DSM-5: An Overview of the Major Changes

Chapter One: The History of the Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition

Oddly enough, the history of mental health diagnosis in the United States goes back to the 1840 Census. In the 1840 Census, individuals were asked to self-identify as one of two categories of individuals. A person could be "normal" or could be classified as "idiot/insane." Imagine yourself a census taker in 1840, walking up to a door, knocking, and asking if there were normal people who lived there or idiots and insane people. That was the first attempt, in an organized fashion, to make a distinction between people on the basis of psychological and emotional difficulties.

By 1880, the Census had expanded the dichotomous classification system to seven categories, including: mania, melancholia, monomania, dementia, paresis, epilepsy, and dipsomania. But the first real advances in diagnosis of mental illnesses began to occur after World War II. After WWII, a number of men and women came back from the war who were physically sound, but emotionally and psychologically shattered, distressed, and overwhelmed. The Veterans Administration was overwhelmed by the variety of symptoms and presentations. As a result of the extreme variety of issues that the veterans presented, the Veterans Administration believed they needed some way to classify and organize these individuals based on presenting problems, severity, and behavioral symptoms to ensure proper treatment and housing for these veterans. The goal was to appropriately identify the disorders and then house, provide treatment, and manage these individuals on the basis of their disorders. In response, the Veteran's Administration developed their own classification system which included 10 psychotic disorders, nine neurotic disorders, and seven disorders of character, behavior and intelligence. The disorders of character, behavior, and intelligence were the precursors of what we now consider to be Axis II Disorders.

Psychiatry, which was the dominant force for the treatment of mental disorders at the time, recognized the work of the Veteran's Administration and its ability to bring organization out of chaos. However, they thought the VA had overstepped its boundaries by diagnosing mental disorders, which was clearly the purview of psychiatry. As a result the American Psychiatric Association began to work on its own classification system which was called the *Diagnostic and Statistical Manual of Mental Disorders.* The *DSM-I,* which was published in 1952, included not only disorders that had a clear medical and organic basis, but also recognized a psychological view and utilized the terminology of psychological reaction. By today's standards, the *DSM-I* was a relatively crude and unsophisticated document, but was embraced by the psychiatric profession. Consequently, by virtue of psychiatry's

position in mental health at the time, the *DSM-I* was forced upon all the other professions working in the area of mental health including nursing, psychology, social work, and occupational therapy.

By the mid 60's there was recognition of the need to update the manual with contemporary thinking regarding the major advances in mental health since the publication of *DSM-I*. The changes were largely spurred by the development of the new families of neuroleptic medications that were revolutionizing mental health and allowing many individuals to be treated on an outpatient basis. The *DSM-II* was published in 1968 and was similar to the *DSM-I*, but eliminated the concept of reaction. The revised manual was still a relatively unsophisticated system and only provided a brief two to three sentence description of disorders, leaving much of the actual diagnosis up to the clinical judgment of the individual practitioner. As a result, there was a particularly significant issue with inter-rater reliability. Inter-rater reliability was examined by the Rosencrans Study, in which graduate students were given a protocol and a script to follow and charged with seeking admission at state psychiatric hospitals. Although each student was provided the same script, many different diagnoses were assigned, based on relatively the same presentation. As illustrated by the study, in spite of the revisions to the manual, there still existed a significant problem with inter-rater reliability.

In *DSM-II,* the typical descriptions of diagnoses were so vague and amorphous that almost anyone could justify a diagnosis of any particular disorder. For example, in DSM-II (1968), Anxiety Neurosis (300.0) was described as follows, "This neurosis is characterized by anxious overconcern, extending to panic, and frequently associated with somatic symptoms." The lack of specificity provided opportunities for in this diagnosis, resulted in a high rate of misdiagnosis, and many individuals received inappropriate treatment or failed to make therapeutic progress. Additionally, the *DSM-II* advocated a psychoanalytic approach and focused on disorders as being neuroses or psychoses, a theoretical system that was starting to be questioned by many other professionals in the field, as well as many individuals within the psychiatric community.

Recognizing the problems with reliability and with adopting a system that had at its basis, only one theory, psychoanalysis, work began on the *DSM-III* in 1974. The document was published in 1980 and was a major breakthrough in the field of diagnosis that created a true paradigm shift. Instead of a brief narrative description of disorders, the *DSM-III* developed specific diagnostic criteria for each recognized disorder on the basis of the presence or absence of certain symptoms, occupational, social, and interpersonal impact, and spelled out specific time frames and frequency rates for which symptoms had to be present. The quantification and qualification of each disorder would inevitably help clear up the reliability issues that had been seen in diagnosis under the *DSM-II.*

Another major advance in the *DSM-III* was the recognition that within any given diagnostic classification there was likely to be significant variability in causality, functionality, physical health issues, and environmental factors. Often these individual factors produced significantly different presentations of the same disorder. To address the variability, the Multi-Axial System of Diagnosis was developed, which allowed for a diagnosis on the basis of the proper classification of the disorder, but also allowed for further description, clarification, and qualification of the individual's psychological issue. For example, two individuals may both carry the appropriate diagnosis of Schizophrenia, Paranoid Type; however, individual A has an extremely high Intelligence Quotient, is very well educated, has very good general health with no physical complications, has an active network of friends and supportive family members, and is functioning with the disorder having very little impact on their day to day existence. Individual B may also appropriately carry a diagnosis of Schizophrenia, Paranoid Type, but has very limited intelligence, less than a primary education, has major health issues that contribute to or exacerbate their diagnosis, has a limited or dysfunctional family and poor community support, and is barely functional or responsive. Each of these individuals is appropriately diagnosed, but the presentation of their disorder will require significantly different treatment approaches, and a significantly different level of intervention. The Multi-Axial System of Diagnosis allowed for a description of underlying personality issues and characterological issues, recognition of medical issues, identification of psychosocial stressors, and a general assessment of the individual's level of functioning.

Two other significant shifts in the *DSM-III* were the attempt to develop a document that was" theory-neutral" and an increased recognition of the reality of psychiatric disorders occurring in children. The shift toward a "theory neutral diagnostic system" was an important step in insuring the *DSM-III* would be equally accepted by all professions and all theoretical backgrounds. The terminology of neurosis was dropped and language discussing disorders was refined to be discipline and value neutral. The attempt was to develop a system of classification and diagnosis that all professions could readily adopt and feel comfortable operating within that schema and paradigm.

Whenever you drastically alter the schema people rely on to bring meaning and order to their professional life, "all hell will break loose." The *DSM-III* created a firestorm of controversy from the day it was released and created conflict within and between professionals and professions. Some professionals were violently opposed to the "confining" requirements of a diagnostic classification that required the patient to meet certain criteria for a specific diagnosis. Many practitioners were extremely vociferous about objecting to certain classifications and disorders. And still others saw the *DSM-III* as an attempt to further perpetuate the "Myth of Mental Illness" by dressing it up in a pseudoscientific system.

Articles were written roundly criticizing the *DSM-III* and all it stood for; others then wrote articles criticizing the article criticizing the *DSM-III*; and still others wrote articles criticizing the articles that criticized the article criticizing the DSM-III; and so on, and so on. As a result a number of committees were almost immediately set in place to address the multitude of objections and criticisms presented about the *DSM-III* in order to develop a revision that would address concerns. This resulted in the *Diagnostic and Statistical Manual of Mental Disorders: Third Edition- Revised (DSM-III-R)* being published in 1987. One political and philosophical shift that occurred in the DSM-III-R was the elimination of homosexuality as a diagnostic classification through the inclusion of a disorder labeled Ego-Dystonic Homosexuality (this classification was ultimately dropped in DSM-IV). The *DSM-III-R* was viewed by many as a "temporary fix" while work was being undertaken to develop a more comprehensive revision to be created in the *DSM-IV.*

Despite the controversies, mental health professionals became comfortable with diagnoses based on criteria and the multi-axial system of diagnosis. Seven years later, the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV)* was published in 1994. The most significant change in the *DSM-IV* was the expansion of the number of diagnostic categories from approximately 220 to 340. Greatly expanding the scope and number of diagnostic categories available, the document was criticized by some as "pathologizing everything." The *DSM-IV* was denounced in some circles for creating "false constructs" for normal behaviors. The categories themselves had a great deal of symptom overlap that blurred the edges between categories and did not satisfactorily address comorbid conditions. The *DSM-IV* was also criticized for being too "culture bound" and not allowing for behavioral variations that within certain cultures are seen as normal behaviors.

Rapid advances in research, particularly in neurology and neural imaging prompted an update of the *DSM-IV* in 2001. In this update, titled *DSM-IV-TR,* the text sections were updated to reflect advances in research and conceptualization of disorders, but no changes were made to diagnostic criteria and no disorders were added or removed. The specific disorders and criteria remained unchanged from *DSM-IV.* The text changes in *DSM-IV-TR* generated little controversy and were quickly embraced within the mental health professions.

Under a grant from the National Institute of Mental Health, work began in earnest on the *DSM-5* in 2000. A number of issues were identified that became incorporated as goals in the development of the *DSM-5.* A particular goal that was addressed almost immediately was the discrepancies between the *DSM-IV*, a system primarily used in North America, and the *International Classification of Diseases*, the system of diagnosis that is predominately utilized widely in the rest of the world. As part of the preliminary work leading up to the *DSM-5,* a number of meetings were held with the World Health Organization to try and resolve some of the inconsistencies between the two systems of classification. The overall goal was to develop a document that had the highest degree of agreement

possible with *ICD,* and minimized the differences in approach. In 2006 and 2007, work on the *DSM-5* began concretely with the appointment of members of the subcommittees and the appointment of Drs. Kupfer and Reigart as the chair and vice chair respectively. The Workgroups began meeting in 2007 and for the next two years, conducted literature searches, reviewed critiques of the *DSM-IV*, and began work on adding disorders, removing or combining disorders, or modifying criteria for disorders.

In order to have a greater openness in the development of the *DSM-5,* the decision was made to publish a first draft and allow for comments, to field test the first draft to see if the changes were workable and productive, and then publish a second draft for public comment. The committees were overwhelmed by the number and volume of comments received through electronic media and in writing. After the second draft was published and the period for comment had expired, the website for the *DSM-5* was closed and the work groups went into a period of quiet isolation to prepare the final draft to be presented to the American Psychiatric Association Board of Directors at their December 2012 meeting. Although the process began with an attempt at transparency, little information was available about what was actually going to be included in the *DSM-5* until it was released for publication at the APA annual meeting on May 18, 2013.

Chapter Two: Controversies Generated by the *DSM-5*

Even prior to its release, the *DSM-5* was mired in controversy that was widely covered by the popular press, as well as the professional literature. In a controversial move, Allen Frances resigned his position on the *DSM-5* work group over what Frances has labeled a" lack of scientific integrity." Frances (2013b) openly criticized the *DSM-5* on a number of issues. "All changes to the diagnostic system should be science driven and evidence based, not influenced by my personal whims or anyone else's.....Normal enough people would be captured in DSM-5's excessively wide diagnostic net and exposed to unnecessary medication...the drug companies should be licking their chops." Frances and others are especially critical of new disorders added in DSM-5 including*:* Binge-Eating Disorder, Disruptive Mood Dysregulation Disorder, and Mild Neurocognitive Disorder. Paris (2013) commented that these "three new disorders in DSM-5 share a fuzzy boundary with normality."

Frances (2103b) views the *DSM-5* as taking common, transitional life experiences and creating diagnostic labels that will result in an increase in medication usage and a society that continues to view itself in pathological terms. "*DSM-5* will mislabel normal people, promote diagnostic inflation, and encourage inappropriate medication. The pool of normality is shrinking to a mere puddle. Loose diagnosis is causing a national drug overdose. From 2005 to present, there has been an 800 percent increase in prescriptions among active duty troops. 110,000 soldiers are now taking at least 1 psychotropic drug. 11 percent of all adults took an antidepressant in 2010, 4 percent of children are on stimulants, and 4 percent of teens are on antidepressants. In Canada, SSRIs went up 44 % between 2005 and 2009. Psychiatric meds are the star producers for drug companies."

Frances (2013b) states that "Blurring the lines between normality and pathology are the likely negative effects of a carelessly done DSM-5, driven by its grand, but quixotic ambition to be a paradigm shift." A major example of this has been the controversy surrounding dropping the Bereavement Exclusion contained in the diagnostic criteria for Major Depressive Episode. The symptoms of grief (sadness, loss of interest, reduced energy, difficulty with eating and sleeping) are made the equivalent of a Major Depression. Frances (2103a) feels that the *DSM-5* has now taken two weeks of normal grief symptoms and turned these symptoms into Major Depressive Disorder. Frances (201b3) states that "the previous *DSM's* have recognized this distortion by having an explicit 'bereavement exclusion.' *DSM-5* has made a serious error in removing this exclusion." He strongly believes that the Major Depression diagnosis should be reserved for those who are having severe and prolonged depressive symptoms and not the more transitory symptoms of a normal grieving process. Critics fear that many ordinary, but painful reactions to life (grief, anger, angst), will now be labeled as illnesses in the *DSM-5* and people will be prescribed unnecessary medications.

Paris (2103) also expresses concerns that the DSM-5 may have gone too far in identifying individual variations in behavior as pathologies. "Some of the problems derive from the concept that psychopathology lies on a continuum with normality. This makes it difficult to separate mental disorders from normal variations and therefore runs the risk of overdiagnosis." The medicalization of ordinary life has sometimes been called "Psychiatric Imperialism" (Moncrieff, 1997). The Kraepelin Model (which has been the basis of *DSM-I* through *DSM-IV)* views psychiatric concerns with mental illnesses, and not the natural pain, discomfort, and unhappiness of life. This has given way to a model which views normality and illness as lying on a vast continuum. The rationale for this change comes from considerable research which suggests the underlying biology of mental disorders is more dimensional than categorical (First, 2014).

DSM-5 states an underlying assumption that all disorders stem from biological brain and neurological disorders. This is commonly referred to in the literature as a "medicalization" of mental disorders and many individuals have rejected this assumption. "Psychiatry has bet on neuroscience as the best way to understand mental disorders.....only time will tell how this wager will pan out" (Paris, 2013). While recognizing the advances in neuroscience and neural imaging, we must also recognize the primitive infancy of current neural imaging. Basing a diagnostic classification system on such primitive data, and attempting a paradigm shift before the reality of the information is fully understood may be a mistake. Pathology is also associated with changes in neurotransmitters, but a theory that chemical imbalances cause mental disorders is overly simplistic. Attempting to fully explain mental disorders as brain disorders may be ill advised. The DSM-5 "hybrid approach" to diagnosis appears to accept continuing with discrete diagnostic categories as a temporary expedient, rather than making a total shift to viewing illness as a point on a broad continuum that shades into normalcy. Paris (2013) stated, "Mental phenomena reflect the activity of the human brain, which happens to be the most complex structure known in the universe. There are more synapses in the brain than there are stars in the sky." It may be that in attempting to move toward a "medicalization" of mental disorders we are overestimating what we know about brain functioning and are "skating on thin ice" with some of these conclusions.

As mentioned before, others have expressed concern that the *DSM-5* has been overly influenced by the pharmaceutical industry. The pharmaceutical industry has a strong interest in how the *DSM-5* defines and identifies disorders. Maximizing profits means prescribing more drugs to more people, and it is in the pharmaceutical industry's best interest to have an approach that defines more disorders and current disorders in broader inclusionary terms. Paris (2013) has stated that "Some of the most problematic trends in psychiatry have come from attempts to make patients fit into categories that justify the use of prescription drugs. The over-inclusiveness of *DSM-5* should make the pharmaceutical industry very happy." No one can claim the pharmaceutical industry has direct

influence over what is included in the *DSM,* but when so many of psychiatry's leaders benefit financially from the pharmaceutical industry, there is room for concern. In 2008, Senator Charles Grassley held public hearings regarding academic and research psychiatrists taking millions of dollars from the pharmaceutical industry in "consulting fees" and for openly, and not so openly, promoting products on lecture tours. The issue of the relationship between psychiatry and the pharmaceutical industry has been further compounded by the fact that over 70 percent of the committee members who served in developing the *DSM-5* have had financial ties to the pharmaceutical industry. The *DSM-5* process required that all *DSM-5* Workgroup members have only minimal involvement with pharmaceutical companies. This "vetting" process slowed down the *DSM-5* development to insure that members of task forces and committees were "clean," but the fact that they have taken money from pharmaceutical companies in the past, or hope for financial support in the future, can raise questions as to whether their objectivity is permanently compromised.

Another major controversy was the Personality Disorders Workgroup. The suggested revised criteria indicated that Personality Disorders were seen as a category that was ripe for "dimensionalization." Many who opposed this approach were left out of the process or "silenced." However, the proposal for a new classification system for Personality Disorders was roundly attacked through letters of protests and in other public forums. Ultimately, the international members of the committee resigned in protest over the proposed new approach. Their discussions and recommendations were so controversial, that ultimately, the American Psychiatric Association Board of Directors rejected the Personality Disorders Workgroup's proposal on the advice of its scientific advisors (Paris, 2013). The Workgroup's recommendations were placed in Section III, Conditions for Further Study, and *DSM-5* continued the use of the current *DSM-IV-TR* criteria. The controversy was avoided temporarily by "tabling" the new proposal and assigning it to the Conditions for Further Study Chapter.

Two weeks before publication of the *DSM-5*, the National Institute of Mental Health (NIMH) withdrew support from the *DSM-5*, and advocated a biological approach based on their own diagnostic system, the RDoC (Research Domain Criteria). The NIMH system of diagnosis (RDoC) offered a system based on a matrix in which broad spectra of behavior are regulated by a Negative Valence Systems, Positive Valence Systems, Cognitive Systems, Systems for Social Processes, and Arousal/Modulatory Systems. These systems are matched with data based on genes, molecules, neural circuits, physiology, and behaviors. (Paris, 2013). A former director of The National Institute of Mental Health, (Hyman, 2011) notes that when he was in charge, billions of dollars were spent on genetic studies of DSM categories, but the money did not produce the clarity of results hoped for when originally funded. The reason for this disappointment was that psychiatric diagnosis, as contained in the *DSM,* are not true endophenotypes. The Research Domain Criteria is an idea that may or may not prove valid or viable. The assumption that mental disorders are brain disorders has become a launching point for a new direction in diagnosis. "RDoCs are not a fact, but an ideology used to validate psychiatry and represents the hope that mental illness can be translated into neural science (Paris, 2013)."

Chapter Three: *DSM-5* Philosophy, Cultural Considerations, and Cross-Cutting Dimensional Assessments

Paris (2013) states that traditionally, medicine has attempted to separate pathology from normality. Psychiatry has also traditionally had to make the same distinction, and so "disease-like" disorders such as schizophrenia and bi-polar disorder were separated from reaction patterns like mild depression, anxiety disorders, and difficulties in adjustments to living. All past DSMs have been adopted using the Kaeplin assumption that disorders are distinct from non-pathology and distinct from each other. *DSM-5* seeks to overturn the Kraepelinian Model and replace it with one in which illness is not separate from normality, but defined by a cutoff point on a continuum. Kupfer and Reiger (2011) have suggested that diagnostic spectra are supported by neuroscience research rather than categories of unique phenomena.

Many diagnoses that are included in *DSM-5* are conditions that can be found in normal human existence. Poorly behaving children can be diagnosed as Oppositional Defiant; painfully shy adults can be diagnosed with Social Anxiety Disorder; feelings of loss and apathy can justify a diagnosis of Major Depression; episodes of rage can be diagnosed as Intermittent Explosive Disorder; and betting on football games has found a home in *DSM-5's* Gambling Disorder. What is the point at which distress, pain, emotionality, and loss of functioning qualify as mental illness? Thus, everyone has a mental disorder, the only question is one of degree. In *DSM-5, m*any issues of normal living have become diagnosable, and while these conditions are certainly painful and debilitating, they probably lack support in neuroscience as being abnormal or pathological.

Being unable to resolve the basic epistemological question between a categorical approach to diagnosis or a dimensional approach to diagnosis, *DSM-5* has opted to adopt a "hybrid approach." The "hybrid" approach retains many of the familiar categories of the earlier approaches in *DSM-I* through *DSM-IV,* but attempts to allow for and emphasize a more dimensional approach to diagnosis. *DSM-5 (2013)* has stated that "despite the problems posed by categorical diagnoses, the DSM-5 Task Force recognized that it is premature scientifically to propose alternative definitions for most disorders. The organizational structure is meant to serve as a bridge to new diagnostic approaches without disrupting current clinical practice or research." Many have expressed concerns that mental disorders as classified in *DSM-5* are no more than descriptive syndromes. Children and teenagers may be especially hard to diagnose. They have a short track record, mature at varying rates, are prone to

abuse drugs, and are reactive to family stress. The younger, less mature children in classroom settings are at serious risk for a diagnosis of ADHD, and overdiagnosis of ADHD is particularly likely if parents and/or teachers are stressed and overworked. A child's initial diagnosis is likely to be unstable and inappropriate over time as these children catch up to the older "peers" in their class. "Psychiatric diagnosis has an inadequate scientific base, including massive comorbidity, inadequate coverage, leaving many patients to fit only into an NOS option, while categories obscure a clinically important difference between patients meeting criteria for the same diagnosis. These difficulties have led to the conclusion that categorical diagnosis and psychiatry should either be scrapped entirely, or kept only as a short-term expedient (Kupfer and Reiger, 2011)."

Cultural issues and a lack of cultural sensitivity in *DSM-IV-TR* have lead many minority groups to be particularly wary of any *DSM* classification of disorders. A great deal of time and effort have gone into attempting to make *DSM-5* as culturally sensitive and as culture neutral as possible. In the text section following each diagnostic classification particular attention is paid in discussing cultural aspects, as they might uniquely impact that disorder. *DSM-5* has included an *Appendix, The Glossary of Cultural Concepts of Distress* in the document to encourage looking at disorders from a sensitivity as to how different cultures may define the disorder. Cultural Perceptions of Cause, Context, and Support of a mental disorder and Cultural Factors Affecting Self Coping & Past Help Seeking are discussed with the particular implications that those factors might have on diagnostic issues. *DSM-5* also contains a structured 16 question interview format to identify cultural issues, *The Cultural Formulation Interview,* which is included in the Section III, Emerging Measures and Models.

An additional goal of *DSM-5* was the development of a universal screening and assessment device that could be used by all professionals and in all settings. This cross-cutting and dimensional assessment would look at symptoms more globally and allow for cutting across separate diagnostic classifications to provide a more accurate and thorough assessment and diagnosis. A cross-cutting assessment would also allow for establishing an initial baseline for all individuals requesting assistance from mental health services. The goal of the screening document was to provide additional information for the purpose of assessment, diagnosis, treatment planning, and treatment evaluation. *DSM-5* developers wanted the universal assessment tool to be something that would be useful in clinical practice, brief, simple to read, simple to evaluate, and suitable for most patients in most clinical settings. A practical decision had to be made as to whether the clinician would complete the form or whether it would be a self-report, with the client completing the assessment. Weighing both options, the decision was made that it would be most effective if completed by the client, or in the case of a child by a parent or guardian.

The results of this effort produced *DSM-5 Self-Rated Level I Cross Cutting Symptom Measure-Adult* and the *Parent/Guardian-Rated DSM-5 Level I Cross Cutting Symptom Measure-Child Age 6-17* that

are found in Section III of the *DSM-5 (2013).* These instruments are based on a five point scale with a rating of zero indicating an absence of any symptoms depicted by that item and a rating of four indicating a severe (nearly every day) presence of a symptom or dysfunction. A client who rated themselves as being symptomatic in any area would trigger a further investigation in that symptom area, or a Level II Assessment. A number of devices and screeners were reviewed, and while these were not published in the *DSM-5,* they are listed at the *DSM-5* web site: www.psychiatry.org/DSM-5. The web site also lists a self-report format, *DSM5 Self-Rated Level I Cross Cutting Symptom Measure (ages 10-17)* for use with children and adolescents who are capable of providing their own self-report.

Many individuals have become increasingly concerned about the nexus between psychiatry and the legal system. An entire section of *DSM-5* has been devoted to clarify that the *Diagnostic and Statistical Manual of Mental Disorders* was designed to assist clinicians in assessment, case formulation and treatment planning. It was never intended to be used in forensic settings, even though it has become increasingly relied upon by the legal system to assess the forensic consequences of mental disorders. Paris (2013) cautions that lawyers have a different agenda, often using the information contained in *the DSM-IV-TR* regarding a diagnosis, to get a client off a charge. "When *DSM-5* categories, texts, and criteria are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise as a result of the imperfect fit between questions of ultimate concern for the law, and information contained in a clinical diagnosis." The "McNaghten Rule," establishing that a defendant must be able to distinguish right from wrong has come to rely heavily on the *DSM* criteria for schizophrenia. *DSM-5* cautions that "even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that the particular individual is (or was) unable to control his or her behavior at that particular point in time (Paris, 2013)." The *DSM* has also come to play an important role in civil hearings, particularly child custody cases where nonclinical or nonmedical, or otherwise insufficiently trained persons may have implied or stated the presence of a mental disorder on the basis of an untrained reading of *DSM-5*.

Chapter Four: Major Differences Between DSM-IV-TR and DSM-5

A number of general changes regarding the mechanics of reporting diagnoses are suggested in *DSM-5,* not the least of which is a transition from a pure numerical designation of a diagnosis to an alphanumeric system. This change will undoubtedly require significant environmental and procedural changes for organizations, clinicians, and third party payors who will need to convert existing information systems from a numerical designation to an alphanumeric coding system. For example, Obsessive Compulsive Disorder was coded as 300.3 under *DSM-IV-TR* and will now be coded as F42.0. Organizations will have to plan to transition diagnostic codes to the new alphanumeric system and make decisions about what to do with both paper and electronic records that contain an older *DSM-IV/ICD-9* designation.

Another major logistical change is the elimination of the multi-axial system of diagnosis. While the multi-axial system has been dropped in *DSM-5,* it is a lot like the old parody *"The king is dead; long live the king."* The *DSM-5* has developed a new "*hybrid diagnostic format*" that combines what was formerly covered by Axis I and Axis II. The distinction, between Axis I and Axis II, is no longer preserved and should eliminate some problems with billing for services that may have existed in the past where Axis II diagnoses were excluded by some insurance carriers. Medical issues that were formerly addressed by Axis III will now be coded as part of a narrative description of "dimensionalizing" a diagnosis. Axis IV had been reserved for identifying general psychosocial and environmental stressors, yet these factors can now be incorporatedin a *DSM-5* diagnosis as "Z" Codes," G" Codes, "T" Codes, and "R" Codes, or as additional narrative descriptors. Axis V, the GAF score has been eliminated from the "hybrid diagnosis," but some authors are advocating including some assessment of level of functioning by also listing the World Health Organization Disability Assessment Score (WHODAS). While this is acceptable, it is not required.

A diagnosis that looked like the following under *DSM-IV-TR:*

> ***Axis I:* 296.24 Major Depressive Disorder, Single Episode, Severe with Psychotic Features**
> ***Axis II:* V71.09 No Diagnosis**
> ***Axis III:* HIV positive**
> ***Axis IV:* homeless, unemployed**
> ***Axis V:* GAF 40**

Under *DSM-5,* will now be written as:

F32.0 Major Depressive Disorder, Single Episode, Severe with Psychotic Features, HIV positive, Z59.5 Extreme Poverty, WHODAS Score 23.

DSM-5 **allows for the identification of the proper diagnostic classification (e.g., Major Depressive Disorder) and then allows the clinician to describe or "dimensionalize" the diagnosis by adding specifiers and qualifiers, including what had formerly been contained on Axis III and IV in the Multi-Axial System. This "hybridization" of both a Categorical Model and a Dimensional Model is viewed by some as the first step toward abandoning a Kraeplinian categorical approach and developing a more dimensional and functional diagnostic system. Rather than becoming the paradigm shift that *DSM-5* hoped that it would be, this hybrid approach may ultimately be viewed as a transitional period leading to a true paradigm shift in diagnosis that will be borne out as greater neurological data becomes available.**

An additional adjustment proposed in the *DSM-5* is the elimination of the Not Otherwise Specified diagnostic category. Moran (2013) indicates that approximately one-quarter of all diagnoses made under DSM-IV-TR are Not Otherwise Specified diagnoses. This lack of diagnostic clarity and specificity associated with a NOS diagnosis has led to individuals receiving a diagnosis without presenting a clear-cut symptom pattern, often resulting inappropriate treatment regimens. While the designation of Not Otherwise Specified has been eliminated*, *DSM-5* allows for some "wiggle room" with the inclusion of two additional categories, Other Specified Disorder and Unspecified Disorder.

The *Other Specified Disorder* Category allows clinicians to communicate that the presentation does not meet the criteria for any specific category, followed by the specific criteria that are not met or undetermined. For example, a person who only meets four symptom criteria for Major Depressive Disorder, or who has been symptomatic for less than the required two weeks could be recorded by the clinician as: *Other Specified Depressive Disorder, only presenting with four symptoms and not symptomatic for two weeks.* The *Unspecified* Category can be used when the clinician does not wish to specify the reasons the criteria are not met for a specific disorder. Other options include: 300.9 (F99) *Unspecified Mental Disorder,* in which symptoms of a mental disorder are present, but sufficient information to make a more specific diagnosis is unavailable, and 298.9 (F29) *Unspecified schizophrenia spectrum and other psychotic disorder,* where the patient is having a psychotic episode, but further diagnostic specification is not possible.

A (provisional) diagnosis of a specific disorder indicates that enough information is available to make a "working diagnosis," but the clinician wishes to indicate a significant level of diagnostic uncertainty by recording it as (provisional). A provisional diagnosis can be specified by placing the words

(provisional) in parentheses after the diagnosis. This can be used in those situations where there is a strong presumption that this will be the ultimate diagnosis, but further information or time is needed to clarify the diagnosis. As with *DSM-IV-TR,* the words rule/out or rule/in can still be used to indicate a lack of diagnostic certainty that may become apparent at a later point.

DSM-5 **encourages using multiple diagnostic categories to reflect the level of comorbidity that exists for many patients. Many individuals may meet criteria for a number of diagnoses, but there is typically a principal diagnosis that is the focus of treatment at that time. The principal diagnosis can be indicated by placing the words (principal diagnosis) in parentheses right after the listed diagnosis. If the principal diagnosis is not specified, the convention is that whichever diagnosis is listed first in the series is the principal diagnosis and therefore, the focus of treatment. For example, if a child meets criteria for Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Conduct Disorder, and Alcohol Use Disorder, severe, the diagnosis should be written as:**

F10.20 Alcohol Used Disorder,severe, F90.2 Attention Deficit Hyperactivity Disorder, combined presentation, mild, F91.1 Conduct Disorder, childhood-onset type, with limited prosocial emotions, moderate, and F32.0 Major Depressive Episode, single episode, mild. **The diagnosis could also be augmented by description of relevant health issues and Z Codes, R Codes, or T Codes as are appropriate to describe significant environmental issues and other relevant factors.**

The fact that the Alcohol Use Disorder is listed first indicates that the disorder is considered to be the *Principal Diagnosis* and is the focus of treatment. In this particular example the focus of treatment would almost have to be the Alcohol Use Disorder. Without achieving some progress with remediating the symptoms of the Alcohol Use Disorder, treatment for the other disorders would even be ineffective or ill-advised.

DSM-5 has made a number of major conceptual changes and philosophical departures from *DSM-IV-TR.* Diagnostic classes have been added in response to clinical need and scientific advances, including: sections on Trauma and Stress Related Disorders, Obsessive-Compulsive and Related Disorders, and Disruptive, Impulse-control, and Conduct Disorders. Several classes of disorders have been substantially revised, renamed, or reorganized, including: Neurodevelopmental Disorders, Somatic Symptom and Related Disorders, Substance-Related and Addictive Disorders, and Neurocognitive Disorders. Several Classes have been divided or consolidated. Mood Disorders were separated into two chapters: Bipolar and Related Disorders and Depressive Disorders. Sexual and Gender Identity Disorders were split into three chapters: Sexual Dysfunction, Gender Dysphoria, and Paraphillic Disorders. Elimination Disorders now have their own chapter, and Feeding Disorders of *DSM-IV-TR* are combined with Eating Disorders.

A number of new disorders have also been included in *DSM-5.*

Autism Spectrum Disorder

The handling of some disorders has been fairly controversial and has generated significant discussion between practitioners and scholars. One of the most controversial changes in *DSM-5* has been the Autism Spectrum Disorder diagnosis. Autism was first described by Leo Kanner (1948) as a syndrome of social communication deficits, combined with repetitive and stereotyped behaviors, and beginning in early childhood. In *DSM-IV,* other related disorders were included in the category, including Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder. *DSM-5* has now replaced all of these with a single diagnosis, Autism Spectrum Disorder, which is considered as a neurodevelopmental disorder. The belief is that these disorders represent a single continuum from mild to severe impairments in the two domains of social communication and restrictive, repetitive interests and behaviors, rather than separate, distinct disorders.

Opposition to this change has been very vocal with a large grass roots uprising. Many families of patients are very concerned about whether or not their family member would qualify for a diagnosis under broader rules and categories. They are worried that removing these four diagnostic categories could interfere with payments for expensive treatment. Of particular concern to these families is the potential impact the removal of these former diagnostic labels might have on academic accommodations or specialized school services. Thus demonstrating, that the DSM-5 has many constituents, including practitioners, parents, clients, schools, and governmental and private organizations, not all of whom are satisfied by a diagnostic approach driven by pure scientific information (Paris, 2013).

Rationale for the changes included the fact that differentiation between Autism Spectrum Disorder and other development and "nonspectrum disorders" is done reliably and consistently via neuroimaging; whereas, differentiation among these four disorders is clouded by severity, language, and intelligence issues. The Workgroup concluded that Autism is defined by a common set of behaviors, as a single diagnostic category, adapted to clinical presentation by specifiers and associated features. Gray matter volume can distinguish between Autism and neurotypicals, but there are no apparent neurological distinctions between Autism and Pervasive Developmental Disorder, Childhood Disintegrative Disorder, and Asperger's Disorder. It would appear that the distinction between Asperger's, Pervasive Developmental Disorder, Childhood Disintegrative Disorder, and Autism is an artificial one. The essential features of Autism Spectrum Disorder are persistent

deficits in reciprocal social communication, in nonverbal communicative behaviors used for social interaction, and in developing and maintaining social relationships, and restricted and repetitive patterns of behavior, interests, or activities. Because Autism is defined by a common set of behaviors, it was felt that Autism is best represented by a single diagnostic category, *Austism Spectrum Disorder,* adapted to the individual's clinical presentation, as reflected through specifiers. These specifiers include the level of support required by the individual, intellectual impairment, language impairment, and associated features (Paris, 2013).

One essential feature of Autism Spectrum Disorder is a persistent impairment in reciprocal social communication. Typically this symptom is pervasive and sustained across the developmental continuum. Language ability can be impacted, but communication skills will be impaired even if vocabulary and grammar are intact. Young children may show little or no initiation of social interaction, no sharing of emotion, and poor or absent eye contact. These individuals may not develop a pattern of smiling or respond to cuddling. The second essential feature of Autism Spectrum Disorder is a restrictive and repetitive pattern of behavior and interests. These individuals often prefer rigid routines and sameness in their daily activities. An intense interest in particular topics, high or low reactivity to sensory input, and stereotyped or repetitive motor movements are also frequently observed. In adulthood, rigidity and difficulty with novelty may limit independence even in highly intelligent people with Autism Spectrum Disorder (Black and Grant, 2014).

First (2014) indicates that Autism Spectrum Disorder is characterized by persistent deficits in social communication and social interaction across multiple contexts, accompanied by restricted, repetitive patterns of behavior, interests, and activities. This is in contrast to childhood-onset Schizophrenia in which early development is near-normal. Schizophrenia in children, as a part of the prodromal state, may include social impairment and atypical interests and beliefs; however, hallucinations and delusions, which are the more defining features of Schizophrenia, are not typically observed in Autism Spectrum Disorder. Intellectual Developmental Disorder involves a general impairment in intellectual functioning, but there is not a discrepancy between the level of social communication skills and other intellectual abilities. A dual diagnosis of Autism Spectrum Disorder and Intellectual Developmental Disorder is now appropriate under *DSM-5,* when social communication and interaction are significantly impaired relative to the developmental level of the individual's nonverbal skills.

Frazier et al., (2012) have suggested that adopting the Autism Spectrum Disorder requirements would mean that 12% of the current patients carrying one of the five eliminated diagnoses would no longer meet criteria for a diagnosis of Autism Spectrum Disorder. *DSM-5* offers a new category called Social Communication Disorder, which will address many of these individuals. Social Communication Disorder describes a milder constellation of symptoms in which impaired verbal and non-verbal communication are the dominant symptom pattern, but the restrictive and repetitive behaviors are

absent. A note at the end of diagnostic criteria for Autism Spectrum Disorder would seem to allow "grandfathering in" those individuals who formerly held one of the four diagnoses. Individuals with "a well-established *DSM-IV* diagnosis of Autistic Disorder, Asperger's Disorder, or Pervasive Developmental Disorder should be given the diagnosis of Autism Spectrum Disorder, unless Social (Pragmatic) Communication Disorder is more appropriate (DSM-5, 2013)."

Social (Pragmatic) Communication Disorder

Social (Pragmatic) Communication Disorder is a disorder evidenced in children who have difficulty with the pragmatic or practical aspects of social communication. It is a category that is supported by a body of research identifying a group of children who have a dominant symptom pattern of difficulty with language comprehension, formulation, and idiomatic or non-literal language (Bishop, 2000). The impetus to include this category is, at least in some part, an attempt to provide an accurate diagnosis for the majority of those 12% of current patients who would not appear to meet criteria for a diagnosis of Autism Spectrum Disorder. Research indicates that these children exhibit socially inappropriate behavior and significant communication issues, but do not meet criteria Autism Spectrum Disorder (Bishop and Norbury, 2002).

Children with this disorder display the difficulties in social communication, but not the restrictive and repetitive behaviors or restrictive interests consistent with Autism Spectrum Disorder. Moran (2013) stated that many of these individuals had been diagnosed with Pervasive Developmental Disorder Not Otherwise Specified in the past and had significant difficulty using language to narrate, explain, or carry on a conversation. While these children had many similar characteristics of children with Autism, they lacked the restrictive and repetitive behaviors. Autism Spectrum Disorder, Intellectual Disability and Global Developmental Delay must first be ruled out before utilizing this diagnostic category. First (2014) states that Autism Spectrum Disorder is characterized by restricted, repetitive patterns of behavior, interests, or activities, in addition to social communication deficits; hereas, with Social (Pragmatic) Communication Disorder, the restrictive, repetitive behaviors, interests, and activities are virtually absent. Social (Pragmatic) Communication Disorder is distinguishable from Social Anxiety Disorder, in that with the onset of Social Anxiety Disorder, the lack of communication and social interaction is due to anxiety and fear, or distress about social interactions. The affective component, present in Social Anxiety Disorder is typically absent in individuals who meet criteria for Social (Pragmatic) Communication Disorder.

Binge Eating Disorder

Binge Eating Disorder has now been included in *DSM-5,* but has generated little controversy or discussion. Perhaps this is due to Binge Eating Disorder having taken the most appropriate and planful route for inclusion in *DSM-5*. Binge Eating Disorder was first discussed as a part of the development of *DSM-IV-TR.* At that time there was some disagreement as to the legitimacy of this category as a separate disorder, and many individuals questioned its existence as separate and distinct diagnosis from Bulimia Nervosa. At the time the disagreements could not be resolved, so Binge Eating was included in the chapter for further study in *DSM-IV* and *DSM-IV-TR.* The studies have been done and there is a substantial archive of data suggesting that Binge Eating Disorder is a diagnosis of its own, separate and distinct from Bulimia Nervosa. The new disorder has essentially the same criteria that were included in *DSM-IV* for further study, with the exception of lowering the minimum average frequency of binge eating required to once weekly over the past three months, similar to the revised criteria for Bulimia Nervosa.

Binge Eating Disorder is characterized by recurrent episodes of binge eating accompanied by marked emotional and psychological distress. While both Bulimia Nervosa and Binge Eating Disorder may be characterized by binge eating, in Bulimia Nervosa, there are recurrent inappropriate compensatory behaviors (e.g., purging, exercise, laxatives, diuretics, enemas, fasting, etc.). Both Major Depressive Disorder and Bipolar I Disorder may involve overeating, but the overeating does not necessarily occur in the form of, or meet the diagnostic criteria for binge eating. The impulsivity criteria of Borderline Personality Disorder does include binge eating, and these two disorders can certainly exist in a co-morbid fashion. If the full criteria for Binge Eating Disorder and Borderline Personality Disorder are met, both diagnoses should be given (First, 2014).

Binge Eating Disorder is characterized by recurrent episodes of binge eating without the use of compensatory behaviors. Binge eating is the most common eating disorder in the United States with estimates of 1.6% of all women and 0.8% of all men. Compared with individuals with Bulimia Nervosa, people with Binge Eating Disorder are generally older, more likely to be male, and have a later age of onset. Although weight and body shape concerns are not required for the diagnosis, they are a common part of the presentation. The clinician can rate the current severity of the disorder based on the number of binge eating episodes per week, and can also specify whether the disorder is in partial or full remission. Binge eating is controversial for the same reason that most of the innovations in DSM-5 are controversial, as it may "widen the nets" and pathologize individuals who may fall within normal limits. Frances (2010) has recommended that clinicians not utilize the diagnosis, and that eating disorders be restricted to the classical forms that are known to produce severe dysfunction. He feels that Binge-Eating Disorder describes symptoms that are fairly common, fall within the "normal range", and probably do not deserve to be classified as a mental disorder.

Conduct Disorder and the Limited Prosocial Emotions Specifier

Conduct Disorder is relatively unchanged, but a new specifier has been added in *DSM-5* to reflect a discussion in the literature of a subset of Conduct Disordered Individuals who present as calloused and unemotional. The Workgroup added this new specifier using the terminology of Limited Prosocial Emotions. This terminology was seen as a less pejorative and judgmental way of describing these individuals who are the childhood equivalent of adults with psychopathy, a syndrome falling within the antisocial spectrum, which is characterized by a lack of empathy and concern for the feelings and well-being of others. These traits are found in a very small percentage of youth with Conduct Disorder. Individuals with Conduct Disorder who demonstrate this lack of prosocial emotions have a poorer prognosis and response to treatment than those who still demonstrate prosocial emotions. Individuals with a lack of prosocial emotions typically display deficits in processing signs of fear and distress in others, less sensitivity to punishment, and more fearlessness or thrill-seeking behaviors. The limited prosocial emotions are relatively stable from childhood to early adolescence and early adulthood, and may be genetically influenced (Black and Grant, 2014).

***DSM-5* requires that clinicians utilize a specifier to indicate the age of onset for these behaviors: *Childhood-Onset Type (one symptom prior to age ten), Adolescent-Onset Type (no symptoms prior to age ten), or Unspecified Onset (criteria are met, but there is no information about the age of onset available).* The older the child is before the Conduct Disorder starts, the better the prognosis. Cases with an onset during adolescence usually recover by young adulthood (Moffitt, 1993). But when conduct disorder begins in the preschool and elementary school years, the syndrome is most likely to continue into adulthood and is likely to result in an antisocial personality disorder (Zoccolillo et al., 1992.**

Disruptive Mood Dysregulation Disorder

Disruptive Mood Dysregulation Disorder is new to *DSM-5* and was an attempt to address a diagnostic controversy of pediatric Bipolar Disorder, but has also become controversial in its own right. A petition by 51 mental health agencies requested that the *DSM-5* change, adding Disruptive Mood Dysregulation Disorder, be reviewed by independent experts was rejected without explanation (Division 32 Committee on *DSM-5* (2012): The open letter to the DSM-5 Task Force. http://dsm-5reform.com/the-open-letter-to-dsm-5-task force). Frances (2013) has stated that "Disruptive Mood Dysregulation Disorder is included in DSM-5, despite having been studied by one group for only six years. It is included based on minimal research and was justified on the basis of needing to reduce the over diagnosis of childhood bipolar disorders. I strongly recommend that it be used extremely

sparingly, if at all. It should certainly not be regarded as an indication for medication. In my view Disruptive Mood Dysregulation Disorder was not ready for Prime Time."

The addition of Disruptive Mood Dysregulation Disorder has generated considerable controversy. It was created in part to address concerns about the possible overdiagnosis of bipolar disorder in children under the age of 12 who display irritability and extreme behavioral dyscontrol (Alexson et al., 2006). In the past 20 years, there has been a 40-fold increase in the number of youth diagnosed with Bipolar Disorder. It was hoped that the diagnosis of Disruptive Mood Dysregulation Disorder would help fill an important gap for children with mood dysregulation characterized by chronic, severe, and persistent irritability. Brottman et al., (2006) introduced a different term, Severe Mood Dysregulation, to describe children whose behavior presents in a very similar fashion to Bipolar Disorder, but who don't accurately meet criteria for a diagnosis of Bipolar Disorder. This terminology was eventually replaced by Disruptive Mood Dysregulation Disorder. This terminology views the syndrome as a variant of a new disorder, not as a classical behavior disorder such as Oppositional Defiant Disorder, Conduct Disorder, or Bipolar Disorder. Research shows that children with Disruptive Mood Dysregulation Disorder have a different outcome, gender ratio, and family history than those with Bipolar Disorder, and do not necessarily go on to develop a full-blown manic or hypomanic episode. Originally, the Workgroup considered naming the disorder Temper Dysregulation Disorder, a term used in earlier research, but felt like the word "temper" indicated a willfulness or voluntary aspect of a disorder that is typified by an inability to regulate affective states (Black and Grant, 2014).

One of the purposes of this new terminology would be to discourage automatic prescription of mood stabilizers and antipsychotics typically used to treat Bipolar I. However, the practice of prescribing drugs to seriously disturbed and acting out children does not depend solely on diagnosis. In contrast, when we give drugs to young children seen as bipolar, we do not have the same evidence base and do not know the long-term consequences. No one would be shocked to learn that children diagnosed with Disruptive Mood Dysregulation Disorder (DMDD) might ultimately receive antipsychotics or mood stabilizers, but the new diagnosis may also prevent some children from being diagnosed Bipolar inaccurately and automatically placed on mood stabilizers and antipsychotics. Olfson et al. (2006) states that the members of the *DSM-5* task force were cautious about the concept of bipolar disorder in pre-pubertal children, in part because it leads to frequent prescriptions of mood stabilizers and antipsychotics, many of which have significant side effects. "Many of these medications have broad sedative effects that are often helpful to reduce anger, even if the diagnosis is inappropriate. No one would claim that pain relief from analgesics proves that all patients have the same illness, and psychiatry would not claim that medications typically used for Bipolar individuals prove that a Bipolar diagnosis is appropriate. The medications may have a broad and nonspecific effect in reducing anger, even if the diagnosis is inaccurate (Frances, 2013)."

There is concern that this new diagnosis of Disruptive Mood Dysregulation Disorder may "widen the nets" to include children displaying "normal" temper tantrums, leading to an increased use of inappropriate psychotropic medications with children. Some individuals are concerned that Disruptive Mood Dysregulation Disorder could become the new "fad" diagnosis. Frances (2010) has expressed grave concerns about pediatric Bipolar Disorder as an example of a diagnostic fad. "To become a fad, psychiatric diagnosis requires three preconditions: a pressing need, an engaging story, and influential Prophets." In Frances' opinion, Disruptive Mood Dysregulation Disorder has all the components necessary to become the new "fad" diagnosis.

In *DSM-5,* Disruptive Mood Dysregulation Disorder is viewed as "severe recurrent temper outbursts that are out of proportion in intensity and duration to the situation or the child's developmental level." These outbursts occur, on average, at least three times per week, have been present for 12 months or more, and the child has never had a period of three months where outbursts were not evident. Onset of symptoms is prior to age 10, distinguishing it from Bipolar Disorder, which typically has a much later onset. The outbursts must occur in multiple settings and mood between outbursts is persistently irritable or angry. The diagnosis is not made before age five and does not persist beyond age 18. This diagnosis is not for any individuals who have met the full criteria for a manic or hypomanic episode for at least one day. It is a diagnosis that cannot coexist with Oppositional Defiant Disorder, Intermittent Explosive Disorder, or Bipolar Disorder. If a child's symptoms meet criteria for both Disruptive Mood Dysregulation Disorder and Oppositional Defiant Disorder, *DSM-5* directs that only the Disruptive Mood Dysregulation Disorder diagnosis should be given. Estimates indicate that about 15% of children currently diagnosed with Oppositional Defiant Disorder will have symptoms that meet criteria for Disruptive Mood Dysregulation Disorder (Black and Grant, 2014).

First (2014) has recognized the difficulty of distinguishing Disruptive Mood Dysregulation Disorder from a variety of other disorders or issues that children and adolescents might present. Disruptive Mood Dysregulation Disorder is characterized by severe, recurrent temper outbursts that are grossly out of proportion in intensity and duration to the provocation. These outbursts are accompanied by a persistent irritable or angry mood, most of the day, nearly every day. Disruptive Mood Dysregulation Disorder is distinguishable from Bipolar I and Bipolar II Disorders which are episodic illnesses with cycling and discrete episodes of mood perturbation that are clearly distinguishable from the child's baseline behavior. In addition, the change in mood during a Manic or Hypomanic Episode, required for a Bipolar I or II diagnosis, is accompanied by increased energy and activity as well as cognitive and behavioral symptoms. In contrast, the irritability of Disruptive Mood Dysregulation Disorder is present chronically and persistently over many months. *DSM-5* specifically prohibits a comorbid diagnosis of both Bipolar Disorder and Disruptive Mood Dysregulation Disorder.

Additionally, Oppositional Defiant Disorder, Intermittent Explosive Disorder, and Autism Spectrum Disorder are clearly distinguishable from Disruptive Mood Dysregulation Disorder and cannot be diagnosed as co-morbid conditions in a child. Oppositional Defiant Disorder is characterized by a pattern of angry, irritable mood, argumentative, defiant behaviors, and/or vindictiveness. As indicated previously, If criteria are met for both Oppositional Defiant Disorder and Disruptive Mood Dysregulation Disorder, only Disruptive Mood Dysregulation Disorder is diagnosed. Intermittent Explosive Disorder is characterized by aggressive outbursts that can resemble the severe temper tantrums in Disruptive Mood Dysregulation Disorder; however, there is no persistent irritable or angry mood between outbursts as in Disruptive Mood Dysregulation Disorder. Intermittent Explosive Disorder requires only three months of active symptoms, in contrast to the twelve month requirement for Disruptive Mood Dysregulation Disorder. Furthermore, Intermittent Explosive Disorder is not diagnosed if criteria are met for Disruptive Mood Dysregulation Disorder. Individuals diagnosed with Autism Spectrum Disorder may typically display temper outbursts, particularly when routines are disrupted. If the temper outbursts are better explained by Autism Spectrum Disorder, then *DSM-5* Disruptive Mood Dysregulation Disorder is not diagnosed (First, 2014).

While *DSM-5* specifically prohibits a comorbid diagnosis of both Oppositional Defiant Disorder, Intermittent Explosive Disorder, and Autism Spectrum Disorder and Disruptive Mood Dysregulation. Disruptive Mood Dysregulation Disorder can coexist with Attention Deficit Hyperactivity Disorder, Substance Use Disorder, Depressive Disorders, and Anxiety Disorders if the angry, irritable episodes extend outside the anxiety-provoking situations or the depressed episodes (First, 2014).

Excoriation (Skin Picking) Disorder

Excoriation (Skin Picking) Disorder was first proposed in *DSM-IV,* but research data to justify including it as a disorder at that time was insufficient. In *DSM-IV,* specific criteria for a diagnosis were developed, but Excoriation Disorder was assigned to the chapter for further study. Since that time, sufficient data has been gathered to justify its inclusion in *DSM-5*. Excoriation Disorder is characterized by recurrent, compulsive picking of the skin, resulting in skin lesions. Black and Grant (2014) report that Excoriation Disorder has long been recognized in medical literature, and is now in *DSM-5* due to a growing body of data emphasizing its prevalence and disabling nature. There are a number of similarities between Excoriation Disorder and Trichotillomania and the criteria for the two disorders parallel each other.

***DSM-5* Excoriation Disorder criteria call for recurrent skin picking of sufficient intensity and frequency that it results in skin lesions. The individual has tried and failed to stop the picking, and the disorder causes significant distress in important areas of functioning. The disorder is not better explained by the physiological effects of substance abuse, a medical condition, or another mental disorder.**

Prevalence studies have found that Excoriation Disorder occurs in 1.4% to 5.4% of the general population. Often considered chronic, the disorder may fluctuate over time and in intensity.

First (2014) describes Excoriation Disorder as recurrent skin picking resulting in skin lesions despite repeated attempts to stop. Other diagnoses that involve some picking at the skin, including Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, Psychotic Disorders, and Stereotypic Movement Disorder. In Obsessive-Compulsive Disorder and Body Dysmorphic Disorder, if either of these diagnoses better explain the skin picking or skin lesions, those diagnoses should be used rather than Excoriation Disorder. Psychotic disorders may include skin picking in response to delusions, hallucinations, and other repetitive behaviors. In those cases, Excoriation Disorder should not be diagnosed.

Hoarding Disorder

Hoarding disorder may be the first diagnostic category that received its impetus for inclusion in *DSM-5* as a result of a popular cable television show. *Hoarders* has appeared on the A&E cable channel since 2006. As a result, the show's popularity has also spurred considerable scientific research into Hoarding Disorder. Substantial data exists indicating that Hoarding Disorder is a unique and separate diagnostic category not reflected in a diagnosis of Obsessive Compulsive Disorder. In *DSM-IV,* hoarding was listed as part of the symptom pattern in the criteria for a Compulsive Personality Disorder. In the past, individuals with Hoarding Disorder were typically diagnosed Obsessive Compulsive Disorder. Individuals who meet diagnostic criteria for Hoarding Disorder do not exhibit a classical symptom pattern of Obsessive Compulsive Disorder (OCD) or respond to medications known to be effective with OCD. Hoarding may be a symptom of OCD, but data indicate that hoarding is a separate phenomenon and must be addressed through its own unique set of treatment strategies.

Black and Grant (2014) describe Hoarding Disorder as a persistent difficulty discarding or parting with possessions. In most situations, the quantity of the items retained and the disorganization of those items distinguish Hoarding Disorder from normal messy and disorganized behavior. There also appears to be a set of unique neurological correlates that set Hoarding Disorder apart from normal "collecting" behaviors or Obsessive Compulsive Disorder. The high prevalence and serious consequences of Hoarding Disorder, together with the research on its distinctiveness from Obsessive Compulsive Disorder and Obsessive-Compulsive Personality Disorder, have led the authors of *DSM-5* to classify Hoarding Disorder as a new diagnostic category. Hoarding is fairly common, significantly disabling, and has been shown to be present in 2% to 6% of the general population.

DSM-5 **diagnostic criteria for Hoarding Disorder includes persistent difficulty discarding or parting with their possessions and a perceived "need" to save the items regardless of their actual value. The clutter is due to purposeful saving, rather than just an inability to throw away items, due to attaching emotional significance to the items. The criteria for this disorder can also be met if the living areas are uncluttered, "but only because of the interventions of third parties such as family member or hired cleaners (*DSM-5, 2013).*" Criteria also call for the accumulation of these possessions to congest and clutter living areas to the point they can no longer be used for their intended purpose (Frost et al., 2012). The criteria emphasize the living areas of the home or workplace, rather than unused space like basements or storage facilities. The hoarding symptoms cause significant impairment in functioning and are not better attributable to a medical condition or another mental disorder.** ***DSM-5*** **diagnostic criteria also include a number of specifiers such as "with excessive acquisition," "with good or fair insight," "with poor insight," and "with absent insight/delusional beliefs."**

First (2014) provides insight and guidance for making a differential diagnosis between Hoarding Disorder and Obsessive-Compulsive Disorder. In Obsessive-Compulsive Disorder, the individual feels driven to perform repetitive behaviors in response to an obsession or set of rules that are generally experienced by the individual as ego-dystonic; whereas, Hoarding Disorder is typically ego-syntonic. When the accumulation of objects is a direct consequence of the Obsessive-Compulsive Disorder, a diagnosis of Hoarding Disorder is not made. However, when hoarding appears concurrently with typical symptoms of Obsessive-Compulsive Disorder and are independent of those symptoms, both Hoarding Disorder and Obsessive-Compulsive Disorder may be diagnosed. When the accumulation of objects relates to a fixated interest that is a part of Autism Spectrum Disorder or the delusions/hallucinations associated with psychotic disorders, the diagnosis of Hoarding Disorder is not made. ***DSM-5*** **also encourages clinicians to make a distinction between "normal collecting behavior" which is organized and systematic, even if the amount of possessions is similar in quantity to individuals with Hoarding Disorder.**

Disinhibited Social Engagement Disorder

Disinhibited Social Engagement Disorder is new in ***DSM-5,*** **having been split off from the** ***DSM-IV-TR*** **Reactive Attachment Disorder of Infancy or Early Childhood. What distinguishes these two, both of which have an assumed etiology of pathogenic childcare, is the behavioral response the child makes to being exposed to inadequate or abusive child caring practices. The dominant feature of Disinhibited Social Engagement Disorder is a pattern of behavior that involves inappropriate and overly familiar behavior with unfamiliar adults or strangers. Young children are typically reticent when interacting with unfamiliar adults, but children with this disorder not only lack such reticence, but willingly engage strangers and have no fear of going off with them. The child must have reached a**

cognitive capacity of a nine-month-old child and the disinhibited social behaviors are frequently observed in children between the ages of two years and adolescence (Black and Grant, 2014).

In Disinhibited Social Engagement Disorder, pre-school children's verbal and social intrusiveness and attention seeking behaviors are common. In the middle years, verbal and physical over familiarity are common and by adolescence, the indiscriminate and overly familiar behaviors may extend to peers. Like Reactive Attachment Disorder, Disinhibited Social Engagement Disorder is associated with cognitive, language, and developmental delays as well as signs of neglect like poor nutrition and poor hygiene. Signs of the disorder may persist even when the neglect is no longer present. The diagnosis requires that two or more examples of disinhibited behavior are present. These include a reduced or absent reticence in interacting with adults, overly familiar verbal or physical behaviors with adults, diminished "checking back" behaviors, and a willingness to go off with an unfamiliar adult with no hesitation. These disinhibited behaviors are not just simple impulsivity, as frequently observed in children with Attention Deficit Hyperactivity Disorder, but are more of a social impulsivity, where the child does not recognize boundaries or limitations with adults (Black and Grant, 2014).

Post Traumatic Stress Disorder

While not a new disorder in *DSM-5*, there have been extensive changes in Posttraumatic Stress Disorder, including a separate set of diagnostic criteria for Posttraumatic Stress Disorder in Children Under Six, Dissociative Features, Delayed Onset, and the removal of the criteria calling for an excessive reaction to the traumatic situation.

Black and Grant (2014) describe the lengthy history of the development of Posttraumatic Stress Disorder (Post Traumatic Stress Disorder) which was initially recognized in DSM-I as "gross stress reaction." Post Traumatic Stress Disorder is common in the general population and can occur at any age, even in young children. In women, the most frequent precipitating event is a physical or sexual assault; whereas, in men, the traumatic event often involves a combat experience. Post Traumatic Stress Disorder generally begins soon after the event is experienced, but the onset can be delayed.

The *DSM-5* criteria depart from those in *DSM-IV* in several important aspects (Friedman et al., 2011). The stressors that trigger the Post Traumatic Stress Disorder are more explicitly described, requiring the individual to have had exposure to actual or threatened death, serious injury, or sexual violence. As Nally (2009) points, this change is significant because over diagnosis weakens the main concept of the disorder and fails to focus on the disorder's key idea - the impact of severe trauma. The *DSM-5* criteria specifically states that the trauma cannot be a result of exposure to trauma through electronic

media, television, movies, or pictures. Paris (2000) believes there is substantial evidence that most people exposed to trauma, even severe trauma, never develop Post Traumatic Stress Disorder. Post Traumatic Stress Disorder is likely as much a consequence of personality traits as it is of life events. For example, Post Traumatic Stress Disorder in firefighters was best predicted by traits of neuroticism prior to exposure, rather than by the severity of the fire.

The excessive reaction to the stressor, that was an integral part of the *DSM-IV* criteria for Post Traumatic Stress Disorder, has been eliminated. Many individuals who are first responders do not necessarily show an excessive reaction to trauma, but do display symptoms consistent with a diagnosis of Post Traumatic Stress Disorder. *DSM-5* also dropped *DSM-IV* criteria A2, which required individuals to have subjectively experienced fear, helplessness, or horror at the time of the traumatic event. Research indicates that an individual's initial response to the stressor is not always useful in predicting who will later exhibit symptoms of Post Traumatic Stress Disorder. Furthermore, criteria A2 did not take into account that some individuals who experience trauma as a result of an occupational hazard, for which they have been extensively trained, often viewed the event as "just doing my job."

While *DSM-IV* had three major symptom clusters re-experiencing, avoiding, and changes in arousal levels, *DSM-5* has added a new, fourth symptom cluster identified as negative alterations in cognitions and mood. The new symptom cluster includes persistent, exaggerated, negative expectations about one*'s* self, others, and the world itself. The new symptom cluster also includes avoidance and numbing symptoms. Criteria call for an individual to have displayed two or more of seven specified symptoms, including: an inability to remember, persistent and exaggerated negative beliefs, persistent and distorted cognitions, persistent negative emotional states, a diminished interest or participation in activities, feelings of detachment or strangeness, and an inability to experience positive emotions (Black and Grant, 2014). *DSM-5* criteria also call for alterations in arousal associated with the traumatic event. These include irritable behavior and angry outbursts, hypervigilance, an exaggerated startle response, problems with concentration, and disturbances in sleep. The new criteria also allow for specifiers of Dissociative Symptoms that may involve depersonalization or derealization, as well as the possibility of delayed expression. In some cases, the individual may not meet full criteria for a diagnosis of Post Traumatic Stress Disorder until at least six months after the traumatizing event. This is not to be confused with the "recovered memory syndrome."

A major addition to *DSM-5* Post Traumatic Stress Disorder provides for specific diagnostic criteria for Post Traumatic Stress Disorder for Children Six Years or Younger. Specifically, symptom thresholds were lowered or eliminated for some symptoms that are difficult to assess in preschool children. A child's exposure to the threat of death, serious injury, or sexual violence may have been a result of

directly experiencing a traumatic event, witnessing the event as it occurred to others, learning that the traumatic event occurred to a close family member, or experiencing repeated or extreme exposure to the details of the trauma. The spontaneous and intrusive memories, so typical with adults, may not necessarily appear as distressing for children under six. In some situations it may not be possible to ascertain that the frightening content of memories or dreams is related to the traumatic event. For many children, their posttraumatic stress may be reflected as enactments in play, as well as, substantially increased frequency of negative emotions, socially withdrawn behavior, or a general reduction in the expression of positive emotions.

First (2014) describes Post Traumatic Stress Disorder as exposure to actual or threatened death, serious injury, or sexual violence, followed by the development of intrusive symptoms, persistent avoidance of stimuli associated with the trauma, negative alterations of cognitions and mood, and marked alterations in arousal and reactivity. Post Traumatic Stress Disorder is distinguished from Adjustment Disorder, which is characterized by a stressor of any level of severity and does not have a specific response pattern. The diagnosis of Adjustment Disorder is used when the response to an extreme stressor does not meet criteria for Post Traumatic Stress Disorder or when the symptom pattern of Post Traumatic Stress Disorder occurs in response to a non-traumatizing stressor.

While there is an overlapping symptom pattern, Post Traumatic Stress Disorder is distinct from Obsessive Compulsive Disorder, Panic Disorder, and Generalized Anxiety Disorder. In Obsessive Compulsive Disorder, there may be recurrent and intrusive thoughts, but these are experienced as inappropriate and not related to an experienced, traumatic event. Panic Disorder may be characterized by arousal and dissociative symptoms, but these occur during Panic Attacks and are not associated with a traumatic stressor. Unlike Post Traumatic Stress Disorder, the persistent symptoms of Generalized Anxiety Disorder, irritability and anxiety, are not associated with any identifiable traumatic stressor. A relatively recent phenomena is the co-occurrence of Traumatic Brain Injury and Post Traumatic Stress Disorder. With Traumatic Brain Injury, neurocognitive symptoms (disorientation, confusion, and memory deficits) develop after a traumatic brain injury which can also lead to Post Traumatic Stress Disorder. In that case, both disorders should be diagnosed (First, 2014).

Premenstrual Dysphoric Disorder

The Mood Disorders Workgroup recommended that Premenstrual Dysphoric Disorder receive full disorder status in *DSM-5.* In *DSM-IV* it was included in the appendix for further study and if present, was coded as Depressive Disorder Not Otherwise Specified. Research evidence has accumulated that would indicate the disorder is a significant cause of distress. It was also felt that information on the

diagnosis, treatment, and validation of the disorder has matured to the point that the disorder qualified for inclusion in *DSM-5*. Additionally, the studies identified a subset of women (about 2%) who suffer intermittently from severe affective symptoms associated with the luteal phase of their menstrual cycle (Black and Grant, 2014)

Premenstrual Dysphoric Disorder is characterized by marked affective lability, irritability, anger, increased interpersonal conflicts, depressed mood, feelings of hopelessness, self-deprecation, anxiety and tension, and feelings of being "keyed up" or "on edge" regularly developing in the final week before the onset of menses. These symptoms start to improve within a few days after the onset of menses, and become minimal or absent in the week post menses (First, 2014). This disorder has a distinctive pattern of onset and resolution that is dissimilar from Bipolar Disorder and Major Depressive Disorder, as in both these, the affective symptoms are unrelated to the menstrual cycle. Prospective daily symptom ratings are important for documenting the time of onset and offset of mood symptoms. Premenstrual Dysphoric Disorder should only be used when there are prominent psychological symptoms not just difficult physical symptoms (Francis, 2103). Premenstrual Dysphoric Disorder is divergent from dysmenorrhea in which painful symptoms begin with the onset of menses.

Bereavement Exclusion

In *DSM-5,* the core criterion items for the diagnosis of Major Depressive Disorder, as well as the two weeks duration criterion, are unchanged from *DSM-IV,* with minor wording changes. The Mood Disorders Workgroup concluded that the Major Depressive Disorder criteria have accumulated considerable research support and have held up well over the past 30 years. One important change in *DSM*-5 is the deletion of the "bereavement exclusion." The deletion of this diagnostic criteria has led to controversy in which critics have claimed eliminating the "bereavement exclusion," has medicalized the normal process of grief. In *DSM-IV*, Major Depressive Episode criteria required that the symptoms are "not better accounted for by bereavement" (Black and Grant, 2014). This exclusion applied to symptoms lasting less than two months following the death of a loved one. Rationale for the change has been provided by many individuals, and included: any stressor, not just grief, is capable of triggering a Major Depressive Episode, the time span specified is arbitrary, and the treatment of both Major Depressive Episode and grief have been shown to respond to a combination of antidepressants and psychotherapy, specifically cognitive behavioral therapy.

One argument for dropping the "bereavement exclusion" was the lack of evidence to support the unique loss of a loved one as different from other stressors in terms of its likelihood of precipitating a major depressive episode. Any significant stressor is capable of triggering a Major Depressive Episode. There is no justification for excluding bereavement. The same rationale could result in a "divorce exclusion," "loss of employment exclusion," "a major health issue exclusion, etc."

Additionally, the time period of two months implies that "normal grief" should only last for two months, which is not substantiated by the available research. . Although bereavement may be painful, most persons do not develop a Major Depressive Episode. Those who do, however, typically experience more suffering, feel worthless, and may have suicidal ideation. For others, bereavement is a severe psychosocial stressor capable of precipitating Major Depressive Episodes in vulnerable persons. Bereavement-related depression has some of the characteristics of a major depressive episode and is most likely to occur in individuals with a personal or family history of Major Depressive Episodes. Finally, the symptoms associated with the bereavement-related Major depressive disorder respond to antidepressant medication and psychotherapy. Many clinicians prefer to observe an individual, within the first two months following the death of a loved one, to determine an appropriate treatment for either Major Depressive Disorder, or to continue to treat the client's reaction as a part of the normal grieving process (Black and Grant, 2014).

Other authors including, Paris (2013) and Frances (2013) have provided cogent arguments for continuing the "bereavement exclusion." While Bereavement and Major Depression have a number of symptoms that are common, there are enough distinctions to insist they be regarded as two separate phenomena. A comparison of the symptom criteria for Major Depression and the proposed Complex Bereavement Disorder would reveal that of the nine symptoms of Major Depression, only four have a comparable counterpart in Complex Bereavement Disorder. There are three symptoms of Complex Bereavement Disorder that have no counterpart in Major Depression criteria. So while both disorders have some common symptoms, they are viewed as separate phenomena. In Bereavement, the symptoms seem to come in waves and then reside from awareness, having minimal impact on the individual's behavior; whereas, in Major Depression, the symptoms are chronic, ongoing, and tend to have a cumulative pact on individuals. The thought content associated with Bereavement generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations of a Major Depressive Episode. In Bereavement, the individual's self-esteem is not significantly impacted: whereas, in Major Depression, chronic depression tends to grind away at self-esteem and many individuals may reach the point of feeling, helpless, hopeless, and worthless. Finally, in Bereavement, the individual may experience some suicidal ideation as a part of a desire to be reunited with a loved one; whereas, in Major Depressive Disorder, the symptom of suicidal ideation is more reflective of a desire for the emotional pain to stop.

Responding to the maelstrom of criticism, *DSM-5 has also provided a note in the diagnostic criteria to address this issue.* "Responses to a significant loss (e.g. bereavement, financial ruin, losses from a natural disaster, a serious medical issue or disability) may include the feelings of intense sadness, ruminations 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. The decision inevitably requires the exercise of clinical judgment based on the individual's history and cultural norms for the expression of distress in the context of loss (*DSM-5, 2013).*"

Clinicians are urged not to diagnose major depression if grief, even if prolonged, best accounts for the symptoms. *DSM-5* also provides a category for further study called Complex Bereavement Disorder (Paris, 2013). The resolution of this controversy has been to provide a note to the diagnostic criteria for a Major Depressive Episode and to establish a category for further study labeled Complex Bereavement Disorder. It remains an issue of great debate and one that will only be resolved by the passage of time and the development of clinical practices (Paris, 2013).

Substance Use Disorder

Black and Grant (2014) describe the evolving history of diagnosing individuals who use substances inappropriately. In *DSM-I,* addictions were placed within the umbrella category of "sociopathic personality disturbance," reflecting a belief that these individuals were violating the norms of society. *DSM-II* placed alcoholism and the renamed drug dependence in the group of "personality disorders and certain other non-psychotic mental disorders." Alcoholism was subdivided into *Episodic Excessive Drinking, Habitual Excessive Drinking, and Alcohol Addiction* (those considered to be dependent on alcohol). Furthermore, ten categories of Drug Dependencies were created to reflect the fact that many drugs were commonly misused. *DSM-III* gave substance use disorders their own chapter and separate diagnostic criteria as well as divisions of abuse and dependence. The constructs of Abuse and Dependence has continued until *DSM-5.* Dependence was thought to have a different cause and course of development from abuse which only resulted in social and personal problems. Substance Intoxication was considered a reversible substance-specific syndrome and likewise, Substance Withdrawal was an identifiable syndrome related to a particular drug and associated with medically important consequences.

DSM-5 defines a Substance Use Disorder as a maladaptive pattern leading to clinically significant impairment or distress for at least 12 months (Paris, 2013). It must be distinguished from non-pathological use of a substance which is characterized by the repeated use at relatively low doses, possibly involving periods of intoxication, but not associated with significant negative behavioral consequences. Substance Use Disorders are characterized by heavy use, leading to significant distress or impaired functioning. Many individuals with Conduct Disorder or Antisocial Personality Disorder also abuse substances and these disorders are often co-morbid with Substance Use Disorder (First, 2014).

Importantly, the distinction between Substance Abuse and Substance Dependence defined in *DSM-IV-TR* no longer exists. The two former diagnoses are merged into a single Substance Use Disorder, because the distinction between abuse and dependence was often arbitrary, had limited utility, and was often confusing. A new symptom - Craving - or a strong desire or urges to use a substance has been added, while the symptom of recurrent legal problems has been dropped and simultaneously, Criterion A3 (legal problems) was eliminated as it had a low prevalence rate relative to other criteria. The severity of the new Substance Use Disorder is specified based on the number of symptoms observed.

Black and Grant (2014) reported there were several reasons to combine abuse and dependence into a single category of Substance Use Disorder. First, many clinicians had trouble distinguishing the two, and while there was good reliability with Substance Dependence diagnoses, Substance Abuse diagnoses were much less reliable and more variable. Substance Abuse was often seen as the prodromal phase of Substance Dependence. Second, most studies indicated that a Substance Abuse diagnosis was most commonly based on hazardous use (driving and drinking or using) with that being the sole basis for the diagnosis. Third, the division between abuse and dependence led to many "diagnostic orphans," i.e. an individual who met only two criteria for dependence and none of the criteria for abuse, resulting in a "no diagnosis." Considering the evidence, the Workgroup recommended Abuse and Dependence be combined into a single disorder of graded clinical severity, and established the symptom threshold as a minimum of two symptoms (Helzer et al., 2006). Mild Substance Use Disorder requires 2 -3 symptoms; Moderate Substance Use Disorder requires 4 - 5 symptoms; and Severe Substance Use Disorder requires more than 6 symptoms.

A number of individuals have expressed concern that the elimination of the abuse/dependence distinction may lead to an "artificial epidemic" in the diagnosis of individuals who have a substance disorder. An Australian study (Mewton et al., 2011) predicts a 60% increase in prevalence as a whole; whereas an American study (Agrawal et al., 2011) projected only a 10% increase. The chair of the Workgroup (O'Brien, 2011) has defended eliminating the terminology of "dependence" because it was a confusing concept that conflates physical and psychological need for the substance. This logic was based on research by (Hasin & Beseler, 2009) which suggests alcoholism is a dimensional, can be rated on a continuum of severity, and then be coded for physiological dependence.

Critics continue to express concern that *DSM-5 r*elabels individuals with a *DSM-IV-TR* Substance Abuse diagnosis in a way that includes them with end-stage addicts. Statistical analysis suggests that there is no sharp boundary between these groupings. Some argue that it is unfair and inaccurate to label someone whose substance abuse problems are intermittent, temporary, or contextual (college), the same as a chronic substance abuser. In addition, being labelled as dependent, or self-labeling oneself as Substance Dependent can become a self-fulfilling prophecy and a great excuse for not meeting

personal responsibilities (O'Brien, 2011). Caffeine Withdrawal and Cannabis Use Disorder and Cannabis Withdrawal have also been added in *DSM-5* as new diagnostic categories.

Gambling Disorder

Black and Grant (2014) state that gambling is encountered in almost all cultures and has been present throughout history. For most individuals gambling is not considered pathological. Disordered gambling was first introduced in *DSM-III,* as *Pathological Gambling.* It was included in the chapter on impulse control disorders, along with pyromania and kleptomania. In *DSM-5*, the disorder has been included in the chapter on Substance-Related and Addictive Disorders because of high rates of comorbidity, similar presentations, and genetic and physiological overlap. The criteria are relatively unchanged from Pathological Gambling contained in *DSM-IV-TR.* Significantly the name itself was changed from Pathological Gambling to Gambling Disorder to avoid the stigma of "pathological," and the number of symptoms required has been reduced from five to four.

***DSM-5* puts one and only one "behavioral disorder" on a par with addiction to substances - Gambling Disorder. Pathological Gambling was listed as a disorder in *DSM-IV-TR* under the chapter of Impulse Control Disorders and has a lengthy history with extensive studies to back it up. Other "disordered" behaviors such as internet use, sex, eating, shopping, video gaming, etc. aren't included, but are likely to have their "day in court" in due time. (Potenza, 2006) concluded "There is substantive research to support the position that pathological gambling and substance use disorders are very similar in the ways that they affect the neurological reward system in the brain. PET scans and MRIs have demonstrated these physical changes in the brains of people with behavioral disorders and substance disorders alike."**

Some fear that *DSM-5* introduced the concept of Behavioral Addictions. The concept suggests that behavior originally intended for pleasurable recreation is now compulsively driven, performed in a repetitive fashion, despite negative consequences and there is an escalating sense of loss of control, now has become an addiction. "The new concept of behavioral addictions has created potentially millions of new "patients" and created excuses for irresponsibility (O'Brien, 2011)." First (2014) separates Gambling Disorder, which is a persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress from gambling. He makes a distinction between Professional Gambling which is highly disciplined and has limited risk taking, Social Gambling which usually occurs with friends and is characterized by limited time spent on gambling activities, and Gambling Disorder.

Chapter Five: Conditions for Further Study

Finally, a number of possible Disorders have been introduced by *DSM-5* in a section entitled Conditions for Further Study. These diagnostic categories are not available for use, but have become useful in providing criteria for further study and research with a temporary criteria set and are "intended to provide a common language for researchers and clinicians who are interested in studying these disorders. It is hoped that this will promote understanding and inform decisions about their placement in future *DSM* editions (*DSM-5, 2013).*"

Attenuated Psychosis

The Psychotic Disorders Workgroup proposed a new diagnosis in order to identify persons at risk for the development of Schizophrenia to facilitate early identification and treatment. The disorder consists of mild psychotic like symptoms, with the assumption that conversion to Schizophrenia or a full-blown psychosis is likely, at a future point. The proposed diagnosis became a focus of controversy. Critics within and outside the field expressed concerns that Attenuated Psychosis might lead to psychiatric labeling of individuals who are not ill and who, in most cases, would never develop a psychotic disorder. Concerns were also expressed this might lead to an overuse of antipsychotic medications, in individuals who do not require them, with the possibility of significant side effects (*DSM-5,* 2013).

Depressive Episodes with Short-Duration Hypomania

The Mood Disorders Workgroup proposed a diagnosis of individuals with short duration Hypomania (2-3 days) who met the criteria for a Major Depressive Episode. Research indicates that these individuals show increased comorbidity with Substance Use Disorder and Bipolar Disorder. Estimates place the rate of incidence at 2.8% of the general population and a greater prevalence in women than men. Critics were concerned the diagnosis could lead to confusion with Bipolar II Disorder, Major Depressive Disorder With Mixed Features, Cyclothymic Disorder, or Borderline Personality Disorder (*DSM-5,* 2013).

Persistent Complex Bereavement Disorder

The Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Workgroups proposed a new category entitled, Persistent Complex Bereavement Disorder. This new diagnosis was seen to address some of the controversy surrounding the elimination of the bereavement exclusion and simultaneously acknowledging the significant distress and functional impairment that some individuals experience after the loss of a close family member or friend. The Workgroups felt that these circumstances are not adequately covered by *DSM-5,* and may need to be addressed in future editions (*DSM-5,* 2013).

Caffeine Use Disorder

The Substance-Related Disorders Workgroup proposed inclusion of Caffeine Use Disorder in recognition that chronic caffeine users develop features of substance dependence: continued use despite recognizable harm, unsuccessful efforts to quit or cut down, and continued use to avoid withdrawal. Recognition of a diagnosis of inappropriate use of caffeine as a disorder could lead to the development of specific cessation strategies and interventions. Critics objected out of concern that recognizing excessive caffeine use as a disorder might trivialize Substance Use Disorders and label a large portion of the adult population, who use caffeine regularly and extensively, as disordered (*DSM-5,* 2013).

Internet Use/Gaming Disorder

Criteria were proposed by the Substance-Related Disorders Workgroup to recognize a new condition that is the result of rapidly expanding technology. Internet/Gaming Disorder is excessive or inappropriate use of the internet to engage in games. Although the condition is relatively common, particularly in Asian countries, Workgroup members felt that it is not reflected in *the DSM.* Concerns were expressed that Internet/Gaming Disorder can only exist in countries where individuals have ready access to technology and the internet and is not a concern in some cultures. The disorder captures the same common clinical features that link it to substance addictions: repetitive and driven behaviors despite the consequences, diminished control, cravings, and experiencing pleasure while engaged in the behavior. Symptoms of tolerance, dependence, and withdrawal similar to substance use disorders have also been observed. This proposed diagnosis has been met with extreme criticism. Some believe its inclusion in a future edition of *DSM* would medicalize "bad behavior" and expand behavioral addictions. Others believe that it is too narrowly defined and a broader category of "Internet Addiction" or "Compulsive Computer Use Disorder" should have been proposed instead (*DSM-5,* 2013).

Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure

There was a proposal for a neurobehavioral disorder associated with in utero exposure to alcohol. The proposed disorder is reflected by impaired neurocognitive functioning, impaired self-regulation, and impaired adaptive functioning. The rationale for including this diagnosis was to increase recognition and to facilitate treatment and referral for children exposed to alcohol during the prenatal period. Others argued that the symptoms of this disorder are already adequately captured in the *DSM-5* and clinicians need simply be more alert to the symptoms. Others are concerned this disorder assumes a causal relationship to alcohol, which is difficult to prove, and overlaps other disorders including Conduct Disorder and Antisocial Personality Disorder (*DSM-5,* 2013).

Suicidal Behavior Disorder

This disorder was proposed to remedy a diagnostic coding problem. Suicidal behavior is limited to E Codes drawn from the ICD-9-CM (E50-E59). Although suicidal behavior and ideation are listed as symptoms of Major Depressive Disorder and Borderline Personality Disorder, it may be recorded as a separate diagnostic category and as a primary focus of treatment. The absence of an approved code may lead to incomplete and misleading information in clinical records. Also, the availability of a codeable disorder might help with prevention and safety monitoring (*DSM-5,* 2013).

Nonsuicidal Self-Injury

The Child and Adolescent Disorders Workgroup proposed Nonsuicidal Self-Injury with the rationale that these behaviors are not represented in *DSM.* While this behavior is reflected in item 5 of Borderline Personality Disorder, it is common in children and adolescents who would not meet criteria for that diagnosis. Research has shown that repeated self-injury co-occurs with a variety of diagnoses, and many of these individuals do not meet criteria for a diagnosis of Borderline Personality Disorder. Separate diagnostic criteria would clear up two misconceptions regarding self-injury: 1) that self-injury is exclusively part of a Borderline Personality Disorder, and 2) that it is a form of attempted suicide. For most individuals, self-injury is not intended to result in death, but rather to bring relief from tension or other negative affective states. The definition proposes that the injuries (e.g., cutting, burning) are superficial, frequently repeated, and are viewed as non-life threatening. Nevertheless, recurrent self-injurious behaviors are associated with increased risk for inadvertent suicide (*DSM-5,* 2013).

At some point in the future, these disorders, or Conditions for Further Study, may or may not be included in future *DSM's* based on the results of the ongoing studies and scientific investigation. At a minimum, they are useful for further study and research.

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