

## ONLINE FIRST

# DSM-5—The Future Arrived

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**T**HE NEXT REVISION OF PSYCHIATRY'S *DIAGNOSTIC AND Statistical Manual of Mental Disorders (DSM-5)*<sup>1</sup> will be published in May 2013 and is the first revision of this psychiatric nomenclature in almost 2 decades. *DSM-5* involved an international, multidisciplinary team of more than 400 individuals who volunteered vast amounts of their time throughout this 6-year official process, as well as many contributions from numerous international conferences that were held during the last decade.

Readers will recognize a few notable differences from *DSM-IV*. One distinction is *DSM-5*'s emphasis on numerous issues important to diagnosis and clinical care, including the influence of development, gender, and culture on the presentation of disorders.<sup>2</sup> This is present in select diagnostic criteria, in text, or in both, which include variations of symptom presentations, risk factors, course, comorbidities, or other clinically useful information that might vary depending on a patient's gender, age, or cultural background. Another distinct feature is ensuring greater harmony between this North American classification system and the *International Classification of Diseases (ICD)* system. For example, the chapter structure of *DSM* now begins with those in which neurodevelopmental influences produce early-onset disorders in childhood. This restructuring brings greater alignment of *DSM-5* to the structuring of disorders in the future *ICD-11* but also reflects the manual's developmental emphasis, rather than the previous edition's sequestering of all childhood disorders to a separate chapter. A similar approach to harmonizing with the *ICD* was taken to promote a more conceptual relationship between *DSM-5* and classifications in other areas of medicine, such as the classification of sleep disorders.

Many of the revisions in *DSM-5* will help psychiatry better resemble the rest of medicine, including the use of dimensional (eg, quantitative) approaches. Disorder boundaries are often unclear to even the most seasoned clinicians and underscore the proliferation of residual diagnoses (ie, "not otherwise specified" disorders) from *DSM-IV*. But a large proportion of *DSM-5* users will not be psychiatrists; most patients, for instance, will first present to their primary care

physician—not to a psychiatrist—when experiencing psychiatric symptoms. The use of definable thresholds that exist on a continuum of normality is already present throughout much of general medicine, such as in blood pressure and cholesterol measurement, and these thresholds aid physicians in more accurately detecting pathology and determining appropriate intervention.<sup>3</sup> Thus *DSM-5* provides a model that should be recognizable to nonpsychiatrists and should facilitate better diagnosis and follow-up care by such clinicians. In addition, the multiaxial system that characterized earlier editions of *DSM*—wherein clinicians recorded diagnoses, comorbid medical conditions, nondisorder reasons for clinical visit (eg, partner/relational problems), and ratings of disability and functioning on 5 separate axes—has been discontinued. This is largely due to its incompatibility with diagnostic systems in the rest of medicine, as well as the result of a decision to place personality disorders and intellectual disability at the same level as other mental disorders.

The above major changes represent those throughout the entire volume. What follows is a sampling from a larger summary of select recommended changes for specific disorders that will be found in the new *DSM-5* manual<sup>4</sup>:

- **Autism spectrum disorder:** The criteria from *DSM-IV*'s autistic disorder, Asperger disorder, childhood disintegrative disorder, and pervasive developmental disorder (not otherwise specified) have been combined into a single diagnosis of autism spectrum disorder. The aim is to more accurately characterize children with social communication and interaction deficits as well as restrictive, repetitive behaviors, activities, or interests. This revision is not expected to significantly alter prevalence rates. The criteria were developed with enough sensitivity and specificity such that most children (91%) previously diagnosed with a pervasive developmental disorder under *DSM-IV* would meet criteria for autism spectrum disorder, allowing them to retain a diagnosis and continue receiving treatment and educational services.<sup>5</sup>

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• **Binge eating disorder** was previously classified in *DSM-IV*'s Appendix of Conditions for Further Study but has been elevated to classification in the main body of *DSM-5*. This reflects research from the previous decades indicating binge eating disorder is a valid and reliable diagnosis. This too appears unlikely to significantly increase prevalence from *DSM-IV*.<sup>6</sup>

• **Disruptive mood dysregulation disorder**: In an effort to address the increase in the diagnosis of pediatric bipolar disorder among children with severe emotional and behavioral disturbance, disruptive mood dysregulation disorder will be included in *DSM-5*. The aim is to reduce confusion about whether severe, chronic irritability should be considered characteristic of mania in children—one of the primary reasons for the increase in pediatric bipolar diagnoses and subsequent inappropriate treatment with antipsychotic medications. In *DSM-5*, nonepisodic irritability is distinguished from mania as the hallmark feature of disruptive mood dysregulation disorder, whereas a diagnosis of bipolar disorder may be considered for children with an episodic course.

• **Posttraumatic stress disorder (PTSD)** will be included in a chapter separate from anxiety disorders, obsessive-compulsive and related disorders, and dissociative disorders (which also are placed in distinct chapters). The revised criteria include expansion of *DSM-IV*'s 3 symptom clusters into 4, with the avoidance/numbing cluster now separated into 2 clusters (avoidance and persistent negative alterations in cognitions and mood). By including an additional criteria set focused solely on symptoms in children aged 6 years and younger, diagnosis will be more developmentally sensitive and call attention to differences in presentation among young children vs adults (eg, the reexperiencing of traumatic events through play or storytelling).

• **Removal of bereavement exclusion**: In *DSM-IV*, individuals meeting criteria for a major depressive episode were excluded from a diagnosis of major depressive disorder if symptoms occurred within 2 months of the death of a loved one. However, the implication that bereavement ends in only 2 months or that major depression and bereavement cannot co-occur appears false.<sup>7</sup> Depression related to bereavement can share many of the same symptoms as nonbereavement-related depression and can accordingly respond to treatment. Similarly, major depression can share features with other forms of significant loss or stress, including job loss and natural disasters, and may be in need of intervention. To prevent the denial of diagnosis (and care) of individuals who meet full criteria for a major depressive disorder, even during bereavement or other significant loss, *DSM-5* now permits such a diagnosis and includes 2 notes, within the major depressive episode criteria set, to guide clinicians in making the diagnosis in this context.

• **Substance use disorder** is a new diagnosis in *DSM-5* that combines the *DSM-IV* disorders of substance abuse and substance dependence. This is due in part to misuse of the term *dependence* to describe the normal withdrawal patterns that can occur during appropriate medication use. Criteria for substance use are largely the same as the criteria in *DSM-IV* for abuse and dependence, except for removal of the criterion requiring recur-

rent legal problems and the addition of a new criterion to address craving or strong desires or urges to use a given substance.

The classification system should be able to incorporate future advances in the neuroscience and genetics of psychiatric illness.<sup>8</sup> *DSM-5* is intended to be readily updatable as relevant knowledge is accumulated in neuroscience, cognitive science, genetics, and in clinical practice. *DSM-5* also will include a third major section following the introductory materials and the descriptions of the fully validated categorical disorders. This third section is intended to provide future directions for *DSM-5* that will lead to its subsequent editions. Section III will guide clinicians and researchers in examining measures and criteria sets that emerged during the process of developing the manual but were deemed in need of further study before official inclusion in the nomenclature. This section will include criteria sets for potential new disorders, including a new approach to the assessment of personality disorders, a listing of the dimensional assessments that were included in the *DSM-5* field trials, and assessments related to culture-specific formulations of the *DSM* disorders.

The most important next challenge is identification of *DSM-5* criteria of particular relevance to specialties outside of psychiatry. Even though the criteria for the most common *DSM* disorders were written with the general medical practitioner in mind, the American Psychiatric Association is developing a collaborative approach to identifying the disorders most frequently seen in primary medical care settings and the particular way in which those disorders are likely to present in such settings—an emphasis to make the *DSM-5* of greater value to all of medicine.<sup>9</sup>

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**Additional Information:** The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, will be published by the American Psychiatric Association in May. For further information, go to [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5).

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