H C
D M-I - D M-5

Chang to the DSM-5 diagnost c criteria and texts are outlined in this chapter in the same order in wh ar in the DSM-5 classi fcat on. This is not an exhaust ve guide; minor changes in text or wo larity are not described here. It should also be noted that Sec t on I of DSM-5 con- tains nges pertaining to the chapter organiza t on in DSM-5, the mul t axial system, and t nsional assessments (in Sec t on III).

Term

The " " is replaced in DSM-5 with "another medical condi t on" wh relev

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Inte Disorder)

Dia developmental disorder) e for t ve func t oning. Seve ada tarda t on was *int* over the m an fe rep t cits in cog in t c criteria, are c m *der* was placed in pare lists "disorders" in the Inter t and bases all "disabili t es" on the I (ICF). Because the ICD-11 will not be ad s as the current preferred term with the bridge t

s include language disorder (which combines DSM-IV expressive anguage disorders), speech sound disorder (a new name for phono- d-onset fuency disorder (a new name for stu t ering). Also included is ica t on disorder, a new condi t on for persistent di f cul t es in the social uses communica t on. Because social communica t on de f cits are one component of rder (ASD), it is important to note that social (pragma t c) communica t on disorder ed in the presence of restricted repe t t ve behaviors, interests, and ac t vi t es (the oth- f ASD). The symptoms of some pa t ents diagnosed with DSM-IV pervasive develop not otherwise speci f ed may meet the DSM-5 criteria for social communica t

sm spectrum disorder is a new DSM-5 name that eparate disorders are actually a single co

domains. ASD now encompasses the previous DSM-IV autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. ASD is characterized by 1) deficits in social communication and social interaction and 2) restricted repetitive behaviors, interests, and activities (RRBs). Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRBs are present.

The diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD) in DSM-5 are similar to those in DSM-IV. The same 18 symptoms are used as in DSM-IV, and continue to be divided into two symptom domains (inattention and hyperactivity/impulsivity), of which at least six symptoms in one domain are required for diagnosis. However, several changes have been made in DSM-5: 1) examples have been added to the criterion items to facilitate application across the life span; 2) the cross-situational requirement has been strengthened to "several" symptoms in each setting; 3) the onset criterion has been changed from "symptoms that caused impairment were present before age 7 years" to "several inattentive or hyperactive-impulsive symptoms were present prior to age 12"; 4) subtypes have been replaced with presentation specifers that map directly to the prior subtypes; 5) a comorbid diagnosis with autism spectrum disorder is now allowed; and 6) a symptom threshold change has been made for adults, to reflect their substantial evidence of clinically significant ADHD impairment, with the cutof for ADHD of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity. Finally, ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the DSM-5 decision to eliminate the DSM-IV chapter that includes all diagnoses usually first made in infancy, childhood, or adolescence.

Specific learning disorder combines the DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified. Because learning deficits in the areas of reading, written expression, and mathematics commonly occur together, coded specifers for the deficit types in each area are included. The text acknowledges that specific types of reading deficits are described internationally in various ways as dyslexia and specific types of mathematics deficits as dyscalculia.

Motor Disorders

The following motor disorders are included in the DSM-5 neurodevelopmental disorders chapter: developmental coordination disorder, stereotypic movement disorder, Tourette's disorder, persistent (chronic) motor or vocal tic disorder, provisional tic disorder, other specified tic disorder, and unspecified tic disorder. The tic criteria have been standardized across all of these disorders in this chapter. Stereotypic movement disorder has been more clearly differentiated from body-focused repetitive behavior disorders that are in the DSM-5 obsessive-compulsive disorder chapter.

O D

Two changes were made to DSM-IV Criterion A for schizophrenia. The first change is the elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing). In DSM-IV, only one such symptom was needed to meet the diagnostic requirement for Criterion A, æ t for†

removed due to the nonspecificity of Schneiderian symptoms and the poor reliability in distinguishing

B D

Bipolar Disorders

To enhance the accuracy of diagnosis and facilitate earlier detec t on in clinical se t ngs, Criterion A for manic and hypomanic episodes now includes an emphasis on changes in ac t vity and energy as well as mood. The DSM-IV diagnosis of bipolar I disorder, mixed episode, requiring that the individual simultaneously meet full criteria for both mania and major depressive episode, has been removed. Instead, a new speci f er, "with mixed features," has been added that can be applied to episodes of mania or hypomania when depressive features are present, and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present.

DSM-5 allows the speci f ca t on of par t cular condi t ons for other speci f ed bipolar and related disorder, including categoriza t on for individuals with a past history of a major depressive disorder who meet all criteria for hypomania except the dura t on criterion (i.e., at least 4 consecu t ve days). A second condi t on cons t tu t ng an other speci f ed bipolar and related disorder is that too few symptoms of hypomania are present to meet criteria for the full bipolar II syndrome, although the dura t on is su f cient at 4 or more days.

In the chapter on bipolar and related disorders and the chapter on depressive disorders, a speci f er for anxious distress is delineated. This speci f er is intended to iden t fy pa t ents with anxiety symptoms that are not part of the bipolar diagnos t c criteria.

D D

DSM-5 contains several new depressive disorders, including disrup t ve mood dysregula t on disorder and premenstrual dysphoric disorder. To address concerns about poten t al overdiagnosis and overtreatment of bipolar disorder in children, a new diagnosis, disrup t ve mood dysregula t on disorder, is included for children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol. Based on strong scien t f c evidence, premenstrual dysphoric disorder has been moved from DSM-IV Appendix B, "Criteria Sets and Axes Provided for Further Study," to the main body of DSM-5. Finally, DSM-5 conceptualizes chronic forms of depression in a somewhat modi f ed way. What was referred to as dysthymia in DSM-IV now falls under the category of persistent depressive disorder, which includes both chronic major depressive disorder and the previous dysthymic disorder. An inability to f nd scien t fcally meaningful di f erences between these two condi t ons led to their combina t on with speci f ers included to iden t fy di f erent pathways to the diagnosis and to provide con t nuity with DSM-IV.

Major Depressive Disorder

Neither the core criterion symptoms applied to the diagnosis of major depressive episode nor the requisite dura t on of at least 2 weeks has changed from DSM-IV. Criterion A for a major depressive episode in DSM-5 is iden t cal to that of DSM-IV, as is the requirement for clinically signi f cant distress or impairment in social, occupa t onal, or other important areas of life, although this is now listed as Criterion B rather than Criterion C. The coexistence within a major depressive episode of at least three manic symptoms (insu f cient to sa t sfy criteria for a manic episode) is now acknowledged by the speci f er "with mixed features." The presence of mixed features in an episode of major depressive disorder in-

creases the likelihood that the illness exists in a bipolar spectrum; however, if the individual concerned has never met criteria for a manic or hypomanic episode, the diagnosis of major depressive disorder is retained.

Bereavement Exclusion

In DSM-IV, there was an exclusion criterion for a major depressive episode that was applied to depressive symptoms lasting less than 2 months following the death of a loved one (i.e., the bereavement exclusion). This exclusion is omitted in DSM-5 for several reasons. The first is to remove the implication that bereavement typically lasts only 2 months when both phy [illegible]

or performing in front of an audience) appear to represent a distinct subset of social anxiety disorder in terms of etiology, age at onset, physiological response, and treatment response.

Although in DSM-IV, separation anxiety disorder was classified in the section "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence," it is now classified as an anxiety disorder. The core features remain mostly unchanged, although the wording of the criteria has been modified to more adequately represent the expression of separation anxiety symptoms in adulthood. For example, attachment figures may include the children of adults with separation anxiety disorder, and avoidance behavior is modified to

acts in response to preoccupations with perceived defects or flaws in physical appearance has been added, consistent with data indicating the prevalence and importance of this symptom. A "with muscle dysmorphia" specifier has been added to reflect a growing literature on the diagnostic validity and clinical utility of making this distinction in individuals with body dysmorphic disorder. The delusional variant of body dysmorphic disorder (which identifies individuals who are completely convinced that their perceived defects or flaws are truly abnormal appearing) is no longer coded as both delusional disorder, somatic type, and body dysmorphic disorder; in DSM-5 this presentation is designated only as body dysmorphic disorder with the absent insight/delusional beliefs specifier.

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

Trichotillomania was included in DSM-IV, although "hair-pulling disorder" has been added parenthetically to the disorder's name in DSM-5.

Excoriation (skin-picking) disorder is newly added to DSM-5, with strong evidence for its diagnostic validity and clinical utility.

DSM-IV included a specifier "with obsessive-compulsive symptoms" in the diagnoses of anxiety disorders due to a general medical condition and substance-induced anxiety disorders. Given that obsessive-compulsive and related disorders are now a distinct category, DSM-5 includes new categories for substance-/medication-induced obsessive-compulsive and related disorder and for obsessive-compulsive and related disorder due to another medical condition. This change is consistent with the intent of DSM-IV, and it reflects the recognition that substances, medications, and medical conditions can present with symptoms similar to primary obsessive-compulsive and related disorders.

DSM-5 includes the diagnoses other specified obsessive-compulsive and related disorder, which can include conditions such as body-focused repetitive behavior disorder and obsessional jealousy, or unspecified obsessive-compulsive and related disorder. Body-focused repetitive behavior disorder is characterized by recurrent behaviors other than hair pulling and skin picking (e.g., nail biting, lip biting, cheek chewing) and repeated attempts to decrease or stop the behaviors. Obsessional jealousy is characterized by nondelusional preoccupation with a partner's perceived infidelity.

tion about these conditions is currently available to document their clinical characteristics and validity or to provide definitive diagnostic criteria.

The DSM-IV criteria for pica and for rumination disorder have been revised for clarity and to indicate that the diagnoses can be made for individuals of any age.

DSM-IV feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder, and the criteria have been significantly expanded. The DSM-IV disorder was rarely used, and limited information is available on the characteristics, course, and outcome of children with this disorder. Additionally, a large number of individuals, primarily but not exclusively children and adolescents, substantially restrict their food intake and experience significant associated physiological or psychosocial problems but do not meet criteria for any DSM-IV eating disorder. Avoidant/restrictive food intake disorder is a broad category intended to capture this range of presentations.

The core diagnostic criteria for anorexia nervosa are conceptually unchanged from DSM-IV with one exception: the requirement for amenorrhea has been eliminated. In DSM-IV, this requirement was waived in a number of situations (e.g., for males, for females taking contraceptives). In addition, the clinical characteristics and course of females meeting all DSM-IV criteria for anorexia nervosa except amenorrhea closely resemble those of females meeting all DSM-IV criteria. As in DSM-IV, individuals with this disorder are required by Criterion A to be at a significantly low body weight for their developmental stage. The wording of the criterion has been changed for clarity, and guidance regarding how to judge whether an individual is at or below a significantly low weight is now provided in the text. In DSM-5, Criterion B is expanded to include not only overtly expressed fear of weight gain but also persistent behavior that interferes with weight gain.

The only change to the DSM-IV criteria for bulimia nervosa is a reduction in the required minimum average frequency of binge eating and inappropriate compensatory behavior frequency from twice to once weekly. The clinical characteristics and outcome of individuals meeting this slightly lower threshold are similar to those meeting the DSM-IV criterion.

Extensive research followed the promulgation of preliminary criteria for binge eating disorder in Appendix B of DSM-IV, and findings supported the clinical utility and validity of binge-eating disorder. The only significant difference Ŀ DS - 6 quency of b Ŀ . The

nosis, all of the DSM-5 sexual dysfunctions (except substance-/medication-induced sexual dysfunction) now require a minimum duration of approximately 6 months and more precise severity criteria. These changes provide useful thresholds for making a diagnosis and distinguish transient sexual difficulties from more persistent sexual dysfunction.

Genito-pelvic pain/penetration disorder is new in DSM-5 and represents a merging of the DSM-IV categories of vaginismus and dyspareunia, which were highly comorbid and difficult to distinguish. The diagnosis of sexual aversion disorder has been removed due to rare use and lack of supporting research.

DSM-IV included the following subtypes for all sexual disorders: lifelong versus acquired, generalized versus situational, and due to psychological factors versus due to combined factors. DSM-5 includes only lifelong versus acquired and generalized versus situational subtypes. Sexual dysfunction due to a general medical condition and the subtype due to psychological versus combined factors have been deleted due to findings that the most frequent clinical presentation is one in which both psychological and biological factors contribute. To indicate the presence and degree of medical and other nonmedical correlates, the following associated features are described in the accompanying text: partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, and medical factors.

G D

Gender dysphoria is a new diagnostic class in DSM-5 and reflects a change in conceptualization of the disorder's defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification per se, as was the case in DSM-IV gender identity disorder. In DSM-IV, the chapter "Sexual and Gender Identity Disorders" included three relatively disparate diagnostic classes: gender identity disorders, sexual dysfunctions, and paraphilias. Gender identity disorder, however, is neither a sexual dysfunction nor a paraphilia. Gender dysphoria is a unique condition in that it is a diagnosis made by mental health care providers, although a large proportion of the treatment is endocrinological and surgical (at least for some adolescents and most adults). In contrast to the dichotomized DSM-IV gender identity disorder diagnosis, the type and severity of gender dysphoria can be inferred from the number and type of indicators and from the severity measures.

The experienced gender incongruence and resulting gender dysphoria may take many forms. Gender dysphoria thus is considered to be a multicategor cat η as a dichot s, a T t ; r

an insistence that he or she is the other gender . . .)" is now necessary (but not sufficient), which makes the diagnosis more restrictive and conservative.

The subtyping on the basis of sexual orientation has been removed because the distinction is not considered clinically useful. A posttransition specifier has been added because many individuals, after transition, no longer meet criteria for gender dysphoria; however, they continue to undergo various treatments to facilitate life in the desired gender. Although the concept of posttransition is modeled on the concept of full or partial remission, the term remission has implications in terms of symptom reduction that do not apply directly to gender dysphoria.

specific criteria defining frequency needed to meet criteria and specifies that the aggressive outbursts are impulsive and/or anger based in nature, and must cause marked distress, cause impairment in occupational or interpersonal functioning, or be associated with negative financial or legal consequences. Furthermore, because of the paucity of research on this disorder in young children and the potential difficulty of distinguishing these outbursts from normal temper tantrums in young children, a minimum age of 6 years (or equivalent developmental level) is now required. Finally, especially for youth, the relationship of this disorder to other disorders (e.g., ADHD, disruptive mood dysregulation disorder) has been further clarified.

- A D

Gambling Disorder

An important departure from past diagnostic manuals is that the substance-related disorders chapter has been expanded to include gambling disorder. This change reflects the increasing and consistent evidence that some behaviors, such as gambling, activate the brain reward system with effects similar to those of drugs of abuse and that gambling disorder symptoms resemble substance use disorders to a certain extent.

Criteria and Terminology

DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Rather, criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant. The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5, and a new criterion, craving or a strong desire or urge to use a substance, has been added. In addition, the threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria, in contrast to a threshold of one or more criteria for a diagnosis of DSM-IV substance abuse and three or more for DSM-IV substance dependence. Cannabis withdrawal is new for DSM-5, as is caffeine withdrawal (which was in DSM-IV Appendix B, "Criteria Sets and Axes Provided for Further Study"). Of note, the criteria for DSM-5 tobacco use disorder are the same as those for other substance use disorders. By contrast, DSM-IV did not have a category for tobacco abuse, so the criteria in DSM-5 that are from DSM-IV abuse are new for tobacco in DSM-5. Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed: 2–3 criteria indicate a mild disorder; 4–5 criteria, a moderate disorder; and 6 or more, a severe disorder. The DSM-IV specifier for a physiological subtype has been eliminated in DSM-5, as has the DSM-IV diagnosis of polysubstance dependence. Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without criteria (except craving). Additional new DSM-5 specifiers include "in a controlled environment" and "on maintenance therapy" as the situation warrants.

N D

Delirium

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

The DSM-IV diagnoses of dementia and amnestic disorder are subsumed under the newly named entity

psychopathological. This change in viewpoint is reflected in the diagnostic criteria sets by the addition of the word disorder to all the paraphilias. Thus, for example, DSM-IV pedophilia has become DSM-5 pedophilic disorder.

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. For more information, go to www.

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