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A Guide to DSM-5

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DSM-5 Revisions

In development for more than a decade, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* [1] (DSM-5) is now a reality. The manual's official release was announced at an early morning press conference on May 18, 2013, at the American Psychiatric Association's Annual Meeting in San Francisco, California.

Revising psychiatry's primary diagnostic resource takes work -- years of planning, conducting field trials, revising, soliciting public feedback, revising again -- and the effort has led to a revamped guide to psychiatric diagnosis. New diagnoses have been added, others amended or combined. Some originally proposed criteria drew so much public and professional controversy they were ultimately withdrawn from the final draft. But perhaps the most significant changes to the manual are conceptual: removing the multiaxial system, adding a dimensional diagnostic approach, and rearranging the chapter order and grouping of disorders.

The current 5-axial diagnostic system has been removed from DSM-5 in favor of nonaxial documentation of diagnosis. The new approach will combine the former axes I, II, and III with separate notations for psychosocial and contextual factors (formerly axis IV) and disability (formerly axis V). In addition to categorical diagnoses, a dimensional approach allows clinicians to rate disorders along a continuum of severity that will largely eliminate the need for "not otherwise specified (NOS)" conditions, now termed "not elsewhere defined" (NED)" conditions. The dimensional diagnostic system also better correlates with treatment planning.

Furthermore, the revised chapter order is intended to better reflect advances in the understanding of the underlying vulnerabilities of disease, as well as symptom characteristics of mental health disorders. Finally, diagnostic criteria for some disorders have been added or revised and are included in Section 2 of the manual, whereas those requiring further investigation are included in Section 3 (appendix).

Critics of DSM-5 have raised concern that it may be too early to create a new classification of psychiatric diseases. The main question is whether there have been sufficient advances in the pathophysiologic, phenomenologic, and therapeutic understanding of mental illness to warrant a revised DSM. Although the ultimate aim is to base diagnoses mostly on objective and, ideally, biologically measurable criteria, psychiatry is unfortunately still far from this goal.

This controversy has played out in initial comments by the director of the National Institute of Mental Health (NIMH), Thomas Insel, who urged for the development of a more biologically based nosology of mental disorders. In a blog post published on the NIMH Website, Dr. Insel pointed to the new NIMH Research Domain Criteria (RDoC) project as a possible replacement diagnostic tool sometime in the future, which will incorporate genetics, imaging, and other data into a new classification system and as "a first step towards precision medicine." In a later joint statement by Dr. Insel and newly-appointed American Psychiatric Association president Jeffrey Lieberman, both commented that DSM and the International Classification of Diseases (ICD) "remain the contemporary consensus standard to how mental disorders are diagnosed and treated," and that "what may be realistically feasible today for practitioners is no longer sufficient for researchers." However, both also acknowledged that "looking forward, laying the groundwork for a future diagnostic system that more directly reflects modern brain science, will require openness to rethinking traditional categories. It is increasingly evident that mental illness will be best understood as disorders of brain structure and function that implicate specific domains of cognition, emotion, and behavior," which is at the core of the RDoC initiative. These statements all converged in the belief that "DSM-5 and RDoC represent complementary, not competing, frameworks for this goal."

In this context, the DSM-5 committee members have attempted a rational reexamination of the DSM-IV criteria on the

basis of longitudinal research, incorporating data on the apparent relatedness of certain diagnoses with one another, including similarities in underlying vulnerabilities, symptom characteristics, and disease trajectories. Overall, most of the diagnoses and relevant criteria included in DSM-5 remain identical, or similar, to those in DSM-IV. However the updates are significant and represent a new diagnostic era in psychiatry.

What follows is a guide highlighting the major additions and revisions in the new DSM-5 edition.

Field Trial Results

As part of the DSM-5 field trials, 2246 patients with various diagnoses and degrees of comorbidity were interviewed (86% twice) on the basis of the DSM-5 criteria. Interviews were conducted by 279 clinicians in various disciplines who received training similar to what would be available to clinicians after publication of the DSM-5.[2,3]

The field trials tested the criteria for 23 disorders: 15 adult and 8 child/adolescent diagnoses. Reliability as a measure of agreement between 2 independent clinicians was measured with kappa statistics. For example, if 2 clinicians agreed on a diagnosis 85% of the time, the kappa value was 0.46 -- as it was for schizophrenia and conduct disorder. Overall, 5 diagnoses were in the "very good" range (kappa = 0.60-0.79), 9 were in the "good" range (kappa = 0.40-0.59), 6 were in the "questionable" range (kappa = 0.20 0.39), and 3 were unacceptable (kappa < 0.20) (Figures 1 and 2).

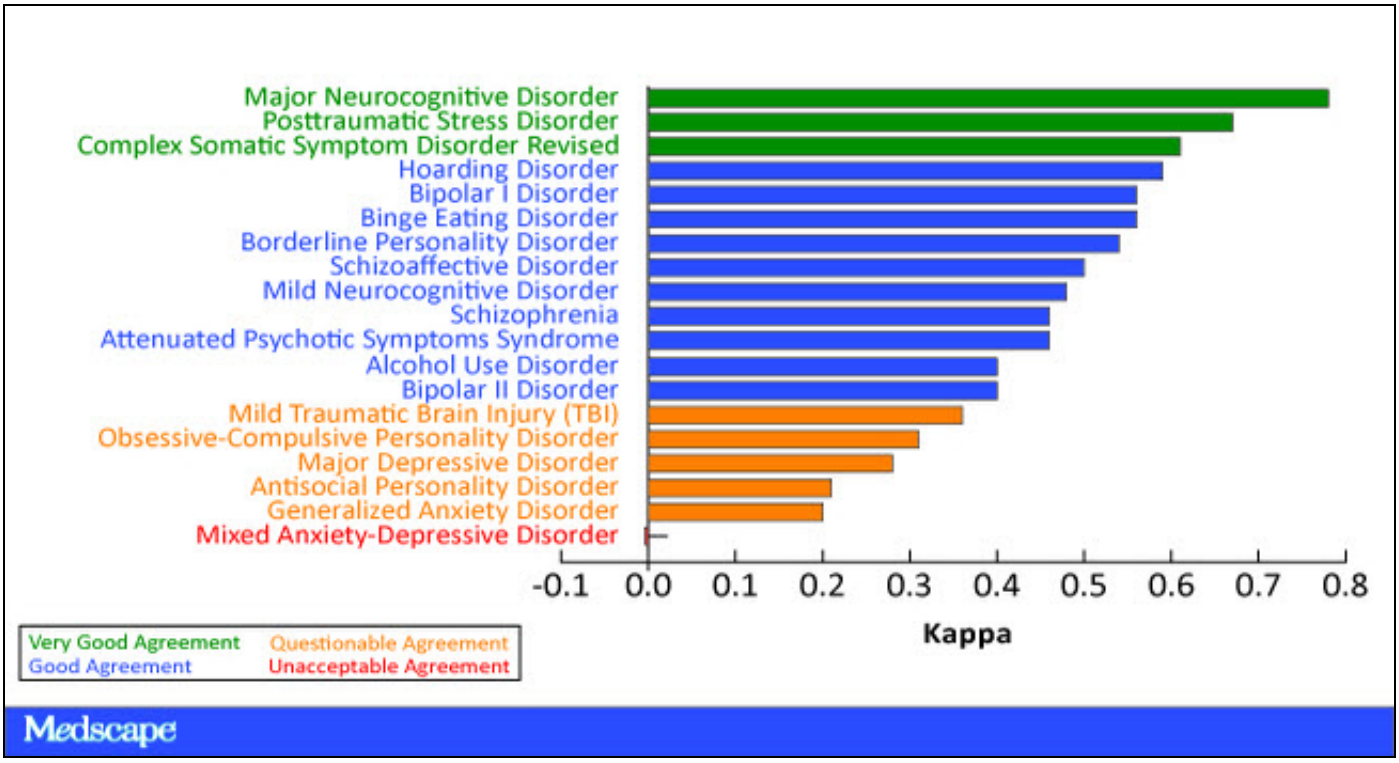

Figure 1.

DSM-5 field trials: diagnostic reliability in adults. Modified from Freedman R, et al.[2]

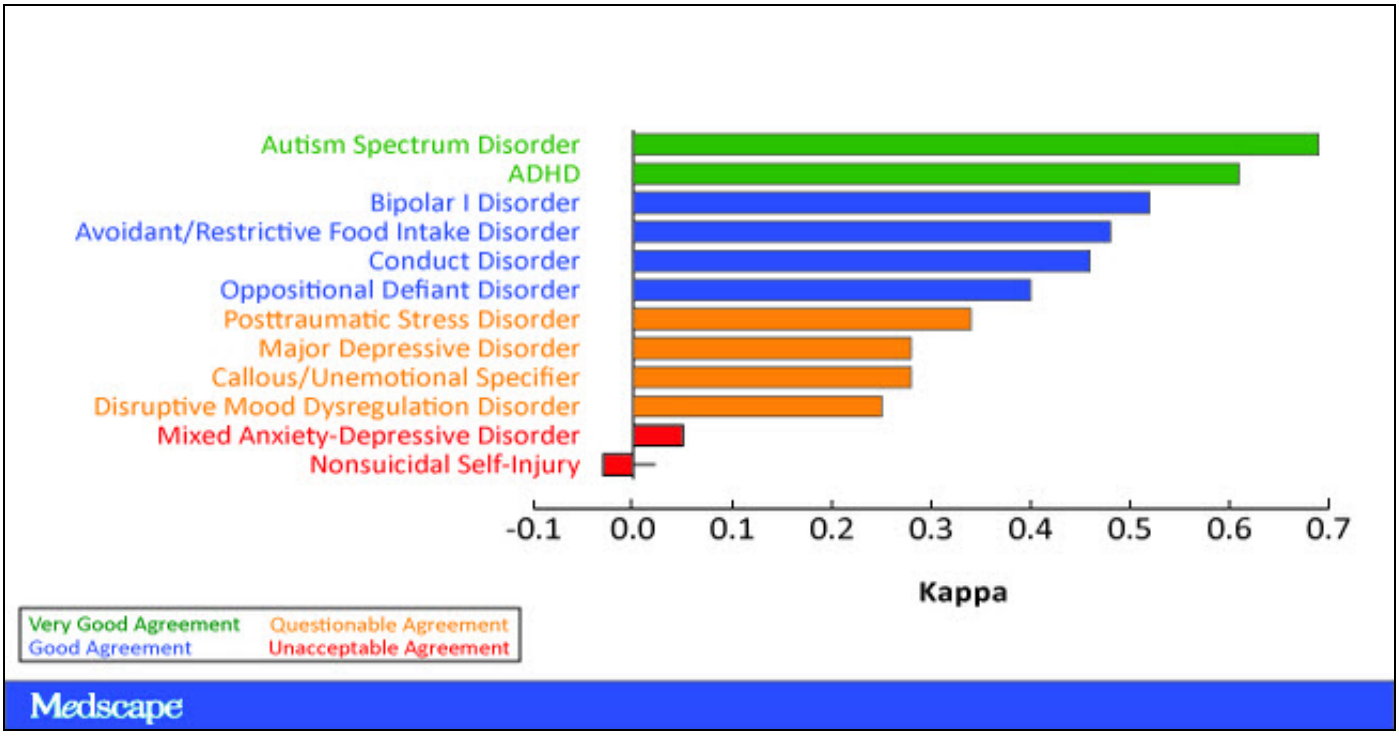

Figure 2.

DSM-5 field trials: diagnostic reliability in children and adolescents aged 6-17 years. Modified from Freedman R, et al.[2]

For 8 diagnoses, including several personality disorders, sample sizes were insufficient to generate precise kappa estimates. Among the 14 most reliable diagnoses were posttraumatic stress disorder, bipolar I disorder, borderline personality disorder, schizoaffective disorder, schizophrenia, bipolar II disorder, and alcohol use disorder in adults, as well as autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder, bipolar I disorder, conduct disorder, and oppositional defiant disorder in youth.

Whereas new DSM-5 entries, such as major neurocognitive disorder, complex somatic symptom disorder, hoarding disorder, binge eating disorder, and ASD were among the most reliable diagnoses, disruptive mood dysregulation disorder was in the "questionable" reliability range, as were the unmodified major depressive disorder (MDD) and generalized anxiety disorder (GAD) diagnoses. The 2 diagnoses that fell into the "unacceptable" reliability category, mixed anxiety-depressive disorder and nonsuicidal self-injury, have been removed or included in Section 3, respectively.

Critics of the field trial results have focused on the fact that the unchanged disorders MDD and GAD were among the 6 disorders with questionable reliability, and that the kappa thresholds for "good" by the DSM-5 field trials were lower than traditional thresholds. Moreover, for conditions where several different sites contributed data, there were considerable variations in reliability.[3]

Neurodevelopmental Disorders

The Change

In DSM-5, "mental retardation" has a new name: "intellectual disability (intellectual developmental disorder)," the first section in the neurodevelopmental disorders chapter. The change is due to a gradual call for destigmatization among clinicians, the public, and advocacy groups. Also included in this chapter are communication disorders -- formerly phonological disorder and stuttering -- which include language disorder, speech sound disorder, childhood-onset

fluency disorder, and a new condition characterized by impaired social verbal and nonverbal communication called social (pragmatic) communication disorder. Attention-deficit/hyperactivity disorder (ADHD), specific learning disorder, and motor disorders (eg, Tourette disorder) are also included, as is the new DSM-5 diagnosis, autism spectrum disorder (see page 4).

The Implications

This category groups conditions with onset in childhood and adolescence that are thought to be due to abnormal neural circuit development, causing various dysfunctions in cognition, learning, communication, and behavior. The grouping of these conditions hopefully will urge clinicians to try to differentiate them from each other and consider differential diagnoses and comorbidities more carefully.

Autism Spectrum Disorders

The Change

DSM-5 includes a single ASD category that does not differentiate between the previously used diagnoses. The new criteria group the following formerly distinct diagnoses into a single ASD diagnosis: autistic disorder, Asperger disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS).

The Implications

Among the most controversial of the DSM-5 revisions, this change was made owing to the DSM-5 Task Force's dimensional approach to categorizing psychopathology. Although there was concern that a large percentage of persons formerly diagnosed with an ASD would fall outside of the new diagnostic criteria, and thus be ineligible for certain services, this seems unlikely in most situations. Rather, patients will be diagnosed more consistently across a single spectrum, with indicators of different severity of symptoms.

In a commentary published on *Medscape* in June 2012, DSM-5 Task Force Chair, Dr. David Kupfer, commented, "Advocates for those who suffer from Asperger syndrome and autism disorders want to ensure that children with DSM-IV-defined conditions are not denied services under DSM-5. Our field trial data do not show that people with treatment needs will be negatively affected, and all will be helped because clinicians will be guided by more explicit definitions and descriptions of symptoms and behaviors."

However, concern remains that the revised criteria could result in a confounding of very heterogeneous clinical presentations, with mild PDD-NOS on the one end and severe autism on the other. On the other hand, clinicians can diagnose across a meaningfully related spectrum of symptoms and behaviors -- recognizing overlapping features of and differences in individual presentations and focusing on the severity of the symptoms, which will help guide treatment approaches more directly. Clinicians will probably need to take some time to discuss with parents any changes in the diagnosis of their children based on DSM-5 criteria.

Binge Eating Disorder

The Change

In DSM-5, binge eating disorder graduated from DSM-IV's Appendix B -- Criteria Sets and Axes Provided for Further Study -- to an official diagnosis in the new manual's Section 2.

The Implications

DSM-IV recognized only 3 eating disorder diagnostic categories: anorexia nervosa, bulimia nervosa, and eating disorder NOS. The update allows for additional diagnostic nuance.

Binge eating disorder seems to have a distinct clinical profile from the eating disorders included in DSM-IV. Like

bulimia nervosa, the condition is characterized by recurrent episodes of binge eating. However, unlike bulimia, patients do not exhibit inappropriate compensatory behaviors, such as purging, fasting, or excessive exercise.

Critics have noted that (1) a binge eating diagnosis may share considerable symptom overlap with nonpathologic problematic eating, and (2) binge eating can be a manifestation of other illnesses, and therefore the new manual fails to address causation. This controversy highlights the complexities of abnormal eating behaviors that, again, are on a continuum from normal to problematic to a becoming a disorder. Inclusion of binge eating disorder without compensatory behaviors also implies the recognition of psychiatric underpinnings of certain types of obesity.

Disruptive Mood Dysregulation Disorder (DMDD)

The Change

This new diagnostic category includes children exhibiting persistent irritability and severe behavioral outbursts 3 or more times per week for more than 1 year. The mood in between temper outbursts is persistently negative (irritable, angry, or sad), which is observable by others, and the tantrums and negative mood are present in at least 2 settings. To meet criteria for the new diagnosis, onset of illness has to be before age 10 years and in a child with a chronological or developmental age of at least 6 years.

DMDD is intended to capture children with frequent temper tantrums and irritability, in part to prevent the overdiagnosis of bipolar disorder in youth with prepubertal onset of these symptoms. Often, such presentations result in a diagnosis of bipolar disorder or oppositional defiant disorder.[4]

The Implications

Critics of this update cite the modest body of research into the validity of DMDD as a viable diagnostic entity,[5] as well as the worry that such a diagnosis could increase the number of children diagnosed with mental illness and subsequent exposure to psychotropic medications with potential long-term side effects.

Furthermore, a recent study by Axelson and colleagues[6] concluded that "In this clinical sample, DMDD could not be delimited from oppositional defiant disorder and conduct disorder, had limited diagnostic stability, and was not associated with current, future-onset, or parental history of mood or anxiety disorders. These findings raise concerns about the diagnostic utility of DMDD in clinical populations." In a follow-up editorial,[7] Dr. Axelson wrote, "One can conclude that at this time, not enough scientific data about these kids are available to create a new diagnosis. However, we should all agree on the vital importance of this problem and the need to expand our efforts to better understand the complex construct of irritability so that we can improve the assessment, diagnosis, and treatment of some of our sickest children."

Although the validity and specificity of the new DMDD diagnosis remain in question, the hope is that the rise in bipolar disorder diagnoses for nonepisodic mood dysregulation and aggression with prepubertal onset may decrease. Whether this new diagnosis will also lead to a more judicious use of psychotropic medications and increased utilization of behavioral, psychosocial, and family interventions remains to be seen, but the addition of DMDD in DSM-5 will hopefully encourage such research.

Hoarding, Skin-Picking, and Rethinking OCD

New to the manual is a chapter grouping obsessive-compulsive disorder (OCD) with related disorders, including body dysmorphic disorder, and conditions formerly found in the "impulse control disorder (ICD) not elsewhere classified" section, including trichotillomania (pulling out one's hair). Two new diagnoses are included in this chapter: excoriation (skin-picking) disorder, characterized by repetitive and compulsive picking of skin resulting in tissue damage; and hoarding disorder, in which sufferers have persistent difficulty discarding with possessions regardless of their value.

The Implications

Distinguishing between OCD and disorders that were formerly included in the ICD section can be difficult, owing to symptom overlap. Skin-picking and other impulsive behaviors are sometimes seen as manifestations or symptoms of underlying OCD or anxiety, and therefore adding a new excoriation disorder diagnosis risks stigmatizing patients with 2 psychiatric diagnoses. However, a large body of research suggests that ICDs are distinct from OCD, both neurobiologically and clinically,[8,9] and data do support the new diagnostic criteria.[10] In addition, treatment effects also tend to differ.

The addition of the hoarding disorder diagnosis to the DSM-5 is supported by extensive research suggesting that although OCD and hoarding can co-occur, they are also neurobiologically and clinically distinct and may respond differently to therapy.[11] Patients with OCD and compulsive hoarding have a different pattern of cerebral glucose metabolism than that of nonhoarding patients with OCD.[12] Also, many patients who exhibit hoarding behaviors do not have other symptoms of OCD.[11,12]

Personality Disorders

The Change

In developing diagnostic criteria for personality disorders, the DSM-5 Work Group initially proposed a somewhat dramatic new approach: Maintain 6 personality disorder diagnoses from the prior 10 in DSM-IV, and move from a categorical to a trait-based, dimensional classification system. Per the categorical system, a patient either has a diagnosis or not, whereas a dimensional system better captures the nuances of human personality by measuring a variety of traits on a continuum. The proposal was ultimately voted down; however, the alternative hybrid dimensional-categorical model is included in a separate chapter in Section 3 of DSM-5 to stimulate further research on this modified classification system.

Of note, despite the required enduring and impairing nature of personality disorder symptoms and traits, in the field trials, only borderline personality disorder had good interrater reliability. In contrast, obsessive-compulsive personality disorder and antisocial personality disorder were in the questionable reliability range, and too few patients with other personality disorders were included to test their reliability. Although all original 10 personality disorders from DSM-IV were finally retained, DSM-5 has moved from the multiaxial to a monoaxial system that removes the arbitrary boundaries between personality disorders and other mental disorders.

The Implications

The integration of personality disorders with other psychiatric diagnoses that were previously separated and classified on a different axis returns to a more unified and dimensional view of personality, character, temperament, and mental illness. On the other hand, retention of personality disorders with questionable or untested reliability can lead to the perpetuation of stigmatizing diagnoses that may lack validity and for which treatment approaches are also often unclear. Moreover, too few patients in the field trials were available to test 7 of the 10 personality disorders, suggesting that future field trials should urgently include community mental health centers and clinicians working in nonacademic private settings, where these patients are more likely to be found and treated -- often with psychotherapy.

However, the fact that borderline personality disorder had such good interrater reliability, whereas the other personality disorders did not, may support previously endorsed views that it could belong in the bipolar disorder spectrum rather than being classified as a personality disorder. Future research will hopefully help clarify this further.

Posttraumatic Stress Disorder

The Change

Formerly in the "Anxiety Disorders" chapter, in DSM-5 posttraumatic stress disorder (PTSD) is now included in a new chapter titled "Trauma- and Stressor-Related Disorders." Furthermore, a fourth diagnostic cluster (in addition to

Criteria B, C, and D) capturing behavioral symptoms has been added. The 6 diagnostic criteria included in DSM-IV were maintained, with minor revisions, and 2 additional criteria have been added: (1) negative alterations in cognition and mood associated with the traumatic event, beginning or worsening after the event, and (2) the disturbance is not attributed to the direct physiologic effects of a substance or another medical condition.

In addition, a new diagnostic subtype has been created to include preschool-aged children with PTSD symptoms. Finally, DSM-5 further defines traumatic events, criteria are more culturally applicable, and the prior distinction between acute and chronic PTSD has been removed.

The Implications

The creation of a separate chapter on trauma- and stressor-related disorders will give PTSD the appropriate attention that it deserves as a condition with associated, traceable causal factors that should be addressed. The highlighting of behavioral aspects of PTSD by the creation of a fourth dimension will also probably help focus clinicians' attention on this important component of the disease. The new criteria will also better characterize PTSD in pediatric populations, who unfortunately are all too often victims of PTSD.

Removal of the Bereavement Exclusion From MDD

The Change

The bereavement exclusion in DSM-IV, which has been removed in DSM-5, was intended to exclude individuals experiencing depressive symptoms lasting less than 2 months after the death of a loved one from a diagnosis of MDD. The new edition characterizes bereavement as a severe psychological stressor that can incite a major depressive episode even shortly after the loss of a loved one.

The Implications

As detractors have pointed out, this contentious revision risks pathologizing a normal human process, grief. Individuals may be diagnosed with depression even in the absence of severe depression symptoms (ie, suicidal ideation) and even though their symptoms may be transient. Furthermore, in a recent article in *World Psychiatry,* [13] Drs. Jerome Wakefield and Michael First call into question the validity of research supporting removing the exclusion, concluding, "...there is no scientific basis for removing the bereavement exclusion from the DSM-5."

Proponents of eliminating the exclusion argue that grief does not preclude the development of full-blown depression, and further that grief predisposes to MDD. A categorical exclusion of MDD for 2 months after the death of a loved one wrongly presumes that nobody can become seriously depressed while also grieving. Dr. Ronald Pies, Medscape columnist and Professor of Psychiatry at SUNY Upstate Medical University commented in a recent column, "There are...substantial differences between grief and MDD, and experienced clinicians will be able to tell the difference." Thus, it will be important for clinicians to continue to assess the quality, reactivity, and extent of the depressive symptoms and to diligently differentiate bereavement from MDD in clinical practice. If in doubt, pharmacologic treatment may need to be delayed to assess the trajectory of the symptoms, unless they are severe or dangerous.

Substance Use Disorder

The Change

In DSM-5, the DSM-IV criteria substance abuse and substance dependence have been combined into single substance use disorders specific to each substance of abuse within a new "addictions and related disorders" category. Each substance use disorder is divided into mild, moderate, and severe subtypes. Whereas DSM-IV substance abuse diagnostic criteria required only 1 symptom, a DSM-5 diagnosis even for just mild substance use disorder now requires at least 2.

The Implications

The DSM-5 revisions are intended to (1) strengthen the reliability of substance use diagnoses by increasing the number of required symptoms and (2) clarify the definition of "dependence," which is often misinterpreted as implying addiction and has at its core compulsive drug-seeking behaviors. In contrast, features of physical dependence, such as tolerance and withdrawal, can be normal responses to prescribed medications that affect the central nervous system and that need to be differentiated from addiction. Moreover, although marijuana abuse can be functionally very impairing, physical dependence is not part of the clinical picture, even in severe cases. In this sense, the new DSM-5 criteria recognize that mental and behavioral aspects of substance use disorders are more specific to substance use disorders than the physical domains of tolerance and withdrawal, which are not unique to addiction.

Although the new criteria require an increased number of symptoms to qualify for a substance-related diagnosis, critics of the revision argue that chances of meeting the new criteria are now much greater. They further worry that many individuals who qualify for a substance use disorder diagnosis per the new criteria have only minor symptoms, making it more difficult for those with more severe symptoms and distress to access already scarce treatment resources.

Mixed-Mood Specifier

The Change

In DSM-5, the new specifier "with mixed features" can be applied to bipolar I disorder, bipolar II disorder, bipolar disorder NED (previously called "NOS") and MDD. The change was made to reflect the clinical phenomenon of "mixed" mood states that do not meet full criteria for a mixed episode of bipolar I disorder, reflected by co-occurrence of full mania and MDD. Thus, the predominant mood can either be depression, mania, or hypomania. The secondary mood can be "subclinical," in that some aspects of the secondary mood diagnosis would be present but not sufficiently so to make a formal diagnosis.

Patients who meet the full criteria for both depression and mania together will be labeled as having a manic episode with mixed features owing to the clinical severity of mania. To be diagnosed with the "with mixed features" specifier, a person has to meet the full criteria for one mood (depression, mania or hypomania) and have 3 or more symptoms of the other mood pole. Symptoms that are common to both mood poles (mania/hypomania and depression) are not included in the possible criteria for a mixed mood. These include distractibility, irritability, insomnia, and indecisiveness.

For someone with predominant mania or hypomania, at least 4 of the following depressive symptoms must be present nearly every day during the most recent week of a manic episode or during the most recent 4 days of a hypomanic episode: depressed mood, diminished interest or pleasure, slowed physical and emotional reaction, fatigue or loss of energy, and recurrent thoughts of death. For someone with predominant depression, at least 3 of the following symptoms must be present nearly every day during the most recent 2 weeks of the major depressive episode: elevated mood, inflated self-esteem, decreased need for sleep, and an increase in energy or goal-directed activity.

The Implications

Until now, mixed mood, which is commonly seen in clinical practice, could only be diagnosed in bipolar I disorder, indicating the co-occurrence of full criteria for mania and MDD. The addition of a mixed-mood specifier to bipolar I disorder, bipolar II disorder, bipolar disorder NED, and MDD follows the dimensional approach of DSM-5 and allows clinicians to formally diagnose and treat subthreshold expressions of the admixture of depressive symptoms to mania or hypomania as well as of subthreshold mania-like symptoms to depression.

This is clinically relevant, because the availability of this specifier will sharpen clinicians' view on the dimensional overlap of such symptom admixtures, which have clear relevance for patients' functioning and clinicians' treatment selection. However, critics have raised the concern that classifying MDD with 3 relevant mania-like symptoms as a

depressive disorder rather than a bipolar spectrum disorder may be misleading and that it is unclear what exact treatment recommendations are to be made for patients with MDD and mixed manic or hypomanic features or for patients with bipolar I or II disorder and mixed depressive symptoms.

Neurocognitive Disorder

The Change

At the DSM-5 press conference, Dr. Dilip Jeste -- at that point still APA president -- referred to the movement among some psychiatrists to retire the term "dementia" for stigmatic reasons, the literal Latin translation being "without mind." Jeste pointed out that not only does the term hold negative connotations, but it is also simply inaccurate; many patients with diagnosed "dementia" maintain faculties, awareness, and haven't actually "lost" their mind. However, because of the term's long medical history and its familiarity among clinicians and patients, the new DSM recognizes "dementia" as an acceptable alternative for the newly preferred and more scientific term "neurocognitive disorder."

This new diagnosis includes both the dementia and amnestic disorder diagnoses from DSM-IV. Furthermore, DSM-5 recognizes specific etiologic subtypes of neurocognitive dysfunction, such as Alzheimer disease, Parkinson disease, HIV infection, Lewy body disease, and vascular disease. Each subgroup can be further divided into *mild* or *major* degrees of cognitive impairment on the basis of cognitive decline, especially the inability to perform functions of daily living independently. In addition, a subspecifier "with" or "without behavioral disturbances" is available.

The Implications

The nosologic distinctions between varying dementia etiologies should prove helpful in determining prognosis and therapeutic course. Moreover, clinicians will be able to more clearly determine whether the cognitive decline alone should be the focus of concern and intervention, or whether behavioral disturbances should also be considered and addressed.

The addition of a mild degree of cognitive impairment is consistent with recent research suggesting that treatments for declining cognition may be phase-specific, with certain medications and approaches possibly only working early in the disease course. Although distinguishing mild from major impairment may, in some cases, rely on clinician judgement, DSM-5 does attempt an objective distinction. Mild neurocognitive disorder requires "modest" cognitive decline which does not interfere with "capacity for independence in everyday activities" like paying bills or taking medications correctly. Cognitive decline meets the "major" criteria when "significant" impairment is evident or reported and when it does interfere with a patient's independence to the point that assistance is required. In other words, the diagnostic distinction relies heavily on observable behaviors.

Hopefully, this new classification system will stimulate research in the area of prevention and early intervention of neurocognitive disorders.

Paraphilias and Paraphilic Disorders

The Change

Additional changes in DSM-5 include a rethinking of paraphilic disorders. While their diagnostic criteria remain unchanged from DSM-IV, the updated manual distinguishes between paraphilic behaviors, or paraphilias, and paraphilic disorders. A paraphilic disorder is a "paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others."

The Implications

The new approach to paraphilias demedicalizes and destigmatizes unusual sexual preferences and behaviors, provided they are not distressing or detrimental to one's self or others. Clinicians are tasked with determining whether

a behavior qualifies as a disorder, based on a thorough history provided by both the patient and qualified informants.

Section 3 Disorders

Section 3 of DSM-5 includes self-assessment tools intended to better incorporate patient perspective, as well as cultural differences, into clinical assessment and care. Also included are a number of conditions requiring further research before consideration as official diagnoses. As mentioned previously, the alternative, trait-based personality disorder classification system was ultimately moved to Section 3 (see page 8).

Because of the frequent co-occurrence of depressive and anxiety disorders, as well as the potential for concurrent treatment response of both conditions, this diagnostic hybrid had been considered for the main text of DSM-5, but it performed poorly in the field trials (see page 2).

Another new diagnosis that ultimately was included in Section 3, "attenuated psychotic symptoms syndrome," had the same reliability as schizophrenia in the DSM-5 field trials. However, there was significant concern in the psychiatric community that including the condition in Section 2 would risk overmedicalizing often nonspecific phenomena that transition to psychosis in only 20%-30% of individuals over a period of 1-3 years. Moreover, in the field trials, the attenuated psychotic symptoms syndrome was assessed only in academic centers, some of which had been involved in research on this topic, and interviews were probably conducted with more time than is usually available in busy clinical settings. Still, considering attenuated psychotic symptoms syndrome as a new condition that warrants study as a potentially important diagnostic entity will hopefully contribute to enabling targeted prevention in the future.

Whereas in DSM-IV non-suicidal self-injury (NSSI) was considered a symptom of borderline personality disorder (BPD), in the revised manual it is recognized as a distinct condition. Research suggests that NSSI can occur independent of BPD, such as in patients with depression or even in those with no other diagnosable psychopathology. Criteria for NSSI require 5 or more days of intentional self-inflicted damage to the surface of the body without suicidal intent within the past year. Patients also must engage in the self-injurious behavior with at least 1 of the following expectations: to seek relief from a negative feeling or cognitive state, to resolve an interpersonal difficulty, or to induce a positive state. The behavior must also be associated with 1 of the following criteria: interpersonal difficulty or negative feelings and thoughts eg, depression, anxiety), premeditation, and ruminating on (non-suicidal) self-injury. Socially sanctioned behaviors, like body piercing and tattooing, do not qualify for the diagnosis, nor do scab picking or nail biting. Important to note is that patients who express suicidal behavior within the past 24 months, but who don't qualify for another psychiatric disorder, now fall under the new "suicidal behavior" diagnosis category.

Finally, Internet gaming disorder is also included in Section 3. It is distinct from Internet gambling disorder, which is categorized as the only non-substance-related addictive disorder. To qualify for Internet gaming disorder, patients must meet at least 5 of the 9 following criteria within the past year: (1) preoccupation with games; (2) psychological withdrawal symptoms (eg, anxiety, irritability); (3) tolerance (the need to spend an increasing amount of time playing games); (4) unsuccessful attempts to control or limit game participation; (5) loss of interest in previous hobbies; (6) continued use despite knowledge of problem; (7) deceiving family members and/or therapists; (8) use of Internet games to escape a negative mood; and (9) has jeopardized or lost a relationship, job, or educational opportunity. Despite its name, the new diagnosis can apply to non-Web-based games as well.

Time and research will tell whether this condition has sufficient neuropathologic and clinical similarities to other addictive disorders to be included in the Substance-Related and Addictive Disorder chapter in Section 2, as the second non-substance-related disorder.

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