# A GUIDE TO *DSM-5*

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## Introduction

The American Psychiatric Association's *Diagnostic and Statistical Manual (DSM),* is the description of psychological disorders used by clinicians and researchers in the United States and around the world to diagnose psychopathology. The 5th and newest edition of this manual—*DSM-5*—was published in May of 2013 (American Psychiatric Association, 2013). With this new edition came many changes to the descriptions of the psychological disorders provided in the previous version of this publication. These revisions range from slight modifications of diagnostic criteria for some disorders to the addition of new disorders not covered in the 4th edition, text revision (i.e., *DSM-IV-TR*) published in 2000. Some of these changes have received much attention in the media, sometimes as harbingers of doom for patients and families, sometimes as important cultural or political statements, and sometimes as simply overrated. To help students acquire an accurate "big picture" of the extent of these alterations, this guide outlines the major, though not exhaustive, differences between *DSM-IV-TR* and *DSM-5.* We first highlight the general changes to each of the major disorder categories in *DSM-5*, followed by a discussion of controversial issues that swirled around the changes that did and did not get included in the final version of *DSM-5.* Where appropriate, we illustrate the detailed changes for a specific disorder in a comparative table (the bolded type within the diagnostic tables indicates new criteria in *DSM-5*).

## Mood Disorders

OVERVIEW OF CHANGES

- *DSM-IV* diagnoses of dysthymia, characterized by lasting low-level depressive symptoms, and chronic major depressive disorder, characterized by lasting severe depressive symptoms, have been combined in the *DSM-5* diagnosis of persistent depressive disorder.
- There are two new mood disorders in *DSM-5*:
    - Premenstrual dysphoric disorder, which had been identified in *DSM-IV* as a condition for further study, is now listed as a mood disorder in its own right (see below). This disorder refers to the experience of severe, impairing mood symptoms in women during the week before menstruating.
    - Disruptive mood dysregulation disorder is a new disorder that reflects persistent irritability and frequent episodes of extreme behavioral dyscontrol in the form of temper tantrums in children, who in the past would have been (often erroneously) diagnosed with bipolar disorder.
- The *DSM-IV* bereavement exclusion, which suggested that depressive symptoms cannot be diagnosed as a depressive disorder in the context of bereavement lasting less than two months after a major loss (e.g., death of a loved one), has been removed. This highlights the fact that grief and major depression are related yet independent conditions.

*DSM-5* CONTROVERSIES: IS GRIEF THE SAME THING AS DEPRESSION?

When should normal grief be considered major depressive disorder? Prior to *DSM-5*, if you met criteria for a major depressive episode in the two months following a loss, such as the death of a loved one, you would not receive a diagnosis of major depressive disorder even if you otherwise met criteria for it (unless you had very severe symptoms such as strong suicidal ideation or psychotic features). This was called the "bereavement exclusion". This exclusion was dropped in *DSM-5* for several reasons (Zisook et al., 2012). For example, it was noted that major depressive episodes often are triggered by stressful events other than loss of a loved one in vulnerable individuals and, if all of the criteria are otherwise met for a major depressive episode, there seemed no reason to exclude people simply because the precipitating event was the death of a loved one. Furthermore, data from a number of sources suggested no differences between depressive episodes triggered by loss or not triggered by loss, and that the biological, psychological, and social factors that make one vulnerable to developing major depression are the same whether the trigger is loss of a loved one or not (Shear et al., 2011; Zisook et al., 2012). Finally, the data indicated that eliminating the two months bereavement exclusion would not greatly increase the numbers of people requiring treatment for major depression (Gilman et al., 2012; Zisook et al., 2012).

Nevertheless, this change was controversial as some concluded that *DSM-5* would be making the natural grieving process a disorder resulting in, among other things, frequent prescriptions of antidepressant medication to those who might be undergoing a normal process of grieving (Fox & Jones, 2013; Maj, 2008)! This is one part of the larger criticism levied at *DSM-5* that the major purpose of *DSM* is to increase business for mental health professionals and make sure that large drug companies remain profitable. Advocates for dropping the bereavement exclusion point out that the diagnosis of major depressive disorder or posttraumatic stress disorder in response to other major life stressors is not controversial, nor should be the development of major depressive disorder in some people in response to the loss of a loved one. Furthermore, the advocates continue, there are differences between a major depressive episode and grief. Individuals undergoing grief experience feelings of emptiness and loss, and these feelings come in waves sometimes referred to as the "pangs of grief." Furthermore, grieving individuals are most usually able to experience some positive emotions and even humor, and self-esteem is generally intact. In a major depressive episode, feelings of depression are persistent and are seldom accompanied by any positive emotions, and thought processes are typically very generally pessimistic and self-critical, accompanied by very low self-esteem and a sense of worthlessness (American Psychiatric Association, 2013).

In response, some mental health professionals propose that all intense sadness, stress, or even depression that is proportionate to the loss, trauma, or stress should not be considered a disorder as it is a natural experience of being human (Wakefield, Schmitz, First, & Horwitz, 2007). Time will tell if removing the bereavement exclusion from the diagnosis of major depressive disorder is a positive or negative development.

SPOTLIGHT ON *DSM-5*: NEW DIAGNOSTIC CRITERIA FOR PREMENSTRUAL DYSPHORIC DISORDER

As you examine the diagnostic criteria below, consider the implications of classifying these symptoms as a mental disorder. For example, this change may contribute to stigmatization of female emotional expression in women, if fluctuating mood in women comes to be associated with psychopathology. On the other hand, the diagnostic criteria specify that the disorder must be accompanied by distress and impairment for the individual, and recognizing the debilitating nature of these symptoms in some women contributes to more effective research and treatment.

| Diagnostic Criteria for Premenstrual Dysphoric Disorder | |
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| MAJOR CHANGES:<br>• Premenstrual dysphoric disorder is a new disorder in *DSM-5*. Previously, it was identified in *DSM-IV* as a condition in need of further study. Thus, all diagnostic criteria are new. | |
| Diagnostic Criterion | *DSM-5* |
| **Criterion A**<br>*Timing of symptoms* | In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses. |
| **Criterion B**<br>*Symptoms* | One (or more) of the following symptoms must be present:<br>1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).<br>2. Marked irritability or anger or increased interpersonal conflicts.<br>3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.<br>4. Marked anxiety, tension, and/or feelings of being keyed up or on edge. |
| **Criterion C**<br>*Additional symptoms* | One (or more) of the following symptoms must additionally be present to reach a total of *five* symptoms when combined with symptoms from Criterion B above.<br>1. Decreased interest in usual activities (e.g., work, school, friends, hobbies)<br>2. Subjective difficulty in concentration<br>3. Lethargy, easy fatigability, or marked lack of energy<br>4. Marked change in appetite; overeating; or specific food cravings<br>5. Hypersomnia or insomnia<br>6. A sense of being overwhelmed or out of control<br>7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of bloating, or weight gain<br>Note: The symptoms in Criteria A-C must have been met for most menstrual cycles that occurred in the preceding year. |
| **Criterion D**<br>*Distress or interference* | The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home). |
| **Criterion E**<br>*Distinction from other mental disorders* | The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders). |
| **Criterion F**<br>*Confirmatory daily ratings* | Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles.<br>Note: The diagnosis may be made provisionally prior to this confirmation. |
| **Criterion G**<br>*Distinction from other conditions* | The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism). |

## Anxiety Disorders, Trauma- and Stressor-Related Disorders, and Obsessive-Compulsive and Related Disorders

OVERVIEW OF CHANGES

In *DSM-5,* the *DSM-IV* category for anxiety disorders has been divided into three categories: anxiety disorders, trauma- and stressor-related disorders, and obsessive-compulsive and related disorders. All of these disorders involve a heightened level of anxiety. As described below, trauma- and stressor-related disorders are grouped together because of their similarities in origin, while obsessive-compulsive and related disorders are grouped together because of their similar types of symptoms.

*Changes to DSM-5 Anxiety Disorders:*

- Selective mutism, characterized by a failure to speak in certain situations, is newly classified as an anxiety disorder. In the past, it was grouped among disorders diagnosed in childhood.
- Separation anxiety disorder, characterized by intense anxiety about being separated from important others, is newly classified as an anxiety disorder. Like selective mutism, it was grouped among childhood disorders in *DSM-IV*. For the first time, separation anxiety disorder may be diagnosed in adults.
- Agoraphobia, or a fear of being in situations from which escape would be difficult in the event of an unpleasant experience like a panic attack, is now a disorder in its own right. In the past, agoraphobia was linked to panic disorder or classified only in the context of other disorders.
- For some anxiety disorders, the individual no longer has to recognize that his or her anxiety is excessive to be diagnosed.

*Changes to DSM-5 Obsessive-Compulsive and Related Disorders:*

- In *DSM-IV,* these disorders were classified as anxiety disorders. The new *DSM-5* category of obsessive-compulsive and related disorders highlights the importance of obsessive thoughts and compulsive, repetitive behavior in these disorders.
- Body dysmorphic disorder, or an intense preoccupation with a perceived physical flaw, has been moved to this new category. In the past, it was classified among somatic symptom disorders.
- Trichotillomania (hair-pulling disorder), previously classified as an impulse-control disorder in *DSM-IV,* is also new.
- There are two entirely new disorders in this category:
    - Excoriation, characterized by pathological picking of one's skin.
    - Hoarding disorder, characterized by amassing a large amount of items and having difficulty parting with items, was previously thought of as a type of OCD. It is now classified as a disorder in its own right.

*Changes to DSM-5 Trauma- and Stressor-Related Disorders:*

- In *DSM-IV,* these disorders were classified as anxiety disorders. The new category of trauma- and stressor-related disorders emphasizes that these disorders follow exposure to an acute or chronic stressor (e.g., assault, combat, abuse during childhood).
- There are two new disorders in this category: Reactive attachment disorder and disinhibited social engagement disorder. These are comparable to variations of a previous *DSM-IV* attachment disorder. They represent responses to long-term problems forming attachments to others, as in childhood neglect.

*DSM-5* CONTROVERSIES: EMERGING VIEWS IN CLASSIFYING ANXIETY AND RELATED DISORDERS

The anxiety disorders as classified in *DSM-IV* are now divided into three separate groupings or classes of disorders, and 10 disorders have been added to these groupings either by splitting existing disorders, relocating disorders from other diagnostic sections such as the somatoform disorders, or introducing new disorders appearing for the first time in the *DSM-5.* These changes reflect a new emphasis on commonalities among psychological disorders.

Clinical psychologists are increasingly realizing that multiple anxiety and related disorders often occur together in the same individual, and that these have many features in common. For example, the majority of patients with anxiety disorders experience some degree of depression. They also show behavioral avoidance (e.g., not attending a party in social anxiety; not taking public transportation in agoraphobia) and often avoid unpleasant physical sensations. Many patients with anxiety disorder engage in cognitive and emotional avoidance, or trying not to experience troubling thoughts and feelings (e.g., avoiding thinking about a previous traumatic events). Some defining features of one disorder, like intrusive thoughts in obsessive-compulsive disorder, are also found in other anxiety disorders.

The division of anxiety disorders into subcategories, as well as the other changes to this section, reflect this new appreciation that anxiety and related disorders reflect variations on common underlying processes. Nevertheless, there is disagreement in the field about whether it is best to retain *categorical* diagnoses (i.e., focusing on specific disorders) or move more fully into *dimensional* diagnoses (e.g., to what degree does an individual display varying levels of certain traits?). As you learn about anxiety and related disorders, consider the advantages and disadvantages of each approach in thinking about these and other mental health problems.

SPOTLIGHT ON *DSM-5*: NEW DIAGNOSTIC CRITERIA FOR POSSTRAUMATIC STRESS DISORDER

<table>
<tr><th colspan="3">Diagnostic Criteria for Posttraumatic Stress Disorder</th></tr>
<tr><td colspan="3">MAJOR CHANGES:<ul><li>Posttraumatic stress disorder was classified as an anxiety disorder in DSM-IV. It is now classified under the more specific category of trauma- and stressor-related disorders.</li><li>In DSM-5, trauma exposure includes indirect exposure to a traumatic event through intense exposure to aversive elements of the event (as in rescue workers).</li><li>DSM-5 no longer requires that the person react to the event with intense fear, helplessness, or horror.</li><li>DSM-5 acknowledges that exposure may consist of multiple events.</li><li>DSM-5 no longer includes the distinction between acute and chronic PTSD.</li><li>DSM-5 added a subtype for PTSD diagnosed in preschool-age children.</li><li>DSM-5 added a specifier for PTSD with significant dissociative symptoms.</li></ul></td></tr>
<tr><td>Diagnostic Criterion</td><td>DSM-5</td><td>Highlights of changes from DSM-IV to DSM-5</td></tr>
<tr><td>Criterion A<br>Exposure to a traumatic event</td><td>Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:<br>1. Directly experiencing the traumatic event(s).</td><td><ul><li>DSM-5 newly notes that trauma exposure may occur if the patient learned that threatened or actual violent or accidental death occurred to a loved one. This constitutes elimination of</li></ul></td></tr>
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| | 2. Witnessing, in person, the event(s) as they occurred to others.<br>**3. Learning that the event(s) occurred to a close relative or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.**<br>**4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).**<br><br>**Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.** | possibility that the event may be a loved one's nonviolent, nonaccidental death (e.g., from illness).<br>• *DSM-5* also notes that repeated or extreme exposure to aversive details of events may constitute trauma exposure.<br>• Removed specification that the person's response must involve intense fear, helplessness, or horror as this was a difficult decision to make and the presence of the symptoms listed below are more important to establishing the diagnosis.<br>• Added specification that the trauma may consist of multiple events.<br>• Added mention of actual or threatened sexual violation.<br>• Changed wording. |
| **Criterion B**<br>*Intrusion symptoms* | Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:<br>1. Recurrent, **involuntary,** and intrusive distressing memories of the traumatic event(s). Note: In young children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.<br>2. Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content.<br>3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event**(s)** were recurring. (**Such reactions occur on a continuum, with the most extreme expression** | • *DSM-IV* Criterion B referred to re-experiencing the event and listed five forms of re-experiencing similar to *DSM-5* criteria for intrusion symptoms.<br>• Removed specification that intrusive recollections may be spontaneous or cued.<br>• Changed wording to reflect that multiple traumatic events may be involved.<br>• Removed part of *DSM-IV* Criterion B3 indicating that hallucinations or illusions may occur and that these reactions include those occurring on awakening or intoxication.<br>• Added note that dissociative reactions vary in severity.<br>• Changed wording. |

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| | **being a complete loss of awareness of present surroundings).** Note: In young children, trauma-specific reenactment may occur in play.<br>4. Intense **or prolonged** psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event**(s).**<br>5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event**(s).** | |
| **Criterion C** *Avoidance of associated stimuli* | Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by **one or more** of the following:<br>1. Avoidance of or efforts to avoid **distressing memories,** thoughts, or feelings about or closely associated with the traumatic event(s).<br>2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, **objects**, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).<br>3. Inability to recall an important aspect of the trauma.<br>4. Markedly diminished interest or participation in significant activities.<br>5. Feeling of detachment or estrangement from others.<br>6. Restricted range of affect (e.g., unable to have loving feelings).<br>7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span). | • Removed *DSM-IV* text specifying "and numbing of general responsiveness."<br>• Changed wording of some elements in Criteria C1 and C2 (e.g., moving "conversations" from option C1 to C2).<br>• Added avoidance of objects associated with the trauma.<br>• Added avoidance of distressing memories.<br>• Changed wording.<br>• *DSM-IV* Criterion C also included options referring to loss of memory for the trauma, diminished interest in activities, feelings of detachment, restricted affect, and sense of foreshortened future. These elements were removed from *DSM-5* Criterion C, but they are now included in *DSM-5* Criterion D. |
| **Criterion D** *Negative alterations in cognitions or* | **Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as** | • Criterion D is new to *DSM-5*, but *DSM-5* Criteria D1, D5, D6, and D7 were previously listed under *DSM-IV* Criteria C3-C6. |

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| *mood* | **evidenced by two (or more) of the following:**<br>1. Inability to remember an important aspect of the traumatic event**(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).**<br>2. **Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted" "The world is completely dangerous," "My whole nervous system is permanently ruined").**<br>3. **Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.**<br>4. **Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).**<br>5. Markedly diminished interest or participation in significant activities<br>a. Feelings of detachment or estrangement from others<br>b. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings) | • *DSM-5* newly requires at least two symptoms to be present.<br>• Added specification that memory loss must not be due to injury or substances.<br>• Criteria D3, D3, and D4 (i.e., negative beliefs, blame, and negative emotional state) are new in *DSM-5*.<br>• Criterion D2 is a reframing and extension of the *DSM-IV* Criterion C7 of perceiving a foreshortened future. |
| **Criterion E**<br>*Increased arousal* | Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:<br>1. Irritable behavior and angry outbursts **(with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.**<br>2. **Reckless or self-destructive behavior.**<br>3. Hypervigilance.<br>4. Exaggerated startle response. | • Previously found in *DSM-IV* Criterion D.<br>• Added self-destructive behavior.<br>• Added mention of verbal and physical aggression.<br>• Changed wording.<br>• Added examples. |

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| | 5. Problems with concentration.<br>6. Sleep disturbance (e.g., difficulty falling or staying asleep or **restless sleep**). | |
| **Criterion F**<br>*Duration* | Duration of the disturbance (Criteria B, C, D, **and E)** is more than 1 month. | • Previously listed under *DSM-IV* Criterion E.<br>• Added mention of new *DSM-5* Criterion E. |
| **Criterion G**<br>*Distress or impairment* | The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. | • Previously listed under *DSM-IV* Criterion F. |

## Schizophrenia Spectrum and Other Psychotic Disorders

OVERVIEW OF CHANGES

- *DSM-IV* subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) have been removed in *DSM-5*. This elimination was based on the subtypes' limited diagnostic stability, reliability and validity, as well as the subtypes' similarity in course and treatment response patterns.
- *DSM-5* is introducing a dimensional assessment that rates not only the presence of a symptom, but also its severity. The 0-4 scale allows a symptom to be judged "not present" (0), having "equivocal evidence" (1), "present but mild" (2), "present but moderate" (3), or "present and severe" (4).
- *DSM-5* now includes catatonia as a separate schizophrenia spectrum disorder.
- Shared psychotic disorder was removed.
- Attenuated psychosis syndrome was added as a condition for further study in the *DSM-5*.

*DSM-5* CONTROVERSIES: REALITY CHECK

One of the most discussed changes in *DSM-5* related to schizophrenia spectrum and other psychotic disorders was the possible inclusion of a new diagnosis—attenuated psychosis syndrome. This diagnosis would be given to a person who is beginning to experience one or more of the symptoms of schizophrenia such as hallucinations or delusions but is aware that these are unusual experiences and are not typical for a healthy person (i.e., he or she still has relatively intact reality testing). They are at high risk for having more severe symptoms as displayed in schizophrenia spectrum disorder. The argument for including this set of symptoms as a new disorder is that catching the person in these early stages might prove helpful for early intervention efforts (Pagsberg, 2013). It is possible that getting the symptoms under control before they become severe might save the person from years of suffering (Woods, Walsh, Saksa, & McGlashan, 2010).

On the other hand, some psychologists doubt that early intervention for these individuals will, in fact, prevent later, more severe problems. From a public health perspective, some also suggest that rather than limit prevention efforts to this group, broader attention should be paid to the mental health status of the general population (van Os, 2011). In other words, *DSM-5* "cut the baby in half" by including the disorder in its Appendix for further study. It remains to be seen if this set of criteria will

eventually make its way into the *DSM* and what impact that will have on treatment and outcomes for those affected.

SPOTLIGHT ON *DSM-5*: PROPOSED DIAGNOSTIC CRITERIA FOR ATTENUATED PSYCHOSIS SYNDROME

| Diagnostic Criteria for Attenuated Psychosis Syndrome (proposed as a condition for further study in the *DSM-5*) | |
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| Diagnostic Criterion | *DSM-5* |
| **Criterion A** *Characteristic symptoms* | At least one of the following symptoms is present in attenuated form with relatively intact reality testing, but of sufficient severity and/or frequency to warrant clinical attention:<br>1. Delusions/delusional ideas.<br>2. Hallucinations/perceptional abnormalities.<br>3. Disorganized speech/communication. |
| **Criterion B** *Frequency/Duration* | Symptoms in Criterion A must be present at least once per week for the past month. |
| **Criterion C** *History* | Symptoms in Criterion A must have begun or worsened in the past year. |
| **Criterion D** *Impairment* | Symptoms in Criterion A are sufficiently distressing and disabling to the individual and/or legal guardian to lead them to seek help. |
| **Criterion E** *Current other psychiatric disorders and substance exclusion* | Symptoms in Criterion A are not better explained by any other *DSM-5* diagnosis, including substance-related disorders. |
| **Criterion F** *Lifetime psychotic disorders exclusion* | Clinical criteria for a psychotic disorder have never been met. |

## Neurodevelopmental Disorders

OVERVIEW OF CHANGES

- The *DSM-5* combined four previous diagnoses into the new autism spectrum disorder, reflecting an increasing consensus among scientists that autism, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified are actually one condition with different levels of severity.
- The *DSM-5* also combined four previous diagnoses into specific learning disorder, integrating the often co-occurring mathematics disorder, disorder of written expression, and learning disorder not otherwise specified.
- The *DSM-5* diagnostic criteria for attention deficit/hyperactive disorder (AD/HD) have been revised to better allow the diagnosis of adults with AD/HD.
- AD/HD is now included in the *DSM-5*'s neurodevelopmental disorders chapter instead of the chapter for disorders usually first diagnosed in infancy, childhood, or adolescence (which was eliminated), in order to better reflect the role brain development plays in this disorder.

*DSM-5* CONTROVERSIES: IS AUTISM A SPECTRUM?

One of the most talked about and debated changes to occur in *DSM-5* was the elimination of separate categories for "autistic disorder" and "Asperger's disorder," which were present in *DSM-IV*. For example, take the cases of Michael and Juan – two five year old boys who would today both receive the DSM-5 diagnosis of "autism spectrum disorder" (ASD). Michael does not speak, but can point to a few pictures to make his basic needs known (e.g., pointing to a picture of a glass to indicate he wants a drink). If left alone at home or in school, Michael would sit by himself making flapping gestures with his hands. He would always avoid other children – not even looking over at them if they were playing nearby. If he wanted something at home he would take his mother's hand and lead her over to it. He had a few rituals (e.g., touching every door as he walked down the hall) and would scream loudly. On the other hand, Juan at the same age could speak quite articulately – especially if it was about insects which were an obsession with him. He would look at and talk to other children, but would always steer the conversation back to his passion – insects. This annoyed other children and they would avoid him. He could not understand why other children would not talk to him and he did not pick up on the negative nonverbal signals the other children would use to try to get him to stop dominating all conversations. At home Juan would study insects online and he would tantrum if interrupted.

Previously, Michael received the DSM-IV diagnosis of "autistic disorder" and Juan was labeled with "Asperger's disorder." However, because they both display impairments in social communication and display repetitive and restricted interests and activities, they would now be diagnosed with autism spectrum disorder under the *DSM-5* (Durand, 2014). The rationale behind this reorganization of the separate autism related disorders under one rubric was that "autism spectrum disorders" could be reliably distinguished from other disorders but within this category there were considerable inconsistencies (Frazier et al., 2012; Rutter, 2011). In other words, it was not always clear if someone had a milder form of autistic disorder (e.g., with more speech) or whether it was Asperger's disorder. They all share the pervasive deficits in social communication skills as well as the restricted patterns of behaviors. It was argued that the main differences among the disorders are ones involving the severity of the symptoms, language level and levels of intellectual deficit and therefore could be grouped together on a single spectrum, with varying degrees of severity.

One of the first concerns was that these new criteria might exclude some individuals who previously met *DSM-IV* criteria and, in turn, it might result in the denial of treatment services for those left out. This concern was precipitated by researchers who evaluated cases that received a *DSM-IV* diagnosis of autism or a related disorder and tried to see how many would now fall into the new ASD category (McPartland, Reichow, & Volkmar, 2012). Their initial findings caused considerable alarm because they concluded that almost 40% of individuals would not meet the *DSM-5* criteria. Although subsequent analyses found this number to be lower (e.g., approximately 9% in one study; Huerta, Bishop, Duncan, Hus, & Lord, 2012), there remains a concern that some individuals will no longer be eligible for needed services.

In addition to the concern about treatment eligibility, many of those individuals who have been previously diagnosed with Asperger's disorder feel that this decision takes away part of their identity (Pellicano & Stears, 2011). Rather than feeling shame or embarrassment about receiving this diagnosis, a good number of these individuals embrace their distinctiveness. Juan, for example, was very proud of his extensive knowledge of insects and did not see that obsession as a problem for him. Some adults advocate for seeing these differences in terms of "neurodiversity," or viewing their "disorder" as just a different and not abnormal way to view the world (Armstrong, 2010; Singer, 1999). In fact, the word "Aspies" is sometimes used with pride by individuals with this label (e.g., Beardon & Worton, 2011), and those who do not have this disorder are often referred to as "neurotypical"—sometimes in a negative

way. It is likely that despite the elimination of Asperger's disorder from *DSM-5*, some in this community will continue to hold on to the label with pride.

SPOTLIGHT ON *DSM-5*: NEW DIAGNOSTIC CRITERIA FOR AUTISM SPECTRUM DISORDER

<table>
<tr><th colspan="3">Diagnostic Criteria for Autism Spectrum Disorder</th></tr>
<tr><td colspan="3">MAJOR CHANGES:<ul><li>The DSM-5 combined four previous diagnoses into autism spectrum disorder, reflecting an increasing consensus among scientists that autism, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified are actually one condition with different levels of severity.</li><li>Note that many of the symptoms and criteria have been rearranged (when compared to DSM-IV diagnosis for autistic disorder) in order to better represent the primary (Criterion A) and secondary (Criterion B) nature of the symptoms.</li></ul></td></tr>
<tr><td>Diagnostic Criterion</td><td>DSM-5</td><td>Highlights of changes from DSM-IV to DSM-5</td></tr>
<tr><td>Criterion A<br>Social deficits</td><td>Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative not exhaustive):<br>1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.<br>2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gesture; to a total lack of facial expressions and nonverbal communication.<br>3. Deficits in developing, maintaining and understanding relationships,</td><td><ul><li>Criterion A items in the DSM-5 essentially encompass Criteria A1 and A2 of DSM-IV (i.e., impairments in social interaction and impairments in communication), with the added domain of deficits in developing, maintaining and understanding relationships.</li><li>This organization of Criterion A in the DSM-5 emphasizes the "core" of autism spectrum disorder—deficit in relating and communicating socially.</li></ul></td></tr>
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| | **ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.** | |
| **Criterion B**<br>*Restricted, repetitive behaviors* | Restricted, repetitive patterns of behavior, interests, or activities, as manifested by **at least two of the following**, currently or by history (examples are illustrative, not exhaustive; see text):<br>1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).<br>2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).<br>3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).<br>**4. Hyper-or hyporeactivity to sensory input or unusual interest in sensory aspects of environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual** | ▪ The requirement for fulfillment of this criterion has been increased from at least one in the *DSM-IV* to at least two in the *DSM-5.*<br>▪ In *DSM-5*, hyper- or hypo-reactivity to sensory input has been added to the list of symptoms in this domain.<br>▪ In *DSM-5*, preoccupation with parts of objects has been removed.<br>▪ Symptoms are described in more detail in *DSM-5*, which has introduced broad wording changes. |

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| | **fascination with lights or movement).** | |
| **Criterion C**<br>*Onset* | **Symptoms must be present in early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).** | ▪ The requirement of onset prior to age three in the *DSM-IV* has been relaxed to "early developmental period" in *DSM-5.*<br>▪ The onset criterion in *DSM-5* is less specific (i.e., instead of specifying which domains must be impaired in childhood, it merely refers to whichever symptoms exists for the individual patient). |
| **Criterion D**<br>*Impairment* | **Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.** | ▪ The criterion for impairment is new in *DSM-5.* |
| **Criterion E**<br>*Exclusionary diagnoses* | **These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.** Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level. | ▪ In *DSM-5*, Rett's disorder and childhood disintegrative disorder no longer exist and are therefore not exclusionary diagnoses. Instead, symptoms cannot be better explained by intellectual disability and global developmental delay. |

## Substance-Related and Addictive Disorders

OVERVIEW OF CHANGES

- The distinction between substance abuse disorder and substance dependence disorder has been eliminated in *DSM-5*. Now, these two previously separate disorders are replaced by a combined substance use disorder, which includes symptoms of both substance abuse and substance dependence.
- Diagnostic criteria for substance intoxication are now specified for each group of substances, and there is no longer a general substance intoxication diagnosis in the *DSM-5.*
- Additional diagnoses have been added, including gambling disorder and tobacco use disorder.
- There is a move to characterize substance-related disorders by severity instead of by diagnostic cut-off alone. For the general diagnosis of substance use disorder, there is a severity rating in *DSM-5* based on the number of symptoms endorsed: mild (2 to 3), moderate (4 to 5), or severe (6 or more).

*DSM-5* CONTROVERSIES: ABUSE VERSUS DEPENDENCE—ONE PACKAGE? AND WHAT COUNTS AS AN ADDICTION?

One of the changes to *DSM-5* that caused concern among some researchers was dropping the distinction between dependence and abuse (Edwards, 2012; Hasin, 2012; Schuckit, 2012). Although there is general agreement that abusing a substance (e.g., binge drinking) and being dependent on that substance (e.g., increasing tolerance to alcohol and going through withdrawal symptoms if drinking is stopped) are different processes, research shows that practically speaking they go hand in hand. In other words, if someone is routinely abusing a drug that person will likely become dependent on it (O'Brien, 2011). From a scientific point of view, therefore, there is an obvious difference between abuse and dependence, but from a clinical perspective (which is the main function of the *DSM*) the argument was made that keeping abuse and dependence as separate diagnoses was more complicated than necessary.

A second major change that caused a stir was the addition of "addictive disorders" (e.g., gambling disorder) to the substance-related disorders section in the *DSM*. Here again the science suggests that substance use disorders and pathological gambling are quite similar, showing the same patterns of dependence, cravings, and working on similar brain pathways (Ashley & Boehlke, 2012). However, this potentially opens up the category for the inclusion of many different kinds of "addictions," including "Internet addiction" (Block, 2008; Van Rooij, Schoenmakers, Vermulst, Van Den Eijnden, & Van De Mheen, 2011) and even "tanning addiction" (Poorsattar & Hornung, 2010). These are problems that cause real dysfunction among some people and are being taken seriously as similar to substance use disorders. These and other activities have the potential for causing dependence because they activate the reward systems in our brains in much the same way as drugs do, and ultimately, what constitutes a "disorder" may come down to whether or not these activities cause the harmful distress that is part of most psychological diagnoses.

SPOTLIGHT ON *DSM-5*: NEW DIAGNOSTIC CRITERIA FOR GAMBLING DISORDER

<table>
<tr><th colspan="3">Diagnostic Criteria for Gambling Disorder (Previously Pathological Gambling)</th></tr>
<tr><td colspan="3">MAJOR CHANGES:<ul><li>Gambling disorder was previously "pathological gambling," classified under impulse-control disorders not elsewhere classified in DSM-IV. In DSM-5, it is fully recognized as a disorder belonging with substance and addictive disorders.</li><li>DSM-5 no longer specifies committing illegal acts as a symptom.</li></ul></td></tr>
<tr><td>Diagnostic Criterion</td><td>DSM-5</td><td>Highlights of changes from DSM-IV to DSM-5</td></tr>
<tr><td>Criterion A<br>Characteristic symptoms</td><td>Persistent and recurrent problematic gambling behavior leading to significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:<br>1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.</td><td><ul><li>A time period for symptoms to meet criteria has been added in the DSM-5 (i.e. 12-month period).</li><li>The number of symptoms required for diagnosis has been lowered from five to four in DSM-5.</li><li>Committing illegal acts has been removed from the DSM-IV list of symptoms.</li></ul></td></tr>
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| | 2. Is restless or irritable when attempting to cut down or stop gambling.<br>3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.<br>4. Is often preoccupied with gambling (e.g., persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble).<br>5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).<br>6. After losing money gambling, often returns another day to get even ("chasing" one's losses).<br>7. Lies to conceal the extent of involvement with gambling.<br>8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.<br>9. Relies on others to provide money to relieve desperate financial situations caused by gambling. | ▪ Minor rewording of the symptom describing gambling when feeling distressed (previously "as a way of escaping from problems"). |
| **Criterion B**<br>*Exclusionary diagnoses* | The gambling behavior is not better accounted for by a manic episode. | ▪ No changes. |

## Somatic Symptom Disorders and Dissociative Disorders

OVERVIEW OF CHANGES

- In *DSM-5*, somatic symptom disorders were renamed from what were called "somatoform disorders" in *DSM-IV*.
- *DSM-5* reflects efforts to consolidate and rearrange *DSM-IV* diagnoses that were overlapping and poorly defined.

- The following *DSM-IV* somatoform disorder diagnoses are not present in *DSM-5*: hypochondriasis, somatization disorder, pain disorder, undifferentiated somatoform disorder; some have been altered to become one or more new *DSM-5* diagnoses.
- Several new disorders were introduced in *DSM-5*, including illness anxiety disorder, somatic symptom disorder, and "psychological factors affecting other medical conditions." This last disorder occurs when there is both a diagnosed medical condition and a psychological or behavioral factor that is making that condition worse (e.g., the anxiety in panic disorder might worsen a person's asthma).
- Body dysmorphic disorder (BDD) was classified among somatic disorders in *DSM-IV,* but is now classified among obsessive-compulsive and related disorders, reflecting the important role played by obsessive thoughts and compulsions in BDD.

*DSM-5* CONTROVERSIES: AGE-OLD DISORDERS IN A NEW LIGHT

Somatic and related disorders are among the oldest recognized mental disorders. And yet, recent evidence indicates that we have much to learn about the nature of these disorders (Mayou et al., 2005). For example, the grouping of somatic symptom disorders was based until recently on the assumption that "somatization" is a common process in which a mental disorder manifests itself in the form of physical symptoms. The specific disorders, then, simply reflect the different ways in which symptoms can be expressed physically. But major questions arose concerning the classification of these disorders (Noyes, Stuart, & Watson, 2008; Voigt et al., 2010; Voigt et al, 2012).

Specifically, the somatic symptom disorders all share presentations of somatic symptoms accompanied by cognitive distortions in the form of misattributions of, or excessive preoccupation with, symptoms. These cognitive distortions may include excessive anxiety about health or physical symptoms, a tendency to think the worst or "catastrophize" about these symptoms, and very strong beliefs that physical symptoms might be more serious than health-care professionals have recognized. Also, people presenting with these disorders often make health concerns a very central part of their lives; in other words, they adopt the "sick role." For this reason, *DSM-5* has changed very substantially the definitions of these disorders to focus on two major factors: the severity and number of physical symptoms, as well as the severity of anxiety focused on the symptoms and the degree of behavior change as a consequence of the symptoms. Gone is the requirement to determine whether the physical symptom actually has a medical basis or not. Preliminary explorations of the validity and utility of this dimensional approach may be very helpful to clinicians in predicting the course of the disorder as well as selecting among possible treatments (Noyes et al., 2008; Voigt et al., 2010; Voigt et al., 2012; Wollburg et al., 2013). Another advantage of this approach is that there is less burden on physicians to make very tricky determinations on whether the symptoms have physical causes, as was the case in *DSM-IV*. Rather, the combination of chronic physical symptoms accompanied by the psychological factors of misattributing the meaning of the symptoms and excessive concern is sufficient to make the diagnosis. Needless to say, the very radical nature of change in this major category of disorders is proving to be very controversial, primarily because so little data exist on the validity of these new categories or even the reliability with which they can be diagnosed. But they appear to be an improvement, and clinical investigators are already busy attempting to confirm or disconfirm the utility of this new approach.

SPOTLIGHT ON *DSM-5*: DIAGNOSTIC CRITERIA FOR ILLNESS ANXIETY DISORDER

| Diagnostic Criteria for Illness Anxiety Disorder |
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| MAJOR CHANGES:<br>• Illness anxiety disorder is new to the *DSM-5*. It replaces part of the *DSM-IV* diagnosis of |

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| hypochondriasis. Individuals with high health anxiety in the absence of reports of notable symptoms (except for anxiety about developing them) would be diagnosed with illness anxiety disorder, while those who are also experiencing and reporting significant somatic symptoms would be diagnosed with somatic symptom disorder. | | |
| Diagnostic Criterion | *DSM-5* | Highlights of changes from *DSM-IV* to *DSM-5*<br>*(Changes reflect a comparison to DSM-IV hypochondriasis)* |
| **Criterion A**<br>*Preoccupation with fears of serious illness* | Preoccupation with having **or acquiring** a serious illness. | • Added specification that fears may surround acquiring an illness. |
| **Criterion B**<br>*Absence of notable somatic symptoms* | **Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.** | • Criterion B is new to *DSM-5*. |
| **Criterion C**<br>*High health anxiety* | **There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.** | • Criterion C is new to *DSM-5*. |
| **Criterion D**<br>*Health-related behaviors* | **The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctors' appointments and hospitals).** | • Criterion D is new to *DSM-5*. |
| **Criterion E**<br>*Duration* | Illness preoccupation has been present for at least 6 months, **but the specific illness that is feared may change over that period of time.** | • Noted that the preoccupation does not have to be consistent, although it must be chronic. |
| **Criterion F**<br>*Distinction from other mental disorders* | The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, or obsessive-compulsive disorder. | • Added distinction from somatic symptom disorder (new to *DSM-5*).<br>• Changed examples. |

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| Specifiers | **Specify whether:**<br>**Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.**<br>**Care-avoidant type: Medical care is rarely used.** | • The care-seeking and care-avoidant subtypes are new to *DSM-5*.<br>• Removed the *DSM-IV* specifier "with poor insight." |

## Dissociative Disorders

OVERVIEW OF CHANGES

- Compared to other categories of mental disorders, there have been relatively few alterations to the dissociative disorders from *DSM-IV* to *DSM-5.*
- The *DSM-IV* diagnosis of depersonalization disorder has been renamed to depersonalization/derealization disorder, accompanied by several changes to diagnostic criteria. This disorder is characterized by experiences of feeling disconnected from oneself or one's body (depersonalization), as well as experiences of unreality related to one's environment (derealization).
- Dissociative fugue, characterized by a dissociative experience where an individual wanders or travels away from home, is no longer classified as its own disorder. Instead, in *DSM-5* it is considered a type of dissociative amnesia.
- As shown below, the diagnostic criteria for dissociative identity disorder are now more inclusive.

*DSM-5* CONTROVERSIES: DO "MULTIPLE PERSONALITIES" REALLY EXIST?

Dissociative disorders are among the oldest recognized mental disorders. In spite of this, there is a history of controversy surrounding these disorders, particularly dissociative identity disorder (DID) (see Barlow & Durand, 2012; Durand & Barlow, 2013). In DID, an individual experiences systematic changes in personality and experience, shifting between different identities or "alters", each with its own behavior, emotion and thought.

Many psychologists have pointed out that the symptoms of dissociative identity disorder are possible to fake, and indeed, it is likely that some patients fabricate symptoms of DID as a way of seeking attention. Furthermore, researchers have raised the concern that therapists may involuntarily influence suggestible patients to display the symptoms of DID, by raising the possibility of fragmented identity to patients who then behave as they believe they are expected to (e.g., Spanos, 1996). As a result, a majority of American psychiatrists have reservations about including dissociative identity disorder in the DSM (Pope, Oliva, Hudson, Bodkin, & Gruber, 1999).

On the other hand, some studies have documented physiological changes between different personalities within an individual, suggesting that DID is a very real experience for some patients (e.g., Ludwig et al., 1972). Further support for the validity of DID as a mental disorder comes from the fact that there is evidence of shared etiology among DID patients: virtually all have experienced a history of childhood abuse, usually physical or sexual in nature (e.g., Putnam et al., 1986).

In light of the disagreement surrounding the validity of DID as a diagnosis, as well as concerns that some patients may be exaggerating symptoms purposefully or inadvertently, *DSM-5* diagnostic criteria for this disorder are especially important. New criteria are more inclusive, allowing disrupted personality states to be observed by others or reported by the individual. Additionally, *DSM-5* now

requires that patients experience some distress or impairment as a result of their condition, and that the condition be distinguished from cultural or religious practices. As you examine the diagnostic criteria below, consider how they impact research and treatment in this hotly debated disorder.

SPOTLIGHT ON *DSM-5*: NEW DIAGNOSTIC CRITERIA FOR DISSOCIATIVE IDENTITY DISORDER

<table>
<tr><th colspan="3">Diagnostic Criteria for Dissociative Identity Disorder</th></tr>
<tr><td colspan="3">MAJOR CHANGES:<ul><li>DSM-5 notes that symptoms of dissociative identity disorder may either be reported by the individual or observed by others.</li><li>DSM-IV Criterion B (at least two of the person's identity states routinely take control) has been removed.</li><li>DSM-5 Criterion C is new (distress or impairment).</li><li>DSM-5 Criterion D is new (distinction from cultural or religious practices).</li></ul></td></tr>
<tr><td>Diagnostic Criterion</td><td>DSM-5</td><td>Highlights of changes from DSM-IV to DSM-5</td></tr>
<tr><td>Criterion A<br>Distinct personality states</td><td>Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption of marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.</td><td><ul><li>Changed wording.</li><li>Added note that the disturbance may be described as an experience of possession. This change was made to make the criteria more broadly applicable across cultures.</li><li>Expanded upon the ways in which individual personality states differ from each other.</li><li>Added note that symptoms may be either reported by the patient or observed by others.</li></ul></td></tr>
<tr><td>Criterion B<br>Forgetting</td><td>Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.</td><td><ul><li>Previously listed under DSM-IV Criterion C.</li><li>Noted that forgetting may occur for everyday events or traumatic events in addition to personal information.</li><li>Changed wording.</li></ul></td></tr>
<tr><td>Criterion C<br>Distress or impairment</td><td>The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</td><td><ul><li>This is a new criterion in DSM-5.</li></ul></td></tr>
<tr><td>Criterion D<br>Distinction from cultural or religious practices</td><td>The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not attributable to imaginary</td><td><ul><li>This is a new criterion in DSM-5.</li><li>The distinction from imaginary play was previously listed in DSM-IV Criterion D.</li></ul></td></tr>
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| | playmates or other fantasy play. | |
| **Criterion E**<br>*Distinction from other conditions* | The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures). | • Previously listed under *DSM-IV* Criterion D.<br>• Changed wording. |

## Personality Disorders

OVERVIEW OF CHANGES

- DSM-5 diagnostic criteria for personality disorders are identical to those criteria found in DSM-IV.
- During the development of the *DSM-5*, some professionals working on the *DSM-5* personality disorders criteria proposed an alternative model for conceptualizing personality disorders (see below). Following this model, all personality disorders would be described using standardized criteria that described impaired personality *functioning* related to self and others, and pathological personality *traits.*
- Although the alternative model was *not* officially adopted, it is included in the *DSM-5*, separate from diagnostic criteria. The table below outlines the proposed diagnostic structure of personality disorders. This structure provides a useful way of thinking about personality functioning, because it highlights areas that are problematic across all personality disorders.

*DSM-5* CONTROVERSIES: TO CHANGE OR NOT TO CHANGE PERSONALITY DISORDERS?

Discussion about the personality disorders in *DSM-5* included proposals for a number of major changes to this category. As we have seen, the elimination of the distinction between "Axis I" and "Axis II" disorders elevated the personality disorders into the mainstream of problems experienced by individuals. However, other major changes that appeared to be ready for inclusion in *DSM-5* never occurred. The goal of creating dimensions of different personality traits rather than the specific disorders outlined in this chapter (e.g., borderline personality disorder, antisocial personality disorder) never materialized. In part this proposal was not included in *DSM-5* due to the difficulty in making a diagnosis (too many permutations) and potential problems in using that information to design treatments (Skodol, 2012).

However, one of the biggest changes proposed was to completely eliminate four of the personality disorders (paranoid, schizoid, histrionic, avoidant, and dependent personality disorders). Instead, people previously diagnosed with these disorders would be identified as having a general personality disorder with the traits specified (e.g., suspiciousness, emotional liability, hostility, etc.). The rationale for their removal included a relative lack of research on these disorders and significant overlap among the disorders (comorbidity) (Skodol, 2012). In anticipation of this significant change, one set of researchers authored a paper with the title "The Death of Histrionic Personality Disorder" (Blashfield, Reynolds, & Stennett, 2012) and the personality disorders community of researchers in general was divided over this change (Pull, 2013). Ultimately, the final draft retained these disorders and left for a

later time proposals for dealing with the problems of lack of research and specificity. This back and forth on how to carve up diagnoses exemplifies the difficulties that continue to exist for any diagnostic system, even after decades of arduous and dedicated research.

SPOTLIGHT ON *DSM-5*: ALTERNATIVE MODEL FOR CLASSIFYING PERSONALITY DISORDERS

| General Diagnostic Criteria: Alternative *DSM-5* Model for Personality Disorders | |
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| Diagnostic Criterion | *DSM-5* Alternative Model |
| **Criterion A**<br>*Impairment in personality function* | Significant impairments in personality functioning manifest by:<br>1. Impairments in self functioning (a or b):<br>a. Identity<br>b. Self-direction<br>AND<br>2. Impairments in Interpersonal Functioning (a or b)<br>a. Empathy<br>b. Intimacy |
| **Criterion B**<br>*Pathological personality traits* | Pathological personality traits in the following domains: [List areas relevant to the disorder in question]<br>*Examples:* Attention seeking (narcissistic personality disorder), rigid perfectionism (obsessive-compulsive personality disorder), impulsivity (borderline personality disorder) |
| **Criterion C**<br>*Stability across time and place* | The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations. |
| **Criterion D**<br>*Distinction from normal developmental or cultural behavior* | The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or sociocultural environment. |
| **Criterion E**<br>*Distinction from other conditions* | The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma). |

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