11 - 6 Classification in Psychiatry

01 - 6 Classification in Psychiatry

6 Classification in Psychiatry

6

Classification in Psychiatry Classification is the process by which the complexity of phenomena is reduced by arranging them into categories according to some established criteria for one or more purposes. At present, the classification of mental disorders consists of specific mental disorders that are grouped into various classes on the basis of some shared phenomenological characteristics. The ultimate purpose of classification is to improve treatment and prevention efforts. Ideally, a classification of disorders is based on knowledge of etiology or pathophysiology because this increases the likelihood of improving treatment and prevention efforts. But neuroscientists have not yet produced sufficient data to design a diagnostic system that relies on biomarkers that enable psychiatric diagnoses to be based on causes rather symptoms. Instead, the diagnosis of mental disorders is based on clinical observations of clusters of signs and symptoms that are grouped together into disorders or syndromes which are then agreed upon by a consensus of psychiatrists and other mental health professionals. Systems of classification for psychiatric diagnoses have several purposes: to distinguish one psychiatric diagnosis from another, so that clinicians can offer the most effective treatment; to provide a common language among health care professionals; and to explore the still unknown causes of many mental disorders. The two most important psychiatric classifications are the Diagnostic and Statistical Manual of Mental Disorders (DSM) developed by the American Psychiatric Association in collaboration with other groups of mental health professionals, and the International Classification of Diseases (ICD), developed by the World Health Organization. HISTORY The various classification systems used in psychiatry date back to Hippocrates, who introduced the terms mania and hysteria as forms of mental illness in the fifth century BC. Since then, each era has introduced its own psychiatric classification. The first US classification was introduced in 1869 at the annual meeting of the American MedicoPsychological Association, which later became the American Psychiatric Association. In 1952, the American Psychiatric Association’s Committee on Nomenclature and Statistics published the first edition of the DSM (DSM-I). Six editions (Table 6-1) have been published since then: DSM-II (1968); DSM-III (1980); a revised DSM-III, DSM-III-R (1987); DSM-IV (1994); DSM-IV-TR (TR stands for text revision) (2000); and DSM-5 published in 2013 (the roman numerals are no longer used). Table 6-1 DSM Editions*

RELATION TO ICD-10 ICD-10 is the official classification system used in Europe and many other parts of the world. DSM-5 was designed to correspond to the 10th revision of ICD (ICD-10), first developed in 1992. This was done to ensure uniform reporting of national and international health statistics. In addition, Medicare requires that billing codes for reimbursement follow ICD. All categories used in DSM-5 are found in ICD-10, but not all ICD-10 categories are in DSM-5. The DSM-5 is the official psychiatric coding system used in the United States. Although some psychiatrists have been critical of the many versions of DSM that have appeared since 1952, including the current edition, DSM-5 is the official US nomenclature. All terminology used in this textbook conforms to DSM-5 nomenclature. Either DSM or ICD codes may be used for insurance purposes and medical reporting. On October 1, 2014 all US health care providers and systems, as recommended by the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC-NCHS) and the Centers for Medicare and Medicaid Services (CMS), were expected to use the ICD-10 codes for mental disorders, the DSM-5 codes no longer being required for coding purposes. That date was postponed to October 1, 2015. Basic Features Descriptive Approach. The approach to DSM-5 is atheoretical with regard to causes. Thus, DSM-5 attempts to describe the manifestations of the mental disorders and only rarely attempts to account for how the disturbances come about. The definitions of the disorders usually consist of descriptions of clinical features. Diagnostic Criteria. Specified diagnostic criteria are provided for each specific mental disorder. These criteria include a list of features that must be present for the diagnosis to be made. Such criteria increase the reliability of the diagnostic process. Systematic Description. DSM-5 systematically describes each disorder in terms of its associated features: specific age-, culture-, and gender-related features; prevalence, incidence, and risk; course; complications; predisposing factors; familial pattern; and

differential diagnosis. In some instances, when many specific disorders share common features, this information is included in the introduction to the entire section. Laboratory findings and associated physical examination signs and symptoms are described when relevant. DSM-5 is a diagnostic manual, not a textbook. It makes no mention of theories of causes, management, or treatment or the controversial issues, of which there are many, that surround a particular diagnostic category. For that, one requires a textbook such as Comprehensive Textbook of Psychiatry, which is free to discuss controversy and alternative points of view. DSM-5 CLASSIFICATION The DSM-5 lists 22 major categories of mental disorders, comprising more than 150 discrete illnesses. All of the disorders listed in DSM-5 are described in detail in the sections of the book that follow and cover epidemiology, etiology, diagnosis, differential diagnoses, clinical features, and treatment of each disorder. In this section, only a brief description of the disorders is provided to give the reader an overview of psychiatric classification, including some of the changes made from DSM-IV to DSM-5. The organization of the disorders in DSM-5 attempts to follow the lifespan. Thus, neurodevelopmental disorders that occur early in life are listed first in the classification system, and neurocognitive disorders that occur toward the end of life are listed last. Some disorders, however, such as encopresis and enuresis, which are associated with childhood, are assigned to the middle of the classification system, which presumably refers to adulthood. The justification for this organization is explained in the introduction to DSM-5 as a way to assist the diagnostic decision-making process; but whether or not this organizational schema is of any heuristic value is open to question. Neurodevelopmental Disorders These disorders are usually first diagnosed in infancy, childhood, or adolescence. Intellectual Disability or Intellectual Developmental Disorder (previously called mental retardation in DSM-IV). Intellectual disability (ID)

is characterized by significant, below average intelligence and impairment in adaptive functioning. Adaptive functioning refers to how effective individuals are in achieving age-appropriate common demands of life in areas such as communication, self-care, and interpersonal skills. In DSM-5, ID is classified as mild, moderate, severe, or profound based on overall functioning; in DSM-IV, it was classified according to intelligence quotient (IQ) as mild (50–55 to 70), moderate (35–40 to 50–55), severe (20– 25 to 35–40), or profound (below 20–25). A variation of ID called global developmental delay is for children younger than 5 years with severe defects exceeding those above. Borderline intellectual functioning is used in DSM-5 but is not clearly differentiated from mild ID. In DSM-IV, it meant an IQ of about 70, but in DSM-5, it is categorized as a

condition that may be the focus of clinical attention, but no criteria are given. Communication Disorders. There are four types of communication disorders that are diagnosed when problems in communication cause significant impairment in functioning: (1) language disorder is characterized by a developmental impairment in vocabulary resulting in difficulty producing age-appropriate sentences; (2) speech sound disorder is marked by difficulty in articulation; (3) childhood-onset fluency disorder or stuttering is characterized by difficulty in fluency, rate, and rhythm of speech; and (4) social or pragmatic communication disorder is profound difficulty in social interaction and communication with peers. Autism Spectrum Disorder. The autistic spectrum includes a range of behaviors characterized by severe difficulties in multiple developmental areas, including social relatedness; communication; and range of activity and repetitive and stereotypical patterns of behavior, including speech. They are divided into 3 levels: Level 1 is characterized by the ability to speak with reduced social interaction (this level resembles Asperger’s disorder, which is no longer part of DSM-5); Level 2, which is characterized by minimal speech and minimal social interaction (diagnosed as Rett’s disorder in DSMIV but not part of DSM-5); and Level 3, marked by a total lack of speech and no social interaction. Attention-Deficit/Hyperactivity Disorder (ADHD). Since the 1990s, ADHD has been one of the most frequently discussed psychiatric disorders in the lay media because of the sometimes unclear line between age-appropriate normal and disordered behavior and because of the concern that children without the disorder are being misdiagnosed and treated with medication. The central features of the disorder are persistent inattention, hyperactivity and impulsivity, or both that cause clinically significant impairment in functioning. Specific Learning Disorders. These are maturational deficits in development that are associated with difficulty in acquiring specific skills in reading (also known as dyslexia), in written expression, or in mathematics (also known as dyscalculia). Motor Disorders. Analogous to learning disorders, motor disorders are diagnosed when motor coordination is substantially below expectations based on age and intelligence and when coordination problems significantly interfere with functioning. There are three major types of motor disorders: (1) developmental coordination disorder is an impairment in the development of motor coordination (e.g., delays in crawling or walking, dropping things, or poor sports performance); (2) stereotypic movement disorder consists of repetitive motion activity (e.g., head banging and body rocking); and (3) tic disorder is characterized by sudden involuntary, recurrent, and stereotyped movement or vocal sounds. There are two types of tic disorders; The first is Tourette’s disorder, characterized by motor and vocal tics, including coprolalia, and the second is persistent

chronic motor or vocal tic disorders marked by a single motor or vocal tic. Schizophrenia Spectrum and Other Psychotic Disorders The section on schizophrenia and other psychotic disorders includes eight specific disorders (schizophrenia, schizophreniform disorder, schizoaffective disorder,

delusional disorder, brief psychotic disorder, substance/medication-induced psychotic disorder, psychotic disorder due to another medical condition, and catatonia) in which psychotic symptoms are prominent features of the clinical picture. The grouping of disorders in DSM-5 under this heading includes schizotypal personality disorder, which is not a psychotic disorder but that sometimes precedes full-blown schizophrenia. In Synopsis, this is discussed under personality disorders (see Chapter 22). Schizophrenia. Schizophrenia is a chronic disorder in which prominent hallucinations or delusions are usually present. The individual must be ill for at least 6 months, although he or she need not be actively psychotic during all of that time. Three phases of the disorder are recognized by clinicians, although they are not included in DSM-5 as discrete phases. The prodrome phase refers to deterioration in function before the onset of the active psychotic phase. The active phase symptoms (delusions, hallucinations, disorganized speech, grossly disorganized behavior, or negative symptoms such as flat affect, avolition, and alogia) must be present for at least 1 month. The residual phase follows the active phase. The features of the residual and prodromal phases include functional impairment and abnormalities of affect, cognition, and communication. In DSM-IV, schizophrenia was subtyped according to the most prominent symptoms present at the time of the evaluation (paranoid, disorganized, catatonic, undifferentiated, and residual types); however, those subtypes are no longer part of the official DSM-5 nomenclature. Nevertheless, they are phenomenologically accurate, and the authors of Synopsis believe they remain useful descriptions that clinicians will still find helpful when communicating with one another. Delusional Disorder. Delusional disorder is characterized by persistent delusions (e.g., erotomanic, grandiose, jealous, persecutory, somatic, mixed, unspecified). In general, the delusions are about situations that could occur in real life such as infidelity, being followed, or having an illness, which are categorized as nonbizarre beliefs. Within this category one finds what was termed in DSM-IV, Shared Delusional Disorder (also known as folie a deux) but which has been renamed delusional symptoms in partner with delusional disorder in DSM-5 and is characterized by a delusional belief that develops in a person who has a close relationship with another person with the delusion, the content of which is similar. Paranoia (a term not included in DSM-5) is a rare condition characterized by the gradual development of an elaborate delusional system, usually with grandiose ideas; it has a chronic course, and the rest of the personality remains intact.

Brief Psychotic Disorder. Brief psychotic disorder requires the presence of delusions, hallucinations, disorganized speech, grossly disorganized behavior, or catatonic behavior for at least 1 day but less than 1 month. It may be precipitated by an external life stress. After the episodes, the individual returns to his or her usual level of functioning. Schizophreniform Disorder. Schizophreniform disorder is characterized by the same active phase symptoms of schizophrenia (delusions, hallucinations, disorganized speech, grossly disorganized behavior, or negative symptoms), but it lasts between 1 and 6 months and has no prodromal or residual phase features of social or occupational impairment. Schizoaffective Disorder. Schizoaffective disorder is also characterized by the same active phase symptoms of schizophrenia (delusions, hallucinations, disorganized speech, grossly disorganized behavior, or negative symptoms), as well as the presence of a manic or depressive syndrome that is not brief relative to the duration of the psychosis. Individuals with schizoaffective disorder, in contrast to a mood disorder with psychotic features, have delusions or hallucinations for at least 2 weeks without coexisting prominent mood symptoms. Substance/Medication-Induced Psychotic Disorder. These are disorders with symptoms of psychosis caused by psychoactive or other substances (e.g., hallucinogens, cocaine). Psychotic

Disorder Due to Another Medical Condition. This disorder is characterized by hallucinations or delusions that result from a medical illness (e.g., temporal lobe epilepsy, avitaminosis, meningitis). Catatonia. Catatonia is characterized by motor abnormalities such as catalepsy (waxy flexibility), mutism, posturing, and negativism. It can be associated with another mental disorder (e.g., schizophrenia or bipolar disorder) or due to another medical condition (e.g., neoplasm, head trauma, hepatic encephalopathy). Bipolar and Related Disorders Bipolar disorder is characterized by severe mood swings between depression and elation and by remission and recurrence. There are four variants: bipolar I disorder, bipolar II disorder, cyclothymic disorder, and bipolar disorder due to substance/medication or another medical condition. Bipolar I Disorder. The necessary feature of bipolar I disorder is a history of a manic or mixed manic and depressive episode. Bipolar I disorder is subtyped in many ways, including type of current episode (manic, hypomanic depressed, or mixed),

severity and remission status (mild, moderate, severe without psychosis, severe with psychotic features, partial remission, or full remission), and whether the recent course is characterized by rapid cycling (at least four episodes in 12 months). Bipolar II Disorder. Bipolar II disorder is characterized by a history of hypomanic and major depressive episodes. The symptom criteria for a hypomanic episode are the same as those for a manic episode, although hypomania only requires a minimal duration of 4 days. The major difference between mania and hypomania is the severity of the impairment associated with the syndrome. Cyclothymic Disorder. This is the bipolar equivalent of dysthymic disorder (see later discussion). Cyclothymic disorder is a mild, chronic mood disorder with numerous depressive and hypomanic episodes over the course of at least 2 years. Bipolar Disorder Due to Another Medical Condition. Bipolar disorder caused by a general medical condition is diagnosed when evidence indicates that a significant mood disturbance is the direct consequence of a general medical condition (e.g., frontal lobe tumor). Substance/Medication-Induced Bipolar Disorder. Substance-induced mood disorder is diagnosed when the cause of the mood disturbance is substance intoxication, withdrawal, or medication (e.g., amphetamine). Depressive Disorders Depressive disorders are characterized by depression; sadness; irritability; psychomotor retardation; and, in severe cases, suicidal ideation. They include a number of conditions described below. Major Depressive Disorder The necessary feature of major depressive disorder is depressed mood or loss of interest or pleasure in usual activities. All symptoms must be present nearly every day, except suicidal ideation or thoughts of death, which need only be recurrent. The diagnosis is excluded if the symptoms are the result of a normal bereavement and if psychotic symptoms are present in the absence of mood symptoms. Persistent Depressive Disorder or Dysthymia Dysthymia is a mild, chronic form of depression that lasts at least 2 years, during which, on most days, the individual experiences depressed mood for most of the day and at least two other symptoms of depression. Premenstrual Dysphoric Disorder. Premenstrual dysphoric disorder occurs

about 1 week before the menses and is characterized by irritability, emotional lability, headache, and anxiety or depression that remits after the menstrual cycle is over. Substance/Medication-Induced Depressive Disorder. This disorder is characterized by a depressed mood that is due to a substance (e.g., alcohol) or medication (e.g., barbiturate). Depressive Disorder Due to Another Medical Condition. This condition is a state of depression secondary to a medical disorder (e.g., hypothyroidism, Cushing’s syndrome). Other Specified Depressive Disorder. This diagnostic category includes two subtypes: (1) recurrent depressive episode, which is a depression that lasts

between 2 to 13 days and that occurs at least once a month, and (2) short-duration depressive episode, which is a depressed mood lasting from 4 to 14 days and which is nonrecurrent. Unspecified Depressive Disorder. This diagnostic category includes four major subtypes: (1) melancholia, which is a severe form of major depression characterized by hopelessness, anhedonia, and psychomotor retardation, and which also carries with it a high risk of suicide; (2) atypical depression, which is marked by a depressed mood that is associated with weight gain instead of weight loss and with hypersomnia instead of insomnia; (3) peripartum depression, which is a depression that occurs around parturition or within 1 month after giving birth (called post-partum depression in DSM-IV); and (4) seasonal pattern, which is a depressed mood that occurs at a particular time of the year, usually winter (also known as seasonal affective disorder [SAD]). Disruptive Mood Dysregulation Disorder. This is a new diagnosis listed as a depressive disorder, which is diagnosed in children older than age 6 years and younger than age 18 years and is characterized by severe temper tantrums, chronic irritability, and angry mood. Anxiety Disorders The section on anxiety disorders includes nine specific disorders (panic disorder, agoraphobia, specific phobia, social anxiety disorder or social phobia, generalized anxiety disorder, anxiety disorder caused by a general medical condition, and substanceinduced anxiety disorder) in which anxious symptoms are a prominent feature of the clinical picture. Because separation anxiety disorder and selective mutism occur in childhood, they are discussed in the childhood disorders section of this book. Panic Disorder. A panic attack is characterized by feelings of intense fear or terror that come on suddenly in situations when there is nothing to fear. It is accompanied by heart racing or pounding, chest pain, shortness of breath or choking, dizziness,

trembling or shaking, feeling faint or lightheaded, sweating, and nausea. Agoraphobia. Agoraphobia is a frequent consequence of panic disorder, although it can occur in the absence of panic attacks. Persons with agoraphobia avoid (or try to avoid) situations that they think might trigger a panic attack (or panic-like symptoms) or situations from which they think escape might be difficult if they have a panic attack. Specific Phobia. Specific phobia is characterized by an excessive, unreasonable fear of specific objects or situations that almost always occurs on exposure to the feared stimulus. The phobic stimulus is avoided, or, when not avoided, the individual feels severely anxious or uncomfortable. Social Anxiety Disorder or Social Phobia. Social phobia is characterized by the fear of being embarrassed or humiliated in front of others. Similar to specific phobia, the phobic stimuli are avoided, or, when not avoided, the individual feels severely anxious and uncomfortable. When the phobic stimuli include most social situations, then it is specified as generalized social phobia. Generalized Anxiety Disorder. Generalized anxiety disorder is characterized by chronic excessive worry that occurs more days than not and is difficult to control. The worry is associated with symptoms, such as concentration problems, insomnia, muscle tension, irritability, and physical restlessness, and causes clinically significant distress or impairment. Anxiety Disorder Due to Another Medical Condition. Anxiety disorder caused by a general medical condition is diagnosed when evidence indicates that significant anxiety is the direct consequence of a general medical condition (e.g., hyperthyroidism). Substance/Medication-Induced Anxiety Disorder. Substance-induced anxiety disorder is diagnosed when the cause of the anxiety is a substance (e.g., cocaine) or is the result of a medication (e.g., cortisol). Separation Anxiety Disorder. Separation anxiety disorder occurs in children and is characterized by excessive anxiety about separating from home or attachment figures beyond that expected for the child’s developmental level. Selective Mutism. Selective mutism is characterized by a persistent refusal to speak in specific situations despite the demonstration of speaking ability in other situations.

Obsessive-Compulsive and Related Disorders

There are eight categories of disorders listed in this section, all of which have associated obsessions (repeated thoughts) or compulsions (repeated activities). Obsessive-Compulsive Disorder (OCD). OCD is characterized by repetitive and intrusive thoughts or images that are unwelcome (obsessions) or repetitive behaviors that the person feels compelled to do (compulsions) or both. Most often, the compulsions are done to reduce the anxiety associated with the obsessive thought. Body Dysmorphic Disorder. Body dysmorphic disorder is characterized by a distressing and impairing preoccupation with an imagined or slight defect in appearance. If the belief is held with delusional intensity, then delusional disorder, somatic type, might be diagnosed. Hoarding Disorder. Hoarding disorder is a behavioral pattern of accumulating items in a compulsive manner that may or may not have any utility to the person. The person is unable to get rid of those items even though they may create hazardous situations in the home such as risk of fire. Trichotillomania or Hair-Pulling Disorder. Trichotillomania is characterized by repeated hair pulling causing noticeable hair loss. It may occur anywhere on the body (e.g., head, eyebrows, pubic area). Excoriation or Skin-Picking Disorder. Skin-picking disorder is marked by the compulsive need to pick at one’s skin to the point of doing physical damage. Substance/Medication-Induced Obsessive-Compulsive Disorder. This disorder is characterized by obsessive or compulsive behavior that is secondary to the use of a medication or a substance such as abuse of cocaine that can cause compulsive skin picking (called formication). Obsessive-Compulsive Disorder Due to Another Medical Condition. The cause of either obsessive or compulsive behavior is due to a medical condition, as sometimes may occur after a streptococcal infection. Other Specified Obsessive-Compulsive and Related Disorder. This category includes a group of disorders such as obsessional jealousy in which one person has repeated thoughts about infidelity in the spouse or partner. It must be distinguished from a delusional belief such as Koro, which is a disorder found in South and East Asia in which the person believes the genitalia are shrinking and disappearing into the body; and body-focused repetitive behavior disorder in which the person engages in a compulsive behavioral pattern such as nail biting or lip chewing. Trauma- or Stressor-Related Disorder

This group of disorders is caused by exposure to a natural or human-made disaster or to a significant life stressor such as experiencing abuse. There are six conditions that fall under this category in DSM-5. Reactive Attachment Disorder. This disorder appears in infancy or early childhood and is characterized by a severe impairment in the ability to relate because of grossly pathological caregiving. Disinhibited Social Engagement Disorder. This is a condition in which the child or adolescent has a deep-seated fear of interacting with strangers, especially adults, usually as a result of a traumatic upbringing. Posttraumatic Stress Disorder (PTSD). PTSD occurs after a traumatic event in which the individual believes that he or she is in physical danger or that his or her life is in jeopardy. PTSD can also occur after witnessing a violent or life-threatening event happening to someone else. The symptoms of PTSD usually occur soon after the traumatic event, although, in some cases, the symptoms develop months or even years after the trauma. PTSD is diagnosed when a person reacts to the traumatic event with fear and re-experiences symptoms over time or has symptoms of avoidance and hyperarousal. The symptoms persist for at least 1 month and cause clinically significant impairment in functioning or distress. Acute Stress Disorder. Acute stress disorder occurs after the same type of stressors that precipitate PTSD; however, acute stress disorder is not diagnosed if the symptoms last beyond 1 month. Adjustment Disorders. Adjustment disorders are maladaptive reactions to clearly defined life stress. They are divided into

subtypes depending on symptoms—with anxiety, with depressed mood, with mixed anxiety and depressed mood, disturbance of conduct, and mixed disturbance of emotions and conduct. Persistent Complex Bereavement Disorder. Chronic and persistent grief that is characterized by bitterness, anger, or ambivalent feelings toward the dead accompanied by intense and prolonged withdrawal characterizes persistent complex bereavement disorder (also known as complicated grief or complicated bereavement). This must be distinguished from normal grief or bereavement. Dissociative Disorders The section on dissociative disorders includes four specific disorders (dissociative amnesia, dissociative fugue, dissociative identity disorder, and depersonalization/derealization disorder) characterized by a disruption in the usually integrated functions of consciousness, memory, identity, or perception.

Dissociative Amnesia. Dissociative amnesia is characterized by memory loss of important personal information that is usually traumatic in nature. Dissociative Fugue. Dissociative fugue is characterized by sudden travel away from home associated with partial or complete memory loss about one's identity. Dissociative Identity Disorder. Formerly called multiple personality disorder, the essential feature of dissociative identity disorder is the presence of two or more distinct identities that assume control of the individual's behavior. Depersonalization/Derealization Disorder. The essential feature of depersonalization/derealization disorder is persistent or recurrent episodes of depersonalization (an altered sense of one's physical being, including feeling that one is outside of one's body, physically cut off or distanced from people, floating, observing oneself from a distance, as though in a dream) or derealization (experiencing the environment as unreal or distorted). Somatic Symptom and Related Disorders This group of disorders (previously called somatoform disorders in DSM-IV) is characterized by marked preoccupation with the body and fears of disease or consequences of disease (e.g., death). Somatic Symptom Disorder. Somatic symptom disorder is characterized by high levels of anxiety and persistent worry about somatic signs and symptoms that are misinterpreted as having a known medical disorder. It is also known as hypochondriasis. Illness Anxiety Disorder. Illness anxiety disorder is the fear of being sick with few or no somatic symptoms. It is a new diagnosis in DSM-5. Functional Neurological Symptom Disorder. Formerly known as conversion disorder in DSM-IV, this condition is characterized by unexplained voluntary or motor sensory deficits that suggest the presence of a neurological or other general medical condition. Psychological conflict is determined to be responsible for the symptoms. Psychological Factors Affecting Other Medical Conditions. This category is for psychological problems that negatively affect a medical condition by increasing the risk of an adverse outcome. Factitious Disorder. Factitious disorder, also called Munchausen syndrome, refers to the deliberate feigning of physical or psychological symptoms to assume the sick role. Factitious disorder imposed on another (previously called factitious disorder by proxy) is

when one person presents the other person as ill, most often mother and child. Factitious disorder is distinguished from malingering in which symptoms are also falsely reported; however, the motivation in malingering is external incentives, such as avoidance of responsibility, obtaining financial compensation, or obtaining substances. Other Specified Somatic Symptom and Related Disorder. This category is for disorders that are not classified above. One such disorder is pseudocyesis, in which a person believes falsely that she (or he in rare instances) is pregnant. Feeding and Eating Disorders Feeding and eating disorders are characterized by a marked disturbance in eating behavior. Anorexia Nervosa. Anorexia nervosa is an eating disorder characterized by loss of body weight and refusal to eat. Appetite is usually intact. Bulimia Nervosa.

Bulimia nervosa is an eating disorder characterized by recurrent and frequent binge eating with or without vomiting. Binge Eating Disorder. Binge eating disorder is a variant of bulimia nervosa with occasional, once a week, binge eating. Pica. Pica is the eating of non-nutritional substances (e.g., starch). Rumination Disorder. The essential feature of rumination disorder is the repeated regurgitation of food, usually beginning in infancy or childhood. Avoidant/Restrictive Food Intake Disorder. Previously called feeding disorder of infancy or childhood in DSM-IV, the main feature of this disorder is a lack of interest in food or eating, resulting in failure to thrive. Elimination Disorders These are disorders of elimination caused by physiological or psychological factors. There are two: encopresis, which is the inability to maintain bowel control, and enuresis, which is the inability to maintain bladder control. Sleep-Wake Disorders Sleep-wake disorders involve disruptions in sleep quality, timing, and amount that result in daytime impairment and distress. They include the following disorders or disorder groups in DSM-5.

Insomnia Disorder. Difficulty falling asleep or staying asleep is characteristic of insomnia disorder. Insomnia can be an independent condition, or it can be comorbid with another mental disorder, another sleep disorder, or another medical condition. Hypersomnolence Disorder. Hypersomnolence disorder, or hypersomnia, occurs when a person sleeps too much and feels excessively tired despite normal or because of prolonged quantity of sleep. Parasomnias. Parasomnias are marked by unusual behavior, experiences, or physiological events during sleep. This category is divided into three subtypes: non-REM movement sleep arousal disorders, which involve incomplete awakening from sleep accompanied by either sleepwalking or sleep terror disorder; nightmare disorder in which nightmares induce awakening repeatedly and cause distress and impairment; and REM sleep behavior disorder, which is characterized by vocal or motor behavior during sleep. Narcolepsy. Narcolepsy is marked by sleep attacks, usually with loss of muscle tone (cataplexy). Breathing-Related Sleep Disorders. There are three subtypes of breathingrelated sleep disorders. The most common of the three is obstructive sleep apnea hypopnea in which apneas (absence of airflow) and hypopneas (reduction in airflow) occur repeatedly during sleep, causing snoring and daytime sleepiness. Central sleep apnea is the presence of Cheyne-Stokes breathing in addition to apneas and hypopneas. Last, sleep-related hypoventilation causes elevated CO_2 levels from decreased respiration. Restless Legs Syndrome. Restless legs syndrome is the compulsive movement of legs during sleep. Substance/Medication-Induced Sleep Disorder. This category includes sleep disorders that are caused by a drug or medication (e.g., alcohol, caffeine). Circadian Rhythm Sleep-Wake Disorders. Underlying these disorders is a pattern of sleep disruption that alters or misaligns a person’s circadian system, resulting in insomnia or excessive sleepiness. There are six types: (1) delayed sleep phase type is characterized by sleep-wake times that are several hours later than desired or conventional times; (2) advanced sleep phase type is characterized by earlier than usual sleep-onset and wake-up times; (3) irregular sleep-wake type is characterized by fragmented sleep throughout the 24-hour day with no major sleep period and no discernible sleep-wake circadian rhythm; (4) non-24-hour sleep-wake type is a circadian period that is not aligned to the external 24-hour environment, most common among blind or visually impaired individuals; (5) shift work type is from working on a nightly schedule on a regular basis; and (6) unspecified type that does not meet any of the above

criteria. Sexual Dysfunctions Sexual dysfunctions are divided into ten disorders that are related to change in sexual desire or performance. Delayed Ejaculation. Delayed ejaculation is the inability or marked delay in the ability to ejaculate during coitus or masturbation. Erectile Disorder. Erectile

disorder is the inability to achieve or maintain an erection sufficient for coital penetration. Female Orgasmic Disorder. Female orgasmic disorder is the absence of the ability to achieve orgasm or a significant reduction in the intensity of orgasmic sensations during masturbation or coitus. Female Sexual Interest/Arousal Disorder. Female sexual interest/arousal disorder is absent or decreased interest in sexual fantasy or behavior that causes distress in the individual. Genito-Pelvic Pain/Penetration Disorder. Genito-pelvic pain/penetration disorder replaces the terms vaginismus and dyspareunia (vaginal spasm and pain interfering with coitus). It is the anticipation of or actual pain during sex activities, particularly related to intromission. Male Hypoactive Sexual Desire Disorder. Male hypoactive sexual desire disorder is absent or reduced sexual fantasy or desire in men. Premature or Early Ejaculation. Premature ejaculation is manifested by ejaculation that occurs before or immediately after intromission during coitus. Substance/Medication-Induced Sexual Dysfunction. Substance/medicationinduced sexual dysfunction is impaired function due to substances (e.g., fluoxetine). Other Unspecified Sexual Dysfunction. These include sexual disorder due to a medical condition (e.g., multiple sclerosis). Gender Dysphoria Gender dysphoria, previously called Gender Identity Disorder, is characterized by a persistent discomfort with one's biological sex and, in some cases, the desire to have sex organs of the opposite sex. It is subdivided into gender dysphoria in children and gender dysphoria in adolescents and adults.

Disruptive, Impulse-Control, and Conduct Disorders Included in this category are conditions involving problems in the self-control of emotions and behaviors. Oppositional Defiant Disorder. Oppositional defiant disorder is diagnosed in children and adolescents. Symptoms include anger, irritability, defiance, and refusal to comply with regulations. Intermittent Explosive Disorder. Intermittent explosive disorder involves uncontrolled outbursts of aggression. Conduct Disorder. Conduct disorder is diagnosed in children and adolescents and is characterized by fighting and bullying. Pyromania. Repeated fire setting is the distinguishing feature of pyromania. Kleptomania. Repeated stealing is the distinguishing feature of kleptomania. SUBSTANCE-RELATED DISORDERS Substance-Induced Disorders. Psychoactive and other substances may cause intoxication and withdrawal syndrome and induce psychiatric disorders, including bipolar and related disorders, obsessive-compulsive and related disorders, sleep disorders, sexual dysfunction, delirium, and neurocognitive disorders. Substance Use Disorders. Sometimes referred to as addiction, this is a group of disorders diagnosed by the substance abused—alcohol, cocaine, cannabis, hallucinogens, inhalants, opioids, sedative, stimulant, or tobacco. Alcohol-Related Disorders. Alcohol-related disorders result in impairment caused by excessive use of alcohol. They include alcohol use disorder, which is recurrent alcohol use with developing tolerance and withdrawal; alcohol intoxication, which is simple drunkenness; and alcohol withdrawal, which can involve delirium tremens. Other Alcohol-Induced Disorders. This group of disorders includes psychotic, bipolar, depressive, anxiety, sleep, sexual, and neurocognitive disorders, including amnestic disorder (also known as Korsakoff's syndrome). Wernicke's encephalopathy, a neurologic condition of ataxia, ophthalmoplegia, and confusion, develops from chronic alcohol use. The two may coexist (Wernicke-Korsakoff syndrome). Alcohol-induced persisting dementia is differentiated from Korsakoff's syndrome by multiple cognitive deficits. Similar categories (intoxication, withdrawal, and induced disorders) exist for caffeine,

cannabis, phencyclidine, other hallucinogens, inhalants, opioids, sedative, hypnotic, or anxiolytics, stimulants, and tobacco. Gambling Disorder. Gambling disorder is classified as a non-substance-related disorder. It involves compulsive gambling with an inability to stop or cut down, leading to

social and financial difficulties. Some clinicians believe sexual addiction should be classified in the same way, but it is not a DSM-5 diagnosis. NEUROCOGNITIVE DISORDERS These are disorders characterized by changes in brain structure and function that result in impaired learning, orientation judgment, memory, and intellectual functions. (They were previously called dementia, delirium, amnestic, and other cognitive disorders in DSM-IV.) They are divided into three categories. Delirium. Delirium is marked by short-term confusion and cognition caused by substance intoxication or withdrawal (cocaine, opioids, phencyclidine), medication (cortisol), general medical condition (infection), or other causes (sleep deprivation). Mild Neurocognitive Disorder. Mild neurocognitive disorder is a mild or modest decline in cognitive function. It must be distinguished from normal age-related cognitive change (normal age-related senescence). Major Neurocognitive Disorder. Major neurocognitive disorder (a term that may be used synonymously with dementia, which is still preferred by most psychiatrists) is marked by severe impairment in memory, judgment, orientation, and cognition. There are 13 subtypes (Table 6-2): Alzheimer's disease, which usually occurs in persons older than age 65 years and is manifested by progressive intellectual deterioration and dementia; vascular dementia, which is a stepwise progression in cognitive deterioration caused by vessel thrombosis or hemorrhage; frontotemporal lobar degeneration, which is marked by behavioral inhibition (also known as Pick's disease); Lewy body disease, which involves hallucinations with dementia; traumatic brain injury from physical trauma; HIV disease; prion disease, which is caused by slow-growing transmissible prion protein; Parkinson's disease; Huntington's disease; caused by a medical condition; substance/medication-induced (e.g., alcohol causing Korsakoff's syndrome); multiple etiologies; and unspecified dementia. Table 6-2 Major Subtypes of Neurocognitive Disorder (Dementia)

Personality Disorders Personality disorders are characterized by deeply engrained, generally lifelong maladaptive patterns of behavior that are usually recognizable at adolescence or earlier. Paranoid Personality Disorder. Paranoid personality disorder is characterized by unwarranted suspicion, hypersensitivity, jealousy, envy, rigidity, excessive selfimportance, and a tendency to blame and ascribe evil motives to others. Schizoid Personality Disorder. Schizoid personality disorder is characterized by shyness, oversensitivity, seclusiveness, avoidance of close or competitive relationships, eccentricity, no loss of capacity to recognize reality, daydreaming, and an ability to express hostility and aggression. Schizotypal Personality Disorder. Schizotypal personality disorder is similar to schizoid personality, but the person also exhibits slight losses of reality testing, has odd beliefs, and is aloof and withdrawn. Obsessive-Compulsive Personality Disorder (OCPD). OCPD is characterized by excessive concern with conformity and standards of conscience; the individual may be rigid, overconscientious, overdutiful, overinhibited, and unable to relax (three Ps— punctual, parsimonious, and precise). Histrionic Personality Disorder. Histrionic personality disorder is characterized by emotional instability, excitability, overreactivity, vanity, immaturity, dependency, and self-dramatization that is attention seeking and seductive. Avoidant Personality Disorder. Avoidant personality disorder is characterized by low levels of energy, easy fatigability, lack of enthusiasm, inability to enjoy life, and oversensitivity to stress.

Antisocial Personality Disorder. Antisocial personality disorder covers persons in conflict with society. They are incapable of loyalty, selfish, callous, irresponsible, impulsive, and unable to feel guilt or learn from experience; they have low levels of frustration tolerance and a tendency to blame others. Narcissistic Personality Disorder. Narcissistic personality disorder is characterized by grandiose feelings, a sense of entitlement, a lack of empathy, envy, manipulativeness, and a need

for attention and admiration. Borderline Personality Disorder. Borderline personality disorder is characterized by instability, impulsiveness, chaotic sexuality, suicidal acts, selfmutilating behavior, identity problems, ambivalence, and feeling of emptiness and boredom. Dependent Personality Disorder. This is characterized by passive and submissive behavior; the person is unsure of himself or herself and becomes entirely dependent on others. Personality Changes Due to Another Medical Condition. This category includes alterations to a person's personality due to a medical condition (e.g., brain tumor). Unspecified Personality Disorder. This category involves other personality traits that do not fit any of the patterns described above. Paraphilic Disorders and Paraphilia In paraphilia, a person's sexual interests are directed primarily toward objects rather than toward people, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances. A paraphilic disorder is acted out sexual behavior that can cause possible harm to another person. Included are exhibitionism (genital exposure), voyeurism (watching sexual acts), frotteurism (rubbing against another person), pedophilia (sexual attraction toward children), sexual masochism (receiving pain), sexual sadism (inflicting pain), fetishism (arousal from an inanimate object), and transvestism (cross-dressing). Other Mental Disorders This is a residual category that includes four disorders that do not meet the full criteria for any of the previously described mental disorders: (1) other specified mental disorder due to another medical condition (e.g., dissociative symptoms secondary to temporal lobe epilepsy), (2) unspecified mental disorder due to another medical condition (e.g., temporal lobe epilepsy producing unspecified symptoms), (3) other specified mental disorder in which symptoms are present but subthreshold for a specific mental illness, and (4)

unspecified mental disorder in which symptoms are present but subthreshold for any mental disorder. Some clinicians use the term forme fruste (French, "unfinished form") to describe atypical or attenuated manifestation of a disease or syndrome, with the implication of incompleteness or partial presence of the condition or disorder. This term might apply to 3 and 4 above. Medication-Induced Movement Disorders and Other Adverse Effects of Medication Ten disorders are included: (1) neuroleptic or other medication–induced Parkinsonism presents as rhythmic tremor, rigidity, akinesia, or bradykinesia that is reversible when the causative drug is withdrawn or its dosage reduced; (2) neuroleptic malignant syndrome presents as muscle rigidity, dystonia, or hyperthermia; (3) medication-induced acute dystonia consists of slow, sustained contracture of musculature, causing postural deviations; (4) medication-induced acute akathisia presents as motor restlessness with constant movement; (5) tardive dyskinesia is characterized by involuntary movement of the lips, jaw, and tongue and other involuntary dyskinetic movements; (6) tardive dystonia or akathisia is a variant of tardive dyskinesia that involves extrapyramidal syndrome; (7) medication-induced postural tremor is a fine tremor, usually at rest, that is caused by medication; (8) other medication-induced movement disorder describes atypical extrapyramidal syndrome from a medication; (9) antidepressant discontinuation syndrome is a withdrawal syndrome that arises after abrupt cessation of antidepressant drugs (e.g., fluoxetine); and (10) other adverse effect of medication includes changes in blood pressure, diarrhea, and so on due to medication. Other Conditions That May Be a Focus of Clinical Attention These are conditions that may interfere with overall functioning but are not severe enough to warrant a psychiatric diagnosis. These conditions are not mental disorders but may aggravate an existing mental disorder. A broad range of life problems and stressors are included in this section, among which are (1) relational problems, including problems related to family upbringing, such as problems with siblings or upbringing away from parents, and problems related to primary support group, such as problems with a spouse or

intimate partner, separation or divorce, family-expressed emotion, or uncomplicated bereavement; and (2) abuse and neglect, which includes child maltreatment and neglect problems, such as physical abuse, sexual abuse, neglect, or psychological abuse, and adult maltreatment and neglect problems, which involves spouse or partner physical, sexual, and psychological violence and neglect or adult abuse by a nonspouse or nonpartner. Borderline intellectual functioning is included here in DSM-5. Conditions for Further Study In addition to the diagnostic categories listed above, other categories of illness are listed

in DSM-5 that require further study before they become part of the official nomenclature. Some of these disorders are controversial. There are eight disorders in this group: (1) attenuated psychosis syndrome refers to subthreshold signs and symptoms of psychosis that develops in adolescence; (2) depressive episodes with short-duration hypomania are short episodes (2–3 days) of hypomania that occur with major depression; (3) persistent complex bereavement disorder is bereavement that persists over 1 year after loss; (4) caffeine use disorder is dependence on caffeine with withdrawal syndrome; (5) Internet gaming disorder is the excessive use of Internet that disrupts normal living; (6) neurobehavioral disorder associated with prenatal alcohol exposure covers all developmental disorders that occur in utero due to excessive alcohol use by mother (e.g., fetal alcohol syndrome); (7) suicidal behavior disorder is repeated suicide attempts that occur irrespective of diagnostic category of mental illness; and (8) non-suicidal self-injury is skin cutting and other self-harm without suicidal intent. Research Domain Criteria (RDC) In contrast to DSM-5, which describes mental disorders as clusters of signs and symptoms, there is another way of classifying mental disorders that is based on neurobiological measures. Developed by the National Institute of Mental Health, this system requires integrating findings from genetic, imaging, neurochemical, neurophysiological, and clinical studies so that there is a common thread in understanding mental illness. The system relies on examining research domains that tap into the structure and function of the brain, including the mapping of neural circuits that elicit normal and abnormal behavioral patterns. Five domains have been identified for study: (1) negative valence systems, which encompass fear, anxiety, and loss; (2) positive valence systems, which cover reward, reward learning, and reward valuation; (3) cognitive systems, which cover attention, perception, working memory, and cognitive control; (4) systems for social processes, which cover attachment formation, social communication, and perception of self and others; and (5) arousal/modulatory systems, which cover arousal, circadian rhythm, sleep, and wakefulness. By studying domains, common antecedents to mental disorders may be found. For example, studying patients with DSM diagnoses of psychotic disorders might reveal genetic polymorphisms and specific changes in certain brain areas that relate to the cognitive system domain. Similarly, patients with a variety of anxiety disorders might share biological characteristics associated with the arousal/modulatory dimension that represent one disease process rather than many. The RDC classification system is in its infancy and is most useful for researchers mapping brain–behavior relationships as well as genomic discoveries in human and nonhuman animal studies. The ultimate goal is to develop a new classification system based on scientific findings to replace the descriptive DSM classification currently in use, thus bringing psychiatric diagnoses more in line with other branches of medicine. Until such time, however, DSM remains the best tool to guide psychiatrists and other mental health professionals to diagnose and treat patients with mental disorders.

REFERENCES American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013. Carpenter WT. The psychoses in DSM-S and in the near future. Am J Psychiatry. 2013;170:961. Clegg J, Gillott A, Jones

J. Conceptual issues in neurodevelopmental disorders: Lives out of synch. Curr Opin Psychiatry. 2013;26(3):289–293. Craddock N, Mynors-Wallis L. Psychiatric diagnosis: impersonal, imperfect and important. The British Journal of Psychiatry, 2014; 204(2):93–95. Del Vecchio V. Following the development of ICD-11 through World Psychiatry (and other sources). World Psychiatry, 2014;13(1):102–104. First MB, Pincus HA. The DSM-IV text revision: Rationale and potential impact on clinical practice. Psychiatr Servo. 2002;53:288. First MB, Spitzer RL, Williams JBW, Gibbon M. Structured Clinical Interview for DSM-IV (SCID). Washington, DC: American Psychiatric Association; 1997. Frances AJ, Widiger TA, Pincus HA. The development of DSM-IV. Arch Gen Psychiatry. 1989;46:373. Frances AJ. Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-S, Big Pharma and the Medicalization of Ordinary Life. New York: Harper Collins; 2013. Kendell RE. The Role of Diagnosis in Psychiatry. Oxford: Blackwell; 1975. Kendler KS. Setting boundaries for psychiatric disorders. Am J Psychiatry. 1999;156:1845. Keshavan MS. Classification of psychiatric disorders: Need to move toward a neuroscience-informed nosology. Asian J Psychiatry. 2013;6(3):191–192. Kihlstrom JF. To honor Kraepelin: From symptoms to pathology in the diagnosis of mental illness. In: Beutler LE, Malik ML, eds. Rethinking the DSM. Washington, DC: American Psychological Association; 2002:279. Lilienfeld SO, Marino L. Essentialism revisited: Evolutionary theory and the concept of mental disorder. J Abnorm Psychol. 1999;108:400. Narrow WE, Rae DS, Robins LN, Regier DA. Revised prevalence estimates of mental disorders in the United States. Arch Gen Psychiatry. 2002;59:115. Paris J. The Intelligent Clinicians Guide to DSM-5. New York: Oxford University Press; 2013. Robins E, Guze SB. Establishment of diagnostic validity in psychiatric illness: Its application to schizophrenia. Am J Psychiatry. 1970;126:983.