third world countries.
b. disabilities in children.
c. disabilities in adults.
d. disabilities during an initial assessment.

24. True or False: DSM codes are used by mental health professionals to identify and diagnose mental disorders, while ICD codes are used by billing professionals to code mental disorders and submit them for billing.

a. True
b. False

25. Which of the following is NOT one of the six domains assessed in the WHODAS 2.0?

a. Social supports
b. Getting around
c. Self care
d. Getting along with people

26. In instances where the patient is unable to participate in the Cultural Formulation Interview (“CFI”) process

a. the interview is not performed.
b. an informant is used.
c. the clinician completes the questions.
d. an alternate process is used.
27. **Under DSM-5, there is an alternative model for diagnosing personality disorders, which is useful in diagnosing the following disorder(s):**

   a. Narcissistic  
   b. Schizophrenia  
   c. Major Depressive Disorder  
   d. All of the above

28. **The APA lists disorders in the DSM-5 that have not been researched or developed enough to include in a “Section” but that warrant further study. As to these disorders:**

   a. they are officially recognized mental disorders.  
   b. these conditions cannot be diagnosed.  
   c. they are listed for clinical use.  
   d. All of the above

29. **True or False: In most instances, there is NOT a direct connection between cultural concepts of distress and a specific psychiatric disorder recognized in the DSM-5.**

   a. True  
   b. False

30. **The following statement(s) are correct regarding the interaction between the DSM codes and HIPAA:**

   a. DSM codes are not HIPAA compliant.  
   b. The DSM codes are not considered HIPAA compliant from a billing standpoint.  
   c. ICD codes are not used by billing professionals to code and bill mental disorders.  
   d. All of the above

31. **The APA guidelines state that when the names of the DSM-5 disorders do not match the names of the ICD disorders,**

   a. only DSM-5 disorder name should be recorded.  
   b. the clinician may choose which code to use.  
   c. the disorder must be listed by medical name, with the listing code.  
   d. the ICD name and code is the default choice.
32. When the ICD-10-CM coding system was released and became effective, medical practitioners, coders and billers were required

a. to continue with ICD-9-CM since DSM-5 was incompatible with ICD-10-CM.
b. to choose the ICD-9-CM or ICD-10-CM coding system.
c. to discard the prior ICD-9-CM coding system.
d. to be familiar with both ICD-9-CM and ICD-10-CM coding systems.

33. True or False: The expanded number of characters of the ICD-10 diagnosis codes provides greater specificity to identify disease etiology, anatomic site, and severity.

a. True  
b. False

34. Which of the following describes the nonaxial system used by the DSM-5?

a. It allows for a multi-dimensional approach to diagnosis.
b. allows clinicians to rate disorders along a continuum of severity.
c. allows clinicians to rate disorders as part of individual categories.
d. All of the above

35. In the DSM-5, the depression category has been revised

a. to include normal grieving.
b. to include intense sadness.
c. to include grief.
d. to exclude bereavement as a category of depression.

36. To be diagnosed with Disruptive Mood Dysregulation Disorder (“DMDD”), a child must display DMDD behaviors

a. in at least two different settings, e.g., home and school.
b. at least one day a week.
c. such as irritability or anger.
d. through outbursts at least one day a week.
37. True or False: The DSM-5 includes both the DSM diagnostic codes, as well as ICD-9-CM and ICD-10-CM codes for billing purposes.
   a. True
   b. False

38. Which of the following is NOT listed as a Personality Disorder in the DSM-5?
   a. Borderline Personality Disorder.
   b. Obsessive Compulsive Personality Disorder.
   c. Narcissistic Personality Disorder.
   d. Hoarding Disorder.

39. The APA decided to include mild neurocognitive disorder in the DSM-5 manual in response to the growing need to find a way to classify patients
   a. with dementia.
   b. who suffer from intense sadness.
   c. who are clinically impaired but not diagnosed with dementia.
   d. who are clinically depressed.

40. Prior to DSM-5, Somatoform Disorders were separated into four disorders but these were combined in the DSM-5 because
   a. all four meet the criteria of hypochondriasis.
   b. there were too many similarities between the four disorders.
   c. Munchausen syndrome already covered these disorders.
   d. excessive time and energy were devoted to these disorders.

41. True or False: Using DSM-IV, patients could be diagnosed with four separate disorders: autistic disorder, Asperger’s disorder, childhood disintegrative disorder, or the catch-all diagnosis of pervasive developmental disorder not otherwise specified.
   a. True
   b. False
42. Previous editions of the DSM did not include a separate diagnostic category for

   a. hypochondriasis.
   b. obsessive-compulsive disorder.
   c. autism.
   d. excoriation.

43. Which of the following was NOT included in the DSM-5 as a disorder?

   a. Anxious depression
   b. Trauma and Stressor Related Disorders
   c. Developmental Coordination Disorder
   d. Brief Psychotic Disorder

44. In the DSM-IV, Post Traumatic Stress Disorder ("PTSD") was included in the chapter on anxiety disorders; however, in the DSM-5, PTSD is included in a new class of disorders called

   a. Hypochondriasis Disorder.
   b. Obsessive-compulsive Disorder.
   c. Persistent Negative State Disorder.
   d. Trauma and Stressor Related Disorders.

45. The DSM-5 includes the following new addiction:

   a. Alcohol.
   b. Cocaine.
   c. Cannabis withdrawal.
   d. Inhalants.

46. True or False: According to the APA, 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.

   a. True
   b. False
47. The concern(s) of adding Disruptive Mood Dysregulation Disorder ("DMDD") to the DSM-5 is that adding this disorder to the manual will result in

a. an increase in diagnosis of relatively healthy children.
b. an increase in medication of relatively healthy children.
c. more children being labeled with a mental disorder.
d. All of the above

48. Which of the following conditions/criteria is NOT symptomatic of a Major Depressive Episode?

a. Markedly diminished interest or pleasure in all
b. Insomnia or Hypersomnia nearly every day
c. Episode attributable to a medical condition (e.g., hypothyroidism).
d. Recurrent thoughts of death (not just fear of dying)

49. In DSM-5, a mild neurocognitive disorder is defined by the following:

a. Significant cognitive decline in learning and memory.
b. Significant cognitive decline during periods of delirium.
c. Significant cognitive decline in complex attention.
d. Significant cognitive decline in social cognition.

50. The APA explains that adding the diagnosis for mild neurocognitive disorder ("NCD") in the DSM-5 provides an opportunity

a. for early detection and treatment of cognitive decline.
b. will help providers identify the etiological subtype of NCD.
c. will help identify unspecified NCD.
d. for early detection of substance induced NCD.

51. True or False: The APA explains in the DSM-5 why DMDD is the same as Oppositional Defiant Disorder and Bipolar Disorder.

a. True
b. False
52. **When diagnosing a minor neurocognitive disorder**

a. one standard deviation below appropriate norms is required.
b. one and two standard deviations below appropriate norms are required.
c. two or more standard deviations below appropriate norms are required.
d. more than two standard deviations below appropriate norms are required.

53. **Critics of the changes in the DSM-5 chapter on neurocognitive disorders argue that the addition of major and mild neurocognitive disorders ("NCD")**

a. will only result in more diagnoses of NCD.
b. is not necessary since we understand the difference between dementia and Alzheimer’s.
c. will only result in additional confusion for NCD patients.
d. will cause patients to exaggerate a diagnosis of mild NCD.

54. **Prior to the DSM-5, the presence of severe pain that is considered to be primarily psychological, not physical, in nature was known as**

a. Hypochondriasis.
b. Undifferentiated Somatoform Disorder.
c. Somatization Disorder.
d. Pain Disorder.

55. **Under the DSM-5, to be diagnosed with Somatic symptom disorder ("SSD"), the individual must be persistently symptomatic, typically at least for**

a. 6 months.
b. 1 year.
c. two months.
d. three months.
56. Critics of SSD argue that it is difficult to determine the ____________ caused by a physical illness, and SSD will make it much easier for practitioners to diagnose someone with a mental disorder who may not have one.

   a. pain
   b. symptoms
   c. mental anguish
   d. medical condition

57. The binge eating occurs, on average, at least ____________ for three months.

   a. once a week
   b. once daily
   c. three times a week
   d. once a month

58. True or False: Binge eating is NOT associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa.

   a. True
   b. False

59. Hoarding disorder is a new diagnosis in DSM-5. DSM-IV listed hoarding as one of the possible symptoms of

   a. Prader Willi syndrome.
   b. obsessive-compulsive personality.
   c. minor depressive disorder.
   d. persistent negative state disorder.

60. Critics argue that the creation of a separate disorder for individuals who show signs of hoarding will likely result in

   a. disease deflation.
   b. mistaken minor depressive disorder diagnoses.
   c. disease inflation.
   d. more individuals hoarding.
61. Patients who experience anxious depression have all following symptoms except:

a. Mania with psychotic features  
b. Diminished appetite  
c. Poor sleep  
d. Restlessness

62. The British Psychological Association highly criticized the DSM-5 for all except:

a. the changes in diagnostic criteria.  
b. the broad approach the manual takes.  
c. inclusion of a number of disorders that they do not consider true mental disorders.  
d. None of the above.

**CORRECT ANSWERS:**

1. According to the American Psychiatric Association (“APA”), the purpose of the DSM was
   
d. All of the above

2. It was the _______ that truly established the manual as the standard for identifying and diagnosing mental disorders.
   
c. DSM-III

3. A new section in the DSM-5 includes the role of _____________ in diagnosing mental illness.
   
b. culture

4. Some conditions listed in DSM-5 for further study are:
   
d. All of the above
5. **True or False:** The section on personality disorders changed significantly in the DSM-5 because of a new model to classify personality disorders.
   
   b. False

6. **Learning Disorder has been changed to**
   
   c. Specific Learning Disorder.

7. **True or False:** DSM-5 utilizes a single diagnostic category, called Specific Learning Disorders, to capture all individuals who meet the diagnostic criteria.
   
   a. True

8. **DSM-5 consolidates autism and Asperger’s into**
   

9. **Many of the symptoms of autism, Asperger’s, and such disorders are now part of a continuum of symptoms that**
   
   a. make up one disorder.

10. **In this manual, DSM-5, “substance abuse” and “substance dependence” have been**
    
    b. combined into one category: substance use disorders.

11. **The DSM-5 differentiates between the various neurocognitive disorders that were once grouped into the category known as**
    
    c. dementia.

12. **True or False:** It was the intent of the APA that the DSM-5 would be simple enough that it could and should be used by nonclinical or nonmedical individual to assess or diagnose an individual.
    
    b. False
13. The new “Section III: New Disorders and Features,” provides information regarding disorders that are

b. not yet recognized as classifiable disorders.

14. One criticism of the DSM-5 was the perceived ________________ in the review process.

c. lack of scientific rigor

15. Much of the controversy surrounding the release of the DSM-5 centers around changes to specific disorders, such as the removal of ________________ from the manual.

a. Asperger’s Disorder

16. True or False: Temper tantrums in children, which may have been considered a general behavior problem, may now (under DSM-5) be a diagnosable condition, “disruptive mood dysregulation disorder.”

a. True

17. The new ________________ coding system allows a patient to be diagnosed on a broad spectrum that focuses more on severity level than individual symptoms.

c. nonaxial

18. Although the DSM-5 was developed to help clinicians identify and diagnose mental disorders, it was not developed to meet all the technical needs of

d. the courts and legal professionals.

19. Previous editions of the manual did not contain a section on ________________ but this was added to DSM-5.

b. emerging measures and models

20. True or False: The DSM codes are used to diagnose mental disorders and they may also be used for medical billing purposes, as they are HIPAA compliant.

b. False
21. The “Clinician Rated Dimensions of Psychosis Symptom Severity” is intended for use when diagnosing individuals with
   a. psychotic disorders.

22. The Cultural Formulation Interview (“CFI”) is primarily intended for use
   c. during an initial assessment.

23. The World Health Organization Disability Assessment Schedule 2.0 (“WHODAS 2.0”) is a 36-item measure that assesses
   c. disabilities in adults.

24. True or False: DSM codes are used by mental health professionals to identify and diagnose mental disorders, while ICD codes are used by billing professionals to code mental disorders and submit them for billing.
   a. True

25. Which of the following is NOT one of the six domains assessed in the WHODAS 2.0?
   a. Social supports

26. In instances where the patient is unable to participate in the Cultural Formulation Interview (“CFI”) process
   b. an informant is used.

27. Under DSM-5, there is an alternative model for diagnosing personality disorders, which is useful in diagnosing the following disorder(s):
   a. Narcissistic

28. The APA lists disorders in the DSM-5 that have not been researched or developed enough to include in a “Section” but that warrant further study. As to these disorders:
   b. these conditions cannot be diagnosed.
29. True or False: In most instances, there is NOT a direct connection between cultural concepts of distress and a specific psychiatric disorder recognized in the DSM-5.
   
a. True

30. The following statement(s) are correct regarding the interaction between the DSM codes and HIPAA:
   
b. The DSM codes are not considered HIPAA compliant from a billing standpoint.

31. The APA guidelines state that when the names of the DSM-5 disorders do not match the names of the ICD disorders,
   
c. the disorder must be listed by medical name, with the listing code.

32. When the ICD-10-CM coding system was released and became effective, medical practitioners, coders and billers were required
   
d. to be familiar with both ICD-9-CM and ICD-10-CM coding systems.

33. True or False: The expanded number of characters of the ICD-10 diagnosis codes provides greater specificity to identify disease etiology, anatomic site, and severity.
   
a. True

34. Which of the following describes the nonaxial system used by the DSM-5?
   
b. allows clinicians to rate disorders along a continuum of severity.

35. In the DSM-5, the depression category has been revised
   
c. to include grief.

36. To be diagnosed with Disruptive Mood Dysregulation Disorder (“DMDD”), a child must display DMDD behaviors
   
a. in at least two different settings, i.e., home and school.
37. True or False: The DSM-5 includes both the DSM diagnostic codes, as well as ICD-9-CM and ICD-10-CM codes for billing purposes.

   a. True

38. Which of the following is NOT listed as a Personality Disorder in the DSM-5?

   d. Hoarding Disorder.

39. The APA decided to include mild neurocognitive disorder in the DSM-5 manual in response to the growing need to find a way to classify patients

   c. who are clinically impaired but not diagnosed with dementia.

40. Prior to DSM-5, Somatoform Disorders were separated into four disorders but these were combined in the DSM-5 because

   b. there were too many similarities between the four disorders.

41. True or False: Using DSM-IV, patients could be diagnosed with four separate disorders: autistic disorder, Asperger’s disorder, childhood disintegrative disorder, or the catch-all diagnosis of pervasive developmental disorder not otherwise specified.

   a. True

42. Previous editions of the DSM did not include a separate diagnostic category for

   d. excoriation.

43. Which of the following was NOT included in the DSM-5 as a disorder?

   a. Anxious depression

44. In the DSM-IV, Post Traumatic Stress Disorder (“PTSD”) was included in the chapter on anxiety disorders; however, in the DSM-5, PTSD is included in a new class of disorders called

   d. Trauma and Stressor Related Disorders.
45. The DSM-5 includes the following new addiction:
   
c. Cannabis withdrawal.

46. True or False: According to the APA, 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.
   
a. True

47. The concern(s) of adding Disruptive Mood Dysregulation Disorder (“DMDD”) to the DSM-5 is that adding this disorder to the manual will result in
   
d. All of the above

48. Which of the following conditions/criteria is NOT symptomatic of a Major Depressive Episode?
   
c. Episode attributable to a medical condition (e.g., hypothyroidism).

49. In DSM-5, a mild neurocognitive disorder is defined by the following:
   
b. Significant cognitive decline during periods of delirium.

50. The APA explains that adding the diagnosis for mild neurocognitive disorder (“NCD”) in the DSM-5 provides an opportunity
   
a. for early detection and treatment of cognitive decline.

51. True or False: The APA explains in the DSM-5 why DMDD is the same as Oppositional Defiant Disorder and Bipolar Disorder.
   
b. False

52. When diagnosing a minor neurocognitive disorder
   
b. one and two standard deviations below appropriate norms are required.
53. Critics of the changes in the DSM-5 chapter on neurocognitive disorders argue that the addition of major and mild neurocognitive disorders (“NCD”) will only result in additional confusion for NCD patients.

54. Prior to the DSM-5, the presence of severe pain that is considered to be primarily psychological, not physical, in nature was known as Pain Disorder.

55. Under the DSM-5, to be diagnosed with Somatic symptom disorder (“SSD”), the individual must be persistently symptomatic, typically at least for 6 months.

56. Critics of SSD argue that it is difficult to determine the mental anguish caused by a physical illness, and SSD will make it much easier for practitioners to diagnose someone with a mental disorder who may not have one.

57. The binge eating occurs, on average, at least once a week for three months.

58. True or False: Binge eating is NOT associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa.

59. Hoarding disorder is a new diagnosis in DSM-5. DSM-IV listed hoarding as one of the possible symptoms of obsessive-compulsive personality.

60. Critics argue that the creation of a separate disorder for individuals who show signs of hoarding will likely result in disease inflation.
61. **Patients who experience anxious depression have all following symptoms except:**

   a. Mania with psychotic features

62. **The British Psychological Association highly criticized the DSM-5 for all EXCEPT:**

   d. None of the above.

### References Section

The reference section of in-text citations include published works intended as helpful material for further reading. Unpublished works and personal communications are not included in this section, although may appear within the study text.

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