07 - Section I DSM 5 Basics

01 - Introduction

Introduction

5 Introduction The creation of the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was a massive undertaking that involved hundreds of people working toward a common goal over a 12-year period. Much thought and deliberation were involved in evaluating the diagnostic criteria, considering the organization of every aspect of the manual, and creating new features believed to be most useful to clinicians, such as dimensional measures that can help to identify emerging symptoms or determine and monitor changes in severity. All of these efforts have been directed toward the goal of enhancing the usefulness of DSM-5 as a clinical guide in the diagnosis of mental disorders, as well as its value for research. DSM-5 strives to fulfill the need of clinicians, patients, families, and researchers for a clear and concise description of each mental disorder, which has been operationalized using diagnostic criteria that are supplemented by dimensional measures of severity and is accompanied by a digest of information about the diagnosis, including risk factors and culture- and sex- and gender-related issues. Clinical training and experience are needed to use DSM for determining a clinical diagnosis. The diagnostic criteria identify symptoms and signs comprising affects, behaviors, cognitive functions, and personality traits along with physical signs, symptom combinations (syndromes), and durations that require clinical expertise to differentiate from normal variation and transient responses to stress. The diagnostic process can be facilitated by a thorough examination of the range of symptoms that might be present, such as by conducting a review of mental systems using the DSM-5 Level 1 Cross-Cutting Symptom Measure as recommended by The American Psychiatric Association (APA) Practice Guidelines for the Psychiatric Evaluation of Adults (see “Cross-Cutting Symptom Measures”). The use of DSM criteria has the clear virtue of creating a common language for communication between clinicians about the diagnosis of disorders. Officially recognized disorders are located in Section II of the manual. However, it should be noted that these diagnostic criteria and their placement within the classification are based on current research and may need to be modified as research advances. Development of DSM-5-TR Brief History of Prior DSM Editions The first edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders appeared in 1952. This was the first official manual of mental disorders to

contain a glossary of descriptions of the diagnostic categories. The use of the term “reaction” throughout the classification reflected the influence of Adolf Meyer’s psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors. In the development of the second edition (DSM-II), a decision was made to base the classification on the mental disorders section of the eighth revision of the International Classification of Diseases (ICD-8), for which representatives of the APA had provided consultation. Both DSM-II and ICD-8 went into effect in 1968. As had been the case for DSM-I and DSM-II, the development of DSM-III was coordinated with the development of the International Classification of

Diseases, specifically ICD-9, which was published in 1975 and implemented in 1978. Work began on DSM-III in 1974, with publication in 1980. DSM-III, under the direction of Robert L. Spitzer, M.D., introduced a number of important methodological innovations, including explicit diagnostic criteria and a descriptive approach that attempted to be neutral with respect to theories of etiology of mental disorders. Experience with DSM-III revealed a number of inconsistencies in the system. Therefore, the APA appointed a Workgroup to Revise DSM-III, which developed the revisions and corrections that led to DSM-III-R in 1987. DSM-IV was published in 1994. It was the culmination of a 6-year effort that involved more than 1,000 individuals and numerous professional organizations. Much of the effort involved conducting a comprehensive review of the literature to establish a firm empirical basis for making modifications. Developers of DSM-IV and the tenth revision of the ICD worked closely to coordinate their efforts, resulting in increased congruence between the two systems. ICD-10 was published in 1992. A thorough history of all DSM editions is located on the APA website: https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm. DSM-5 Revision Process In 1999, the APA launched an evaluation of the strengths and weaknesses of DSM. This effort was coordinated with the World Health Organization's (WHO) Division of Mental Health, the World Psychiatric Association, and the National Institute of Mental Health (NIMH) in the form of several conferences, the proceedings of which were published in the 2002 monograph A Research Agenda for DSM-V. Thereafter, from 2003 to 2008, a cooperative agreement between the APA and WHO, supported by the NIMH, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), led to the convening of 13 international DSM-5 research planning conferences, involving 400 participants from 39 countries, to review the world literature in specific diagnostic areas to prepare for revisions in developing both DSM-5 and the International Classification of Diseases, 11th Revision (ICD11). Reports from these conferences formed the basis for future DSM-5 Task Force reviews and set the stage for the new edition of DSM. In 2006, the APA named David J. Kupfer, M.D., as Chair and Darrel A. Regier, M.D., M.P.H., as Vice-Chair of the DSM-5 Task Force. They were charged with recommending chairs

for the 13 diagnostic work groups and additional task force members with a multidisciplinary range of expertise who would oversee the development of DSM-5. An additional vetting process was initiated by the APA Board of Trustees to disclose sources of income and thus avoid conflicts of interest by task force and work group members. The full disclosure of all income and research grants from commercial sources, including the pharmaceutical industry, in the previous 3 years, the imposition of an income cap from all commercial sources, and the publication of disclosures on a website set a new standard for the field. Thereafter, the task force of 28 members was approved in 2007, and appointments of more than 130 work group members were approved in 2008. More than 400 additional work group advisors with no voting authority were also approved to participate in the process. A clear concept of the next evolutionary stage for the classification of mental disorders was central to the efforts of the task force and the work groups. This vision emerged as the task force and work groups recounted the history of DSM-IV's classification, its current strengths and limitations, and strategic directions for its revision. An intensive 6-year process involved conducting literature reviews and secondary analyses, publishing research reports in scientific journals, developing draft diagnostic criteria, posting preliminary drafts on the DSM-5 website for public comment, presenting preliminary findings at professional meetings, performing field trials, and revising criteria and text. Overall, many health professional and educational groups were involved in this development and testing of DSM-5, including physicians, psychologists, social workers, nurses, counselors, epidemiologists, statisticians, neuroscientists, and neuropsychologists.

Also, individuals with mental disorders and families of individuals with mental disorders, lawyers, consumer organizations, and advocacy groups participated in revising DSM-5 by providing feedback on the mental disorders described in this volume. Proposals for Revisions Proposals for the revision of DSM-IV diagnostic criteria were developed by members of the work groups on the basis of rationale, scope of change, expected impact on clinical management and public health, strength of the supporting research evidence, overall clarity, and clinical utility. Proposals encompassed changes to diagnostic criteria; the addition of new disorders, subtypes, and specifiers; and the deletion of existing disorders. In the proposals for revisions, strengths and weaknesses in the current criteria and nosology were first identified. Novel scientific findings over the previous two decades were considered, leading to the creation of a research plan to assess potential changes through literature reviews and secondary data analyses. Four principles guided the draft revisions: 1) DSM-5 is primarily intended to be a manual to be used by clinicians, and revisions must be feasible for routine clinical practice; 2) recommendations for revisions should be guided by research evidence; 3) where possible, continuity should be maintained with previous editions of DSM; and 4) no a priori constraints should be placed on the degree of change between DSM-IV and DSM-5. Building on the initial literature reviews, work groups identified key issues within their diagnostic areas. Work groups also examined broader methodological concerns, such as the presence of contradictory findings within the literature; development of a refined definition of

mental disorder; and a consideration of cross-cutting issues relevant to all disorders. Inclusion of a proposal for revision in Section II was informed by consideration of its advantages and disadvantages for public health and clinical utility, the strength of the evidence, and the magnitude of the change. New diagnoses and disorder subtypes and specifiers were subject to additional stipulations, such as demonstration of reliability (i.e., the degree to which two clinicians could independently arrive at the same diagnosis for a given patient). Disorders with low clinical utility and weak validity were considered for deletion. Placement of proposed conditions in “Conditions for Further Study” in Section III was contingent on the amount of empirical evidence generated on the proposed diagnosis, diagnostic reliability or validity, presence of clear clinical need, and potential benefit in advancing research. DSM-5 Field Trials The use of field trials to empirically demonstrate reliability was a noteworthy improvement introduced in DSM-III. The design and implementation strategy of the DSM-5 Field Trials represented several changes from approaches used for DSM-III and DSM-IV, particularly in obtaining data on the precision of kappa reliability estimates (a statistical measure that assesses level of agreement between raters that corrects for chance agreement due to prevalence rates) in the context of real-world clinical settings with high levels of diagnostic comorbidity. For DSM5, field trials were extended by using two distinctive designs: one in large, diverse medicalacademic settings and the other in routine clinical practices. The former capitalized on the need for large sample sizes to test hypotheses on reliability and clinical utility of a range of diagnoses in a variety of patient populations; the latter supplied valuable information about how proposed revisions performed in everyday clinical settings among a diverse sample of DSM users. It is anticipated that future clinical and basic research studies will focus on the validity of the revised categorical diagnostic criteria and the underlying dimensional features of these disorders (including those now being explored by the NIMH Research Domain Criteria initiative). The medical-academic field trials were conducted at 11 North American medical-academic sites from December 2010 to October 2011 and assessed the reliability, feasibility, and clinical utility of select revisions, with priority given to those that represented the greatest degree of change from

DSM-IV or those potentially having the greatest public health impact. The full clinical patient populations coming to each site were screened for DSM-IV diagnoses or qualifying symptoms likely to predict several specific DSM-5 disorders of interest. Stratified samples of four to seven specific disorders, plus a stratum containing a representative sample of all other diagnoses, were identified for each site. Patients consented to the study and were randomly assigned for a clinical interview by a clinician blind to the clinical diagnosis, followed by a second interview that occurred within 2 weeks with a clinician blind to the diagnoses made by the first interviewer. Patients first filled out a computer-assisted inventory of cross-cutting symptoms in more than a dozen psychological domains. These inventories were scored by a computer, and results were provided to clinicians before they conducted a typical clinical interview (with no structured protocol). Clinicians were required to score the presence of

qualifying criteria on a computer-assisted DSM-5 diagnostic checklist, determine diagnoses, score the severity of the diagnosis, and upload the data to a central repository. This study design allowed the calculation of the degree to which two independent clinicians could agree on a diagnosis (using the intraclass kappa statistic) and on clinician-administered ratings of crosscutting and diagnosis-specific symptom severity (using intraclass correlation coefficients), as well as the level of agreement on measures of self-reported cross-cutting symptoms, personality traits, disability, and diagnostic severity administered to the same patient on two occasions up to 2 weeks apart (using intraclass correlation coefficients), along with information on the precision of these estimates of reliability. It was also possible to assess the prevalence rates of both DSMIV and DSM-5 conditions in the respective clinical populations. The routine clinical practice field trials involved recruitment of individual psychiatrists and other mental health clinicians and were conducted from October 2011 to March 2012. A volunteer sample was recruited that included generalist and specialty psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice psychiatric mental health nurses. The field trials provided exposure of the proposed DSM-5 diagnoses and dimensional measures to a wide range of clinicians to assess their feasibility and clinical utility. Public and Professional Review In 2010, the APA launched a website devoted to the DSM-5 revision to facilitate public and professional input into DSM-5. All draft diagnostic criteria and proposed changes in organization were posted on www.dsm5.org for a 2-month comment period. Feedback totaled more than 8,000 submissions, which were systematically reviewed by each of the 13 work groups, whose members, where appropriate, integrated questions and comments into discussions of draft revisions and plans for field trial testing. After revisions to the initial draft criteria and proposed chapter organization, a second posting occurred in 2011. Work groups considered feedback from both web postings and the results of the DSM-5 Field Trials when drafting proposed final criteria, which were posted on the website for a third and final time in 2012. These three iterations of external review produced more than 13,000 individually signed comments on the website that were received and reviewed by the work groups, plus thousands of organized petition signers for and against some proposed revisions, all of which allowed the task force to actively address concerns of DSM users, as well as patients and advocacy groups, and ensure that clinical utility remained a high priority. Expert Review and Final Approval The members of the 13 work groups, representing expertise in their respective areas, collaborated with advisors and reviewers under the overall direction of the DSM-5 Task Force to draft the diagnostic criteria and accompanying text. This effort was supported by a team of APA Division of Research staff and developed through a network of text coordinators from each work group. The preparation of the text was coordinated by the text editor, working in close

collaboration

with the work groups and under the direction of the task force chairs. The Scientific Review Committee (SRC) was established to provide a scientific peer review process that was external to that of the work groups. The SRC chair, vice-chair, and six committee members were charged with reviewing the degree to which the proposed changes from DSM-IV could be supported with scientific evidence. Each proposal for diagnostic revision required a memorandum of evidence for change prepared by the work group and accompanied by a summary of supportive data organized around validators for the proposed diagnostic criteria (i.e., antecedent validators such as familial aggregation, concurrent validators such as biological markers, and prospective validators such as response to treatment or course of illness). The submissions were reviewed by the SRC and scored according to the strength of the supportive scientific data. Other justifications for change, such as those arising from clinical experience or need or from a conceptual reframing of diagnostic categories, were generally seen as outside the purview of the SRC. The reviewers' scores, which varied substantially across the different proposals, and an accompanying brief commentary were then returned to the APA Board of Trustees and the work groups for consideration and response. The Clinical and Public Health Committee (CPHC), composed of a chair, vice-chair, and six members, was appointed to consider additional clinical utility, public health, and logical clarification issues for criteria that had not yet accumulated the type or level of evidence deemed sufficient for change by the SRC. This review process was particularly important for DSM-IV disorders with known deficiencies for which proposed remedies had neither been previously considered in the DSM revision process nor been subjected to replicated research studies. These selected disorders were evaluated by four to five external reviewers, and the blinded results were reviewed by CPHC members, who in turn made recommendations to the APA Board of Trustees and the work groups. Forensic reviews of diagnostic criteria and text were conducted by the members of the APA Council on Psychiatry and Law for disorders frequently appearing in forensic environments and ones with high potential for influencing civil and criminal judgments in courtroom settings. Work groups also added forensic experts as advisors in pertinent areas to complement expertise provided by the Council on Psychiatry and Law. A final recommendation from the task force was then provided to the APA Assembly's Committee on DSM-5 to consider some of the clinical utility and feasibility features of the proposed revisions. The Assembly is a deliberative body of the APA representing the district branches and wider membership that is composed of psychiatrists from throughout the United States who provide geographic, practice size, and interest-based diversity. The Committee on DSM-5 was composed of a diverse group of Assembly leaders. Following the preceding review steps, executive "summit committee" sessions were held to consolidate input from review, including Assembly committee chairs, task force chairs, a forensic advisor, and a statistical advisor, for a preliminary review of each disorder by the Assembly and APA Board of Trustees executive committees. This preceded a preliminary review by the full APA Board of Trustees. The Assembly voted, in November 2012, to recommend that the Board approve the publication of DSM-5, and the APA Board of Trustees approved its publication in December 2012. The many experts, reviewers, and

advisors who contributed to this process are listed in the Appendix. Revisions to DSM-5 DSM-5 Iterative Revision Process Advances in digital publishing that allow timely dissemination of changes have paved the way for the American Psychiatric Association to adopt an iterative improvement model for DSM, in which revisions are pegged to specific scientific advances. The DSM Steering

Committee (analogous to the DSM-5 Task Force) was appointed in Spring 2014, with Paul S. Appelbaum, M.D., as Chair and Ellen Leibenluft, M.D., and Kenneth Kendler, M.D., as Vice Chairs, to oversee the iterative revision process, along with the establishment of a web portal (www.dsm5.org) to field proposals on a continuous basis. Proposed changes can include the addition of new disorders and deletion or modification of diagnostic criteria sets in Sections II and III of DSM-5, as well as changes to the text. Submissions must be accompanied by supportive information in a structured format, including the reasons for the change, the magnitude of change, data documenting improvements in validity across a range of validators, evidence of reliability and clinical utility, and consideration of current or potential deleterious consequences associated with the proposed change. Approaches to validating diagnostic criteria for categorical mental disorders have included the following types of evidence: antecedent validators (similar genetic markers, family traits, temperament, and environmental exposure), concurrent validators (similar neural substrates, biomarkers, emotional and cognitive processing, and symptom similarity), and predictive validators (similar clinical course and treatment response). New criteria for current disorders are adopted if they produce improvement in some of these classes of validators. Furthermore, new disorders are added to DSM if they are shown to be valid by a substantial subset of these validators as well as meet the criteria for a mental disorder and demonstrate clinical utility. Proposals submitted to the DSM web portal undergo an initial review by the Steering Committee to determine whether the evidence for the proposal, on its face, appears substantially likely to meet the criteria for approval. If so, the proposal is referred to one of the five standing Review Committees (functionally analogous to the DSM Work Groups), which cover broad domains of psychiatric diagnosis. On receipt of a proposal from the Steering Committee, the assigned Review Committee considers the evidence in support of the proposed change, requests additional information if necessary, and returns the proposal to the Steering Committee with recommendations for disposition and, in some cases, suggested modifications. If the Steering Committee concurs that sufficient evidence appears to exist in support of the proposal, the proposed revision is posted on the DSM-5 website for public comment. The final stage involves making necessary adjustments based on the comments and then forwarding the final version to the APA Assembly and Board of Trustees for their approval. Once approved, the online version of the manual (see https://psychiatryonline.org) is updated to reflect the changes. All changes that have been approved since the publication of DSM-5 in 2013 are included in DSM-5-TR. DSM-5 Text Revision Process In Spring 2019, APA started work on DSM-5-TR, with Michael B. First, M.D., and Philip Wang, M.D., Dr.P.H., as Revision Subcommittee Co-Chairs and Wilson M. Compton, M.D., and Daniel

S. Pine, M.D., as Revision Subcommittee Vice Chairs. The DSM-5-TR development effort involved more than 200 experts (the majority of whom were involved in the development of DSM-5), who were given the task of conducting literature reviews covering the past 10 years and reviewing the text to identify out-of-date material. A review of conflicts of interest for all proposed changes to the text was conducted to eliminate any possible compromise of the objectivity of the content. Mirroring the structure of the DSM-5 process, experts were divided into 20 Disorder review groups, each headed by a section editor. Four cross-cutting review groups (Culture, Sex and Gender, Suicide, and Forensic) reviewed all the chapters, focusing on material involving their specific expertise. The text was also reviewed by a work group on Ethnoracial Equity and Inclusion to ensure appropriate attention to risk factors such as racism and discrimination and the use of nonstigmatizing language. Although the scope of the text revision did not include conceptual

changes to the criteria sets, some necessary clarifications to certain diagnostic criteria became apparent during the review of the text. Proposals for changes in diagnostic criteria or specifier definitions that were a result of the text revision process were reviewed and approved by the DSM Steering Committee, as well as the APA Assembly and Board of Trustees, as part of the DSM-5 iterative revision process described in the prior section. Changes in DSM-5 Organizational Structure DSM is a medical classification of disorders and as such serves as a historically determined cognitive schema imposed on clinical and scientific information to increase its comprehensibility and utility. The classification of disorders (the way in which disorders are grouped) provides a high-level organization for the manual. Regrouping of Disorders in DSM-5 Members of the DSM-5 diagnostic spectra study group examined whether scientific validators could inform possible new groupings of related disorders within the existing categorical framework. Eleven such indicators were recommended by the study group for this purpose (i.e., their ability to meaningfully separate groups of psychiatric illness from each other): neural substrates, family traits, genetic risk factors, specific environmental risk factors, biomarkers, temperamental antecedents, abnormalities of emotional or cognitive processing, symptom similarity, course of illness, high comorbidity, and shared treatment response. These indicators served the study group as empirical guidelines to inform decision-making by the work groups and the task force about how to cluster disorders to maximize their validity and clinical utility (i.e., the more likely that disorders shared these validators, the more likely they would be in the same diagnostic grouping). A series of papers was developed and published in a prominent international journal (Psychological Medicine, Vol. 39, 2009) as part of both the DSM-5 and the ICD-11 developmental processes to document that such validators were most useful for suggesting large

groupings of disorders, as well as for “validating” proposed changes to diagnostic criteria. As the APA and WHO began to plan their respective revisions of DSM and the International Classification of Diseases (ICD), both considered the possibility of improving clinical utility (e.g., by helping to explain apparent comorbidity) and facilitating scientific investigation by rethinking the organizational structures of both publications. It was critical to both the DSM-5 Task Force and the WHO International Advisory Group on the revision of the ICD-10 Section on Mental and Behavioral Disorders that the revisions to organization enhance clinical utility and remain within the bounds of well-replicated scientific information. In that spirit, revision of the organizational structure was approached as a conservative, evolutionary diagnostic reform that would be guided by emerging scientific evidence on the relationships between disorder groups. By reordering and regrouping the existing disorders, the revised structure is meant to stimulate new clinical perspectives and to encourage researchers to identify the psychological and physiological cross-cutting factors that are not bound by strict categorical designations. Early in the course of the revisions, it became apparent that a shared organizational structure would help harmonize the classifications. To the surprise of participants in both revision processes, large sections of the content fell relatively easily into place, reflecting real strengths in some areas of the scientific literature, such as epidemiology, analyses of comorbidity, twin studies, and certain other genetically informed designs. When disparities emerged, they almost always reflected the need to make a judgment about where to place a disorder in the face of incomplete—or, more often, conflicting—data. Thus, for example, on the basis of patterns of symptoms, comorbidity, and shared risk factors, attention-deficit/hyperactivity disorder (ADHD) was placed within the DSM-5 chapter “Neurodevelopmental Disorders,” although the same data also supported strong arguments to place ADHD within the chapter “Disruptive, ImpulseControl, and Conduct Disorders.” These issues were settled with the

preponderance of evidence supporting placement in the “Neurodevelopmental Disorders” chapter in DSM-5. The organization of chapters of DSM-5 after the neurodevelopmental disorders is based on groups of internalizing disorders (i.e., disorders with prominent anxiety, depressive, and somatic symptoms), externalizing disorders (i.e., disorders with prominent impulsive, disruptive conduct, and substance use symptoms), neurocognitive disorders, and other disorders. It is hoped that this organization will encourage further study of underlying pathophysiological processes that give rise to diagnostic comorbidity and symptom heterogeneity. Furthermore, by arranging disorder clusters to mirror clinical reality, DSM-5 should facilitate identification of potential diagnoses by non–mental health specialists, such as primary care physicians. Despite the problem posed by categorical diagnoses, the DSM-5 Task Force recognized that it would have been premature scientifically to propose alternative dimensional definitions for most disorders. The organizational structure is meant to serve as a bridge to new diagnostic approaches without disrupting current clinical practice or research. It is anticipated that the more dimensional DSM-5 approach and organizational structure will facilitate research across current diagnostic categories by encouraging broad investigations within the proposed chapters and across adjacent chapters. Such research should also keep DSM-5 central to the development of dimensional approaches to diagnosis that will likely supplement or supersede current categorical

approaches in coming years. Combining Developmental and Life Span Considerations To improve clinical utility, DSM-5 is organized along developmental and life span trajectories. It begins with diagnoses thought to reflect developmental processes that manifest early in life (e.g., neurodevelopmental disorders and schizophrenia spectrum and other psychotic disorders), followed by diagnoses that more commonly manifest in adolescence and young adulthood (e.g., bipolar and related disorders, depressive disorders, and anxiety disorders), and ends with diagnoses relevant to adulthood and later life (e.g., neurocognitive disorders). A similar approach has been taken, where possible, within each chapter. This organizational structure facilitates the comprehensive use of life span information as a way to assist in diagnostic decision-making. Harmonization With ICD-11 The groups tasked with revising the DSM and ICD systems shared the overarching goal of harmonizing the two classifications as much as possible, for the following reasons: The existence of two major classifications of mental disorders hinders the collection and use of national health statistics, the design of clinical trials aimed at developing new treatments, and the consideration of global applicability of the results by international regulatory agencies. More broadly, the existence of two classifications complicates attempts to replicate scientific results across national boundaries. Even when the intention was to identify identical patient populations, DSM-IV and ICD-10 diagnoses did not always agree. As discussed earlier in this introduction, the effort to harmonize with ICD-11 was confined to the largely successful harmonization of the organizational structure. Because of differences in timing, complete harmonization of the DSM-5 diagnostic criteria with the ICD-11 disorder definitions was not possible because the DSM-5 developmental effort was several years ahead of the ICD-11 revision process. Consequently, the DSM-5 diagnostic criteria were finalized just as the ICD-11 working groups were beginning to develop the ICD-11 clinical descriptions and diagnostic guidelines. Some improvement in harmonization at the disorder level was still achieved; many ICD-11 working group members had participated in the development of the DSM-5 diagnostic criteria, and the ICD-11 working groups were instructed to review the DSM-5 criteria sets and to strive to make ICD-11 diagnostic guidelines as similar to DSM-5 as possible unless there was a considered reason for them to differ. A review comparing DSM-5/ICD-11 differences with DSM-IV/ICD-10 differences found that ICD and

DSM are now closer than at any time since DSM-II and ICD-8 and that current differences are based largely on differing priorities and uses of the two diagnostic systems and on differing interpretations of the evidence. Although ICD-11 was officially endorsed for use by WHO member nations during the 72nd World Health Assembly in May 2019 and officially came into effect on January 1, 2022, each country chooses when to adopt ICD-11. There is currently no proposed timeline for implementation of ICD-11 in the United States. Consequently, for the foreseeable future the

official coding system in the United States continues to be the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Key Conceptual Frameworks and Approaches Definition of a Mental Disorder Each disorder identified in Section II of the manual (excluding those in the chapters “Medication-Induced Movement Disorders and Other Adverse Effects of Medication” and “Other Conditions That May Be a Focus of Clinical Attention”) must meet the definition of a mental disorder. Although no definition can capture all aspects of the range of disorders contained in DSM-5, the following elements are required: 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. The diagnosis of a mental disorder should have clinical utility: it should help clinicians to determine prognosis, treatment plans, and potential treatment outcomes for their patients. However, the diagnosis of a mental disorder is not equivalent to a need for treatment. Need for treatment is a complex clinical decision that takes into consideration symptom severity, symptom salience (e.g., the presence of suicidal thoughts), the individual’s distress (mental pain) associated with the symptom(s), disability related to the individual’s symptoms, risks and benefits of available treatments, and other factors (e.g., psychiatric symptoms complicating other illness). Clinicians may thus encounter individuals whose symptoms do not meet full criteria for a mental disorder but who demonstrate a clear need for treatment or care. The fact that some individuals do not show all symptoms indicative of a diagnosis should not be used to justify limiting their access to appropriate care. It should be noted that the definition of mental disorder was developed for clinical, public health, and research purposes. Additional information is usually required beyond that contained in the DSM-5 diagnostic criteria in order to make legal judgments on such issues as criminal responsibility, eligibility for disability compensation, and competency (see “Cautionary Statement for Forensic Use of DSM-5” at the conclusion of Section I).

Categorical and Dimensional Approaches to Diagnosis Structural problems rooted in the categorical design of DSM have emerged in both clinical practice and research. Relevant evidence of such problems includes high rates of comorbidity among disorders, symptom heterogeneity within disorders, and the substantial need for other specified and unspecified diagnoses to classify the substantial number of clinical presentations that do not meet criteria for any of the specific DSM disorders. Studies of both genetic and environmental risk factors, whether based on twin designs, familial transmission, or molecular analyses, have also raised questions about whether a

categorical approach is the optimal way to structure of the DSM system. There is broad recognition that a too-rigid categorical system does not capture clinical experience or important scientific observations. The results of numerous studies of comorbidity and disease transmission in families, including twin studies and molecular genetic studies, make strong arguments for what many astute clinicians have long observed: the boundaries between many disorder “categories” are more fluid over the life course than has been recognized, and many symptoms that make up the essential features of a particular disorder may occur, at varying levels of severity, in many other disorders. A dimensional approach classifies clinical presentations on the basis of quantification of attributes rather than the assignment to categories and works best in describing phenomena that are distributed continuously and that do not have clear boundaries. Although dimensional systems increase reliability and communicate more clinical information (because they report clinical attributes that might be subthreshold in a categorical system), they also have serious limitations, and thus far, they have been less useful than categorical systems in clinical practice. Numerical dimensional descriptions are much less familiar and vivid than are the category names of mental disorders. Moreover, as yet there is no agreement on the choice of the optimal dimensions to be used for classification purposes. Nonetheless, with the increasing research on, and familiarity with, dimensional systems and the establishment of clinically meaningful cut points to guide treatment decisions, greater acceptance of dimensional approaches both as a method of conveying clinical information and as a research tool is eventually likely. For reasons of both clinical utility and compatibility with the categorical ICD classification required for coding, DSM-5 continues to be a primarily categorical classification with dimensional elements that divides mental disorders into types based on criteria sets with defining features. Despite the categorical framework, it is important to recognize that in DSM-5 there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways. The clinician using DSM-5 should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion. This outlook allows greater flexibility in the use of the system, encourages more specific attention to boundary cases, and emphasizes the need to capture additional clinical information that goes

beyond diagnosis. Cross-Cutting Symptom Measures Given that psychiatric pathologies are not reliably discrete with sharp boundaries from one another, clinicians need to shift their approach to assessment and look beyond the prototypical presentations that neatly coincide with DSM categories. To assist with that transition, Section III, “Emerging Measures and Models,” provides the DSM-5 Level 1 Cross-Cutting Symptom Measure, developed to help clinicians assess all major areas of psychiatric functioning (e.g., mood, psychosis, cognition, personality, sleep) and more thoroughly uncover possible disorders, atypical presentations, subsyndromal conditions, and coexistent pathologies. Just as the review of systems performed in general medicine acts as an inventory designed to call attention to symptoms or signs that otherwise could have been overlooked, the DSM-5 Level 1 Cross-Cutting Symptom Measure acts as a review of mental systems, intended to aid clinicians in better identifying latent disorders and symptoms in need of more detailed assessment (and potentially in need of treatment). The DSM-5 Level 1 Cross-Cutting Symptom Measure is recommended as an important component of the psychiatric evaluation of individuals presenting for psychiatric care, with The American Psychiatric Association Practice

Guidelines for the Psychiatric Evaluation of Adults endorsing its use as a first step in identifying and addressing the heterogeneity of symptoms across diagnostic categories. Self-, parent/guardian-, and child (age 11–17)–rated versions of the DSM-5 Level 1 Cross-Cutting Symptom Measure are available online without charge for clinical use at www.psychiatry.org/dsm5. Removal of the DSM-IV Multiaxial System DSM-IV offered a multiaxial system of recording diagnoses that involved an assessment on several axes, each of which referred to a different domain of information. DSM-5 has moved to a nonaxial documentation of diagnosis. Disorders and conditions formerly listed on Axis I (clinical disorders), Axis II (personality disorders and intellectual developmental disorders), and Axis III (other medical conditions) are listed together without formal differentiation, typically in order of clinical importance. Psychosocial and contextual factors (formerly listed on Axis IV) are listed along with the diagnoses and conditions using Z codes in the chapter “Other Conditions That May Be a Focus of Clinical Attention.” DSM-IV Axis V consisted of the Global Assessment of Functioning (GAF) scale, representing the clinician's judgment of the individual’s overall level of “functioning on a hypothetical continuum of mental health–illness.” This scale has been replaced by the WHO Disability Assessment Schedule (WHODAS), which is included in Section III of DSM-5 (see the chapter “Assessment Measures”). The WHODAS is based on the International Classification of Functioning, Disability and Health (ICF) for use across all of medicine and health care. Cultural and Social Structural Issues

Mental disorders are defined and recognized by clinicians and others in the context of local sociocultural and community norms and values. Cultural contexts shape the experience and expression of the symptoms, signs, behaviors, and thresholds of severity that constitute criteria for diagnosis. Sociocultural contexts also shape aspects of identity (such as ethnicity or race) that confer specific social positions and differentially expose individuals to social determinants of health, including mental health. These cultural elements are transmitted, revised, and recreated within families, communities, and other social systems and institutions and change over time. Diagnostic assessment should include how an individual’s experiences, symptoms, and behaviors differ from relevant sociocultural norms and lead to difficulties in adaptation in his or her current life context. Clinicians should also take into account how individuals’ clinical presentations are influenced by their position within social structures and hierarchies that shape exposure to adversity and access to resources. Key aspects of sociocultural context relevant to diagnostic classification and assessment have been carefully considered in the development of DSM-5-TR. Impact of Cultural Norms and Practices The boundaries between normality and pathology vary across cultural contexts for specific types of behaviors. Thresholds of tolerance for specific symptoms or behaviors differ across cultural contexts, social settings, and families. Hence, the level at which an experience becomes problematic or is perceived as pathological will differ. The judgment that a given behavior, experience, or concern requires clinical attention depends on cultural norms that are internalized by the individual and applied by others around him or her, including family members and clinicians. To accurately assess potential signs and symptoms of psychopathology, clinicians should routinely consider the impact of cultural meanings, identities, and practices on the causes and course of illness, for example, through any of the following factors: levels of vulnerability and the mechanisms of specific disorders (e.g., by amplifying fears that maintain panic disorder or health anxiety); social stigma and support generated by family and community responses to mental illness; coping strategies that enhance resilience in response to illness or help-seeking pathways to access health care of various types, including alternative and complementary treatments; and acceptance or rejection of a diagnosis and adherence to

treatments, affecting the course of illness and recovery. Cultural contexts also affect the conduct of the clinical encounter, including the diagnostic interview. Cultural differences between the clinician/members of the treatment team and the individual have implications for the accuracy and acceptance of diagnosis, as well as for treatment decisions, prognostic considerations, and clinical outcomes. Cultural Concepts of Distress Historically, the construct of the culture-bound syndrome was a focus of work on descriptive phenomenology in cultural psychiatry and psychology. Since DSM-5, this construct has been replaced by three concepts that offer greater clinical utility:

1. Cultural idiom of distress refers to a behavior or linguistic term, phrase, or way of talking about symptoms, problems, or suffering among individuals with similar cultural backgrounds to express or communicate essential features of distress (e.g., stating, “I feel so depressed” to express low mood or discouragement that does not meet the threshold for major depressive

disorder). An idiom of distress need not be associated with specific symptoms, syndromes, or perceived causes. It may be used to convey a wide range of discomfort, including everyday concerns, subclinical conditions, or suffering due to social circumstances rather than mental disorders. For example, most cultural groups have common bodily idioms of distress used to express a wide range of suffering and concerns. 2. Cultural explanation or perceived cause refers to a label, attribution, or feature of an explanatory model that provides a culturally coherent concept of etiology or cause for symptoms, illness, or distress (e.g., the attribution of psychopathology to “stress,” spirits, or failure to follow culturally prescribed practices). Causal explanations may be salient features of local classifications of disease used by laypersons or healers. 3. Cultural syndrome refers to a cluster or group of co-occurring, distinctive symptoms found in specific cultural groups, communities, or contexts (e.g., ataque de nervios [attack of nerves]). The syndrome may or may not be recognized as an illness in the local cultural context (i.e., it might be labeled in nonmedical ways), but such cultural patterns of distress and features of illness may nevertheless be recognizable by an outside observer. These three concepts (for which discussion and examples are provided in the Section III chapter “Culture and Psychiatric Diagnosis”) suggest cultural ways of understanding and describing experiences of distress or illness that can be elicited in the clinical encounter. They influence symptomatology, help-seeking, clinical presentations, expectations of treatment, illness adaptation, and treatment response. The same cultural term often serves more than one of these functions, and usage can change over time. For example, “depression” names a syndrome but has also become a common idiom of distress. Impact of Racism and Discrimination on Psychiatric Diagnosis Clinical work and research in psychiatry are deeply affected by social and cultural constructions of race and ethnicity. Race is a social, not a biological, construct. It is used to divide people into groups based on superficial physical traits such as skin color. Although there is no biological basis for the construct of race, discriminatory practices based on race have profound effects on physical and mental health. The social process by which specific categories of identity are constructed on the basis of racial ideologies and practices is termed racialization. Racialized identities are important because they are strongly associated with systems of discrimination, marginalization, and social exclusion. Other aspects of identity, including ethnicity, gender, language, religion, and sexual orientation, may also be the focus of bias or stereotyping that can affect the process of diagnostic assessment. Racism exists at personal, interpersonal, systemic/institutional, and social structural levels. At the personal level, racism gives rise to internalized stereotypes and experiences of threat, devaluation, neglect,

and injustice that affect individuals' health and well-being. At the interpersonal level, racism includes not only explicit behaviors but also microaggressions, which are everyday slights and offenses that communicate negative attitudes toward specific stigmatized groups, with stress-inducing and traumatizing consequences. Systemic/institutional racism refers to the ways that discrimination is embedded in everyday practices of institutions or organizations, including health care and psychiatry. Systemic racism may not be expressed in overt racial ideologies but may be maintained by

18 implicit and unintentional biases, habits, routines, and practices that result in misrecognition and inequity. As a result, individuals can participate in and inadvertently contribute to systemic racism without consciously endorsing racist ideas. The concept of social structural racism emphasizes the ways that racism and discrimination are manifested in the organization and norms of society and public policy with pervasive inequities in economic resources, power, and privilege that impact exposure to health risk and access to health care. The structural violence and oppression of racism have physical, psychological, and social consequences, including negative effects on mental health. Racism is an important social determinant of health that contributes to a wide variety of adverse health outcomes, including hypertension, suicidal behavior, and posttraumatic stress disorder and can predispose individuals to substance use, mood disorders, and psychosis. Negative racial stereotypes and attitudes affect the psychological development and well-being of racialized groups. Other adverse consequences of discrimination include unequal access to care and clinician bias in diagnosis and treatment; for example, misdiagnosis of schizophrenia among African Americans presenting with mood disorders and other conditions, more coercive pathways to care, less time in outpatient treatment, and more frequent use of physical restraints and suboptimal treatments. Clinicians should make active efforts to recognize and address all forms of racism, bias, and stereotyping in clinical assessment, diagnosis, and treatment. Attention to Culture, Racism, and Discrimination in DSM-5-TR During the DSM-5-TR review process, steps have been taken to address the impact of culture, racism, and discrimination on psychiatric diagnosis in the text of the disorder chapters. A CrossCutting Review Committee on Cultural Issues, composed of 19 U.S.-based and international experts in cultural psychiatry, psychology, and anthropology, reviewed the texts for cultural influences on disorder characteristics, incorporating relevant information in the sections on culture-related diagnostic issues. A separate Ethnoracial Equity and Inclusion Work Group, composed of 10 mental health practitioners from diverse ethnic and racialized backgrounds with expertise in disparity-reduction practices, reviewed references to race, ethnicity, and related concepts to avoid perpetuating stereotypes or including discriminatory clinical information. DSM-5-TR is committed to the use of language that challenges the view that races are discrete and natural entities. The text uses terminology such as racialized instead of racial to highlight the socially constructed nature of race. When the term ethnoracial is used in the text, it denotes the U.S. Census categories, such as Hispanic, White, or African American, that combine ethnic and racialized identifiers. The emerging term Latinx (singular and plural) is used in place of Latino/a to promote gender-inclusive terminology. The term Caucasian is not used because it is based on obsolete and erroneous views about the geographic origin of a prototypical panEuropean ethnicity. The terms minority and non-White are avoided because they describe social groups in relation to a racialized "majority," a practice that tends to perpetuate social hierarchies. When necessary for clarity in reporting epidemiological or other information based on specific studies, however, the text uses the group labels from the relevant studies. The term culture is used not to refer to a discrete social group

(e.g., “prevalence differs across cultures”) but rather to indicate the heterogeneity of cultural views and practices within societies; the terms cultural contexts or cultural backgrounds are preferred instead.

The sections on prevalence for each disorder were reviewed to ensure that findings are presented with clear reference to the geographic areas or social groups included in data collection (e.g., “in the U.S. general population”); this avoids overgeneralizing the findings to communities not yet studied. Prevalence data on specific ethnoracial groups were included when existing research documented reliable estimates based on representative samples. The work group was concerned that data from nonrepresentative samples may be misleading. This explains the limited inclusion of data on certain ethnoracial groups, notably Native Americans. There is an urgent need for research on this and other important groups. Prevalence estimates also depend on the absence of assessment bias; the text indicates when more research is needed to ensure the accuracy of available data. Users are encouraged to read the sections on culture-related diagnostic issues to contextualize the sections on prevalence. Sex and Gender Differences Sex and gender differences as they relate to the causes and expression of medical conditions are established for a number of diseases, including a growing number of mental disorders. Sex refers to factors attributable to an individual’s reproductive organs and XX or XY chromosomal complement. Gender is a result of reproductive organs as well as an individual’s selfrepresentation and includes the psychological, behavioral, and social consequences of the individual’s perceived gender. Much of the information on the expression of psychiatric illness in women and men is based on self-identified gender, and thus we commonly use gender differences or “women and men” or “boys and girls” in DSM-5-TR. However, if information is available and pertinent to “sex”—for example, sex differences in metabolism of substances, or life stages restricted to only one sex, such as pregnancy or menopause—we use the term sex differences or “male and female.” Sex and gender can influence illness in a variety of ways. First, sex may exclusively determine whether an individual is at risk for a disorder (e.g., as in premenstrual dysphoric disorder). Second, sex or gender may moderate the overall risk for development of a disorder as shown by marked differences in the prevalence and incidence rates for selected mental disorders in men and women. Third, sex or gender may influence the likelihood that particular symptoms of a disorder are experienced by an individual. For example, ADHD may manifest differently in boys and girls. Sex or gender may also have other effects on the experience of a disorder that are indirectly relevant to psychiatric diagnosis. For example, certain symptoms may be more readily endorsed by men or women, and this endorsement contributes to differences in service provision (e.g., women may be more likely to recognize a depressive, bipolar, or anxiety disorder and endorse a more comprehensive list of symptoms than do men). Reproductive life cycle events, including variations in ovarian hormones during the menstrual cycle, pregnancy, or menopause, may contribute to sex differences in risk and expression of illness. Thus, the specifier “with peripartum onset” that can apply to brief psychotic disorder or to a manic, hypomanic, or major depressive episode denotes a time frame wherein women may be at increased risk for the onset of an illness episode. In the case of sleep and energy, postpartum alterations are often normative and thus may have lower diagnostic

reliability in postpartum women. The manual is configured to include information on sex and gender at multiple levels. If there are gender-specific symptoms, they have been added to the diagnostic criteria. A sex-related specifier, such as “with peripartum onset” of a mood episode, provides additional information on sex and diagnosis. Prevalence estimates based on sex and

gender are included in the “Prevalence” section of each disorder text. Finally, other issues that are pertinent to diagnosis and influenced by sex and/or gender considerations can be found in the section “Sex- and Gender-Related Diagnostic Issues” in the text for relevant disorders. Association With Suicidal Thoughts or Behavior DSM-5-TR contains a new text section for each diagnosis, “Association With Suicidal Thoughts or Behavior,” when such information is available in the literature. The information included is generally based on studies demonstrating associations of suicidal thoughts or behavior with a given diagnosis. Within groups of individuals with the same diagnosis, a wide range of relevant psychopathology could have an impact on suicide risk, ranging from none to severe. Therefore, in the assessment of a specific individual’s suicide risk, clinicians should use clinical judgment informed by known risk factors and not rely solely on the presence of a diagnosis that has been associated with suicidal thoughts or behavior. The information in these sections should serve as an alert to clinicians that further inquiry may be indicated for an individual with a particular diagnosis. Clinical risk assessment requires an individualized assessment encompassing many factors and goes well beyond the formulation of a DSM-5 diagnosis and the scope of this manual. Additional Resources and Future Directions Conditions for Further Study Described in Section III, “Conditions for Further Study,” are those proposed conditions for which sufficient scientific evidence is not yet available to support widespread clinical use. These proposed criteria and supporting text are included to highlight conditions that could benefit from further research. Assessment and Monitoring Tools: Now and Looking to the Future The various components of DSM-5 are provided to facilitate clinical assessment and to aid in developing a comprehensive case formulation (see “Use of the Manual”) and identification of characteristics that can influence the prognosis of any diagnosed mental disorders. Whereas the diagnostic criteria in Section II are well established and have undergone extensive review, the

assessment tools, Cultural Formulation Interview, and conditions for further study included in Section III are those for which additional scientific evidence may be needed to support widespread clinical use. These diagnostic aids and proposed criteria are included to highlight the evolution and direction of scientific advances in these areas and to stimulate further research. Each of the measures in Section III, “Assessment Measures,” is provided to aid in a comprehensive assessment of individuals that will contribute to a diagnosis and treatment plan tailored to the individual presentation and clinical context. Cross-cutting symptom and diagnosisspecific severity measures provide quantitative ratings of important clinical areas that are designed to be used at the initial evaluation to establish a baseline for comparison with ratings on subsequent encounters to monitor changes and inform treatment planning. Where cultural dynamics are particularly important for diagnostic assessment, the Cultural Formulation Interview (located in the Section III chapter “Culture and Psychiatric Diagnosis”) should be considered as a useful aid to communicate with the individual. All of these measures are available online at: www.psychiatry.org/dsm5. The organizational structure of DSM-5, its use of dimensional measures, and its compatibility with ICD codes will allow it to be readily adaptable to future scientific discoveries and refinements that enhance its clinical utility.

02 - Use of the Manual

Use of the Manual

21 Use of the Manual This text is designed to provide a practical guide to using DSM-5, particularly in clinical practice. Approach to Clinical Case Formulation The primary purpose of DSM-5 is to assist trained clinicians in the diagnosis of mental disorders as part of a case formulation assessment that leads to an informed treatment plan for each individual. The case formulation for any given individual should involve a careful clinical history and concise summary of the social, psychological, and biological factors that may have contributed to developing a given mental disorder. It is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis. A thorough evaluation of these criteria may assure more reliable assessment (which may be aided by the use of dimensional symptom severity assessment tools); the relative severity and salience of an individual's signs and symptoms and their contribution to a diagnosis will ultimately require clinical judgment. Diagnosis requires clinical training to recognize when the combination of predisposing, precipitating, perpetuating, and protective factors has resulted in a psychopathological condition in which the signs and symptoms exceed normal ranges. The ultimate goal of a clinical case formulation is to use the available contextual and diagnostic information in developing a comprehensive treatment plan that is informed by the individual's cultural and social context. However, recommendations for the selection and use of the most appropriate evidence-based treatment options for each disorder are beyond the scope of this manual. Elements of a Diagnosis Diagnostic criteria are offered as guidelines for making diagnoses, and their use should be informed by clinical judgment. Text descriptions, including introductory sections of each diagnostic chapter, can help support diagnosis (e.g., describing the criteria more fully under "Diagnostic Features"; providing differential diagnoses). Following the assessment of diagnostic criteria, clinicians should consider the application of disorder subtypes and/or specifiers as appropriate. Most specifiers are only applicable to the current presentation and may change over the course of the disorder (e.g., with good to fair insight; predominantly inattentive presentation; in a controlled environment) and can be given only if full criteria for the disorder are currently met. Other specifiers are indicative of the lifetime course (e.g., with seasonal pattern, bipolar type in schizoaffective disorder) and can be assigned regardless of current status.

When the symptom presentation does not meet full criteria for any disorder and the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, the "other specified" or "unspecified" category corresponding to the predominant symptoms should be considered. Subtypes and Specifiers Subtypes and specifiers are provided for increased diagnostic specificity. Subtypes define mutually exclusive and jointly exhaustive phenomenological subgroupings within a diagnosis and are indicated by the instruction "Specify whether" in the criteria set (e.g., in anorexia nervosa, Specify whether restricting type or binge-eating/purging type). In contrast, specifiers are not intended to be mutually exclusive or jointly

exhaustive, and as a consequence, more than one specifier may be applied to a given diagnosis. Specifiers (as opposed to subtypes) are indicated by the instruction “Specify” or “Specify if” in the criteria set (e.g., in social anxiety disorder, “Specify if: performance only”). Specifiers and subtypes provide an opportunity to define a more homogeneous subgrouping of individuals with the disorder who share certain features (e.g., major depressive disorder, with mixed features) and to convey information that is relevant to the management of the individual’s disorder, such as the “with other medical comorbidity” specifier in sleep-wake disorders. Although the fifth character within an ICD-10-CM code is sometimes designated to indicate a particular subtype or specifier (e.g., “0” in the fifth character in the F02.80 diagnostic code for major neurocognitive disorder due to Alzheimer’s disease, to indicate the absence of a behavioral disturbance versus a “1” in the fifth character of the F02.81 diagnostic code for major neurocognitive disorder due to Alzheimer’s disease to indicate the presence of a behavioral disturbance), the majority of subtypes and specifiers included in DSM5-TR are not reflected in the ICD-10-CM code and are indicated instead by recording the subtype or specifier after the name of the disorder (e.g., social anxiety disorder, performance type). Use of Other Specified and Unspecified Mental Disorders Although decades of scientific effort have gone into developing the diagnostic criteria sets for the disorders included in Section II, it is well recognized that this set of categorical diagnoses does not fully describe the full range of mental disorders that individuals experience and present to clinicians on a daily basis throughout the world. Hence, it is also necessary to include “other specified” or “unspecified” disorder options for presentations that do not fit exactly into the diagnostic boundaries of disorders in each chapter. Moreover, there are settings (e.g., emergency department) where it may only be possible to identify the most prominent symptom expressions associated with a particular chapter (e.g., delusions, hallucinations, mania, depression, anxiety, substance intoxication, neurocognitive symptoms). In such cases, it may be most appropriate to assign the corresponding “unspecified” disorder as a placeholder until a more complete differential diagnosis is possible. DSM-5 provides two diagnostic options for presentations that do not meet the diagnostic criteria for any of the specific DSM-5 disorders: other specified disorder and unspecified disorder. The other specified category is provided to allow the clinician to communicate the

specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class. This is done by recording the name of the category, followed by the specific reason. For example, with an individual with persistent hallucinations occurring in the absence of any other psychotic symptoms (a presentation that does not meet criteria for any of the specific disorders in the chapter “Schizophrenia Spectrum and Other Psychotic Disorders”), the clinician would record “other specified schizophrenia spectrum and other psychotic disorder, with persistent auditory hallucinations.” If the clinician chooses not to specify the reason that the criteria are not met for a specific disorder, then “unspecified schizophrenia spectrum and other psychotic disorder” would be diagnosed. Note that the differentiation between other specified and unspecified disorders is based on the clinician’s choice to indicate or not the reasons why the presentation does not meet full criteria, providing maximum flexibility for diagnosis. When the clinician determines that there is enough available clinical information to specify the nature of the presentation, the “other specified” diagnosis can be given. In those cases where the clinician is not able to further specify the clinical presentation (e.g., in emergency room settings), the “unspecified” diagnosis can be given. This is entirely a matter of clinical judgment. It is a long-standing DSM convention for conditions included in the “Conditions for Further Study” chapter in Section III to be listed as examples of presentations that can be specified using the “other

specified” designation. The inclusion of these conditions for further study as examples does not represent endorsement by the American Psychiatric Association that these are valid diagnostic categories. Use of Clinical Judgment DSM-5 is a classification of mental disorders that was developed for use in clinical, educational, and research settings. The diagnostic categories, criteria, and textual descriptions are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. It is important that DSM-5 not be applied mechanically by individuals without clinical training. The specific diagnostic criteria included in DSM-5 are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a rigid cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe. On the other hand, lack of familiarity with DSM-5 or excessively flexible and idiosyncratic application of DSM-5 criteria substantially reduces its utility as a common language for communication. Clinical Significance Criterion In the absence of clear biological markers or clinically useful measurements of severity for many mental disorders, it has not been possible to completely separate normal from pathological symptom expressions contained in diagnostic criteria. This gap in information is particularly problematic in clinical situations in which the individual’s symptom presentation by itself (particularly in mild forms) is not inherently pathological and may be encountered in those for

whom a diagnosis of “mental disorder” would be inappropriate. Therefore, a generic diagnostic criterion requiring distress or disability has been used to establish disorder thresholds, usually worded “the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.” Assessing whether this criterion is met, especially in terms of role function, is an inherently difficult clinical judgment. The text following the definition of a mental disorder acknowledges that this criterion may be especially helpful in determining an individual’s need for treatment. Use of information from the individual as well as from family members and other third parties via interview or self- or informantreported assessments regarding the individual’s performance is often necessary. Coding and Recording Procedures The official coding system in use in the United States since October 1, 2015, is the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), a version of the World Health Organization’s ICD-10 that has been modified for clinical use by the Centers for Disease Control and Prevention’s National Center for Health Statistics (NCHS) and provides the only permissible diagnostic codes for mental disorders for clinical use in the United States. Most DSM-5 disorders have an alphanumeric ICD-10-CM code that appears preceding the name of the disorder (or coded subtype or specifier) in the DSM-5-TR Classification and in the accompanying criteria set for each disorder. For some diagnoses (e.g., neurocognitive disorders, substance/medication-induced disorders), the appropriate code depends on further specification and is listed within the criteria set for the disorder with a coding note, and in some cases is further clarified in the text section “Recording Procedures.” The names of some disorders are followed by alternative terms enclosed in parentheses. The use of diagnostic codes is fundamental to medical record keeping. Diagnostic coding facilitates data collection and retrieval and compilation of statistical information. Codes also are often required to report diagnostic data to interested third parties, including governmental agencies, private insurers, and the World Health Organization. For example, in the United States, the use of ICD-10-CM codes for disorders in DSM-5-TR has been mandated by the Health Care Financing Administration for purposes of reimbursement under the Medicare system. Principal Diagnosis/Reason for Visit The general convention in DSM-5 is to allow multiple diagnoses to be

assigned for those presentations that meet criteria for more than one DSM-5 disorder. When more than one diagnosis is given in an inpatient setting, the principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission of the individual. When more than one diagnosis is given for an individual in an outpatient setting, the reason for visit is the condition that is chiefly responsible for the ambulatory medical services received during the visit. In most cases, the principal diagnosis or the reason for visit is also the main focus of attention or treatment. It is often difficult (and somewhat arbitrary) to determine which diagnosis is the principal diagnosis or the reason for visit. For example, it may be unclear which diagnosis

should be considered “principal” for an individual hospitalized with both schizophrenia and alcohol use disorder, because each condition may have contributed equally to the need for admission and treatment. The principal diagnosis is indicated by listing it first, and the remaining disorders are listed in order of focus of attention and treatment. When the principal diagnosis or reason for visit is a mental disorder due to another medical condition (e.g., major neurocognitive disorder due to Alzheimer’s disease, psychotic disorder due to malignant lung neoplasm), ICD coding rules require that the etiological medical condition be listed first. In that case, the principal diagnosis or reason for visit would be the mental disorder due to the medical condition, the second listed diagnosis. For maximum clarity, the disorder listed as the principal diagnosis or the reason for visit can be followed by the qualifying phrase “(principal diagnosis)” or “(reason for visit).” Provisional Diagnosis The modifier “provisional” can be used when there is currently insufficient information to indicate that the diagnostic criteria are met, but there is a strong presumption that the information will become available to allow that determination. The clinician can indicate the diagnostic uncertainty by recording “(provisional)” following the diagnosis. For example, this modifier might be used when an individual who appears to have a presentation consistent with a diagnosis of current major depressive disorder is unable to give an adequate history, but it is expected that such information will become available after interviewing an informant or reviewing medical records. Once that information becomes available and confirms that the diagnostic criteria were met, the modifier “(provisional)” would be removed. Another use of “provisional” is for those situations in which differential diagnosis depends exclusively on whether the duration of illness does not exceed an upper limit as required by the diagnostic criteria. For example, a diagnosis of schizophreniform disorder requires a duration of at least 1 month but less than 6 months. If an individual currently has symptoms consistent with a diagnosis of schizophreniform disorder except that the ultimate duration is unknown because the symptoms are still ongoing, the modifier “(provisional)” would be applied and then removed if the symptoms remit within a period of 6 months. If they do not remit, the diagnosis would be changed to schizophrenia. Notes About Terminology Substance/Medication-Induced Mental Disorder The term “substance/medication-induced mental disorder” refers to symptomatic presentations that are due to the physiological effects of an exogenous substance on the central nervous system, including symptoms that develop during withdrawal from an exogenous substance that is capable of causing physiological dependence. Such exogenous substances include typical intoxicants (e.g., alcohol, inhalants, hallucinogens, cocaine), psychotropic medications (e.g., stimulants; sedatives, hypnotics, anxiolytics), other medications (e.g., steroids), and environmental toxins (e.g., organophosphate insecticides). Editions of DSM from DSM-III to DSM-IV referred to these as “substance-induced mental disorders.” To emphasize that medications and not just substances of abuse can cause psychiatric symptoms, the term was

changed to “substance/medication-induced” in DSM-5. Independent Mental Disorders Historically, mental disorders were divided into those that were termed “organic” (caused by physical factors) versus those that were “nonorganic” (purely of the mind; also referred to as “functional” or “psychogenic”), terms that were included in DSM up through DSM-III-R. Because these dichotomies misleadingly implied that the nonorganic disorders have no biological basis and that mental disorders have no physical basis, DSM-IV updated this terminology as follows: 1) the terms “organic” and “nonorganic” were eliminated from DSM-IV; 2) the disorders formerly called “organic” were divided into those due to the direct physiological effects of a substance (substance-induced) and those due to the direct physiological effects of a medical condition on the central nervous system; and 3) the term “nonorganic mental disorders” (i.e., those disorders not due to either substances or medical conditions) was replaced by “primary mental disorder.” In DSM-5, this terminology was further refined, replacing “primary” with “independent” (e.g., Criterion C in substance/medication-induced anxiety disorder starts with “the disturbance is not better accounted for by an anxiety disorder that is not substanceinduced. Evidence of an independent anxiety disorder could include . . .” [italics added for reference]). This was done to reduce the potential for confusion given that the term “primary” has historically had other meanings (e.g., it is sometimes used to indicate which disorder among several comorbid disorders was the first to occur). The use of “independent mental disorder” should not be construed to mean that the disorder is independent of other potential causal factors such as psychosocial or other environmental stressors. Other Medical Conditions Another dichotomy adopted by prior editions of DSM that reflected mind-body dualism was the division of disorders into “mental disorders” and “physical disorders.” In conjunction with the elimination of organic/nonorganic terminology, DSM-IV replaced the “mental disorder” versus “physical disorder” dichotomy with a “mental disorder” vs. “general medical condition” dichotomy, based on chapter location within the International Classification of Diseases (ICD). Medical conditions in ICD have been divided into 17 chapters based on a variety of factors, which include etiology (e.g., Neoplasms [Chapter 2]), anatomical location (e.g., Diseases of the ear and mastoid process [Chapter 8]), body system (e.g., Diseases of the circulatory system [Chapter 9]), and context (e.g., Pregnancy, childbirth and the puerperium [Chapter 15]). In the ICD framework, mental disorders are those located in Chapter 5, and general medical conditions are those located within the other 16 chapters. Because of concerns that the term “general medical condition” could be conflated with general practice, DSM-5 uses the term “another medical condition” to emphasize the fact that mental disorders are medical conditions and that mental disorders can be precipitated by other medical conditions. It is important to recognize that “mental disorder” and “another medical condition” are merely terms of convenience and should not be taken to imply that there is any fundamental distinction between mental disorders and other medical conditions, that mental disorders are unrelated to physical or biological factors or

processes, or that other medical conditions are unrelated to behavioral or psychosocial factors or processes. Types of Information in the DSM-5-TR Text The DSM-5-TR text provides contextual information to aid in diagnostic decision-making. The text appears immediately following the diagnostic criteria for each disorder and systematically describes the disorder under the following headings: Recording Procedures, Subtypes, Specifiers, Diagnostic Features, Associated Features, Prevalence, Development and Course, Risk and Prognostic Factors, Culture-Related Diagnostic Issues, Sex- and Gender-Related Diagnostic Issues, Diagnostic Markers, Association With Suicidal Thoughts or Behavior, Functional Consequences, Differential Diagnosis, and Comorbidity. In general, when limited information is available for a section, that section is not included. Recording

Procedures provides guidelines for reporting the name of the disorder and for selecting and recording the appropriate ICD-10-CM diagnostic code. It also includes instructions for applying any appropriate subtypes and/or specifiers. Subtypes and/or Specifiers provide brief descriptions of applicable subtypes and/or specifiers. Diagnostic Features provides descriptive text illustrating the use of the criteria and includes key points on their interpretation. For example, within the diagnostic features for schizophrenia, it is explained that some symptoms that may appear to be negative symptoms could instead be attributable to medication side effects. Associated Features includes clinical features that are not represented in the criteria but occur significantly more often in individuals with the disorder than those without the disorder. For example, individuals with generalized anxiety disorder may also experience somatic symptoms that are not contained within the disorder criteria. Prevalence describes rates of the disorder in the community, most often described as 12month prevalence, although for some disorders point prevalence is noted. Prevalence estimates are also provided by age group and by ethnoracial/cultural group when possible. Sex ratio (prevalence in men vs. women) is also provided in this section. When international data are available, geographic variance in prevalence rates is described. For some disorders, especially those for which there are limited data on rates in the community, prevalence in relevant clinical samples is noted. Development and Course describes the typical lifetime patterns of presentation and evolution of the disorder. It notes the typical age at onset and whether the presentation may have prodromal/insidious features or may manifest abruptly. Other descriptions may include an episodic versus persistent course as well as a single episode versus a recurrent episodic course. Descriptors in this section may address duration of symptoms or episodes as well as progression of severity and associated functional impact. The general trend of the disorder over time (e.g., stable, worsening, improving) is described here. Variations that may be noted include features related to developmental stage (e.g., infancy, childhood, adolescence, adulthood, late life). Risk and Prognostic Factors includes a discussion of factors thought to contribute to the

development of a disorder. It is divided into subsections addressing temperamental factors (e.g., personality features); environmental factors (e.g., head trauma, emotional trauma, exposure to toxic substances, substance use); and genetic and physiological factors (e.g., APOE4 for dementia, other known familial genetic risks); this subsection may address familial patterns (traditional) as well as genetic and epigenetic factors. An additional subsection for course modifiers includes factors that may incur a deleterious course, and conversely factors that may have ameliorative or protective effects. Culture-Related Diagnostic Issues includes information on variations in symptom expression, attributions for disorder causes or precipitants, factors associated with differential prevalence across demographic groups, cultural norms that may affect level of perceived pathology, risk of misdiagnosis when evaluating individuals from socially oppressed ethnoracial groups, and other material relevant to culturally informed diagnosis. Prevalence rates in specific cultural/ethnic groups are located in the Prevalence section. Sex- and Gender-Related Diagnostic Issues includes correlates of the diagnosis that are related to sex or gender, predominance of symptoms or the diagnosis by sex or gender, and any other sex- and gender-related diagnostic implications of the diagnosis, such as differences in the clinical course by sex or gender. Prevalence rates by gender are located in the Prevalence section. Diagnostic Markers addresses objective measures that have established diagnostic value. These may include physical examination findings (e.g., signs of malnutrition in avoidant/restrictive food intake disorder), laboratory findings (e.g., low CSF hypocretin-1 levels in narcolepsy), or imaging findings (e.g.,

regionally hypometabolic FDG PET imaging for neurocognitive disorder due to Alzheimer's disease). Association With Suicidal Thoughts or Behavior provides information about disorderspecific prevalence of suicidal thoughts or behavior, as well as risk factors for suicide that may be associated with the disorder. Functional Consequences discusses notable functional consequences associated with a disorder that are likely to have an impact on the daily lives of affected individuals; these consequences may affect the ability to engage in tasks related to education, work, and maintaining independent living. These may vary according to age and across the life span. Differential Diagnosis discusses how to differentiate the disorder from other disorders that have some similar presenting characteristics. Comorbidity includes descriptions of mental disorders and other medical conditions (i.e., conditions classified outside of the Mental and Behavioral disorders chapter in ICD-10-CM), likely to co-occur with the diagnosis. Other Conditions and Disorders in Section II In addition to providing diagnostic criteria and text for DSM-5 mental disorders, Section II also includes two chapters for other conditions that are not mental disorders but may be encountered

by mental health clinicians. These conditions may be listed as a reason for a clinical visit in addition to, or in place of, the mental disorders in Section II. The chapter "Medication-Induced Disorders and Other Adverse Effects of Medication" includes medication-induced parkinsonism, neuroleptic malignant syndrome, medication-induced acute dystonia, medicationinduced acute akathisia, tardive dyskinesia, tardive dystonia/tardive akathisia, medicationinduced postural tremor, antidepressant discontinuation syndrome, and other adverse effect of medication. These conditions are included in Section II because of their frequent importance in

1. the management by medication of mental disorders or other medical conditions, and 2) the differential diagnosis with mental disorders (e.g., anxiety disorder vs. medication-induced acute akathisia). The chapter "Other Conditions That May Be a Focus of Clinical Attention" includes conditions and psychosocial or environmental problems that are not considered to be mental disorders but otherwise affect the diagnosis, course, prognosis, or treatment of an individual's mental disorder. These conditions are presented with their corresponding codes from ICD-10CM (usually Z codes). A condition or problem in this chapter may be coded with or without an accompanying mental disorder diagnosis 1) if it is a reason for the current visit; 2) if it helps to explain the need for a test, procedure, or treatment; 3) if it plays a role in the initiation or exacerbation of a mental disorder; or 4) if it constitutes a problem that should be considered in the overall management plan. These include suicidal behavior and nonsuicidal self-injury; abuse and neglect; relational problems (e.g., Relationship Distress With Spouse or Intimate Partner); educational, occupational, housing, and economic problems; problems related to the social environment, interaction with the legal system, and other psychosocial, personal, and environmental circumstances (e.g., problems related to unwanted pregnancy, being a victim of crime or terrorism); problems related to access to medical and other health care; circumstances of personal history (e.g., Personal History of Psychological Trauma); other health service encounters for counseling and medical advice (e.g., sex counseling); and additional conditions or problems that may be a focus of clinical attention (e.g., wandering associated with a mental disorder, uncomplicated bereavement, phase of life problem). Online Enhancements DSM-5-TR is available in online subscriptions at PsychiatryOnline.org, as well as an e-book that reflects the print edition. The online

version provides a complete set of supporting in-text citations and references not available in print or e-book; it is also updated periodically to reflect any changes resulting from the DSM-5 iterative revision process, described in the Introduction. DSM-5 will be retained online in an archived format at PsychiatryOnline.org, joining prior versions of DSM. Clinical rating scales and measures in the print edition and e-book (see “Assessment Measures” in Section III) are included online along with additional assessment measures used in the field trials (www.psychiatry.org/dsm5), linked to the relevant disorders. From the Section III chapter “Culture and Psychiatric Diagnosis,” the Cultural Formulation Interview, Cultural Formulation Interview—Informant Version (both included in print and e-book), and

supplementary modules to the core Cultural Formulation Interview are all available online at www.psychiatry.org/dsm5.

03 - Cautionary Statement for Forensic Use of DSM

Cautionary Statement for Forensic Use of DSM-5

Cautionary Statement for Forensic Use of DSM-5 Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning, DSM-5 is also used as a reference for the courts and attorneys in assessing the legal consequences of mental disorders. As a result, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than the technical needs of the courts and legal professionals. It is also important to note that DSM-5 does not provide treatment guidelines for any given disorder. When used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, DSM-5 may facilitate legal decision-makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information about longitudinal course may improve decision-making when the legal issue concerns an individual's mental functioning at a past or future point in time. However, the use of DSM-5 in forensic settings should be informed by an awareness of the risks and limitations of its use. When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder such as intellectual developmental disorder (intellectual disability), schizophrenia, major neurocognitive disorder, gambling disorder, or pedophilic disorder does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or "mental illness" as defined in law, or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is usually required beyond that contained in the

DSM-5 diagnosis, which might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of risk, impairment, or disability. Use of DSM-5 to assess the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised. Nonclinical decision-makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the

etiology or causes of the individual's mental disorder or the individual's degree of control over behaviors that may be associated with the disorder. Even when diminished control over the individual's own behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.