DSM-5 (DSM-5)

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DSM-5

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The *Diagnostic and statistical manual of mental disorders (DSM)*, published by the American Psychiatric Association, is a compendium of mental disorders, a listing of the diagnostic criteria used to diagnose them, and a detailed system for their definition, organization, and classification. This entry includes information on: (a) the planning and development of the fifth edition of the manual (*DSM-5*), (b) the general features of the *DSM-5* and changes from previous editions, (c) multicultural and diversity issues in the *DSM-5*, and (d) limitations and criticisms of the *DSM-5*. Mental disorder refers to "a health condition characterized by significant dysfunction in an individual's cognitions, emotions, or behaviors that reflects a disturbance in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association, 2012). Diagnosis refers to the identification and labeling of a mental disorder by examination and analysis (Segal & Coolidge, 2001). Mental health professionals diagnose individuals based on the *symptoms* that they report experiencing and the *signs* of disorders with which they present. Whereas the *DSM* aids professionals in understanding, diagnosing, and communicating about mental disorders through its provision of explicit diagnostic criteria and an official classification system, no information about treatment is included.

Planning and Development of the *DSM-5*

The *DSM-5* is the latest incarnation of the manual in an evolving process that began with publication of the original *DSM* in 1952. More recently, the *DSM-IV* was published in 1994 and in 2000 a "text revision" of the manual (*DSM-IV-TR*) was published, which slightly updated some of the content in the manual. Empirical research and extensive literature reviews have guided refinements in the diagnostic manual and its continued development. In 1999, an initial *DSM-5* research planning conference was convened, which set research priorities in an effort to expand the scientific basis for mental health diagnoses and classification. Between 2006 and 2008, the diagnostic workgroups were assembled, comprising more than 160 clinicians and researchers from psychiatry, psychology, social work, psychiatric nursing, pediatrics, and neurology. In an effort to ensure broad perspectives were considered, the work-group members represented more than 90 academic and mental health institutions throughout the world, and approximately 30% of the work-group members were from countries other than the United States. Additionally, more than 300 advisers, known for their expertise in a particular field, provided knowledge to the workgroup members.

Each of the diagnostic workgroups conducted extensive literature reviews, performed secondary data analyses, solicited feedback from colleagues and professionals, and ultimately developed the new diagnostic criteria in their respective areas. Several general principles were established to guide the decisions made by the workgroups about what should be included, removed, or changed in the revised manual. These principles included consideration of the clinical utility of and research evidence for the revisions, continuity with the previous edition of the manual when possible, and no predetermined constraints on the amount of change permitted. Additionally, the workgroups were asked to clarify the boundaries between mental disorders,

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consider symptoms that occur across different diagnoses, demonstrate the strength of the empirical evidence for the recommended changes, and clarify the boundaries among specific mental disorders and normal psychological functioning.

Early drafts of the *DSM-5* were opened for public review; the American Psychiatric Association designated three time periods during which the general public was invited to comment on the new diagnostic criteria. Field trials were conducted between 2010 and 2011 to test the new diagnostic criteria for feasibility, clinical utility, reliability, and validity in both academic and nonacademic clinical practice settings. The release of the final, approved *DSM-5* occurred in May 2013. The manual is expected to become a living document, reflecting more frequent revisions. Thus, the traditional Roman numeral was dropped from the title so that future changes prior to the manual's next complete revision will be signified as *DSM-5.1*, *DSM-5.2*, and so forth. Although far from perfect, the *DSM* functions as one of the most comprehensive and thorough manuals used to classify and diagnose mental disorders. The only major competitor in the developed world is the World Health Organization's *International Classification of Diseases* (*ICD*), which is in its tenth edition. The *ICD* is also currently undergoing revision and is expected to be widely compatible with the *DSM-5*.

General Features of the DSM-5

Section 1 of the *DSM-5* provides an introduction and includes information on how to use the manual. In Section 2, mental disorders are grouped into 22 diagnostic categories. The structural organization of the *DSM-5* is revised from the previous edition, such that the individual disorders within a category are arranged in a developmental lifestyle fashion, with disorders typically associated with childhood presented first. Additionally, the order of the diagnostic categories is designed to closely position diagnostic areas that seem to be related to one another, reflecting advances in the scientific understanding of mental disorders. Section 3 includes conditions that require further research, assessment measures, cultural formulations, a glossary, and a description of an alternative model for diagnosing personality disorder (see below).

According to the *DSM-5*, individuals with a particular diagnosis (e.g., major depressive disorder) need not exhibit identical features, although they should present with certain cardinal symptoms (e.g., either depressed mood or anhedonia). In the *DSM-5*, the criteria for many mental disorders are polythetic, meaning that an individual must meet a minimum number of symptoms to be diagnosed, but not all symptoms need be present (e.g., five of nine symptoms must be present to diagnose depression). Use of polythetic criteria allows for some variation among people with the same disorder. However, individuals with the same disorder should have a similar history in some areas, for example a typical age of onset, prognosis, and common comorbid conditions. Consistent with previous editions, the *DSM-5* primarily relies on a categorical approach to diagnosis so that individuals either have the disorder (i.e., they meet criteria, they are diagnosable) or they do not (despite possibly having several symptoms but not enough to meet formal criteria).

Notably absent from the *DSM-5* is the use of the multiaxial system. Clinical disorders, personality disorders, and general medical conditions (formerly Axes I, II, and III) are combined into a nonaxial documentation, with separate notations for psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V). Regarding the former Axis V, the Global Assessment of Functioning scale has been replaced with the World Health Organization Disability Assessment Schedule (WHODAS) which provides a global measure of disability. The WHODAS is based on the International Classification of Functioning, Disability and Health (ICF) for use across all of medicine and health care, and is located in Section 3 of the *DSM-5* with other

new assessment measures. An added feature in the *DSM-5* is the more prominent use of dimensional and crosscutting assessments. Dimensional assessments are proposed for inclusion within some existing categorical diagnoses, with the goal of providing additional information that assists clinicians in assessment, treatment planning, and treatment monitoring. For example, among individuals with schizophrenia, the severity of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms, may be rated on a dimensional five-point scale ranging from 0 (*not present*) to 4 (*present and severe*). Cross-cutting assessment refers to the measurement of important clinical areas that may be relevant beyond specific diagnostic areas, such as depressed mood, anxiety, substance use, or sleep problems. Such clinical areas may be relevant for prognosis, treatment planning, assessment of outcome, or refinement of diagnosis, and may be evaluated and monitored throughout the course of treatment.

Clinical Disorders

The bulk of the *DSM-5* comprises 22 broad clusters under which specific clinical disorders are subsumed. Examples of clinical disorders include bipolar disorder, generalized anxiety disorder, schizophrenia, and anorexia nervosa. In general, many of the main diagnostic categories remain largely the same in the *DSM-5* as in the previous edition of the manual, although some new categories were created (e.g., Neurodevelopmental Disorders; Bipolar and Related Disorders, Gender Dysphoria, Obsessive-Compulsive and Related Disorders). Other modifications included moving several disorders from one category to another, renaming some disorders, and deleting some disorders that had questionable reliability or validity, reflecting advances in empirical research and understanding of mental-health disorders. For example, disorders that were formally classified as "Dementia" are now renamed "Mild Neurocognitive Disorder" or "Major Neurocognitive Disorder," with subtypes of each identifying the etiology of the cognitive dysfunction (e.g., Major Neurocognitive Disorder due to Alzheimer's Disease). Consistent with the manual's new dimensional approach, Asperger's disorder has been subsumed in a new diagnosis called "Autism Spectrum Disorder," which allows for dimensional ratings of severity of the symptoms on a continuum from mild to severe. In addition, there are a few newly classified disorders, such as Hoarding Disorder, which falls under the "Obsessive-Compulsive and Related Disorders" category. Finally, some clinical disorders such as Non-Suicidal Self Injury Disorder and Persistent Complex Bereavement Disorder are included in the manual under a section designated for disorders that require further study (in the previously mentioned Section 3).

Personality Disorders

Personality disorders are inflexible and maladaptive patterns of behavior reflecting extreme variants of normal personality traits that have become rigid and dysfunctional. Ten prototypical personality disorders were listed in the *DSM-IV-TR*, including the antisocial, avoidant, borderline, dependent, histrionic, narcissistic, obsessive-compulsive, paranoid, schizoid, and schizotypal personality disorders. Substantial comorbidity and overlap exist among the personality disorders. The *DSM-5* Personality and Personality Disorders Work Group proposed substantial changes in the way clinicians assess and diagnose personality pathology. However, after extensive debate and critique of the proposed changes, the *DSM-5* included the 10 standard personality disorders in the main text of the manual and relegated most of the proposed changes to the latter portion of the manual so that the changes can be studied more fully. Nonetheless, the proposal is available for current use if the clinician wishes.

The workgroup initially recommended the previous 10 categories be reduced to six specific personality disorder types, including

antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal. One additional type, Personality Disorder Trait Specified (PDTS) was suggested to replace the former Personality Disorder Not Otherwise Specified diagnosis. The workgroup also proposed that the *DSM-5* criteria should incorporate a dimensional approach, such that in order to be diagnosed with a personality disorder an individual must have impairment in two areas of personality functioning: *self* and *interpersonal*. Impairment of self is related to identity and self-directedness, whereas interpersonal impairment is related to one's capacity for empathy and intimacy. Levels of impairment in these areas are supposed to be rated along a continuum from 0 (*healthy functioning*) to 4 (*extreme impairment*). Finally, the workgroup proposed and defined five broad personality trait domains, including negative affectivity, detachment, antagonism, disinhibition versus compulsivity, and psychoticism. Within these five broad domains are component trait facets, which vary by disorder. It was suggested that the personality domain in *DSM-5* be used to describe the personality characteristics of all patients, whether or not they have a clinically significant personality disorder. The workgroup's full proposal is available for use in Section 3.

In response to these suggested major changes to the Personality Disorders category in *DSM-5,* there has been substantial and sometimes contentious debate in the literature regarding many of these modifications. Most of the criticisms center around questions about the empirical basis for many of the changes, the perceived arbitrariness of the changes, and the perceived limited clinical utility and unnecessary complexity of the changes (e.g., Livesley, 2012; Zimmerman, 2011). Concerns among researchers continue to exist about the limited relevance of some diagnostic criteria for personality disorders as applied to older adults and the unique context of later life (Balsis, Segal, & Donahue, 2009; Segal, Coolidge, & Rosowsky, 2006). Although no major changes in the personality disorders were formally adopted in *DSM-5*, it is likely that many of the proposed changes will be revisited in future editions of the manual especially as the research base continues to clarify whether the proposed modifications increase diagnostic utility and validity.

Multicultural and Diversity Issues in the DSM-5

During the *DSM-5* development process, study groups on gender and cross-cultural issues and on lifespan developmental approaches were included. In addition, there was an effort to include international experts in the revision process, as well as a variety of clinical settings during the field trials, to ensure a wide pool of information on cultural factors in psychopathology and diagnosis. Such information is necessary to help clinicians and researchers diagnose individuals outside the majority culture. The *DSM-5* provides an updated version of the Outline for Cultural Formulation that was introduced in *DSM-IV*. This Outline provides a framework for assessing information about the role of culture in an individual's mental health problems. Specifically, the Outline calls for a thorough assessment of five content areas, including the cultural identity of the individual, cultural conceptualizations of distress, psychosocial stressors and cultural features of vulnerability and resiliency, cultural features of the relationship between clinician and client, and an overall cultural assessment.

The *DSM-5* Outline also presents an approach to assessment using the Cultural Formulation Interview (CFI). The CFI contains a set of 16 questions that clinicians may use during a clinical intake assessment to elicit information from a client about the possible impact of culture on different aspects of care. It is designed to be used regardless of the client's cultural background or the clinician's cultural background or theoretical orientation. The CFI emphasizes four main domains: (a) cultural definition of the problem; (b) cultural perceptions of cause, context, and support;

(c) cultural factors affecting self-coping and past help-seeking behaviors; and (d) cultural factors affecting current help-seeking behaviors. Although *culture* purportedly refers to all aspects of one's membership in diverse social groups (e.g., ethnic groups, the military, faith communities), the CFI appears to emphasize the impact of race and ethnicity on one's understanding of one's difficulties. Additional modules have been developed for populations with unique needs, such as children, older adults, and immigrants and refugees, which can be used to supplement the standard CFI. Despite some apparent improvements, the relevance of criteria for some mental disorders among older adults is addressed in a limited fashion in the *DSM-5*. Finally, a Glossary of Cultural Concepts of Distress is located in the Appendix, and includes information about culture-bound syndromes, the cultures in which they occur, and a description of the main psychopathological features.

Limitations and Criticisms of *DSM-5*

Although anticipated to improve upon its predecessors and provide a state-of-the-art manual for the diagnosis and classification of mental disorders, the *DSM-5* has received some significant criticisms. A major criticism is the dramatic expansion of the boundaries of some categories, for example attention deficit hyperactivity disorder (ADHD), potentially resulting in numerous "false positive" diagnoses. A related controversy regards the expansion in the number of diagnosable mental disorders, potentially prompting unnecessary stigmatization, intervention, and expense. Indeed, across editions of the *DSM*, more mental disorders have been included in each successive version as new disorders have been defined to fill in the gaps between existing disorders. Such proliferation of newly minted disorders raises the question whether they truly represent distinct forms of psychopathology or are merely variations of existing disorders. Other criticisms include the American Psychiatric Association's lack of inclusiveness and transparency in the revision process; the adoption of a dimensional approach to diagnosis without sufficient empirical support; the use of newly developed dimensional and cross-cutting assessments in the absence of evidence of reliability and validity; and limited attention to careful risk-benefit analyses regarding many of the changes. For a more complete discussion of strengths and criticisms of the *DSM-5*, interested readers are referred to Frances and Widiger (2012), Kamens (2012), and Widiger and Gore (2012).

SEE ALSO: Definition of Mental Disorder; *DSM-I* and *DSM-II*; *DSM-III* and *DSM-III-R*; *DSM-IV*; Medical Model of Mental Disorders; Reification

References

American Psychiatric Association. (2012). Definition of a mental disorder. Retrieved from http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=465

Balsis, S., Segal, D. L., & Donahue, C. (2009). Revising the personality disorder diagnostic criteria for the *Diagnostic and statistical manual of mental disorders—fifth edition (DSM-5)*: Consider the later life context. *American Journal of Orthopsychiatry, 79,* 452–460.

Frances, A. J., & Widiger, T. (2012). Psychiatric diagnosis: Lessons from the DSM past and cautions for the DSM-5 future. *Annual Review of Clinical Psychology, 8,* 109–130. doi:10.1146/annurev-clinpsy-032511-143102

Kamens, S. (2012). Controversial issues for the future *DSM-5*. Retrieved from http://www.apadivisions.org/division-32/publications/newsletters/humanistic/2010/01/dsm-v.aspx

Livesley, J. (2012). Tradition versus empiricism in the current *DSM-5* proposal for revising the classification of personality disorders. *Criminal Behaviour and Mental Health, 22,* 81–90. doi:10.1002/cbm.1826

Segal, D. L., & Coolidge, F. L. (2001). Diagnosis and classification. In M. Hersen & V. B. Van Hasselt (Eds.), *Advanced abnormal psychology* (2nd ed., pp. 5–22). New York: Kluwer Academic/Plenum.

Segal, D. L., Coolidge, F. L., & Rosowsky, E. (2006). *Personality disorders and older adults: Diagnosis, assessment, and treatment*. Hoboken, NJ: John Wiley & Sons, Ltd.

Widiger, T. A., & Gore, W. L. (2012). Mental disorders as discrete clinical conditions: Dimensional versus categorical classification. In M. Hersen & D. C. Beidel (Eds.), *Adult psychopathology and diagnosis* (6th ed., pp. 3–32). New York: John Wiley & Sons.

Zimmerman, M. (2011). A critique of the proposed prototype rating system for personality disorders in *DSM-5*. *Journal of Personality Disorders, 25,* 206–221. doi:10.1521/pedi.2011.25.2.206

Further Reading

Alarcón, R. D. (2009). Culture, cultural factors, and psychiatric diagnosis: Review and projections. *World Psychiatry, 8,* 131–139.

Hersen, M., & Beidel, D. C. (Eds.). (2012). *Adult psychopathology and diagnosis* (6th ed.). Hoboken, NJ: John Wiley & Sons.

Jones, K. D. (2012). Dimensional and cross-cutting assessment in the *DSM-5*. *Journal of Counseling and Development, 90,* 481–487. doi:10.1002/j.1556-6676.2012.00059

Keeley, J. W., Burgess, D. R., & Blashfield, R. K. (2008). Diagnostic and statistical manual of mental disorders (DSM). In S. F. Davis & W. Buskist (Eds.), *21st Century Psychology* (pp. 253–261). Thousand Oaks, CA: Sage Publishing.