

## From DSM-IV to DSM-5: What Has Changed in the New Edition?

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### Summary

The fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was published in May 2013. To enable researchers and practitioners to appropriately evaluate and account for advantages and disadvantages, both groups should be informed about amendments to the previous version, DSM-IV. In the present paper, we describe the main differences between DSM-IV and DSM-5. Major changes in the overall structure include the discontinuation of the multiaxial system and the revised order of categories. On the level of specific disorders, the main differences include the introduction of Major and Mild Neurocognitive Disorders, the elimination of bereavement as an exclusion criterion for Major Depressive Disorder, and the inclusion of Agoraphobia as a distinct disorder. Further additional diagnoses in DSM-5 include Binge-Eating Disorder, Premenstrual Dysphoric Disorder, Disruptive Mood Dysregulation Disorder, Hoarding Disorder, Excoriation (Skin Picking) Disorder, and Caffeine Withdrawal. Categories no longer included in the DSM-5 include Sexual Aversion Disorder and Undifferentiated Somatoform Disorder. Finally, for almost all disorders, diagnostic criteria were slightly modified and nosological information was updated. When evaluating the revision, the multiple purposes of the DSM-5 have to be taken into account. As many of these purposes are in conflict or even mutually exclusive, controversial discussions of the new edition by the various interest groups are to be expected.

### Schlüsselwörter

DSM-5 · DSM-IV · Klassifikationssysteme · Psychische Störungen · Diagnostik

### Zusammenfassung

Im Mai 2013 ist die fünfte Auflage des Diagnostischen und Statistischen Manuals Psychischer Störungen (DSM-5) der American Psychiatric Association erschienen. Um die Vor- und Nachteile des DSM-5 beurteilen und gegebenenfalls in Forschung und Praxis angemessen berücksichtigen zu können, sollten Wissenschaftler und Praktiker gleichermaßen über die Änderungen gegenüber dem DSM-IV informiert sein. In diesem Beitrag werden die wesentlichen Unterschiede zwischen dem DSM-IV und DSM-5 beschrieben. Zentrale Unterschiede in dem Gesamtsystem ergeben sich durch die Aufgabe des multiaxialen Systems und die Neuordnung der Störungen. Wesentliche Veränderungen auf Störungsebene enthalten die Einführung Schwerer und Leichter Neurokognitiver Störungen, die Aufhebung von Trauerreaktionen als Ausschlusskriterium für Major Depression und die Aufnahme von Agoraphobie als eigenständige Diagnose. Als neue Störungskategorien wurden beispielsweise die 'Binge-Eating'-Störung, die Prämenstruelle Dysphorische Störung, die Disruptive Stimmungsdysregulationsstörung, Zwanghaftes Horten, Dermatillomanie und Koffeinentzug eingeführt. Ausgeschlossen wurden unter anderem die Störung mit Sexueller Aversion und die Undifferenzierte Somatoforme Störung. Letztlich wurden bei fast allen Störungen die Informationen zur Störungsbeschreibung aktualisiert und/oder die diagnostischen Kriterien geringfügig modifiziert. Bei der Bewertung der vorgenommenen Veränderungen muss berücksichtigt werden, dass das DSM verschiedenen, teilweise konträren Zielstellungen dient. Eine kontroverse Bewertung der Neuauflage ist daher zu erwarten.

## Background

'Psycho trap', 'Back to normal', 'When does psychological suffering become an illness?': These are some of the headlines under which the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 [American Psychiatric Association (APA), 2013]) was being intensively discussed in (popular) scientific articles, even prior to its publication. Among other things, it was feared that there would be an inflation of diagnoses and the pathologizing of everyday phenomena. After a 14-year development process involving ca. 400 people from different professions and 39 countries, the English edition of DSM-5 appeared in May 2013. The purpose of this article is to present the significant changes, in order to fairly evaluate the finalized changes from the previous version (DMS-IV-TR; [APA, 2000]) so that, if appropriate, they may be used effectively in research and clinical practice.

## Basic Changes

The weaknesses of previous systems were an important reason for the further development of DSM. The key points of criticism of the previous version (DSM-IV; [APA, 1995]) concern the categorical classification of disorders as well as high rates of prevalence and comorbidity. On the level of disorders, there was criticism of, among other things, the absence of important diagnoses and the frequent use of the category Not Otherwise Specified. In DSM-5, the categorical approach was maintained for the time being. The organizational structure was changed in order to clarify the biological and psychological relationships/similarities among disorders and their incidence across the lifespan. Table 1 provides an overview of the DSM-5 disorder categories. The multiaxial system was not continued in DSM-5, since it was hardly ever used in research and clinical practice. Axes I-III were integrated into a mono-axial system. In order to assess psychosocial and environment problems and global functioning, reference is made to other instruments (ICD Z Codes [WHO, 1992]; WHO Disability Assessment Schedule [WHO, 2001]). To increase the specificity of diagnoses and to clarify the reasons for a diagnosis, a distinction is made in DSM-5 between Unspecified Disorders and Other Specified Disorders. In DSM-IV, there was only the category of Not Otherwise Specified disorders. For some disorders, additional coding was provided for severity and associated symptoms. Age, gender, and culture are taken into account in the diagnostic features. New diagnoses include, e.g., Binge-Eating Disorder, Premenstrual Dysphoric Disorder, Disruptive Mood Dysregulation Disorder, Hoarding Disorder, Excoriation (Skin Picking) Disorder, and Caffeine Withdrawal. Some of these diagnoses were included in DSM-IV as research diagnoses. In DSM-5, the following disorders were included as research diagnoses: Attenuated Psychosis Syndrome, Depressive Episode with Temporary Hypomania, Persistent Com-

**Table 1.** Disorder categories of DSM-5

Neurodevelopmental Disorders
Schizophrenia Spectrum and Other Psychotic Disorders
Bipolar and Related Disorders
Depressive Disorders
Anxiety Disorders
Obsessive-Compulsive and Related Disorders
Trauma- and Stressor-Related Disorders
Dissociative Disorders
Somatic Symptom and Related Disorders
Feeding and Eating Disorders
Elimination Disorders
Sleep-Wake Disorders
Sexual Dysfunctions
Gender Dysphoria
Disruptive, Impulse-Control, and Conduct Disorders
Substance-Related and Addictive Disorders
Neurocognitive Disorders
Personality Disorders
Paraphilic Disorders
Other Mental Disorders
Medication-Induced Movement Disorders and Other Adverse Effects of Medication
Other Conditions That May Be a Focus of Clinical Attention

plex Bereavement Disorder, Caffeine Use Disorder, Internet Gaming Disorder, Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure, Suicidal Behavior Disorder, Non-suicidal Self-Injury. The conversion to Arabic numbers for the new edition of DSM is intended to underline its role as the foundation and starting point for further development (e.g., DSM-5.1, -5.2, ...).

## Changes on a Disorder Level

Based on the categories and disorders of DSM-IV, we discuss below some changes and features on a diagnostic level in DSM-5.

### *Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence*

Disorders that came under this heading in DSM-IV can be found mainly under Neurodevelopmental Disorders in DSM-5. Some disorders have been moved to other chapters, as part of the overall structural changes. Thus Feeding and Eating Disorders of Infancy and Early Childhood were integrated into the chapter on Feeding and Eating Disorders; Separation Anxiety Disorder and Selective Mutism are in the chapter on Anxiety Disorders. Reactive Attachment Disorder of Infancy or Early Childhood can be found in DSM-5 in a new chapter on Trauma- and Stressor-Related Disorders. Disruptive Behavior Disorder and Oppositional Defiant Disorder now come under the heading of Disruptive, Impulse-Control, and Conduct Disorders. Elimination Disorders now have their own chapter in DSM-5.

*Mental Retardation:* The DSM-5 criteria for Mental Retardation emphasize intellectual impairments and a deficit in adaptive functioning. Individually administered intelligence tests should be supplemented by clinical judgment in the assessment of intellectual ability. The approximate cut-off point of, an intelligence quotient (IQ) of 70 and age of onset before 18 years, are no longer specified in DSM-5. Instead, DSM-5 refers to onset during the individual's developmental period. The severity classification is no longer based on IQ, but on an assessment of adaptive functioning in conceptual, social, and practical domains.

*Learning Disorders:* Disorders covered in the DSM-IV sub-chapter on Learning Disorders (Reading Disorder, Mathematics Disorder, Disorder of Written Expression) are combined in DSM-5 under the diagnosis of Specific Learning Disorder. Academic skills would have to lag behind chronological age by at least 6 months according to DSM-5. The type of Learning Disorder can be conveyed by its specifiers. Further specifiers relate to the severity of the disorder.

*Pervasive Developmental Disorders:* Autistic Disorder, Childhood Disintegrative Disorder, and Asperger's Disorder were combined in DSM-5 as dimensions of Autism Spectrum Disorder. Core areas of Autism Spectrum Disorder include deficits in social communication and restricted, repetitive behaviors. Specifiers are used to determine severity and the diagnosis of associated symptoms. Rett's Disorder may henceforth be diagnosed as Autism Spectrum Disorder Associated with Rett Syndrome.

*Attention-Deficit / Hyperactivity Disorder:* For Attention-Deficit / Hyperactivity Disorder, the age of onset was raised from 7 to 12 years. Based on the number and severity of symptoms and associated social or occupational impairment, 3 degrees of severity are identified.

*Disruptive Behavior Disorder:* For Disruptive Behavior Disorder, additional coding has been introduced in DSM-5 for diagnosing limited pro-social emotions.

*Oppositional Defiant Disorder:* An angry/irritable mood, defiant behavior or vindictiveness for at least 6 months are the characteristics for diagnosis of Oppositional Defiant Disorder according to DSM-5. Specifiers allow the identification of severity.

*Feeding Disorder of Infancy and Early Childhood:* The DSM-5 chapter on Feeding and Eating Disorders includes Avoidant/Restrictive Food Intake Disorder. This diagnosis can be given to both children and adults. In addition to significant weight loss or lack of weight gain in children, the following were added: nutritional deficiencies, dependence on external feeding, and interference with psychosocial functioning as possible A-Criteria. Food shortages, cultural practices, Anorexia and Bulimia Nervosa are explicitly excluded as alternative explanations for the disordered eating behavior.

*Reactive Attachment Disorder:* DSM-5 separates the inhibited and uninhibited types of this disorder into 2 distinct disorders (Reactive Attachment Disorder and Disinhibited

Social Engagement Disorder). Specifiers enable identification of the more severe attachment disorders (all symptoms at a relatively high level) and more persistent attachment disorders (lasting at least 12 months).

#### *Delirium, Dementia, and Amnestic and Other Cognitive Disorders*

Delirium, Dementia, and Amnestic and Other Cognitive Disorders from DSM-IV are included in the Neurocognitive Disorders chapter of DSM-5. Dementia and Amnestic Disorders have been combined under Major and Mild Neurocognitive Disorders. Major Neurocognitive Disorders are characterized by a decline in cognitive abilities; such impairments interfere with independence in activities of everyday life and cannot be better explained as Delirium or another disorder. Mild Neurocognitive Disorder is associated with less cognitive decline and does not interfere with performing activities of everyday life. Compared to subtypes of Dementia in DSM-IV, Frontotemporal Lobar Degeneration, Vascular Disease, Lewy Body Disease, and Prion Disease have been added as potential causes of Neurocognitive Disorders; Pick's Disease and Creutzfeldt-Jakob Disease are no longer listed. In Alzheimer's Disease, there is no longer a distinction between early and late onset.

#### *Mental Disorders Due to a Medical Condition*

This category from DSM-IV was eliminated in DSM-5. Catatonic Disorder Due to a Medical Condition was moved to the category of Schizophrenia and Other Psychotic Disorders. Personality changes due to medical illness are discussed in the chapter on Personality Disorders. Clinical features of Catatonic Disorders are further specified in the criteria.

#### *Substance-Related Disorders*

Substance-Related Disorders are found in the DSM-5 chapter on Substance-Related and Addictive Disorders. Gambling Disorder was also integrated into the DSM-5 chapter on Substance-Related and Addictive Disorders, in a sub-chapter on Non-Substance-Related Disorders. (In DSM-IV, Gambling Disorder was classified under Impulse Control Disorders.) For Substance-Related Disorders, the diagnoses of Cannabis Withdrawal and Caffeine Withdrawal were added to the diagnostic system. Phencyclidin-Related Disorders were grouped in DSM-5 under Hallucinogen-Related Disorders. Disorders Associated with Amphetamine and Cocaine from DSM-IV were grouped in DSM-5 under Stimulant-Related Disorders. Disorders Associated with Multiple Substances were discontinued in DSM-5.

*Substance Dependence and Substance Abuse:* Dependence and abuse were combined into one diagnosis in DSM-5. From the DSM-IV list of criteria for abuse and dependence, problems associated with substance use and recurring legal problems were deleted; craving for a substance was included as a criterion. Depending on the number of criteria fulfilled, the

distinction is made among mild, moderate or severe dependence. The distinctions regarding with/without physical dependence and full/partial remission are omitted in DSM-5.

#### *Schizophrenia and Other Psychotic Disorders*

The distinction between bizarre and non-bizarre delusion was eliminated in the domain of psychotic disorders. Specifiers cover dimensional ratings of severity, and for some disorders, information on the course of the disease and whether there are catatonic features. The diagnosis of shared psychotic disorder (Folie à deux) from DSM-IV is omitted. If the criteria are fulfilled, a Delusional Disorder is diagnosed; otherwise, the diagnosis is Other Schizophrenia Spectrum and Other Psychotic Disorder (delusional symptoms in the partner of an individual with Delusional Disorder).

*Schizophrenia:* The distinction between subtypes of Schizophrenia, such as paranoid type, hebephrenic type, etc., has been dropped. In DSM-IV, 2 of the following 5 symptoms were required: delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and negative symptoms. In the case of bizarre delusions, commenting or conversing voices, 1 symptom was sufficient. However in DSM-5, 2 of these described symptoms must always be present, while 1 must be delusions, hallucinations or disorganized speech.

#### *Mood Disorders*

Mood Disorders are included in the DSM-5 chapters on Bipolar and Related Disorders and on Depressive Disorders. The chapter on Depressive Disorders was expanded in DSM-5 to include Premenstrual Dysphoric Disorder and Disruptive Mood Dysregulation Disorder. The latter diagnosis can be given to children and adolescents aged 6–18 years. Its main feature is repeated angry outbursts. In comparison to Bipolar Disorder, the irritability in this disorder is not episodic. The diagnosis of Bipolar I Disorder, Most Recent Episode Mixed, from DSM-IV, is omitted from DSM-5. Mixed features (occurrence of (hypo)manic and depressive symptoms) could be registered according to DSM-5 as additional coding under Bipolar and Depressive disorders. (In DSM-IV, mixed episodes were an exclusion criterion for the diagnosis of Major Depression.) Other specifiers allow, for example, the specification of anxious distress and degrees of severity (in DSM-5: ‘mild’, ‘moderate’, ‘severe’, ‘with psychotic features’, ‘in partial remission’, ‘in full remission’, ‘unspecified’). Criteria for specifiers for long-term Mood Disorders (‘with full inter-episode remission’, ‘without full inter-episode remission’) were not carried over to the new diagnostic system. Chronic Depressive Disorders are classified with Dysthymic Disorder under Persistent Depressive Disorder in DSM-5. The coding for ‘with postpartum onset’ was replaced by ‘with perinatal onset’ and now includes the 4 weeks after birth as well as the duration of pregnancy.

*Major Depression:* In DSM-5, bereavement reactions have been eliminated. It is noted, however, that bereavement can

be characterized by symptoms similar to those of depressive episodes. The diagnosis of Major Depression should therefore be used with caution in the case of bereavement.

*Manic Episode:* In addition to increased irritability, an increased energy level has been added as a criterion for a manic episode.

#### *Anxiety Disorders*

Separate chapters were introduced in DSM-5 for Anxiety Disorders, Obsessive-Compulsive and Related Disorders as well as Trauma- and Stressor-Related Disorders. Separation Anxiety Disorder and Selective Mutism were also integrated into the chapter on Anxiety Disorders. (These were found in DSM-IV under Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.) The chapter on Obsessive-Compulsive and Related Disorders includes, in addition to OCD, Body Dysmorphic Disorder, Hoarding Disorder, Trichotillomania (Hair Pulling Disorder), Excoriation (Skin Picking) Disorder as well as disorders associated with psychotropic substances, medicines, and other medical conditions. In addition to Posttraumatic/Acute Stress Disorder, the chapter on Trauma- and Stressor-Related Disorders includes Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, and Adjustment Disorder.

*Agoraphobia and Panic Disorder:* Agoraphobia was established as a separate diagnosis. The distinctions were eliminated between Panic Disorder With Agoraphobia, Panic Disorder Without Agoraphobia, and Agoraphobia Without History of Panic Disorder. Agoraphobia and Panic Disorder may henceforth be diagnosed as comorbid.

*Social Phobia, Specific Phobia:* According to DSM-5, the anxiety in phobias (Social Phobia, Specific Phobias, Agoraphobia) must be out of proportion to the actual danger. It is no longer necessary that the person affected recognizes the excessive anxiety. Regardless of age, a minimum duration of 6 months was set. For Social Phobia, the specifier ‘generalized’ was replaced by ‘performance only’ (anxiety limited to speaking and performing before an audience).

*Obsessive-Compulsive Disorders:* Criterion A in DSM-5 includes, in addition to obsessions or compulsions, the possibility that both may be present. There are specifiers for the degree of insight into one’s excessive obsessions and compulsions. The exclusion of exaggerated but real concerns and the requirement that people recognize their thoughts as a product of their own minds were eliminated. There are specifiers for different degrees of insight (from good insight to lack of insight/delusional beliefs) and the existence of a current or former tic disorder.

*Posttraumatic and Acute Stress Disorder:* For both disorders, Criterion A requires exposure to a traumatic event. The person’s response with fear, helplessness, or horror has been eliminated.

*Posttraumatic Stress Disorder:* In DSM-5 there are 4 symptom clusters specified for Posttraumatic Stress Disorder. The



avoidance and numbing cluster in DSM-IV was divided into avoidance of trauma-associated stimuli and negative changes in trauma-associated thoughts, and negative changes in trauma-associated thoughts and moods. A specifier was added for dissociative symptoms (depersonalization, derealization). The distinction between 'acute' and 'chronic' has been eliminated. Children under 6 years have diagnostic criteria of their own.

#### *Somatoform Disorders*

The previous Somatoform Disorders, Factitious Disorders and Psychological Factors Affecting Medical Condition (listed in DSM-IV under Other Conditions That May Be a Focus of Clinical Attention) are mainly found in DSM-5 in the chapter on Somatic Symptom and Related Disorders. Undifferentiated Somatoform Disorder and Pain Disorder were deleted as separate diagnoses; also Somatization Disorder and Hypochondriasis were not continued in their previous form. Body Dysmorphic Disorder has been moved in DSM-5 to the chapter on Obsessive-Compulsive and Related Disorders.

*Somatization Disorder:* Instead of Somatization Disorder, a Somatic Symptom Disorder can often be diagnosed under DSM-5. The presence of one or more stressful or debilitating physical symptoms is sufficient. It is no longer necessary to have multiple symptoms from different areas. The requirement has also been eliminated for a multi-year history of physical complaints beginning before the age of 30, and the requirement that the symptoms are not medically justified and are not feigned. The catalog of criteria for Somatic Symptom Disorder has been expanded to include exaggerated thoughts, feelings, and behavior that are associated with symptoms or health concerns. Specifiers can be used for a severity assessment on the basis of psychological and physical complaints. In the event of an illness duration of more than 6 months, the term 'persistent' can be added.

*Pain Disorder:* A pain disorder may henceforth be diagnosed as a Somatic Symptom Disorder with Predominant Pain.

*Hypochondriasis:* The diagnosis of Illness Anxiety Disorder has been introduced in DSM-5. It may be applied to various illnesses without (strong) somatic symptoms. In the case of physical symptoms, a Somatic Symptom Disorder is diagnosed under DSM-5. In comparison to the DSM-IV Hypochondriasis criteria, the DSM-5 criteria for Illness Anxiety Disorder are specified on the behavioral level (e.g., checking behavior/avoidance behavior). The persistence of anxieties despite medical explanation and the exclusion of delusional beliefs are not prerequisites for the diagnosis of Illness Anxiety Disorder in DSM-5. Specifiers will distinguish between a 'care seeking type' and a 'care avoidant type'.

*Conversion Disorder:* Conversion Disorder can be diagnosed under DSM-5 using specifiers for whether the disorder occurs 'with psychological stressor' or 'without psychological stressor'.

*Body Dysmorphic Disorder:* Muscle dysmorphia and varying degrees of insight are added as specifiers for Body Dysmorphic Disorder.

#### *Factitious Disorders*

Factitious Disorders are found in DSM-5 in the chapter on Somatic Symptom and Related Disorders. DSM-5 eliminates motivation about assuming the role of a sick person from the criteria for Factitious Disorders. The distinction between subtypes according to mental and/or physical symptoms was removed. Subtypes specified in DSM-5 are the feigning of a disorder in relation to oneself or someone else. There are specifiers for the distinction between a single episode and recurrent episodes.

#### *Dissociative Disorders*

Dissociative Fugue is no longer an independently coded diagnosis in DSM-5.

*Depersonalization Disorder:* Depersonalization Disorder was changed to Depersonalization/Derealization Disorder in DSM-5. Criterion A was supplemented with derealization.

#### *Sexual and Gender Identity Disorders*

There is a separate chapter in DSM-5 for each of the subgroups of Sexual and Gender Identity Disorders in DSM-IV (Sexual Dysfunctions, Gender Identity Disorders, Paraphilias). For all Sexual Dysfunctions except Substance-/Medication-Induced Sexual function, a minimum duration of 6 months has been introduced.

*Sexual Dysfunctions:* Specifiers were introduced for severity of Sexual Dysfunctions. Sexual Dysfunction Due to a General Medical Condition and the distinction between psychological and combined factors in DSM-IV were not included in DSM-5. For Disorders of Sexual Desire and Arousal, women can be diagnosed with Female Sexual Interest/Arousal Disorder under DSM-5. Male Hypoactive Sexual Desire Disorder has been introduced. The diagnosis of Sexual Aversion Disorder was eliminated in DSM-5. Dyspareunia and Vaginismus were combined into Genito-Pelvic Pain / Penetration Disorder. In contrast to the emphasis on spasms in the DSM-IV criteria for Vaginismus, the focus is now on problems of penetration.

*Gender Identity Disorders:* Separate criteria were introduced in DSM-5 for Gender Identity Disorder in children and adolescents/adults. The DSM-IV exclusion criterion of Somatic Intersex Syndrome has been omitted. Specifiers allow Disorders of Sexual Development and measures for gender reassignment. Specifiers for sexual orientation have been omitted.

*Paraphilias:* Specifiers for Paraphilic Disorders 'in remission' and 'in a controlled environment' (e.g., patients are in settings where they cannot exercise their preferences) have been added in DSM-5.

#### *Eating Disorders*

In DSM-5, Eating Disorders are included in the chapter on Feeding and Eating Disorders. Binge-Eating Disorder without recurrent compensatory measures was newly included in

this chapter. The minimum average frequency of binge-eating episodes was changed to once a week for 3 months. There are specifiers for (partial) remission and severity (defined by the number of binges per week).

*Anorexia Nervosa:* Criterion A sets the benchmark for low body weight at the lower limit of the normal weight range, taking into account age, gender, course of development, and physical health. Amenorrhea is no longer listed as a criterion. Behaviors that interfere with weight gain were incorporated in the catalog of criteria as an alternative to intense anxiety about gaining weight. Specifiers were also added for (partial) remission and severity. Body mass index (BMI) is used to specify the severity of Anorexia.

*Bulimia Nervosa:* The required number of binges for diagnosing Bulimia Nervosa has been reduced from 2 to 1 per week. Specifiers were introduced for (partial) remission and severity. The number of binge-eating episodes per week determines the measure of severity. The distinction between a 'purging type' and a 'nonpurging type' is omitted.

### *Sleep Disorders*

The distinction between Primary Sleep Disorders and Sleep Disorders Related to Another Mental Disorder in DSM-IV is eliminated in DSM-5. Sleepwalking Disorder and Sleep Terror Disorder are summarized in the new diagnostic system under the category of Non-Rapid Eye Movement Sleep Arousal Disorders. Specifiers make it possible to distinguish between a 'sleepwalking type' and a 'sleep terror type' of disorder. From the DSM-IV group of Not Otherwise Specified Dyssomnias and Parasomnias, diagnostic criteria were specified for Restless Legs Syndrome and Rapid Eye Movement Sleep Behavior Disorder in DSM-5. For Insomnia, Hypersomnia, and Narcolepsy, the time criterion in DSM-5 was set at a minimum of 3 times per week over a period of at least 3 months. Changes and additions were made in the additional coding of these and other disorders. The specification of associated mental and medical illness factors for some disorders likewise has some additional coding in DSM-5.

*Primary Insomnia:* Specifiers in DSM-5 for insomnia allow the coding of comorbid disorders and the distinction among episodic, persistent, and recurring history of the disorder.

*Primary Hypersomnia:* Additional coding is related to comorbid disorders, the duration, and the severity of the disorder.

*Narcolepsy:* Specifiers for Narcolepsy allow the diagnosis of etiological subtypes as well as classifications of severity. Symptoms of Cataplexy are specified in more detail in DSM-5 (also for children). A hypocretin deficiency has been added as a possible criterion.

*Breathing-Related Sleep Disorders:* A separate sub-chapter was established in DSM-5 for Breathing-Related Sleep Disorders. The Breathing-Related Sleep Disorders listed in DSM-IV, such as Obstructive Sleep Apnea Syndrome, Central Sleep Apnea Syndrome, and Hyperventilation Syndrome, are each presented here with their own diagnostic criteria. Specifiers

allow classifications of severity and, except in the case of Obstructive Sleep Apnea Hypoex, the specification of subtypes.

*Circadian Rhythm Sleep Disorder:* Circadian Rhythm Sleep Disorder likewise comes under Breathing-Related Sleep Disorders in DSM-5. Compared to the previous version, other subtypes have been specified for this disorder (e.g., with premature sleep phase).

*Nightmare Disorder:* Nightmare Disorder was extended in DSM-5 with specifiers, e.g., for related disorders, duration, and severity.

### *Impulse-Control Disorders Not Elsewhere Classified*

Along with Oppositional Defiant Disorder and Disruptive Behavior Disorder (formerly in the chapter on Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence), the DSM-IV Impulse-Control Disorders were mainly integrated into the DSM-5 chapter on Disruptive, Impulse Control, and Conduct Disorders. Gambling Disorder and Trichotillomania (Hair Pulling Disorder) have been moved into the category of Addictive Disorders.

*Intermittent Explosive Disorder:* For aggressive behavioral outbursts, time and frequency criteria were added in DSM-5 (2 times per week for 3 months without damage, destruction or injury of property, animals or individuals / 3 times over 12 months with such effects). The outbursts have to be associated with negative personal, social, or occupational consequences and should not be intended to achieve a specific goal. The disorder can be diagnosed according to the DSM-5 from the age of 6 at the earliest.

*Gambling Disorder:* The number of attributes of Gambling Disorder required for a diagnosis of pathological gambling behavior was reduced by 1 in DSM-5. A duration of 12 months was introduced as a criterion.

### *Adjustment Disorders*

Adjustment Disorders are covered in DSM-5 under Trauma- and Stressor-Related Disorders. Cultural influences on stress reactions are more strongly reflected in the criteria. Instead of the distinction between 'chronic' (duration more than 6 months) and 'acute' (less than 6 months), DSM-5 offers the specifier 'persistent'. This can be used for diagnosis if the disorder lasts for more than 12 months.

### *Personality Disorders*

The diagnostic criteria for Personality Disorders remain largely unchanged in DSM-5. DSM-5 also contains an alternative Personality Disorder model in Section III. This puts a stronger focus on functioning and pathological personality traits. Functioning is based on the dimensions of identity, self-direction, empathy, and intimacy. Relevant pathological personality traits include negative affectivity, detachment, antagonism, disinhibition, and psychoticism. The alternative model is intended to form a basis for research and pave the way for changes in the diagnosis of Personality Disorders.

### *Other Conditions That May Be a Focus of Clinical Attention*

There is a separate chapter in DSM-5 for Medication-Induced Movement Disorders and Other Adverse Effects of Medication. Diagnostic criteria here are established for some disorders that were previously listed under Not Otherwise Specified Disorders (e.g., Medication-Induced Parkinsonism, Tardive Dystonia, Antidepressant Discontinuation Syndrome). Some diagnoses were extended from the influence of neuroleptics to the effect of various drugs by being renamed (e.g., Medication-Induced Acute Dystonia instead of Neuroleptic-Induced Acute Dystonia).

V-codings in DSM-5 are included in the chapter on Other Conditions That May Be a Focus of Clinical Attention. This area was extended, e.g., to include Residential and Financial Problems (e.g., homelessness, poverty), Problems Related to Other Psychosocial, Personal, and Environmental Circumstances (e.g., problems related to unwanted pregnancy, terrorism), and Other Circumstances of Personal History (e.g., past self-injury). In the interactional domain, factors were added such as Upbringing Away From Parents, Child Affected by Parental Relationship Distress, Disruption of Family by Separation or Divorce, and High Expressed Emotion Level Within Family. The section on abuse or neglect is clearly differentiated in DSM-5. With children, for instance, distinctions were added between one-time and repeated abuse, neglect, or psychological abuse. Psychological Factors Affecting Medical Condition were moved in DSM-5 to the chapter on Somatic Symptom and Related Disorders.

## **Discussion**

Although the focus of this paper is to describe the changes, we would like to conclude by addressing the criticism of DSM-5.

The chairman of the DSM-IV working group, Allen Frances, is one of the main critics of the revised diagnostic system. Concerning the development process, Frances and Widiger [2012] appreciate the DSM-5 manual as far superior to the DSM-IV manual for decision-making processes. In the same article, they criticize the lack of compliance with the manual by some working groups, a lack of scientific validation (especially inadequate cost-benefit and risk analysis) as well as insufficient transparency and public discussion of the changes. This was complicated by the Commissioners' binding confidentiality agreements. With respect to content, critics such as Frances fear that the new diagnostics and the reduction of thresholds will lead to excessive treatment (with drugs), faulty allocation of scarce health care resources, and an increasing stigmatization of the target population. Frequent criticisms concern the elimination of bereavement as an exclusion criterion for Major Depression, the introduction of Mild Neurocognitive Disorders, and the diagnosis of Disruptive Mood Dysregulation Disorder.

For a fair assessment of the current revision, however, one should also be aware, when assessing the individual criti-

cisms, of the intention behind these changes. Members of the DSM-5 committee express the desire that the innovations will achieve progress in the patient treatment and the user-friendliness of the manual [Regier et al., 2013]. The introduction of new diagnoses such as Disruptive Mood Dysregulation Disorder, which is characterized, in contrast to Bipolar Disorder, by non-episodic irritability; Mild Neurocognitive Disorder; and the distinction among degrees of severity, reflects the effort to provide appropriate treatment as early as possible. Additional specifiers such as 'with anxiety symptoms', 'with mixed features' for Depressive Disorders, or 'with limited prosocial emotions' for Disruptive Behavior Disorder contain important treatment-relevant information [Regier et al., 2013]. Changes in the overall system are intended to bring the diagnostic system up to the level of the latest research. Based on hypothesized genetic factors, Neurodevelopmental Disorders, Schizophrenia, Bipolar and Depressive Disorders, for example, are arranged in successive chapters. In light of international research and lessons learned across national borders, the (structural) design of DSM was also more closely harmonized with the ICD.

Future studies will have to show how helpful the diagnostic system is. Given the highly varied areas of interest and functions of the DSM, we can expect continuing controversy. Thus, patients and patient organizations have an interest in a diagnostic system that strengthens the right to the most effective treatment possible and counteracts stigmatization. Therapists expect syndromes with high clinical relevance to be coded with convenient diagnostics that provide them with significant help in selection of promising treatments. Scientists focus on maximizing the reliability and validity of diagnoses (and the advancement of their own areas of interest). Lawyers want precise and unambiguous criteria. Commercial enterprises working in the field of mental disorders (e.g., the pharmaceutical industry), are most interested in a diagnostic system that allows the largest number of people to be diagnosed in ways that justify the most profitable therapies. Other industries, however, want to reduce costs incurred through absenteeism, and thus want a system of categories that implies higher thresholds for declaring someone unfit for work. Politicians who are focused on a short-term balanced budget prefer systems that give mental health diagnoses to as few patients as possible, so that the cost pressure on the healthcare system is reduced. Politicians for whom the long-term health of the population is a key concern, prefer classification systems that facilitate the financing of early interventions through lower diagnostic thresholds. One point that is already complicating the discussion of DSM-5 and can thus be criticized by all concerned is the extremely rigid treatment of copyright. According to the APA, it is not permitted to quote more than one line from DSM-5 without having obtained a fee-based agreement with the APA. Strictly speaking, this also means that docents would always have to pay a fee if they presented slides with the exact criteria for a disorder in their lectures, apprenticeship, and advanced training, and that the crite-

ria could no longer be printed in textbooks or commercially distributed information for patients without the payment of a fee. In our view, this is a highly problematic obstacle to the important struggle for progress in the understanding and treatment of mental disorders. Here, as with drug prices, the legislature should if necessary ensure that the dissemination and discussion of instruments that are of great importance for the public good are not hindered by the financial interests of individuals.

## Disclosure Statement

The authors hereby declare that they have no conflicts of interest with regard to the manuscript.

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