A PRACTICAL INTRODUCTION TO THE DSM-5:
IMPLEMENTING THE CHANGES IN CLINICAL PRACTICE

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**Introduction**

This introductory text provides professionals and professionals-in-training with a condensed but comprehensive primer to the DSM-5, with its primary goal to facilitate the transition from the DSM-IV to the new manual. Written for practicing clinicians, this text provides a clear and straightforward overview of the specific changes that are most relevant for those using it in outpatient mental health settings. More specifically, the author’s aim is to enable the reader to confidently pick up and competently use the DSM-5 manual after reading this text.

### Lay of the Land: Organization of This Text

This text is designed to provide a comprehensive orientation to the changes in the DSM-5. The chapter is organized as follows:

- **In a Nutshell**: Summarizes the most salient changes in the DSM-5 that impact practicing clinicians.
- **The Big Picture: DSM-5 in Context**: Provides a more philosophical understanding of the changes and the likely future direction of the DSM.
- **Overview of the Revision Process**: Provides a context for understanding how decisions for making changes were made.
- **Manual Organization and Cross-Diagnostic Changes**: Describes changes made throughout the manual and to the diagnosis process itself, such as changes to coding, diagnosis format, chapter reorganization, and dimensional assessment.
- **Changes to Specific Disorders**: Outlines key changes to specific diagnoses.
- **Section III Overview**: Reviews the contents of Section III, including new cross-cutting and severity assessments, cultural formulation, alternative personality disorder model, and conditions for further study.
• Critique: Summarizes several critiques of the DSM and diagnosis more generally.

• Getting Started: Outlines a four-step process of getting started with the new manual.

• Resources: Directs readers to additional online resources on the DSM-5.

In a Nutshell: The Least You Need to Know

The first edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was published in 1952. Since then, it has been the primary mental health diagnostic manual in the United States (APA, 2013). The newest edition, the DSM-5, includes the most comprehensive revisions to the manual since the third edition was released in 1980.

Some of the more significant changes in the DSM-5 include (APA, 2013):

• Elimination of the five-axis diagnosis system

• Inclusion of new ICD-10 diagnostic codes for use after October 2014

• Addition of new V/Z codes, many of which address issues formerly included Axis IV psychosocial and environmental stressors

• Reorganization of chapters to better reflect etiologies of disorders, which included integrating the former “Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence” chapter across the manual

• Better recognition of developmental life span issues related to specific disorders

• Inclusion of an optional cultural formulation interview as well as gender and cultural notes for individual diagnoses
- Consolidation of autistic disorder, Asperger’s disorder and pervasive developmental disorder into a single disorder, autism spectrum disorder, with varying levels of severity
- Restructuring substance use disorders into a single disorder with varying levels of severity
- Integration of emerging genetic and neuroimaging research findings to improve diagnosis, treatment, and research efforts
- Provision of optional cross-cutting symptom and symptom severity assessments to aid in diagnostic evaluation

The Big Picture: The DSM in Context

At a more fundamental and philosophical level, the DSM-5 represents the initial efforts as a shift away from identifying discrete categories of mental disorders, for which there is less supportive evidence, and a move toward a dimensional approach to diagnosis that recognizes heterogeneity of symptoms within and across disorders (APA, 2013). The DSM-5 task force recognized that there is insufficient science to propose alternative definitions for most disorders at this time. However, the new structure of the manual is designed to serve as a bridge between the historic categorical approach to diagnosis to the more likely future version with a dimensional approach, which will better account for the wide variation and forms that mental health disorders can take (see the Critique on page 69).

Making of the Manual: Overview of the Revision Process

More so than prior editions, the revisions of the DSM-5 represent a collaborative and inclusive process. For this edition, the American Psychiatric Association (APA) worked closely with the United States National Institutes of Health (NIH) and World
Health Organization (WHO). A concerted effort was made to harmonize the changes to the DSM-5 and the diagnostic manual, the ICD (see page 16), published by WHO; the ICD-11 is expected for publication in 2015. In total, the revision process took 14 years and cost the APA alone close to $25 million.

### International Effort

Given the involvement of the WHO as well as an increasing recognition of culture in mental health, significant effort was focused on making the diagnostic categories more relevant across cultures. To this end, over 500 professionals from 39 countries were involved. Each work group (the groups that developed the language for the diagnostic criteria) had two co-chairs: one from the U.S. and one non-U.S. In addition, 30% of each appointed work group were international professionals. Although certain cross-cultural differences could not be fully reconciled—such as some countries whose professionals do not report post-traumatic stress disorder in its population—the task force and work groups attempted to remove diagnostic criterion that were not relevant across cultures and address cultural issues where appropriate in the supporting text of each diagnosis (Regier & Kupfer, 2013).

### Public Process

New technologies allowed the task force to solicit feedback from a wide range of stakeholders, including the general public, consumers of mental health and their families, and other mental health professionals. The www.DSM5.org website was used to collect several rounds of feedback from the public. In addition, field trials of the new diagnostic categories were conducted in outpatient, hospital, and educational settings with different populations (child, older adults, etc.) with a wide range of participating clinicians,
including counselors, family therapists, psychologists, social workers, and psychiatric nurses (APA, 2012). The open process generated significant public and media interest, which was also used to inform the revisions. In some cases, interested parties registered their approval, such as the World Professional Association of Transgender Health writing an article endorsing the new Gender Dysphoria diagnosis and chapter (De Cuypere, Knudson & Bockting, 2011). In other situations, stakeholders registered their concerns to proposed changes, such as removing the bereavement exclusion for major depressive disorder (Parker, 2013). Much of this review process is documented on the www.DSM5.org website, which includes the proceedings from planning conferences as well as responses to critiques from third-party stakeholders.

### Guiding Principles

When issuing the charge to the work groups that were responsible for drafting the changes, the following guiding principles were issued (APA, 2012):

- **Clinical Utility**: The first priority for changes was that they have clinical utility, being relevant to the assessment, diagnosis, and treatment of mental health issues. For example, the two former subtypes of reactive attachment disorder were separated to promote clinical utility: although they have the same general cause, they have separate and distinct prognoses and treatments; having separate diagnoses thus helps clinicians in making this practical distinction (Regier & Kupfer, 2013).

- **Evidence-based Recommendations**: The other most significant guiding principle was that proposed changes have sufficient and meaningful evidence to support them. For example, the reorganization of chapters is largely driven by emerging
neuroscience, which provides evidence that certain disorders share genetic markers, neurological processes, and/or etiologies.

- **Continuity**: Wherever possible, the work groups were asked to maintain continuity with the previous edition, DSM-IV.

- **No Pre-Determined Constraints**: While continuity was a guiding principle, the work groups were given no pre-determined constraints on changes from DSM-IV; thus, if a significant change was supported by the evidence and/or clinical utility, the work groups were free to recommend such changes.

In addition to these guiding principles, the work groups were given the following general directives (APA, 2012):

- Clarify boundaries between disorders
- Clarify boundaries between disorders and normal functioning
- Consider “cross-cutting” symptoms (symptoms that may occur across several disorders, such as insomnia or anxiety)
- Demonstrate the strength of research for the recommendations
- Reduce “Not Otherwise Specified” diagnoses
- Identify better “treatment targets” (measurable criteria that can be used for measuring progress)
- Identifying the most useful symptoms to target for treatment

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**DSM-5 Development Process and Timeline**

The development and writing of the DSM-5 was a nearly 14-year process that began by identifying the task at hand in 1999 (APA, 2012). The process began with white papers (authoritative reports on a subject) that identified diagnostic issues related to
research, age, gender, and culture. Then, the APA, NIH, and WHO hosted global conferences with top academics, researchers, and clinicians from around the world to examine the state-of-the-science as well as current clinical issues. For those who want to learn more, most of these papers and conference proceedings are available online at www.DSM5.org.

Between 2006 and 2008, the task force (primary group overseeing the entire revisions), work groups (groups drafting diagnostic criteria), and eventually study groups (groups appointed to investigate special topics such as cross-cutting symptoms) were appointed. The first drafts of the criteria were written between 2008 and 2010 based on extensive literature reviews, data analysis, and professional feedback. These initial sets of criteria were then used in field trials in different psychiatric contexts, such as research hospitals, outpatient clinics, and private group practice. In addition to psychiatrists, a broad range of mental health professionals, such as professional counselors, family therapists, psychologists, and social workers, were also recruited to take part in the field trials. In addition, public and consumer opinions were solicited via the Internet. In 2011 and 2012, the work groups and task force worked on drafting the full text drafts for the manual, which were revised based on data from the field trials and then again submitted for public review. The task force finalized the changes in December 2012, and the final text was published in May 2013.

**DSM-5 Development Timeline**

1999–2007: Pre-planning white papers, including papers on  
a) research agenda,  
b) age and gender, and  
c) culture and spiritual issues  

2004–2007: Global planning conferences (sponsored by APA, NIH, and WHO)
2006–2008: Chairs, task force, work groups and study groups appointed

2008–2010: Work and study groups drafted criteria; solicited feedback from professionals and public

April 2010–December 2011: Field trial testing
- Large, academic medical centers with specific populations
- Field trial testing in Routine Clinical Practices (RCPs)
- Volunteer sample of clinicians, consisting of MDs, Psychs, LCSW, LPCs, LMFTs, and psychiatric nurses

March 2011–November 2012: Drafting complete text for DSM-5

Spring 2012: Final round of public feedback

March–December 2012: Final Revisions by APA Task Force to Board of Trustees

May 18–22, 2013: Text release

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**Manual Organization and Cross-Diagnosis Changes**

One of the first changes you may notice is a change to the shortened title: *DSM-5* (note that using a hyphen is the correct format). The APA decided to stop using the Roman numeral system (DSM-V is considered incorrect) and switch to Arabic numerals to more easily allow for multiple text revisions in the years ahead. Digital technologies will enable updated publication of a DSM-5.1 and DSM-5.2, etc. Given expected changes, such as new diagnosis codes with the ICD-11 due out in 2015 (*see ICD section, page 16*), more frequent text revisions may be particularly important in the future.
 Unlike the DSM-IV, there are three major sections of the DSM-5 in addition to the appendices:

- **Section I: DSM-5 Basics**
  - History of the manual
  - Use of the manual and cautionary statements
  - Definition of a mental disorder

- **Section II: Diagnostic Criteria and Codes**
  - 20 chapters that describe recognized disorders

- **Section III: Emerging measures and models**
  - Emerging assessment measures
  - Cultural formulation
  - Alternative DSM-5 model for personality disorders
  - Conditions for further study

- **Appendices**
  - Highlights of changes
  - Glossaries of technical terms and cultural concepts of distress
  - Various listings of the disorders and codes

**Definition of Mental Disorder**

The definition of a “mental disorder” was clarified and modified in the DSM-5 (APA, 2013). The revised definition emphasizes that the diagnosis of a mental disorder should have clinical utility. However, the diagnosis of a mental disorder “is not equivalent to a need for treatment” (APA, 2013, p. 20); conversely, a person may not
meet the full criteria for a disorder yet their situation warrants treatment. In addition, the revision includes the assumption that a mental disorder represents some form of underlying dysfunction, reflected in the new chapter arrangements based on etiology. The definition also emphasizes that mental disorders are typically associated with distress or disability and that they should be distinguished from culturally approved responses to common stressors, such as loss of a loved one. Furthermore, for the purposes of legal and criminal situations, a mental disorder should not be used to describe conflicts between the individual and society unless it also involves dysfunction in the individual.

**DSM-5 Definition of a Mental Disorder**

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

(APA, 2013, p. 20)

**Reorganization of Diagnostic Chapters**

For those familiar with the DSM-IV, one of the most notable changes in the DSM-5 is the reorganization of chapters in the new Section II. The chapters have been
reorganized to more closely group disorders by known etiologies, underlying vulnerabilities, symptom characteristics, and shared environmental factors. The intention behind this reorganization is to facilitate more comprehensive diagnostic and treatment approaches as well as facilitate research across related disorders (APA, 2013).

Of particular note, the DSM-IV chapter “Disorders Usually Diagnosed in Infancy, Childhood, and Adolescents” was removed, and these disorders have been placed into other chapters based on common causes. Each DSM-5 chapter is organized developmentally, with those occurring in childhood towards the front of the chapter and those associated with later life towards the end.

DSM-5 Chapters Describing Mental Disorders (Section II)

1. Neurodevelopmental Disorders
2. Schizophrenia Spectrum and Other Psychotic Disorders
3. Bipolar and Related Disorders
4. Depressive Disorders
5. Anxiety Disorders
6. Obsessive-Compulsive and Related Disorders
7. Trauma- and Stressor-Related Disorders
8. Dissociative Disorders
9. Somatic Symptom Disorders
10. Feeding and Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse-Control and Conduct Disorders
16. Substance-Related and Addictive Disorders
17. Neurocognitive Disorders
18. Personality Disorders
19. Paraphilic Disorders
20. Other Conditions that May be the Focus of Clinical Attention

Note: Similar to the DSM-IV, the DSM-5 does not include chapter numbers; the above numbers are added to facilitate learning and answer the natural question: how many chapters is that?

### Diagnostic Code Changes and the ICD

The five-digit coding system most mental health practitioners are familiar with from the DSM-IV is derived from another set of diagnostic codes, those published in the *International Statistical Classification of Diseases and Related Health Problems* (ICD). Published by the WHO, the ICD is the most widely used set of diagnostic codes and like DSM attempts to statistically classify health disorders. It is used internationally by virtually all physical health practitioners and is used in most other countries for mental health diagnosis as well. The codes in the DSM-IV correlated to the ICD-9 (the ninth edition). These same codes are included in the DSM-5.

However, in October 2014, the United States is scheduled to finally adopt ICD-10 codes, which have been used in other countries since 1994 (the ICD-10 was released by WHO in 1990). The U.S. has delayed implementation of ICD-10 codes due to the bureaucratic complexity and expense of the task in such a large health care system. The
ICD-10 codes will be different; they will be alphanumeric codes. These codes are included in the DSM-5 in parentheses and grey text next to the old ICD-9 codes. Of particular note, the current “V-codes” will become Z and T codes in the ICD-10 system (see table below).

To complicate matters further, during the revision of the DSM-5, the WHO worked with the APA to correlate DSM-5 and ICD-11 codes and criteria for mental illness. The ICD-11 is due out in 2015; however, it may be awhile until the ICD-11 codes are implemented in the U.S. The ICD-11 codes are expected to be longer alphanumeric codes than those in the ICD-10 to allow for a greater number of diagnostic codes, which is a significant issue for the medical health professions.

<table>
<thead>
<tr>
<th>Diagnostic Code Format</th>
<th>ICD-9 (until 10/14)</th>
<th>ICD-10 (after 10/14)</th>
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</thead>
<tbody>
<tr>
<td>Sample Diagnosis: Major Depression, Recurrent, Severe</td>
<td>296.33</td>
<td>F33.2</td>
</tr>
<tr>
<td>Sample Diagnosis: Disruption of Family by Separation or Divorce</td>
<td>V61.03</td>
<td>Z63.5</td>
</tr>
</tbody>
</table>

**New Diagnosis Format**

The five axis-system used in the DSM-IV was removed from the DSM-5 and a non-axial (i.e., single line) system is used instead (APA, 2013). The non-axial diagnosis approach was identified as an option in the DSM-IV-TR, however, most clinicians and third-party payers used the five-axis approach. In the non-axial system, diagnoses from the former Axis I (mental health diagnosis), Axis II (personality disorders and mental
retardation), and Axis III (physical health issues affecting mental health) are simply listed out, generally on a single line or set of lines. In addition, former Axis IV issues (psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis) are recorded similarly to other diagnoses using ICD-9 “V codes” or ICD-10 “Z codes.” The former Axis V (global assessment of functioning score (GAF)) has been removed. Although no required replacement for the GAF was identified, the WHO Disability Assessment Schedule (WHODAS) is included in Section III of the DSM-5 as an optional global measure of disability (APA, 2013). As in the former diagnosis system, the principal diagnosis or reason for visit should be listed first.

**Summary of Changes to the Diagnosis Format**

<table>
<thead>
<tr>
<th>DSM-IV Five-Axis System</th>
<th>DSM-5 Equivalent</th>
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</thead>
<tbody>
<tr>
<td>Axis I: Mental Health Disorders</td>
<td>Record on diagnosis line (primary reason for visit listed first)</td>
</tr>
<tr>
<td>Axis II: Personality Disorders and Mental Retardation</td>
<td>Record on diagnosis line (primary reason for visit listed first)</td>
</tr>
<tr>
<td>Axis III: General Medical Conditions</td>
<td>Record on diagnosis line (especially those important to understanding mental disorder)</td>
</tr>
<tr>
<td>Axis IV: Psychosocial and Environmental Problems</td>
<td>Record on diagnosis line using V, Z, or T codes from chapter on “Other Conditions that May be the Focus of Clinical Attention”</td>
</tr>
<tr>
<td>Axis V: Global Assessment of Functioning</td>
<td>Optional use of WHODAS scale</td>
</tr>
</tbody>
</table>
The formatting of a DSM-5 diagnosis is simpler than the former five-axis diagnosis. In most cases, third-party payers, such as insurance companies, will provide several numbered lines; these do not correlate to axes but rather are a prompt to write one diagnosis per line. The diagnostic code generally goes first and then the name of the diagnosis followed by any specifiers (see Specifiers section, page 20).

Insurance Company/Third Party Prompt:

Diagnosis(ses)
1. 
2. 
3. 
4. 

The diagnosis is written as follows:

DSM-5 Diagnosis Format Sample (ICD-9 Codes)
1. 296.32 Major depressive disorder, recurrent, moderate, with mild anxious distress
2. 309.81 Post-traumatic stress disorder, with delayed onset
3. V60.1 Inadequate housing
4. V60.2 Extreme poverty

After October 2014 when the ICD-10 codes are adopted the above diagnosis will read as follows:

DSM-5 Diagnosis Format Sample (ICD-10 Codes)
5. F33.1 Major depressive disorder, recurrent, moderate, with mild anxious distress
6. F43.10 Post-traumatic stress disorder, with delayed onset
7. Z59.1 Inadequate housing
8. Z59.5 Extreme poverty
Subtypes and Specifiers

The DSM-5 includes several new subtypes and specifiers. Subtypes identify mutually exclusive subgroups within the diagnostic category, whereas specifiers are more general. All subtypes are diagnosis-specific and many are described below with individual diagnoses. Similarly, many specifiers are used with only specific diagnoses; however, several new specifiers are used across several or all diagnoses in the manual. These specifiers are used to note information about a person’s condition that may be useful for treatment decisions, often alerting clinicians to additional symptoms or qualities of symptoms that need specific attention in treatment planning. When adding a specifier, the diagnostic code does not change; however, the specifier is written after the name of the diagnosis on the diagnosis line (see diagnosis examples on page 19).

Cross-Diagnostic Specifiers

- With catatonia (for neurodevelopmental, psychotic, mood, etc.)
- With anxious distress (depression and bipolar disorders; see example on page 19)
- With panic attacks (all disorders)
- With poor insight (OCD and certain anxiety disorders)
- With mixed features (bipolar and mood disorders)
- In remission or partial remission

In addition, many of the specific diagnoses have new specifiers, such as “with limited prosocial emotions” for conduct disorder (APA, 2013). The new manual clearly lists these condition-specific specifiers after diagnostic criterion, making it easy to identify and include the specifiers.
**Dimensional Assessment**

Emerging research supports a more dimensional approach (variation of intensity on a given symptom or dimension) to mental health diagnosis in contrast to its historical categorical approach (narrow and discrete categories; APA, 2013). Current research is not sufficiently developed to warrant a radical reorganizing of the manual using dimensional approach throughout research; however, in the years ahead, the DSM is likely to move in this direction. Nonetheless, the current DSM takes steps in this direction by organizing chapters by etiology and by separating internalizing from externalizing disorders (APA, 2013). In addition, for certain diagnoses where there was sufficient evidence to support the change, dimensional assessments—such as mild, moderate, and severe—were introduced rather than retaining separate and discrete categories to indicate levels of severity. Among the diagnoses that use dimension assessment in the DSM-5 are:

- Mood disorders (from DSM-IV)
- Substance-related disorders
- Autism spectrum disorder
- Intellectual disability (formerly mental retardation)
- Schizophrenia
- Oppositional defiant

These dimensional assessments are intended to help clinicians assess severity and simplify tracking progress during treatment.

**NOS vs. NEC Diagnosis**

Due to their overuse and lack of clinical utility, the NOS (not otherwise specified) diagnoses of the DSM-IV have been replaced in the DSM-5 with Not-Elsewhere-
Classified (NEC) diagnoses, which may be an “other specified disorder” or an “unspecified disorder.”

**Other Specified Disorder**

The other specified disorder diagnosis allows the clinician to document the specific reason a particular client does not meet the criteria for a specific disorder (APA, 2013). This is done by recording the name of the diagnostic category followed by the specific reason the person does not meet the criteria. The text lists common examples of how to write the “other specified disorder” for a given diagnosis. For example, in the chapter on depression, three examples of “other specified” are given:

- Recurrent brief depression
- Short-duration depressive episode (4-13 days)
- Depressive episode with insufficient symptoms (APA, 2013, p. 183)

Thus, if a client has depressive symptoms for several weeks but does not meet the diagnostic threshold the diagnosis would read: “311. Other specified depressive disorder, depressive episode with insufficient symptoms.”

**Unspecified Disorders**

When the clinician cannot specify or chooses not to specify the characteristics of the disorder, then the “unspecified disorder” can be used. This is used when a client experiences significant clinical distress but does not meet the criteria for the disorder. This can be used when there is insufficient information, such as emergency rooms, to make a full diagnosis. An example of this diagnosis would read: “311. Unspecified depressive disorder.”
Overview of Changes to Specific Disorders

Total Number of Diagnoses

Compared to the DSM-IV, the DSM-5 has 15 fewer specific (non-NOS) diagnoses (Regier & Kupfer, 2013):

- DSM-IV: 172 disorders
- DSM-5: 157 disorders

New Disorders

The DSM-5 has a total of 15 new disorders (Regier & Kupfer, 2013):

1. Social (Pragmatic) Communication Disorder
2. Disruptive Mood Dysregulation Disorder
3. Premenstrual Dysphoric Disorder (formerly in DSM-IV appendix)
4. Hoarding Disorder
5. Excoriation (Skin-Picking) Disorder
6. Disinhibited Social Engagement Disorder (split from Reactive Attachment Disorder)
7. Binge Eating Disorder (formerly in DSM-IV appendix)
8. Central Sleep Apnea (split from Breathing-Related Sleep Disorder)
9. Sleep-Related Hypoventilation (split from Breathing-Related Sleep Disorder)
10. Rapid Eye Movement Sleep Behavior Disorder (Parasomnia NOS)
11. Restless Legs Syndrome (Dyssomnia NOS)
12. Caffeine Withdrawal
13. Cannabis Withdrawal
14. Major Neurocognitive Disorder with Lewy Bodies (Dementia Due to Other Medical Conditions)

15. Mild Neurocognitive Disorder

**Disorders Eliminated Entirely**

The DSM-5 eliminated only two disorders in their entirety (i.e., without combining with another disorder to account for a similar set of symptoms; Regier & Kupfer, 2013):

1. Sexual Aversion Disorder
2. Polysubstance-Related Disorder

**Combined Disorders**

In several cases, the DSM-5 revisions involved combining several separate disorders under a new single diagnosis, often with subtypes. This was generally done based on scientific and neurological evidence that the former separate disorders are better understood as varying severity of the same disorder. These changes resulted in a total of 28 fewer diagnoses (Regier & Kupfer, 2013).

1. Language Disorder (Combines Expressive Language Disorder & Mixed Receptive Expressive Language Disorder)
2. Autism Spectrum Disorder (Combines Autistic Disorder, Asperger’s Disorder, Childhood Disintegrative Disorder, & Rett’s Disorder—Pervasive Development Disorder NOS)
3. Specific Learning Disorder (Combines Reading Disorder, Math Disorder, & Disorder of Written Expression)
4. Delusional Disorder (Combines Shared Psychotic Disorder & Delusional Disorder)
5. Panic Disorder (Combines Panic Disorder Without Agoraphobia & Panic Disorder With Agoraphobia)
6. Dissociative Amnesia (Combines Dissociative Fugue & Dissociative Amnesia)
7. Somatic Symptom Disorder (Combines Somatization Disorder, Undifferentiated Somatoform Disorder, & Pain Disorder)
8. Insomnia Disorder (Combines Primary Insomnia & Insomnia Related to Another Mental Disorder)
9. Hypersomnolence Disorder (Combines Primary Hypersomnia & Hypersomnia Related to Another Mental Disorder)
10. Non-Rapid Eye Movement Sleep Arousal Disorders (Combines Sleepwalking Disorder & Sleep Terror Disorder)
11. Genito-Pelvic Pain/Penetration Disorder (Combines Vaginismus & Dyspareunia)
12. Alcohol Use Disorder (Combines Alcohol Abuse & Alcohol Dependence)
13. Cannabis Use Disorder (Combines Cannabis Abuse & Cannabis Dependence)
14. Phencyclidine Use Disorder (Combines Phencyclidine Abuse & Phencyclidine Dependence)
15. Other Hallucinogen Use Disorder (Combines Hallucinogen Abuse & Hallucinogen Dependence)
16. Inhalant Use Disorder (Combines Inhalant Abuse & Inhalant Dependence)
17. Opioid Use Disorder (Combines Opioid Abuse & Opioid Dependence)
18. Sedative, Hypnotic, or Anxiolytic Use Disorder (Combines Sedative, Hypnotic, or Anxiolytic Abuse & Sedative, Hypnotic, or Anxiolytic Dependence)
19. Stimulant Use Disorder (Combines Amphetamine Abuse, Amphetamine Dependence, Cocaine Abuse, & Cocaine Dependence)

20. Stimulant Intoxication (Combines Amphetamine Intoxication & Cocaine Intoxication)

21. Stimulant Withdrawal (Combines Amphetamine Withdrawal & Cocaine Withdrawal)

22. Substance/Medication-Induced Disorders (Aggregate of Mood, Anxiety, & Neurocognitive)

NOS and NEC

Replacing Not Otherwise Specified (NOS) diagnoses with Not Elsewhere Classified (NEC) diagnoses resulted in a net gain of 24 new diagnoses (Regier & Kupfer, 2013).

- DSM-IV: 41 NOS disorders
- DSM-5: 65 NEC disorders

Changes to Specific Diagnoses

The following section reviews the changes made to specific diagnoses. Virtually all diagnostic criteria were revised to some degree, sometimes only simple text revisions for clarity. Other diagnoses had more significant revisions to their criteria. The following list, based on the highlights of changes in the appendix of the DSM-5 (APA, 2013) as well as related trainings (Reiger & Kupfer, 2013), is designed to orient the reader to the more significant changes made to individual disorder criteria.
Neurodevelopmental Disorders

**Intellectual Disability (Intellectual Developmental Disorder)**

- This diagnosis was formerly “mental retardation”
  - Intellectual disability is the currently preferred term
  - Intellectual developmental disorder is the likely future term in ICD-11 and thus is included in the DSM-5 in parentheses
- Diagnosis requires assessment of both IQ and adaptive functioning
  - Instead of IQ, severity (mild, moderate, severe) determined by *adaptive functioning*

**Communication Disorders**

- These disorders include:
  - Expressive and mixed receptive-expressive language disorder
  - Speech sound disorder (replaces phonological disorder)
  - Childhood-onset fluency disorder (replaces stuttering)
  - Social (pragmatic) communication disorder, a new disorder for social difficulties in verbal and nonverbal communication
    - Due to overlapping symptoms, social communication disorder *cannot* be diagnosed with autism spectrum disorder

**Autism Spectrum Disorder (ASD)**

- New DSM-5 disorder
  - Based on general scientific agreement that the following previously separate disorders are actually a single condition with varying levels of severity
  - Autistic disorder (autism)
- Asperger’s disorder
- Childhood disintegrative disorder
- Pervasive developmental disorder not otherwise specified

- ASD is characterized by both of the following:
  1. Deficits in social communication and interaction **AND**
  2. Restricted repetitive behaviors, interests, and activities

  - *Note: social communication disorder is diagnosed if no repetitive behaviors, interests, or activities are found*

- The criterion of "clinically significant impairment" has been added

**Attention-Deficit/Hyperactivity Disorder (ADHD)**

- Same 18 symptoms as in DSM-IV
  - Still divided into two symptom domains: inattention and hyperactivity/impulsivity

- Changes to criteria include:
  1. Increased cross-situational requirement to “several” symptoms per setting
  2. Increased age of onset criterion from age 7 to 12
  3. Lowered symptom threshold for adults from 6 to 5 symptoms
  4. Specifiers replace former subtypes; specifiers correlate directly with the prior subtypes
  5. Comorbid diagnosis with autism spectrum disorder now allowed
  6. Added examples to improve diagnosis across the life span
  7. ADHD included in the neurodevelopmental disorders chapter based on evidence base
Specific Learning Disorder

- This single new diagnosis combines the following DSM-IV diagnoses:
  - Reading disorder
  - Mathematics disorder
  - Disorder of written expression
  - Learning disorder not otherwise specified
- Specifiers with codes are included for each deficit type
- Specific exclusionary cases prohibit the use of the diagnosis in situations involving intellectual disabilities, uncorrected vision, psychosocial adversity, inadequate educational instruction or lack of proficiency in language of academic instruction

Motor Disorders

- Disorders include:
  - Developmental coordination disorder
  - Stereotypic movement disorder
  - Tourette’s disorder
  - Persistent (chronic) motor or vocal tic disorder
  - Provisional tic disorder
  - Other specified tic disorder
  - Unspecified tic disorder
Schizophrenia

- Two primary changes were made to diagnostic criteria:
  - Increased to two Criterion A symptoms required, removing the special attribution that required only one symptom if bizarre delusions or Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing) were present
  - At least one of three core “positive symptoms” is required
    1. Delusions
    2. Hallucinations
    3. Disorganized speech
- Schizophrenia subtypes
  - Removed former subtypes (paranoid, disorganized, catatonic, undifferentiated, and residual types) due to low reliability and poor validity
  - Added specifier "with catatonia"
- Dimensional approach
  - Added ratings of mild, moderate, severe
  - Section III includes a severity rating scale to assist in the diagnosis

Schizoaffective Disorder

- Primary change: Major mood episode must be present for a majority of the disorder’s total duration
- Re-conceptualized as a longitudinal disorder instead of a cross-sectional diagnosis
  - Change made to improve the reliability and diagnostic stability
Delusional Disorder

- Removed requirement that delusions be non-bizarre for this diagnosis
  - Specifier added for bizarre delusions
- Added new exclusions: Must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorders
- DSM-5 does not separate shared delusional disorder from delusional disorder

Catatonia

- Same criteria used across disorders (psychotic, bipolar, depressive, or other medical disorder, or an unidentified medical condition)
- All contexts now require three or more of the twelve catatonic symptoms
- Catatonia can be diagnosed in one of three ways:
  - Separate diagnosis in the context of another medical condition
  - Specifier for depressive, bipolar, and psychotic disorders
  - Other specified diagnosis

Bipolar and Related Disorders

Bipolar Disorders

- Added “increased energy/activity” as a core symptom to Hypomanic and Manic Episode
- New specifier added: “with mixed features”
  - Does not require the person simultaneously meet full criteria of both mania and depressive episode
  - Instead, “with mixed features” requires some symptoms of each are simultaneously present
“With Anxious Distress” Specifier

- Used to identify clients with clinically relevant anxiety symptoms associated with but not actually part of bipolar or depressive disorders
- Includes specific criteria to further specify whether anxiety is mild, moderate, moderate-severe, or severe (APA, 2013, p. 149)

Depressive Disorders

New Depressive Disorders

- Disruptive mood dysregulation disorder
  - Diagnosis only for children under 18 years
  - Requires exhibiting persistent irritability and frequent episodes of extreme behavioral dyscontrol
  - Added to addresses concerns of over-diagnosis of bipolar disorder in children
- Premenstrual dysphoric disorder
  - Based on strong scientific evidence
  - Moved from topic of further study to main body of DSM
- Persistent depressive disorder
  - Includes both chronic major depressive disorder and the previous dysthymic disorder
  - Emphasizes chronicity rather than severity and allows for presence of major depressive episode
  - Several specifiers part of the diagnosis, including whether dysthymic only or with major depressive episodes
Major Depressive Disorder

- Core criteria are essentially the same
- New specifier added: “with mixed features”
  - Requires depressive episode with at least three manic symptoms
  - Specifier allows clinician to note that a patient’s depression is on bipolar spectrum; however, if full criteria not/never met for hypomanic/manic episode, major depressive disorder is diagnosed with “mixed features” specifier
- The bereavement exclusion removed for the following reasons:
  - Research shows bereavement can trigger depressive episode in the first two months and that such episodes of depression do not end spontaneously because of trigger
  - The exclusion could imply bereavement lasts only two months; duration is more commonly 1–2 years
  - The removal of the exclusion recognizes bereavement can trigger major depressive episode, including risk for suicidal ideation
- Major depressive diagnosis for those experiencing bereavement should be used sparingly
  - Most people experience bereavement without major depressive episode
  - An extensive footnote is provided to make differential diagnosis (APA, 2013, p. 161)

Specifier “With anxious distress”

- Added specifier (see bipolar section, page 31)
Anxiety Disorders

Anxiety Disorders

- Anxiety disorder chapter no longer includes:
  - Obsessive-compulsive disorder
  - Posttraumatic stress and acute stress disorder

- Chapter now includes:
  - Selective mutism
  - Separation anxiety disorder

Agoraphobia, Specific Phobia, and Social Anxiety Disorder (Social Phobia)

- Removed requirement that adults recognize that anxiety is excessive or unreasonable
  - Instead, the anxiety must be “out of proportion to the actual danger or threat” (APA, 2013, p. 197) given cultural context

- Duration of 6 months now required for adults and children
  - To reduce overdiagnosis

Panic Disorder and Agoraphobia

- Panic disorder and agoraphobia disaggregated
  - If they co-occur, each is coded separately
  - Change based on significant number of patients with agoraphobia who do not have panic

Panic Disorder

- Essential features unchanged
  - Chills/Heat sensations added as a characteristic of panic
• “Panic attack” can be listed as a specifier with all DSM-5 disorders

Agoraphobia

• Based on DSM-IV criteria for agoraphobia
  
  o Fears from two or more agoraphobia situations now required to distinguish from other phobias

• Criteria in general revised to be consistent with other anxiety disorders (e.g., fears out of proportion to the actual danger, duration of 6 months or more, etc.)

Specific Phobia

• Minor changes to core features
  
  o Removed requirement that adults recognize that anxiety is excessive or unreasonable
  
  o Added 6 month duration requirement for all ages

• Specifiers added for different types of phobias

Social Anxiety Disorder (Social Phobia)

• Essential features remain the same
  
  o Removed requirement that adults recognize that anxiety is excessive or unreasonable
  
  o Added 6 month duration requirement for all ages

• Specifiers
  
  o Removed “generalized” specifier and replaced with a “performance only” specifier

Separation Anxiety Disorder

• Core features remain the same
• Wording changed to apply to adults
• Age of onset no longer specified
• Added criterion: symptoms lasting 6 months or more to durational criteria

Selective Mutism
• Core features remain the same
• Moved to Anxiety Disorder section
  o Most children with selective mutism are anxious

---

Obsessive-Compulsive and Related Disorders

Obsessive-Compulsive and Related Disorders
• Separate, new chapter based on research that indicates these disorders are related
• New disorders in this chapter include:
  1. Hoarding disorder
  2. Excoriation (skin-picking) disorder
  3. Substance-/medication-induced obsessive-compulsive and related disorder
  4. Obsessive-compulsive and related disorder due to another medical condition

Specifiers for Obsessive-Compulsive and Related Disorders
• “With poor insight” specifier
  o Distinguishes between those with
    ▪ good or fair insight (recognizes fears unreasonable)
    ▪ poor insight (considers beliefs probably true)
    ▪ absent insight/delusional obsessive-compulsive disorder beliefs
      (convinced of beliefs)
Change clarifies that if delusional beliefs are only related to only obsessive-compulsive disorder (OCD) behaviors, OCD is proper diagnosis rather than schizophrenia or other psychotic disorder.

- Parallel “insight” specifiers added for body dysmorphic disorder and hoarding disorder
- “Tic-related” specifier
  - Used to identify clients with a current or past comorbid tic disorder
  - Comorbidity may have important implications for treatment

**Body Dysmorphic Disorder**

- Added criterion for repetitive behaviors or mental acts in response to appearance concerns
- Added specifier: “with muscle dysmorphia”
  - Based on growing literature on the diagnostic importance and clinical utility of this distinction
- Specifiers for insight include:
  - Good/fair insight (recognizes fears unreasonable)
  - Poor insight (considers dysmorphic beliefs probably true)
  - Absent insight/delusional (convinced of dysmorphic beliefs)
- Delusional variant
  - No longer coded as delusional disorder, somatic type, AND body dysmorphic disorder
  - Instead, it is body dysmorphic disorder with the absent insight/delusional beliefs specifier
Hoarding Disorder

- New diagnosis in DSM-5 based on current data:
  - Research does not support hoarding as variant of obsessive-compulsive disorder
  - Evidence supports validity and clinical utility of unique and separate diagnosis
- Essential criterion:
  - “Persistent difficulty discarding or parting with possessions…due to a perceived need to save the items and distress associated with discarding them” (APA, 2013, p. 247)

Trichotillomania

- Trichotillomania (Hair-Pulling Disorder)
  - Trichotillomania in DSM-IV was an impulse control disorder
  - “Hair-pulling disorder” added parenthetically to disorder’s name

Excoriation

- Excoriation (Skin-Picking Disorder)
  - Newly added based on evidence for its diagnostic validity and clinical utility

Substance/Medication-Induced Obsessive-Compulsive and Related Disorder & Obsessive-Compulsive and Related Disorder Due to Another Medical Condition

- Specifier added: “with obsessive-compulsive symptoms”
  - Used for anxiety disorders due to a general medical condition and substance-induced anxiety disorders
Acknowledges that that substances, medications, and medical conditions can include symptoms similar to obsessive-compulsive and related disorders

**Other Specified and Unspecified Obsessive-Compulsive and Related Disorders**

Several “other specified” disorders are included for this chapter:

- Body dysmorphic-like disorder with actual flaws
  - Similar to body dysmorphic disorder but person has actual and very noticeable physical flaws and is overly preoccupied with them to the point of significant impairment

- Body dysmorphic-like disorder without repetitive behaviors
  - Presents like body dysmorphic disorder but without the repetitive behaviors or mental acts

- Body-focused repetitive behavior disorder
  - Recurrent behavior other than hair pulling or skin picking, such as nail biting, lip biting, cheek chewing, etc.

- Obsessional jealousy
  - Non-delusional preoccupation with a partner’s believed infidelity

---

**Trauma- and Stressor-Related Disorders**

**Reactive Attachment Disorder**

- Formerly in "Disorders Usually First Diagnosed in Infancy, Childhood & Adolescents" chapter

- Former subtypes now two separate disorders
  - Emotionally withdrawn/inhibited became Reactive Attachment Disorder
Indiscriminately social/disinhibited became Social Engagement Disorder

- Two disorders separated to improve clinical utility of diagnoses
  - Same etiology: Social neglect or other situations that limit a young child’s opportunity to form healthy attachments
  - Different Prognosis/Treatment: correlates, course, and response to intervention

- Reactive Attachment Disorder
  - More similar to internalizing disorders due to dampened positive affect
  - Entails incomplete or lack of attachment to caregivers
  - New criteria adds “rearing in unusual settings” (such as large institutions) and a 9 month age requirement
  - Specifiers added: “persistent” or “severe”

**Disinhibited Social Engagement Disorder**

- Disinhibited Social Engagement Disorder
  - Involves a pattern of approaching unfamiliar adults with little hesitancy due to history of neglect
  - More closely resembles ADHD with externalizing symptoms
  - Does not necessarily require child lacks attachments
  - New criteria adds “rearing in unusual settings” (such as large institutions) and a 9 month age requirement
  - Specifiers added: “persistent” or “severe”
Posttraumatic Stress Disorder

- Stressor criteria changed: More explicit with regard to how an individual experienced traumatic events (APA, 2013, p. 271):
  - Types of events more clearly specified:
    - Actual or threatened death
    - Serious injury
    - Sexual violence
  - Forms of exposure included specific conditions of witnessing (secondary trauma) in addition to being the victim:
    - Directly experiencing
    - Witnessing the trauma happen to another in person
    - Learning that the trauma occurred to close family member or loved one
    - Extreme and repeated exposure to details of traumatic events (e.g., first responders)
- Removed criterion for subjective reaction of horror
- Four symptom clusters (formerly three):
  - Intrusion symptoms
  - Avoidance symptoms
  - Persistent negative alterations in cognitions and mood (numbing and persistent negative emotional states)
  - Alterations in arousal and reactivity (includes irritable or aggressive behavior and self-destructive behavior)
• Specifiers
  o “Acute” and “chronic” specifiers removed
  o “With delayed onset” specifier changed to “with delayed expression”
• Subtype added: with dissociative symptoms
• Developmentally sensitive
  o Added notes related to expression of criteria in children
  o Separate criteria added for children age 6 years or younger

Acute Stress Disorder
• Stressor criterion changed: see PTSD
• Do not need dissociative symptoms; need any 9 of the 14 symptoms

Adjustment Disorders
• Significantly reconceptualized
  o Varied range of stress-response syndromes that occur after distressing
    (traumatic or nontraumatic) event
  o No longer considered residual category for those with psychological or
    behavioral symptoms that do not meet criteria for a “full” disorder
• Subtypes unchanged
  o Marked by depressed mood, anxious symptoms, or disturbances in
    conduct
Dissociative Disorders

Major changes to Dissociative Disorders

- Dissociative Identity Disorder
  - Added to criteria to include the experience of possession as well as changes in functional neurological
  - Added that transitions in identity may now be observable either by others or self-report
  - Added recurrent gaps in recall for everyday events not just for traumatic experiences
  - Requires that the experiences must be different from acceptable cultural or religious practices

- Dissociative Amnesia and Dissociative Fugue
  - Dissociative fugue now a specifier for dissociative amnesia

- Depersonalization/Derealization Disorder
  - Renamed DSM-IV Depersonalization Disorder as Depersonalization/Derealization Disorder

Somatic Symptom and Related Disorders

Somatic Symptom and Related Disorders

- Reduced the number of these disorders to avoid confusing overlap

- Focus on positive symptoms
  - Rather than “unexplained medical condition” (too vague and unreliable), new focus on a) distressing somatic symptoms with b) abnormal thoughts, feelings, and behaviors in response to symptoms
• Removed the following diagnoses:
  o Somatization disorder
  o Hypochondriasis
  o Pain disorder
  o Undifferentiated somatoform disorder

• Added new disorders:
  o Illness anxiety disorder
  o Somatic symptom disorder

**Somatic Symptom Disorder**

• Similar to former somatization disorder but requires having maladaptive thoughts, feelings, and behaviors along with somatic complaints

• No specific number of somatic symptoms required

• Persons formerly diagnosed with hypochondriasis would qualify for this disorder if they had somatic complaints

**Illness Anxiety Disorder**

• Requires high anxiety about health *without* somatic symptoms

• Specifiers added: "care seeking type" and "care-avoidant type"

• Persons formerly diagnosed with hypochondriasis would qualify for this disorder if they do *not* have somatic complaints

**Pain Disorder Removed**

• New approach to pain
  o Assumes that some pain solely psychological, some associated with medical diseases or injuries, and some with both; research indicates
difficult to make such distinctions reliably

- In fact, a significant amount of research supports idea that psychological factors influence all forms of pain

- Depending on their symptoms and circumstances, patients with chronic pain may be diagnosed with:
  - Somatic symptom disorder, with predominant pain,
  - Psychological factors affecting other medical conditions, or
  - Adjustment disorder

**Psychological Factors Affecting Other Medical Conditions**

- New disorder; formerly in DSM-IV section “other conditions that may be a focus of clinical attention”

**Factitious Disorder**

- Removed subtypes

- Specifier added: “single episode” versus “recurrent”

**Conversion Disorder (Functional Neurological Symptom Disorder)**

- Criteria revised to highlight importance of the neurological examination

- Removed criteria suggesting symptoms caused by psychological stress because this information may not be available at time of diagnosis

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**Feeding and Eating Disorders**

**Pica and Rumination Disorder**

- Previously included in DSM-IV in Disorders First Diagnosed In Infancy and Childhood or Adolescence

- Minor revisions to wording
• Diagnosis can now be made for individuals of any age

Avoidant/Restrictive Food Intake Disorder

• Previously included in DSM-IV in Disorders First Diagnosed In Infancy and Childhood or Adolescence

• Criteria expanded to include adults and children who restrict eating for a variety of reasons

Anorexia Nervosa

• Core criteria mostly unchanged
  o Removed the requirement for amenorrhea
  o Added guidance on how to determine if person is at or below a significantly low weight now provided in the text
  o Severity ratings based on Body Mass Index (BMI)

Bulimia Nervosa

• Primary change: Reduced minimum average frequency of binge eating and inappropriate compensatory behavior frequency from twice to once weekly

Binge-Eating Disorder

• DSM-5 is first edition to define this as a full disorder based on extensive research

• Criteria include:
  o Minimum average frequency of binge eating: at least once weekly over the last 3 months (similar to the DSM-5 criterion for bulimia)

Elimination Disorders

• No significant changes
Sleep-Wake Disorders

Sleep-Wake Disorders

- New paradigm: DSM-5 allows for concurrent diagnosis of both sleep and other disorders to avoid making causal assumptions about whether the sleep problems are caused by another mental or physical condition
  - This highlights the interactional effects of co-occurring disorders and emphasizes that a sleep disorder warrants independent clinical attention
- Insomnia and Narcolepsy
  - Primary insomnia renamed “insomnia disorder”
  - Distinguishes “narcolepsy” (now associated with hypocretin deficiency) from other forms of hypersomnolence
- Criteria more detailed in the DSM-5

Breathing-Related Sleep Disorders

- Divided into three disorders:
  1. Obstructive sleep apnea hypopnea
  2. Central sleep apnea
  3. Sleep-related hypoventilation

Circadian Rhythm Sleep-Wake Disorders

- Subtypes expanded:
  - Advanced sleep phase syndrome
  - Irregular sleep-wake type
  - Non-24-hour sleep-wake type
  - Removed jet lag type
Rapid Eye Movement Sleep Behavior Disorder and Restless Legs Syndrome

- Disorders added to reduce “not otherwise specified” diagnoses

**Sexual Dysfunctions**

**Disorders in Chapter**

- Delayed ejaculation
- Erectile disorder
- Female orgasmic disorder
- Female sexual interest/arousal disorder (combination of two former DSM-IV diagnoses)
- Genito-pelvic pain/penetration disorder (combination of the DSM-IV categories of vaginismus and dyspareunia)
- Male hypoactive sexual desire disorder
- Premature (early) ejaculation
- Substance/medication-induced sexual dysfunction
- Removed: Sexual aversion disorder

**Across-Chapter Changes to Sexual Disorders**

- Increased required duration to reduce over-diagnosis
  - All of the sexual dysfunctions (except substance-/medication-induced sexual dysfunction) require a minimum duration of 6 months
- Subtypes must be specified:
  - Lifelong versus acquired
  - Generalized versus situational
- Severity rating: Mild, moderate, severe
Deleted specifiers: “due to psychological factors vs. due to combined factors”

### Gender Dysphoria

- New diagnostic class
- Change in conceptualization
  - Emphasizing “gender incongruence” rather than cross-gender identification
  - Recognizes wide variation of gender-incongruent conditions
  - Separate criteria sets for children and adolescents and adults
- Diagnosis in children
  - For children, “a strong desire to be of the other gender or an insistence that he or she is the other gender…” (APA, 2013, p. 452) is now necessary but not sufficient, making the diagnosis more restrictive

### Subtypes and Specifiers for Gender Dysphoria

- Removed subtyping on the basis of sexual orientation
- Specifier added: “posttransition” because after transition many no longer meet criteria for gender dysphoria yet may need ongoing treatment for adjustment

## Disruptive, Impulse-Control, and Conduct Disorders

### Oppositional Defiant Disorder

- Four clarifying changes:
  1. Three types of symptoms to emphasize that disorder has emotional and behavioral symptoms:
     - Angry/irritable mood
     - Argumentative/defiant behavior
2. Added severity rating: Based on research that indicated that pervasiveness of symptoms in different settings provides strong indicator of severity

3. Added note on frequency: To distinguish from normal development in children and adolescents

4. Removed: Exclusion criterion for conduct disorder

**Intermittent Explosive Disorder**

- Added verbal aggression and nondestructive/noninjurious physical aggression as sufficient for meeting criteria (but with higher frequency threshold)
- More specific criteria defining frequency
  - Verbal/non-injurious frequency: averaging twice weekly for 3 months
  - Destructing property/physical assault frequency: 3 occurrences in past 12 months
- Minimum age of 6 years of age (or equivalent developmental level) is now required

**Conduct Disorder**

- Criteria largely unchanged
- Specifier added: “with limited prosocial emotions”
  - Applies to those who lack remorse and/or empathy across multiple settings and relationships
  - Indicates more severe condition and may have a different treatment response
Pyromania and Kleptomania

- Largely unchanged

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Substance-Related and Addictive Disorders

Gambling Disorder

- Reflects a significant change from DSM-IV
  - First behavioral addiction
  - Based on research that gambling can activate the brain reward systems similar to substance use disorders
- Note: Internet gaming, shopping, and sex “addictions” did not have sufficient evidence to warrant adding as a disorder; only Internet gaming is included in Section III for further study

Substance Use Disorder

- Significant change: The DSM-5 does not distinguish abuse from dependence; instead severity rating used
- Added severity rating: Severity is based upon number of criteria met
  - Mild: 2-3 criteria (most similar to former substance abuse)
  - Moderate: 4-5 criteria
  - Severe: 6-7 criteria (most similar to former substance dependence)
- Criteria list: Former abuse and dependence criteria combined into single list with two minor modifications:
  - Deleted criterion: legal problems, due to variability across political contexts
  - Added new criterion: craving or a strong desire to use
• Specifiers for the substance use disorders:
  o In early remission (at least 3 months but less than 12 months)
  o Sustained remission (more than 12 months)
  o In controlled environment
  o On maintenance therapy

• Other changes
  o Added cannabis and caffeine withdrawal
  o Deleted physiological subtype and polysubstance dependence

#### Neurocognitive Disorders

**Neurocognitive Disorders**

• Formerly known in the DSM-IV as Delirium, Dementia, and Amnestic and Other Cognitive Disorders

• Many of the diagnoses renamed but correspond to former diagnoses

**Delirium**

• Criteria updated using new research

• Added several types of specifiers to replace previous DSM-IV categories:
  o Specify etiology: Substance intoxication, medication-induced, other medical condition or multiple etiologies
  o Specify: Acute or persistent
  o Specify: Activity level as hyperactive, hypoactive, mixed

**Major and Mild Neurocognitive Disorder (NCD)**

• Replaces dementia and amnestic disorder
• Added mild neurocognitive disorder to allow for diagnosis of less severe forms of impairment
  o Intended to improve outcomes with early intervention
  o Threshold between mild NCD and major NCD somewhat arbitrary
• Specifiers for etiology: Alzheimers, traumatic brain injury, Parkinson’s, etc.
• New additional separate criteria are included for major or mild NCD:
  o Frontotemporal NCD
  o Lewy bodies
  o Traumatic brain injury
  o Parkinson’s disease
  o HIV infection
  o Huntington’s disease
  o Prion disease
  o Another medical condition
  o Multiple etiologies
• Substance/medication-induced NCD and unspecified NCD are also included as diagnoses

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**Personality Disorders**

• Criteria not changed in Section II
  o Although proposed changes were studied in field trials
  o Remain as area of further study
  o Minor wording changes to all diagnostic criteria
• Alternative Model in Section III (see Alternative DSM-5 Model for Personality Disorders on page 63)
  o Assesses level of personality functioning as well as traits
  o Based on a literature review of reliable clinical measures of core personality impairments
  o Revised to increases the stability and empirical foundation

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**Diagnostic Structure and Distinction Between Paraphilia and Paraphilic Disorder**

• Basic structure of the paraphilic disorders:
  o Criterion A specifies the qualitative nature of the paraphilia (i.e., focus of desire)
  o Criterion B specifies the negative consequences of the paraphilia (distress, impairment, or harm—or risk of harm—to others)

• Paraphilia vs. Paraphilic Disorder
  o Paraphilia is not by definition a “mental disorder”
  o Significant distinction between paraphilia and paraphilic disorders
    ▪ To qualify as a disorder, paraphilia must cause distress or impairment to the individual or the satisfaction of which entails harm to others (Criterion B)
    ▪ If person only meets Criterion A, there is no diagnosis

**Specifiers for Paraphilic Disorders**

• “In remission” specifier (for all disorders)
  o Indicates remission from a paraphilic disorder (vs. interest)
• “In a controlled environment” specifier (for all disorders)
  o Indicates no current symptoms due to being in a controlled environment, such as a hospital or prison

• Possibility of remission
  o Cure: Experts do not agree about whether a paraphilia can entirely remit
  o Treatable: Less argument about whether possibility that psychological distress and/or the potential to harm others can be reduced to acceptable levels

Other Conditions that May Be a Focus of Clinical Attention

These are not considered disorders but may nonetheless be a focus of clinical attention; several new conditions are identified, including psychosocial and environmental stressors formerly on Axis IV. The follow is a list of conditions in this chapter (APA, 2013, p. 715-727):

Relational Problems

Problems related to family upbringing

• Parent-child relational problem
• Sibling relational problem
• Upbringing away from parents
• Child affect by parental relational distress

Other problems related to primary support group

• Disruption of family by separation or divorce
• High expressed emotion level within family
• Uncomplicated bereavement

Abuse and Neglect Problems

Child maltreatment and neglect problems

• Child physical abuse
• Child sexual abuse
• Child neglect
• Child psychological abuse

For these, clinicians need to specify whether:

• Confirmed or suspected
• Initial encounter or subsequent encounter

Adult maltreatment and neglect problems

• Spouse or partner violence, physical
• Spouse or partner violence, sexual
• Spouse or partner neglect
• Spouse or partner abuse, psychological
• Adult abuse by nonspouse or nonpartner

For these, clinicians need to specify whether:

• Confirmed or suspected
• Initial encounter or subsequent encounter

Educational and Occupational Problems

• Academic or education problem
• Problems related to current military deployment status
• Other problem related to employment

Housing and Economic Problems

• Homelessness
• Inadequate housing
• Discord with neighbor, lodger, or landlord
• Problem related to living in a residential institution
• Lack of adequate food or safe drinking water
• Extreme poverty
• Low income
• Insufficient social insurance or welfare support
• Unspecified house or economic problem

Other Problems Related to the Social Environment

• Phase of life problem
• Problem related to living alone
• Acculturation difficulty
• Social exclusion or rejection
• Target of (perceived) adverse discrimination or persecution
• Unspecified problem related to social environment

Problems Related to Crime or Interaction with Legal System

• Victim of crime
• Conviction in civil or criminal proceedings without imprisonment
• Imprisonment or other incarceration
• Problems related to release from prison
• Problems related to other legal circumstances

**Other Health Service Encounters for Counseling and Medical Advice Problems**

• Sex counseling

• Other counseling or consultation

**Problems Related to Other Psychosocial, Personal, and Environmental Circumstances**

• Religious or spiritual problem

• Problems related to unwanted pregnancy

• Problems related to multiparity

• Discord with social service provider, including probation officer, case manager, or social services worker

• Victim of terrorism or torture

• Exposure to disaster, war, or other hostilities

• Other problem related to psychosocial circumstances

• Unspecified problem related to unspecified psychosocial circumstances

**Other Circumstances of Personal History Problems**

• Other personal history of psychological trauma

• Personal history of self-harm

• Personal history of military deployment

• Other personal risk factors

• Problems related to lifestyle

• Adult antisocial behavior

• Child or adolescent antisocial behavior
Problems related to access to medical and other health care

- Unavailability or inaccessibility of health care facilities
- Unavailability or inaccessibility of other helping agencies

Nonadherence to Medical Treatment and Other Medical Related Concerns

- Nonadherence to medical treatment
- Overweight or obesity
- Malingering
- Wandering associated with a mental disorder
- Borderline intellectual functioning

Section III: Emerging Measures and Models

In the past, most clinicians could quietly ignore the sections on emerging models with impunity, assuming that these were primarily intended for researchers. In the DSM-5, that is not the case. “Section III”—as it is referred to by insiders—contains many well-developed resources that clinicians and agencies are likely to find useful and/or adopt in one form or another. These include:

- Assessment measures
- Cross-cultural formulation
- Alternative model for diagnosing personality disorders
- Conditions for further study

Cross-Cutting Symptom Measures

Perhaps the most significant of the included assessments are a set of “cross-cutting” symptom measures, which are likely candidates for widespread implementation by third-party payers. Based on general medicine’s review of symptoms, these measures
are used to help clinicians systematically review key psychopathological domains to assist with making a diagnosis and determining overall functioning. These measures are not intended for systematically determining a diagnosis but rather for broad overall assessment. The cross-cutting symptom measures involve two levels of assessment: level 1 and level 2.

**Level 1 Cross-Cutting Symptom Measure**

The level 1 cross-cutting symptom measure is the broadest level of assessment and is used to identify areas for further inquiry. It assesses adult functioning over 13 domains:

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

If a client scores at or above the specific cutoff score in a given domain, then a Level 2 Cross-Cutting Symptom Measure is given (except for Suicidal ideation, psychosis,
memory, dissociation, or personality functioning, which do not have Level 2 measures).

A child-specific cross-cutting symptom measure is available for children 6-17; these measures are completed by a parent or guardian. These measures are available for free download on the APA hosted websites (see Resources, page 75, and List of Online DSM-5 Assessments, page 76).

### Symptom Severity Scales

The text of the DSM-5 includes a psychosis symptom severity scale used for determining if symptoms are mild, moderate, or severe when making a diagnosis. Similar severity scales are available online for other disorders, including:

- Depression
- Separation anxiety disorder
- Specific phobia
- Social anxiety disorder
- Panic disorder
- Agoraphobia
- Generalized anxiety disorder
- Posttraumatic stress disorder
- Acute stress disorder
- Dissociative symptoms

### WHODAS 2.0

Another assessment measure likely to be frequently used in the years ahead is the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0; APA, 2013). The most likely replacement for Axis V, this measure is a 36-item, self-
administered test for adults to assess disability across six domains of functioning: communication, getting around, self-care, getting along with people, life activities, and participation in society. The instrument can be scored in two ways:

- **Simple scoring** involves simply adding up points without weighting individual items; this type of scoring can be done by hand.
- **Complex scoring** involves weighting scores based on multiple levels of difficulty for each item. This method requires a computer program from the WHO website, which can convert the score to a 100-point scale, with 100 being full disability.

The instrument is available on the APA resources for the DSM-5, and the adult version is published in the text.

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**Cultural Formulation**

Building on the cultural formulation in the DSM-IV, the DSM-5 includes a revised outline for cultural formulation as well as an interview guide, complete with sample prompts and questions to be used in session to gather cultural information (APA, 2013, p. 752-75).

The elements of the cultural formulation include:

- **Cultural identity of the individual**: Involves identifying important racial, ethnic, and cultural reference groups as well as other clinically relevant aspects of identity, such as religious affiliation, socioeconomic status, sexual orientation, and migrant status.

- **Cultural conceptualization of distress**: Requires outlining the cultural constructs and significance of presenting symptoms.
• **Psychosocial stressors and cultural features of vulnerability and resilience:**
  Entails identifying specific stressors and supports related to cultural factors, including the role of religion, family, and social networks.

• **Cultural features of the relationship between the individual and the clinician:**
  Requires identifying the cultural, linguistic, and social status issues that may impede communication, therapeutic relationship, diagnosis, and treatment.

• **Overall cultural assessment:** Involves a summary of the key findings and implications of salient issues for diagnosis and treatment.

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**Alternative DSM-5 Model for Personality Disorders**

The DSM-5 field trials included an alternative model for diagnosing personality disorders. However, the DSM-5 task force decided the model was not ready for full implementation, so instead decided to include it in Section III for those clinicians who prefer to use the alternative model (APA, 2013). The DSM-IV model for diagnosing personality disorders is still in the main body of the text (Section II), but typically if a person meets the criteria for one personality disorder they often also meet criteria for other personality disorders, making the diagnoses less than clinically useful (APA, 2013).

The alternative model presented in Section III of the DSM-5 presents personality disorders as involving impairments in a) personality *functioning*, and b) pathological personality *traits* (APA, 2013). This model is included because it has significant clinical utility both for those who meet the criteria for a personality disorder as well as those who do not.
Diagnosis with this model involves meeting a general set of criteria for personality disorder and then a diagnosis with one of seven types:

- Antisocial
- Avoidant
- Borderline
- Narcissistic
- Obsessive-compulsive
- Schizotypal
- Personality disorder: trait specified (does not meet criteria for one of the above types is met)

**Personality Functioning**

The first element in this model, personality functioning, is conceptualized as involving both self and interpersonal elements (APA, 2013, p. 762):

- *Self Elements of Personality Functioning*
  - *Identity:* The ability to experience oneself as a unique entity with clear boundaries with others that is able to accurately self-assess and self-regulate emotional experience.
  - *Self-direction:* The ability to pursue meaningful goals using constructive internal standards that reflect prosocial behavior.

- *Interpersonal Elements of Personality Functioning*
  - *Empathy:* The ability to understand and respect the experience of others.
  - *Intimacy:* The ability and motivation to have deep and enduring relationships with others.
This model of personality functioning can be useful for all clients, even those without a personality disorder.

**Pathological Personality Traits**

The second element in this model is personality traits. A total of 25 specific traits are categorized across five domains, with four traits appearing in more than one domain (APA, 2013, p. 779-781).

**Trait Domain 1: Negative Affectivity**

- Emotional lability
- Anxiousness
- Separation insecurity
- Submissiveness
- Hostility (also see Antagonism)
- Perseveration
- Depressivity (also see Detachment)
- Suspiciousness (also see Detachment)
- Restricted affectivity (also see Detachment)

**Trait Domain 2: Detachment**

- Withdrawal
- Intimacy avoidance
- Anhedonia
- Depressivity
- Restricted affectivity
- Suspiciousness
Trait Domain 3: Antagonism

- Manipulativeness
- Deceitfulness
- Grandiosity
- Attention seeking
- Callousness
- Hostility

Trait Domain 4: Disinhibition

- Irresponsibility
- Impulsivity
- Distractibility
- Risk taking
- Rigid perfectionism

Trait Domain 5: Psychoticism

- Unusual beliefs and experiences
- Eccentricity
- Cognitive and perceptual dysregulation

How the Diagnosis Works

Similar to the current system, to be diagnosed with a personality disorder in this model, the impairments need to involve longstanding and pervasive personality dysfunction across social situations. Each of the six specified types of disorders includes:

1. Criteria specifying how the particular form of personality disorder is expressed across the four dimensions of personality functioning:
a. Identity
b. Self-direction
c. Empathy
d. Intimacy

2. Criteria with the associated personality traits

Key Elements of Alternative Model for Personality Disorder

Each of the six specified personalities (antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal) is identified using two key components: personality functioning and personality traits.

1. Specific criteria for personality functioning in each element of personality functioning:
   a) Identity
   b) Self-direction
   c) Empathy
   d) Intimacy

2. Criteria with specific personality traits from list of 25

Conditions for Further Study

The following conditions are listed for further study, and thus are being widely researched to determine whether they should be added to the main body of the text as a recognized disorder. These conditions include:

- **Attenuated Psychosis Syndrome**: A disorder that includes symptoms that are psychosis-like but below the threshold for a full psychotic disorder.
• **Depressive Episodes with Short-Duration Hypomania:** A disorder that involves at least one major depressive episode as well as two episodes of 2-3 day duration with hypomania symptoms.

• **Persistent Complex Bereavement Disorder:** This disorder would be used to distinguish normal grief from persistent grief, with intense symptoms lasting at least 12 months that affect health, work, and/or social functioning.

• **Caffeine Use Disorder:** This diagnosis would be used for those who continue to use caffeine in high quantities despite negative physical and/or psychological consequences.

• **Internet Gaming Disorder:** The only “behavioral addiction” currently included in the list for further study, this disorder involves a persistent, excessive, and recurrent pattern of problematic Internet gaming that includes tolerance and withdrawal symptoms as well as loss of interest in other hobbies and serious negative consequences in social, occupational, or educational functioning.

• **Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure:** This disorder would be used with children with impaired neurocognitive functioning, self-regulation, and adaptive functioning due to significant levels of alcohol in utero.

• **Suicidal Behavior Disorder:** This disorder would be used with some who made a suicide attempt in the past 24 months.

• **Nonsuicidal Self-Injury:** This disorder would be used with individuals who self injure to manage negative feelings, resolve relational difficulties, and/or induce a positive emotional state.
Critique of the DSM-5

Long before it was published, the DSM-5 has been the focus of numerous public and academic debates and controversies. Underscoring the extent of concern, several books critiquing it were released even before the manual itself was published (Jayson, 2013). The media and public debates have focused on changes to the more widely known disorders, such as the bereavement exclusion for depression, creation of a single autism spectrum disorder, and collapsing substance abuse and dependence into a substance use disorder (APA, 2012). The APA has tried to respond to these and clarify where appropriate. For example, early criticism of the removal of the bereavement exclusion for the diagnosis of major depressive disorder has been partially addressed in an extensive footnote in the manual itself (APA, 2013, p. 161). Similarly, some of the more sensationalized controversies, such as concerns that the number of people diagnosed with mental disorders (substance use disorder in particular) will soar with the release of the new manual, have been directly addressed by the APA with press releases and videos on their websites www.dsm5.org and www.psychiatry.org/dsm5.

However, many other critiques represent longstanding and more fundamental concerns about the DSM, such as the effects of mental health categories, implications of diagnosis in court and school settings, and the corresponding use of psychotropic medications. Much of the critique focuses on the lack of sufficient scientific evidence for many of the disorders and/or the reliable use of the manual for diagnosis (Jayson, 2013). Other critiques focus on the inappropriate influence of the pharmaceutical companies and medications in the conceptualization of mental disorders and concerns about the widespread use of psychotropic medications, especially with children (Littrell & Lacasse, 2012; Moncrieff, 2009). At a more basic level, many mental health professions,
particularly psychotherapists working from humanistic, systemic, and postmodern approaches, have longstanding concerns about the negative effects of diagnosis on the persons diagnosed as well as the effects of diagnosis on the change (e.g., therapeutic) process (Bradford, 2009; Gergen, Hoffman, & Anderson, 1996; Fisch, 1965; Jackson, 1967). Such critics have argued that the diagnostic labels have an unnecessary negative effect on a person’s identity, make a problem seem bigger and more intractable than it is, and make presenting concerns harder to resolve.

In a critique of particular note, Thomas Insel, the Director of the U.S. National Institute of Mental Health (NIMH) published a blog in April 2013, weeks before the release of the DSM, citing its limitations and describing how the NIMH will focus future research on their Research Domain Criteria (RDoC), a project designed to “transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system” (para. 3). He describes the DSM as having more reliability (e.g., clinicians consistently use terms) than validity (i.e., there are few lab tests that can validate the diagnoses). Future federally-funded research will focus more on general domains of symptoms and functioning than specific diagnoses, as it has in the past. Thus, future research may include all clients in a mood disorder clinic rather than exclude participants who don’t meet strict diagnosis criteria. This move away from the focus on specific disorders is recognized in the preface to the DSM-5 and represented in the inclusion of dimensional and cross-cutting symptom assessments as well as the reorganization of chapters based on neuroimaging and genetic data (APA, 2013). Thus, even those intimately involved with the development and future of the manual recognize its limits. However, the DSM-5 nonetheless represents the
“strongest system currently available for classifying disorders” and thus an important resource for our medical community (para. 2). In the end, like its predecessors, the DSM-5 remains a work in progress, dependent on emerging research and clinical practice to refine and improve our ability to address emotional and psychological distress.

### Next Steps: Getting Started

At this point, if you were at all familiar with the DSM-IV, you hopefully feel comfortable picking up the DSM-5 and know how to use it confidently and competently. To help you get started, I recommend four steps—and to avoid making this sound as though the APA or some other more illustrious body recommends these steps, I will highlight that these are only my personal suggestions.

**Step 1: Get a Copy of the DSM-5**

If you have not done so already, I recommend getting a copy of the DSM-5. You have a few options:

- Purchase a hard copy; you will probably need the full-text edition not just the “desk reference”.
- Download an eBook version to your computer, tablet, and/or phone; available from the APA directly.
- Subscribe to DSM Select at www.psychiatry.org for an online subscription that includes several publications about the DSM-5.
- Access a library that has a subscription or eBook of the DSM-5 (many university libraries have such digital access).

**Step 2: Read Strategically**

Once you have access to the DSM-5, I recommend you read the following parts:
• Table of contents

• Section I (pp. 5-25)

• Appendix: Highlights of Changes from DSM-IV to DSM-5 (pp. 809-816)

• Read through the disorders and sections that you use the most in your practice and the ones that interest you

**Step 3: Use It**

Even if you are a seasoned clinician who had the old codes memorized, I recommend you discipline yourself for the next year to pull out the DSM-5 and use it for each new diagnosis you make. By doing so, you will become proficient with the subtleties of the new changes.

If you are a professional-in-training, hopefully you will not need discipline to pull out the text each time you make a diagnosis as you should be doing this already. However, you may be caught between the new and old versions, even being asked to write five axis diagnoses or determine a GAF score. If so, please refer to the “Use of the Manual” chapter in the DSM-IV.

**Step 4: Reflect and Make a Difference**

Finally, I invite you to reflect on manual and diagnosis process itself, and, as a clinician, to ensure that you use it and discuss these with clients in ways that promote client wellness, proactivity, and sense of agency. Making a mental health diagnosis is not a casual matter. Nor is arriving at the “correct” diagnosis the end of the process—or even the goal, at least in the opinion of some. Instead, many, like myself, would argue that that the diagnostic process is best approached by collaboratively, actively engaging clients in the discussion and important considerations (Anderson & Gehart, 2007). Furthermore, it
is a discussion that often leads to more questions than clear-cut answers, so any decisions should be held tentatively and revisited whenever future events or information shed new light on a situation.

Most importantly, clinicians—particularly psychotherapists—should use conversations about “mental health” and “diagnosis” first and foremost to promote the change process: after all, that is their top priority. Getting the “right” diagnosis is pointless if it exacerbates issues, making them more difficult rather than easier to resolve. Of critical importance is never losing sight of our clients’ humanity and what that means. Thus, I believe skilled clinicians must view the DSM-5 and the diagnostic process more generally as tools for promoting change and help clients feel hopeful about and proactive in their lives. And since the manual and its contents are not inherently such, it takes a thoughtful and reflective approach to identify how it can be used to motivate clients to become encouraged and engaged agents of change in their lives. Thus, I hope you develop the art and skill of learning how to use the diagnostic process to make a positive difference in the lives of those you serve.

References


**Resources**

[www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5)

APA webpage with online resources:

- Fact sheets for specific disorders
- Videos with speakers discussing the changes and rationale for the changes
- Assessment measures for download
• News articles on disorders

www.dsm5.org

This website chronicles the development of the DSM-5 and has recently been updated with the assessments, fact sheets, and updates:

• Planning conference monographs
• List of peer reviewed publications from DSM-5 development
• History of development
• Letters/Responses to third party inquiries
• Information about task force
• Fact sheets on specific diagnoses
• Assessments for downloads
• List of revised codes to correct errors in the first print edition

List of DSM-5 Assessments Available Online

The following assessments are available at www.psychiatry.org/dsm5

Level 1 Cross-Cutting Symptom Measures

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult (also available in print book)

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17 (also available in print book)

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17
Level 2 Cross-Cutting Symptom Measures

For Adults

LEVEL 2—Depression—Adult (PROMIS Emotional Distress—Depression—Short Form)

LEVEL 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form)

LEVEL 2—Mania—Adult (Altman Self-Rating Mania Scale [ASRM])

LEVEL 2—Anxiety—Adult (PROMIS Emotional Distress—Anxiety—Short Form)

LEVEL 2—Somatic Symptom—Adult (Patient Health Questionnaire 15 Somatic Symptom Severity Scale [PHQ-15])

LEVEL 2—Sleep Disturbance—Adult (PROMIS—Sleep Disturbance—Short Form)

LEVEL 2—Repetitive Thoughts and Behaviors—Adult (Adapted from the Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale [Part B])

LEVEL 2—Substance Use—Adult (Adapted from the NIDA-Modified ASSIST)

For Parents of Children Ages 6–17

LEVEL 2—Somatic Symptom—Parent/Guardian of Child Age 6–17 (Patient Health Questionnaire 15 Somatic Symptom Severity Scale [PHQ-15])

LEVEL 2—Sleep Disturbance—Parent/Guardian of Child Age 6–17 (PROMIS—Sleep Disturbance—Short Form)

LEVEL 2—Inattention—Parent/Guardian of Child Age 6–17 (Swanson, Nolan, and Pelham, version IV [SNAP-IV])

LEVEL 2—Depression—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Depression—Parent Item Bank)

LEVEL 2—Anger—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—
Calibrated Anger Measure—Parent)

**LEVEL 2—Irritability—Parent/Guardian of Child Age 6–17** (Affective Reactivity Index [ARI])

**LEVEL 2—Mania—Parent/Guardian of Child Age 6–17** (Adapted from the Altman Self-Rating Mania Scale [ASRM])

**LEVEL 2—Anxiety—Parent/Guardian of Child Age 6–17** (Adapted from PROMIS Emotional Distress—Anxiety—Parent Item Bank)

**LEVEL 2—Substance Use—Parent/Guardian of Child Age 6–17** (Adapted from the NIDA-Modified ASSIST)

For Children Ages 11–17

**LEVEL 2—Somatic Symptom—Child Age 11–17** (Patient Health Questionnaire 15 Somatic Symptom Severity Scale [PHQ-15])

**LEVEL 2—Sleep Disturbance—Child Age 11–17** (PROMIS—Sleep Disturbance—Short Form)

**LEVEL 2—Depression—Child Age 11–17** (PROMIS Emotional Distress—Depression—Pediatric Item Bank)

**LEVEL 2—Anger—Child Age 11–17** (PROMIS Emotional Distress—Calibrated Anger Measure—Pediatric)

**LEVEL 2—Irritability—Child Age 11–17** (Affective Reactivity Index [ARI])

**LEVEL 2—Mania—Child Age 11–17** (Altman Self-Rating Mania Scale [ASRM])

**LEVEL 2—Anxiety—Child Age 11–17** (PROMIS Emotional Distress—Anxiety—Pediatric Item Bank)

**LEVEL 2—Repetitive Thoughts and Behaviors—Child Age 11–17** (Adapted from the
Children’s Florida Obsessive Compulsive Inventory [C-FOCI] Severity Scale

**LEVEL 2—Substance Use—Child Age 11–17** (Adapted from the NIDA-Modified ASSIST)

**Disorder-Specific Severity Measures**

*For Adults*

Severity Measure for Depression—Adult (Patient Health Questionnaire [PHQ-9])

Severity Measure for Separation Anxiety Disorder—Adult

Severity Measure for Specific Phobia—Adult

Severity Measure for Social Anxiety Disorder (Social Phobia)—Adult

Severity Measure for Panic Disorder—Adult

Severity Measure for Agoraphobia—Adult

Severity Measure for Generalized Anxiety Disorder—Adult

Severity of Posttraumatic Stress Symptoms—Adult (National Stressful Events Survey PTSD Short Scale [NSESS])

Severity of Acute Stress Symptoms—Adult (National Stressful Events Survey Acute Stress Disorder Short Scale [NSESS])

Severity of Dissociative Symptoms—Adult (Brief Dissociative Experiences Scale [DES-B])

*For Children Ages 11–17*

Severity Measure for Depression—Child Age 11–17 (PHQ-9 modified for Adolescents [PHQ-A]—Adapted)

Severity Measure for Separation Anxiety Disorder—Child Age 11–17
Severity Measure for Specific Phobia—Child Age 11–17

Severity Measure for Social Anxiety Disorder (Social Phobia)—Child Age 11–17

Severity Measure for Panic Disorder—Child Age 11–17

Severity Measure for Agoraphobia—Child Age 11–17

Severity Measure for Generalized Anxiety Disorder—Child Age 11–17

Severity of Posttraumatic Stress Symptoms—Child Age 11–17 (National Stressful Events Survey PTSD Short Scale [NSESS])

Severity of Acute Stress Symptoms—Child Age 11–17 (National Stressful Events Survey Acute Stress Disorder Short Scale [NSESS])

Severity of Dissociative Symptoms—Child Age 11–17 (Brief Dissociative Experiences Scale [DES-B])

Clinician-Rated

Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders

Clinician-Rated Dimensions of Psychosis Symptom Severity (also available in print book)

Clinician-Rated Severity of Somatic Symptom Disorder

Clinician-Rated Severity of Oppositional Defiant Disorder

Clinician-Rated Severity of Conduct Disorder

Clinician-Rated Severity of Nonsuicidal Self-Injury

Disability Measures

WHODAS 2.0 (World Health Organization Disability Schedule 2.0, 36-item version, self-administered) (also available in print book)
WHODAS 2.0 (World Health Organization Disability Schedule 2.0, 36-item version, proxy-administered)

Personality Inventories

For Adults

The Personality Inventory for DSM-5—Brief Form (PID-5-BF)—Adult

The Personality Inventory for DSM-5 (PID-5)—Adult

The Personality Inventory for DSM-5—Informant Form (PID-5-IRF)—Adult

For Children Ages 11–17

The Personality Inventory for DSM-5—Brief Form (PID-5-BF)—Child Age 11–17

The Personality Inventory for DSM-5 (PID-5)—Child Age 11–17

Early Development and Home Background

For Parents of Children Ages 6–17

Early Development and Home Background (EDHB) Form—Parent/Guardian

Clinician-Rated

Early Development and Home Background (EDHB) Form—Clinician

Cultural Formulation Interviews

Cultural Formulation Interview (also available in print book)

Cultural Formulation Interview—Informant Version (also available in print book)

Supplementary Modules to the Core Cultural Formulation Interview (CFI)
On July 15, 2013, the APA published these corrected codes on www.dsm5.org.

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Diane R. Gehart, Ph.D. is a Professor in the Marriage and Family Therapy Program at California State University, Northridge. With the support of the American Association for Marriage and Family Therapy, she participated in the DSM-5 Train-the-Trainer course hosted by the American Psychiatric Association.

She has authored numerous books, including:

- *Mastering Competencies in Family Therapy* (Cengage)
- *Theory and Treatment Planning in Counseling and Psychotherapy* (Cengage)
- *Mindfulness and Acceptance in Couple and Family Therapy*
- *The Complete MFT and Counseling Core Competency Assessment Systems*, and
- *Collaborative Therapy: Relationships and Conversations that Make a Difference* (co-editor)

Her areas of research and specialty include postmodern therapies, mindfulness, Buddhist psychology, sexual abuse, gender, children, relationships, client advocacy, mental health recovery, qualitative research, and education in family therapy and counseling. She maintains a private practice in Thousand Oaks, California, specializing in couples, families, trauma, life transitions, and difficult to treat cases.