

DSM-5: An Overview of Changes and Controversies

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Abstract The DSM-5 offers many changes in the criteria and categories used in clinical diagnosis. The provocative and sometimes controversial nature of the changes has enlivened debate in the mental health field about how we should best understand our clients. I selectively survey what is new in DSM-5, why changes were made, and what about them is so controversial. First, I summarize the main metastructural and organizational changes, including elimination of the multiaxial system and changed chapter groupings. Second, I survey the most important new categories of disorder and the most important changes to the diagnostic criteria for existing categories of disorder. I focus on particularly controversial changes, such as those to substance use and addictive disorders, autism spectrum disorders, and posttraumatic stress disorder. Pros and cons are provided for changes in criteria as well as for the addition of new disorder categories, such as hoarding disorder and binge eating disorder. Finally, I offer a more in-depth review and analysis of the changes to the depressive disorders chapter, which was subject to some of the most intense controversies and had some of the most extensive changes.

Keywords DSM-5 · Clinical social work · Diagnosis · Depressive disorders · Mental disorder · Harmful dysfunction

DSM-5—the fifth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental*

Disorders—is here. Actually, the DSM-5 is scheduled for publication in late May 2013, and will be available by the time you read this, so I am writing about it in the present tense. However, as I write this in early May, I have not yet seen the final product. So a caveat is that it is possible that some last-minute changes made prior to publication may diverge in minor ways from what I am going to describe in this overview.

This is an exciting time for clinicians. The DSM-5 revision process created an opportunity for open discussion of the nature of our patients’ problems and how best to conceptualize them. This resulted in controversies that became so heated that some critics went so far as to suggest that the DSM should be abandoned in favor of the World Health Organization’s *International Classification of Diseases* (ICD; World Health Organization 1978), which is coordinated with and determines the codes used in the DSM. Moreover, the disputes—about proposed changes to diagnosis of depression, substance abuse, attention-deficit/hyperactivity disorder, autism, and many other categories, plus concerns about many new categories from hoarding disorder to binge eating disorder—were of such general interest that they garnered unprecedented media coverage. As a personal example, a scientific review paper I coauthored with Michael First (Wakefield and First 2012) that criticized the DSM-5’s proposal to eliminate the major depression bereavement exclusion made the front page of the New York Times (Carey 2012). The public at large seemed at once fascinated and disturbed by the vehemence of the DSM-5 skirmishes and what it revealed about the state of knowledge in the mental health professions. Now, clinicians will be confronted with the challenge of digesting and adapting to the new criteria and categories from within their own clinical perspectives. So: What is new in the DSM-5, why was it changed, and why are some of the changes so controversial?

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First, why is it DSM-5, and not DSM-V? Roman numerals are traditional, but DSM-5 is slated to be the first DSM that is a “living document” that can be changed piecemeal online as new evidence emerges. (Some supplementary scales and other materials will be online immediately.) The change to Arabic numerals is to facilitate the labeling of later online revisions yielding DSM-5.1, 5.2, and so on. These periodic revisions will no doubt revisit the controversial proposals that in DSM-5 ended up being sidelined as “emerging categories” and placed in the Manual’s section 3, the DSM-5 equivalent of DSM-IV’s appendix of proposed categories requiring further study. Consequently, publication does not at all mean that the DSM controversies are coming to an end.

Why all the controversy? The DSM-5 Task Force’s aspirations were high and suggested there would a paradigm switch in multiple ways (e.g., focus on neurobiological etiology, building in genetic and laboratory tests, reducing NOS diagnoses in favor of specific categories, dimensional diagnosis rather than categories, separating impairment from disorder diagnosis, continuous severity scales) but the goals turned out to be unrealistic and unachievable, so naturally there was disappointment. However, the basic reason for controversy was the expansiveness of DSM-5 psychiatric diagnosis, both in terms of newly introduced categories and loosening the criteria for diagnosis in existing categories. The DSM-5 Task Force was very responsive to clinical utility concerns about being able to label individuals coming for consultations, but tone deaf to broader validity issues of overlabeling normal distress as mental disorder. The excessive secretiveness of the Task Force process added to a situation of frustration for many critics. Because psychiatry is in the grips of a biomedical brain-disease ideology about mental disorder, the perceived classification of normal conditions as disorders triggered the additional concern that a raft of new conditions would become targets of drug development and our already highly medicated society would become even more overmedicated. It is not just American mental health professionals and consumer groups who have expressed concerns, but also British and European professionals have weighed in on the DSM-5. These groups outside the Americas have expressed fear of a spillover effect in their countries that could spuriously swell their already bloated disability rolls.

To get a taste of the tenor of objections, here is a sample. Allen Francis, the Editor of DSM-IV and the most vehement and articulate critic of DSM-5, summarized his major objections in an op-ed, arguing that the DSM-5 is transforming normality into disorder:

DSM-5 will turn temper tantrums into a mental disorder....Normal grief will become Major Depressive Disorder....The everyday forgetting characteristic of

old age will now be misdiagnosed...creating a huge false positive population of people....Excessive eating 12 times in 3 months is no longer just a manifestation of gluttony and the easy availability of really great tasting food. DSM-5 has instead turned it into a psychiatric illness....DSM-5 has created a slippery slope by introducing the concept of Behavioral Addictions that eventually can spread to make a mental disorder of everything we like to do a lot....DSM-5 obscures the already fuzzy boundary between Generalized Anxiety Disorder and the worries of everyday life....Many millions of people with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood, the forgetting of old age, and ‘behavioral addictions’ will soon be mislabeled as psychiatrically sick (Frances 2012).

Has DSM-5 in fact gone overboard in pathologizing normal human distress? You can judge for yourself as you review the major changes surveyed below. I start by outlining the structural and organizational changes to the Manual. I then present the headline news about new disorders and major changes in existing criteria sets, of necessity covering only the most notable or controversial changes. Finally, I offer a more detailed look at the changes in one chapter—depressive disorders—that included some of the most incendiary proposals and far-reaching changes.

Changes to the DSM’s “Metastructure”

When you open the DSM-5, some immediate differences from DSM-IV leap out at you. Most obviously, the organization is different. First, the Manual is divided into three sections. Second, there are different chapter headings, and the disorders are regrouped and may be in different chapters. Third, the multiaxial system is gone.

The DSM-5’s three sections are as follows:

- Section 1 presents an introduction to DSM-5 with information on how to use the updated manual, the definition of mental disorder, and other general information.
- Section 2 contains the categories of disorder diagnoses, with a revised chapter organization. The “V Codes” (soon to be “Z Codes” as in ICD-10) for nondisordered conditions that are sometimes the target of mental health treatment are here as well.
- Section 3 lists “emerging conditions” requiring further study before they are introduced as regular disorders, and additional materials such as a cultural interview. It should be noted that inclusion in DSM-5’s section 3 for

further study allows immediate diagnosis under “other specified” categories in the main listing.

The new chapter organization represents an attempt to rethink how disorders relate to each other and thus how they should be grouped together to represent their likely underlying etiologies. The new sequence of disorder chapters are as follows:

- 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 Disorders
- Feeding and Eating Disorders
- Elimination Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse Control and Conduct Disorders
- Substance Use and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorders
- Other Disorders

The new organization means that your most-accessed disorders may not be where you are used to finding them. Some features of the chapter changes and the disorder re-groupings are as follows:

- The chapter ordering is now supposed to reflect disorders over the life cycle—for example, neurodevelopmental disorders first, and neurocognitive disorders near the end (replacing the former chapter containing dementia and other cognitive disorders)—although this was not followed through systematically.
- “Neurodevelopmental” disorders replace “child and adolescent” disorders to emphasize growing knowledge of brain development as an underpinning for child and adolescent research and treatment.
- Many conditions listed in the eliminated child and adolescent disorders chapter have been moved into other chapters for a more natural grouping based on etiology, with some (e.g., separation anxiety disorder) having revised criteria or examples to allow diagnosis of adults as well as children. For example:
 - Selective mutism and separation anxiety disorder are now in the “Anxiety Disorders” chapter.

- Eliminative disorders of childhood have been moved into their own chapter.
- Conduct disorder and oppositional-defiant disorder have been moved to the “Disruptive, Impulse Control and Conduct Disorders” chapter, an expanded version of the former “Impulse-Control Disorders Not Elsewhere Classified” chapter—which also now includes antisocial personality disorder, appearing both here and in the personality disorders chapter.
- Childhood eating disorders have been moved to the “Feeding and Eating Disorders” chapter.
- Reactive attachment disorder has been moved to the new “Trauma- and Stressor-Related Disorders” chapter and its two subtypes, emotionally withdrawn/inhibited and indiscriminately social/disinhibited, have been separated into two distinct disorders.
- The former “Mood Disorders” chapter is now divided into two chapters, “Bipolar Disorders” and “Depressive Disorders.”
- The former “Anxiety Disorders” chapter is now divided into three chapters representing different etiological subgroups: “Anxiety Disorders,” “Obsessive–Compulsive and Related Disorders,” and “Trauma- and Stressor-Related Disorders.” The classic view that obsessive disorders are in fact attempts to control anxiety is set aside as unproven and likely untrue based on brain studies.
- The former “Adjustment Disorders” chapter is eliminated and the adjustment disorders incorporated within the “Trauma- and Stress-Related Disorders” chapter, where they are reconceptualized as stress-response syndromes to either traumatic or non-traumatic stressors rather than as a residual category for conditions not meeting criteria for other disorders.
- The former “Sexual and Gender Identity Disorders” chapter has been divided into three chapters: “Sexual Dysfunctions”, “Paraphilic Disorders”, and “Gender Dysphoria” (the new name for the former “Gender Identity Disorder” category).
- The former “Factitious Disorders” have been incorporated into the “Somatic Symptom Disorders” chapter (formerly “Somatoform Disorders”).
- The “Schizophrenia Spectrum and Other Psychotic Disorders” chapter is part of the DSM-5’s attempt to be more dimensional in its conceptualizations, and reflects the idea that several psychotic disorders share a genetic basis but reflect different degrees of expression of that common basis. So, schizophrenia spectrum includes not only several psychotic disorders but also the milder schizotypal personality disorder, which appears both here and in the personality disorders section.

- The former “Substance-Related Disorders” chapter is renamed “Substance Use and Addictive Disorders” because it now includes “behavioral addictions.” Only one, gambling disorder, is included so far, but additional behavioral addictions are waiting in the wings and likely to be added. For example, internet gaming disorder is listed in section 3 as a potential behavioral addiction.

The most dramatic structural change in DSM-5 is the elimination of the multiaxial system:

- Axis 2’s personality disorders and intellectual disability (the new name for mental retardation) are moved to the main disorders listing, and are now listed simply as primary or additional diagnoses. There is some hope that the movement of the personality disorders to the main disorder section might make it harder for insurance companies to deny coverage for personality disorders because some insurance companies used the different status of axis 2 disorders to differentiate reimbursability, but it has also triggered concerns about legal ramifications such as workers compensation. A consideration here may be that the original notion behind axis 2 of distinguishing more stable background condition like personality disorder and intellectual disability from disturbances in the individual’s usual functioning has not proven all that helpful, given the chronic course of some mental disorders and the hopeful changeability and occasional instability of personality disorders.
- Axis 3’s general medical disorders are now simply listed as additional diagnoses where relevant.
- Axis 4’s environmental stressors and problems in living—of particular interest to social workers—are eliminated. However, these contextual factors are now mostly found in a much-expanded list of “V Code diagnoses” (or “Z Code diagnoses”—ICD-10’s designation) that are listed as additional diagnoses rather than contextual factors influencing the target disorder. To this extent, this change may actually be useful to social workers because contextual factors will now constitute full additional diagnoses rather than additional factors outside the diagnosis.
- Axis 5’s General Assessment of Functioning (GAF), now required in many settings, is eliminated as an axis in its own right. For assessing general adaptive functioning, the DSM-5 recommends the World Health Organization Disability Assessment Schedule (WHODAS), a much more comprehensive inventory of social functioning that has the advantage that, unlike the GAF, it focuses exclusively on adaptive functioning and does not depend at all on symptom levels. Use of the WHODAS is consistent with ICD practice across

medical specialties. On the other hand, the WHODAS is designed for general medical practice and asks specific questions about longer-term problems such as making new friends, joining in community activities, and living with dignity, so it may be less suitable than the GAF for focused week-to-week psychiatric disability evaluations, such as evaluations for psychiatric hospitalization, for which the GAF is often now used. It remains unclear what insurance reimbursers who now require the GAF will decide to do in response to this DSM-5 recommendation.

Why the elimination of the multiaxial system? The DSM-5 Task Force said it was partly because the multiaxial system is not used all that frequently, but my experience is different. The primary reasons for this change, I think, are the emphasis on making psychiatry more like general medicine and the need to coordinate with the ICD. General medicine does not use a formal multiaxial system, so psychiatry seemed divergent in this regard. Technically the DSM has indicated all along that axes 1–3 are the “real” diagnosis (all of which would be listed in a general medical diagnosis as well, though without the multiaxial framework) and the other 2 axes are ancillary. The goal here was partly to clarify that psychiatric diagnosis is parallel to general medical diagnosis and does not require a divergent multiaxial “diagnosis.”

Coordination with the ICD is also a primary motivation here—even, for example, in recommending that if general functioning is still evaluated (former axis 5), it be evaluated with the WHODAS rather than the GAF. The ICD listing of psychiatric diagnoses does not include an explicit multiaxial system; diagnosis consists strictly of the primary diagnoses themselves. The ICD does have its own not-well-known but quite impressive multiaxial system, developed separately from the main psychiatry and medical disorder listing, that measures contextual factors and adaptive functioning. However, ICD developers explicitly attempt to separate psychosocial and contextual factors from disorder diagnosis because they think that otherwise cross-cultural differences in individuals’ ability to meet local social role demands might be misconstrued as disorders. DSM-5’s elimination of the multiaxial system follows ICD in this regard. Nonetheless, both ICD and DSM have found it impossible to completely eliminate social role impairment from diagnostic criteria because sometimes there is no other way of inferring a dysfunction (Wakefield 2009).

I now turn from the DSM-5’s structural and organizational changes to the substance of the changes in terms of new categories of disorder and major alterations in the diagnostic criteria for existing categories, proceeding in the order of the chapters in which the changes appear. Again,

my coverage is highly selective, addressing only the most controversial or important changes. I skip the depressive disorders because they will be covered separately.

Neurodevelopmental Disorders

Diagnosis of intellectual disability (formerly mental retardation) now emphasizes level of adaptive functioning. DSM-IV's heavy reliance on IQ led to problematic outcomes, especially in forensic contexts; for example, in death penalty cases, where intellectual disability can preclude execution, an IQ score of 69 versus 71 might mean the difference between life and death, irrespective of adaptive functioning level.

The new “autism spectrum disorder” encompasses DSM-IV autistic disorder, Asperger's disorder, and childhood disintegrative disorders. Based on a theory (not universally accepted) that Asperger's is a mild form of autism, diagnosis requires deficits in social communication and repetitive behavioral patterns rated along a dimension of severity. (A new “social (pragmatic) communication disorder” allows diagnosis of verbal and nonverbal communication difficulties without repetitive behaviors.) This change was highly controversial, partly because of fear that classifying milder “Aspies” as autistic spectrum would increase stigma. However, the primary concern was that the lower end of the diagnostic spectrum set a diagnostic threshold that is too high and would exclude a substantial number of current autism and Asperger's cases (McPartland et al. 2012). While some welcomed what they saw as an overdue adjustment to a category in which normal eccentricity and social ineptness may have become pathologized, others were concerned that special education support might be withdrawn from those who need it but no longer qualify for diagnosis. In a bizarre twist from the perspective of diagnostic logic, the DSM-5 resolved the special-education problem simply by “grandfathering in” everyone currently being treated by adding a clause specifying that anyone ever diagnosed in the past still falls under the category even if not satisfying current criteria.

Attention-deficit/hyperactivity disorder (ADHD) criteria and examples have been altered to allow for the growing diagnosis of ADHD in adulthood. Onset of symptoms must now occur by age 12 rather than 7, and the diagnostic threshold for adults has been lowered to 5 symptoms from the usual 6. Critics charge that if ADHD is as claimed a neurodevelopmental disorder, then symptoms should be apparent in childhood, and that the lowering of diagnostic standards will only amplify an adult-ADHD diagnosis fad. This change comes as we learn from Centers for Disease Control and Prevention data that one in five high school boys and 11 % of all US schoolchildren have been

diagnosed with ADHD, with about two-thirds of them taking stimulant medication for the condition (Schwarz and Cohen 2013). Moreover, recent evidence strongly suggests that a substantial proportion of those diagnoses are false-positive diagnoses of normal developmental immaturity (Elder 2010; Evans et al. 2010; Zoëga et al. 2012).

A new category of “specific learning disorder” combines all the DSM-IV learning-disorder diagnoses with specifiers for specific problem areas, reflecting that these disorders often occur together. Another major change in criteria is due to changing federal regulations that specify that the diagnosis of learning disorders cannot depend only on a difference between disorder-specific learning and overall IQ, because this approach disadvantages groups that score lower on IQ tests. Thus a variety of possible baselines other than IQ for evaluating subject-specific performance are provided. While well-intentioned, critics argue that this change makes the meaningfulness and validity of a learning disorder diagnosis more questionable.

Schizophrenia Spectrum and Other Psychotic Disorders

Criterion A for schizophrenia has been changed. Currently, two symptoms are generally required to satisfy criterion A, but certain special symptoms are sufficient by themselves (e.g., bizarre delusions, hearing multiple voices conversing). These judgments turn out to be difficult and unreliably made, so this differentiation has been eliminated, and two symptoms are now always required, with the proviso that at least one must be delusions, hallucinations, or disorganized speech.

A major change in terms of clinical tradition is that the subtypes of schizophrenia—including, for example, paranoid schizophrenia—have been eliminated based on research suggesting they are not really stable and reliable classifications. A dimensional approach to schizophrenia assessment is provided in section 3. Although the catatonic schizophrenia subtype is eliminated, catatonia is added as a cross-cutting specifier across disorders.

The new category of “attenuated psychosis syndrome” is added to section 3's conditions for further study, and likely will be added to the main list eventually. This disorder requires that the individual has intact reality testing but has experienced mild versions of cognitive symptoms (delusions, hallucinations, or disorganized speech). The initial proposal was to add “psychotic risk syndrome” to psychotic disorders with the goal of identifying individuals in the “prodromal” phase who are developing but do not yet have psychotic disorders to allow early treatment in hopes of preventing the disorder or lessening its severity. Critics objected that this confuses risk of disorder with actual disorder. Moreover, it has long been known that

attenuated psychotic-like ideation in the general population does not necessarily indicate actual or prodromal disorder (Wakefield 1997). Recent evidence confirms that forms of eccentric and odd thinking satisfying the criteria are surprisingly common both in the general population (Fusar-Poli and Van Os 2013) and in outpatient populations of individuals being treated for other disorders (Gaudiano and Zimmerman 2013). Of great concern is that generally only a small percentage of those who meet criteria actually go on to develop a psychotic disorder, so diagnosis would involve many false positives who might needlessly get antipsychotic medication and be stigmatized. Rather than abandoning this idea pending further scientific progress in distinguishing true cases from background psychological variation, the condition was simply relabeled and reconceptualized as a mild psychotic disorder in its own right (rather than a risk of disorder) and included in section 3. Critics worry that, without any biomarker to identify true cases, large numbers of eccentric adolescents would be brought in for consultation and potentially diagnosed once this diagnosis is taken out of controlled research settings and used in clinical practice, where false positive rates could be much higher.

Bipolar and Related Disorders

Diagnostic criteria for mania and hypomania now require a change in activity or energy during the manic episode, in addition to mood shifts. The goal is to avoid false positive diagnoses that occur due to, for example, misconstrual of patients' reports of periods of irritability as mania which are in fact contextually normal reactions, an error found to be responsible for very high false-positive rates for mania in epidemiologic studies (Kessler et al. 1997).

The “other specified bipolar and related conditions” category now allows diagnosis of hypomania when duration or number of symptoms is less than that is standardly required (e.g., 2 or 3 days instead of 4).

Obsessive–Compulsive and Related Disorders

The new category of “hoarding disorder” is diagnosed when there is an accumulation of possessions due to difficulty discarding them even when they lack value, and the accumulation is to the extent that living areas are compromised and cannot serve their intended use. Although hoarding was a possible symptom of DSM-IV obsessive–compulsive disorder (OCD), many clearly pathological hoarders do not meet OCD criteria. Moreover, hoarding sometimes represents a health or safety hazard (e.g., apartment floors have collapsed due to excessive weight).

So, having such a diagnosis makes sense in principle. The issue is potential overdiagnosis; people naturally vary in their tendency to collect and save things, so who determines what is of value, what is the intended use of a living area, and how much clutter makes the intended use impossible? The criteria seem vague enough to be misapplied to large numbers of non-neatnik individuals. In an interesting twist, to prevent missing cases, the criteria specify that even if a living area is uncluttered, the disorder can still be diagnosed if the lack of clutter and usability of the living area for its intended purpose is due to the efforts of someone else (e.g., a spouse or cleaning person). So, if your spouse cleans up after you, you are not off the hook. One can easily imagine this disorder playing a prominent role in diagnostic “blaming” in marital couples therapy.

Trauma- and Stress-Related Disorders

Posttraumatic Stress Disorder (PTSD) is no longer conceptualized as an anxiety disorder. Consequently, criteria for traumatic stressors will no longer include DSM-IV's criterion A2, requiring a specific type of initial emotional reaction (intense fear, helplessness or horror) to the stressor. Such reactions, as opposed, for example, to dysphoria or no initial reaction at all (as in first responders or military personnel who are trained to be task-focused and respond professionally no matter what they are witnessing), have not been found to be crucial in predicting PTSD symptom formation. Critics suggest that this opens the door to false positives where there is no intense emotional reaction to a stressor, and that a specifically targeted exclusion for military and first-responder personnel would have been preferable to eliminating all emotional response requirements. For example, studies of women's responses to childbirth suggest that without the requirement of an intense negative emotional reaction many experience symptoms related to the intense pain of childbirth that might qualify for PTSD diagnosis (Polachek et al. 2012).

The nature of traumatic stressors that are so extreme and outside usual experience that they are likely to produce pathological reactions has been controversial ever since PTSD was placed into the DSM. Much effort in the DSM-5 revision of PTSD has gone into reconceptualizing the nature of traumatic stressors (criterion A1) to more validly distinguish PTSD from emotional reactions to negative events more generally. This fresh concern to clarify the nature of traumatic stressors was prompted in particular by debate over widespread PTSD diagnoses applied to the reactions of people in distant cities to television coverage of the World Trade Center attack in New York. DSM-IV required that an individual “experienced, witnessed, or was confronted with” the traumatic event(s), which had to

involve “actual or threatened death or serious injury, or a threat to the physical integrity of self or others.” “Confrontation” clearly was intended to go beyond experiencing or witnessing, which was interpreted as personally witnessing, and so these criteria seemed to allow television coverage of disasters to qualify as traumatic stressors. To many critics, this seemed to diminish the meaningfulness and point of the diagnosis. Indeed, studies show that mild PTSD-like symptoms may be common in people reacting to experiences as mundane as seeing an upsetting movie, so a plausible dividing line between traumatic stressors and other negative events is crucial to retaining the idea of PTSD as a pathology due to an overwhelming stressor that is too much for normal psychological processes to handle.

The DSM-5 attempts to tighten and clarify the traumatic-stressor criteria to avoid false positive problems of the past, but in doing so manages to create some new concerns as well. In DSM-5, a traumatic stressor must involve actual or threatened death, serious injury, or sexual violation, somewhat clearer than DSM-IV criteria. The DSM-5 also clarifies the “experienced or witnessed” criteria by specifying that the individual “directly” experiences or witnesses “in person” the traumatic event. As to the problematic “confronted with” option, it is now limited to learning that a traumatic event occurred to a close family member or friend and, in cases of actual or threatened death, it must have been violent or accidental rather than due to other more expectable circumstances. This eliminates televised disasters occurring to strangers as well as simply learning of a loved one’s death due to disease.

However, the DSM-5 also attempts to address a “false negatives” problem: some individuals are repeatedly indirectly exposed to traumatic stressors as part of their work or for other reasons—such as, for example, police officers or social workers who investigate extreme cases of child abuse or are exposed to first responders’ descriptions of carnage. To address such cases, DSM-5 adds a fourth possible way to meet the traumatic stressor criterion, namely that the individual experiences “first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).” The vagueness and potential expansiveness of his criterion (e.g., does it apply to therapists who treat victims of sexual or physical abuse? to hospital claims processors who see descriptions of traumatic injuries in medical records?) appears to undermine much of the work that went into clarifying and narrowing the other criteria.

PTSD symptom criteria are elaborated somewhat and expanded from three to four groups: re-experiencing, avoidance, persistent negative alterations in mood and cognition, and arousal. Reduced diagnostic thresholds are now provided for children under 6 years old.

Somatic Symptom and Related Disorders

A controversial change allows diagnosis of somatic symptom disorder not only, as in DSM-IV, when an individual is experiencing multiple physically unexplained symptoms, but even when an individual is overly concerned about actual medically explainable symptoms. Critics argue, and the DSM-5 field studies suggest, that a large percentage of anxious physically ill individuals will now qualify for psychiatric diagnosis (Frances 2013).

Feeding and Eating Disorders

For anorexia nervosa, the amenorrhea criterion is eliminated. Although amenorrhea is an indicator of nutritional status and correlates with severity of biological consequences of anorexia, it cannot be evaluated in prepubertal or postmenopausal women and does not correlate with the psychological symptoms and dimensions of the disorder, which look the same whether with or without amenorrhea (Attia and Roberto 2009).

A controversial new category, “binge eating disorder,” has been upgraded to full disorder status from its listing in “conditions for further study” in DSM-IV. The criteria require rapidly eating more than is comfortable or usual, accompanied by a sense of loss of control and other negative feelings such as shame, distress, or self-disgust, at least once a week for 3 months. This frequency/duration threshold is lower than the test criteria that were in the appendix for further study, and seems in our environment to make this potentially into a “bar mitzvah and wedding disorder” in which people who overeat just on the weekends for a few months are diagnosable. Oddly enough, the frequency/duration threshold for bulimia was lowered to the same level, so the number of binge-and-purge episodes that qualifies for bulimia diagnosis is now the same as the number of binge episodes alone that qualifies for binge eating disorder diagnosis; it would have seemed like binge eating alone should require a considerably higher threshold. The prevalence is likely to be substantial, estimated conservatively by the eating disorders work group at 5 % of the population over a lifetime (Moran 2013). It is true that the condition correlates to some extent with anxiety, depression, and obesity, but these seem like expectable and potentially normal correlates of overeating in our society due to plentiful availability of food that is designed to tempt us combined with social disapproval. Critics argue that this diagnosis merely makes the vice of gluttony into a disorder (Frances 2012). It can further be argued that it remains unclear on what basis the common tendency for human beings to overeat when food is plentifully available is classifiable as a disorder versus a normal variation of an

evolutionarily shaped inclination to amass scarce calories while one can (even though this natural inclination may be problematic in our food-rich environment), and feelings of being out of control and of self-disgust could be due to internalized social value judgments about such behavior rather than to the presence of genuine compulsive pathology.

Sleep-Wake Disorders

My favorite commonsense change in the DSM-5 is the addition to insomnia disorder (formerly “primary insomnia”) of the criterion, “The sleep difficulty occurs despite adequate opportunity for sleep.” There was no such provision in DSM-IV, so, for example, you could be diagnosed if your neighbor kept you awake playing his TV until 4 AM, or (like my mother) you were an immigrant who lived near the East River on the lower east side of New York City in the days when foghorns frequently loudly blared during the night and repeatedly jolted you awake.

Gender Dysphoria

The category of gender identity disorder has been taken out of the “Sexual and Gender Identity Disorders” chapter and given its own chapter, and renamed “gender dysphoria.” Both these changes are ways of distancing this condition from the “disorder” label. On the other hand, it was not thought prudent to eliminate this condition from the Manual because of the frequent need by gender dysphoric individuals for a medical diagnosis to justify reimbursement for surgery or other medical procedures related to sex reassignment. The new name, in addition to reducing stigma while retaining access to medical treatment, is supposed to emphasize “gender incongruence” rather than cross-gender identification per se, yet the criteria are not very different. Such destigmatization is a lot of burden to place on what is primarily a semantic change. However, when homosexuality was changed to ego-dystonic homosexuality, that portended the elimination of homosexuality completely from the Manual because logically the fact that one feels dysphoric about something that in itself is not disordered does not constitute a mental disorder unless it reaches major depression levels of severity. The same two-step process of depathologization may be occurring to gender identity disorder.

Disruptive, Impulse-Control, and Conduct Disorders

In DSM-IV, intermittent explosive disorder (IED) criteria required serious assaultive acts or destruction of property.

In DSM-5, the requirement has been weakened to allow criteria to be satisfied by verbal aggression and nondestructive nonassaultive physical aggressiveness as well. With loosened criteria, this disorder suddenly appears to be widespread (McLaughlin et al. 2012), even though the average number of “anger spells” the diagnosed individuals had over their entire lifetimes was only about 17, with most being verbal aggression. IED is supposed to represent anger spells in which the individual loses control, but in many contexts verbal expressions of anger may represent considerable control. The criteria do require that anger must be out of proportion to the actual provocation, but many normal-range angry interchanges (e.g., some chronic marital arguments) are of this nature. As with many DSM diagnoses, this category is a useful one in principle, but the criteria, especially in their newly loosened form, appear vulnerable to misuse and overdiagnosis.

Substance-Related and Addictive Disorders

The substance disorder categories have been radically reformulated in DSM-5. In DSM-IV there were two main substance use disorders, dependence and abuse. Dependence required three out of seven specified symptoms designed to measure out-of-control use. Abuse required just one out of four symptoms indicating harmful use, such as hazardous use (e.g., driving while intoxicated) or interpersonal problems (e.g., arguing with your spouse about alcohol use). In DSM-5, the abuse and dependence categories have been merged into one disorder, “substance use disorder,” applied to each substance, and requiring any 2 or more out of 11 specified symptoms.

This change had several roots (Jones et al. 2012). First, whereas dependence has a pretty good track record in terms of validity, abuse—however problematic and worthy of social intervention it may be—often remits, does not necessarily lead to dependence, and on its face looks like a V Code, not a psychiatric disorder; one need not have a mental disorder to argue with one’s spouse about drinking or drive home from parties intoxicated. So, one idea was to eliminate this weak category. However, rather than simply jettisoning abuse or moving it to the V Codes, it was decided to move the criteria, with all their validity problems, over to dependence. Only the “legal problems” criterion was jettisoned because it is rarely invoked. So three abuse symptoms migrated to dependence, making 10 dependence criteria.

Second, some addiction researchers think that the essence of addiction is unrelenting craving for a substance—that craving is the phenomenological counterpart of the “out of control” idea. So, craving was added to the criteria, making 11 criteria.

Third, one might think that with more symptom options it would be much easier to meet criteria, and thus that the threshold for diagnosis would be raised to a higher number of symptoms. However, the committee wanted to avoid the controversial move of changing the overall prevalence of substance disorder as represented by current dependence and abuse, so it aimed to formulate criteria that would yield a prevalence equal to the total current prevalence of dependence and abuse, seemingly undermining the point of eliminating the invalid category of abuse. In addition, it had long been recognized that people with just two dependence symptoms do not get a diagnosis and thus are “diagnostic orphans,” and may end up being diagnosed in the substance disorder NOS category—and a major goal of DSM-5 was to reduce NOS diagnoses and to bring these “diagnostic orphans” under the criteria. So, the work group lowered the diagnostic threshold from 3 out of 7 symptoms to 2 out of 11 symptoms. These changes have led to concerns that the category of substance use disorder now encompasses so many heterogeneous kinds of cases from simple abuse to severe addiction that it is no longer helpful in guiding understanding, communication, or treatment decisions.

Why the change in terminology from “dependence” to “substance use disorder”? A major concern of the DSM-5 work group was that the DSM’s use of the term “dependence” to refer to addiction (a substitution that had itself originally occurred due to the perceived stigmatizing effect of “addiction”) had caused stigmatization of patients in general medical practice. Tolerance at larger doses of medication are needed and difficulties withdrawing from medication are classified as indicators of dependence by DSM, yet these are common reactions to many prescribed medications, such as pain medication. Both patients and physicians are wary of “creating addiction” or “creating dependence,” and sometimes patients refuse medication or physicians are cautious about prescribing because of this concern. The work group therefore wanted to emphasize that dependence is not the same as addiction (the latter signifying out-of-control compulsive use), and thus eliminated use of the term dependence in referring to substance disorder. Given that with the new 2-symptom threshold tolerance and withdrawal alone are sufficient to qualify for substance use disorder diagnosis, whether the work group’s approach is a conceptually coherent one or not remains to be explored.

In addition to the changes to substance use disorder, the substance-related disorders chapter has been expanded to include a new category of behavioral addictions, of which just one, gambling disorder, appears in DSM-5. A second behavioral addiction, internet gaming disorder, has been added to section 3 for further study. Criteria are formulated roughly in parallel to the substance use disorder criteria.

Critics such as Frances charge that this expansion to behavioral addictions allows us to pathologize anything people strongly desire: “The fundamental problem is that repetitive (even if costly) pleasure seeking is a ubiquitous part of human nature... This type of hard wiring was clearly a winner in the evolutionary struggle when life was “nasty, brutish, and short”. But it gets us into constant trouble in a world where pleasure temptations are everywhere and their long term negative consequences should count for more than our brains are wired to appreciate” (Frances 2010).

Caffeine use disorder has been added to section 3 for consideration. Tobacco use disorder is now in the main section on a par with other substances. This represents an expansion from DSM-IV, because the category now in effect covers tobacco dependence and abuse, whereas before only tobacco dependence was listed.

Neurocognitive Disorders

DSM-IV dementia and amnesic disorder are combined within a new “major neurocognitive disorder” category.

DSM-5 also, controversially, adds a new category of less severe cognitive impairment, “mild neurocognitive disorder,” when there is evidence of minimal diminished cognitive functioning. Critics argue, with some justification, that this is an invitation to diagnose the normal cognitive decline of old age as a disorder. On the other hand, sometimes it is useful to diagnose cognitive decline before it becomes superficially apparent.

Personality Disorders

There are no major changes to the personality disorders except that they are moved to the main disorder section from axis 2. However, this follows a vigorous controversy about several successive versions of a proposal to radically overhaul the personality disorders. One of the central aspirations of the DSM-5 from the beginning was to bring dimensional diagnosis to the personality disorders both as a demonstration of the superiority of dimensional rather than categorical diagnosis generally and to address such specific personality disorder problems as excessive comorbidity, high NOS diagnoses, and heterogeneity within categories. The work group included many leading researchers, some of whom were convinced that the same system of dimensional trait descriptions that has been found by personality researchers to describe normal personality can be used to describe personality disorders. The idea was that personality disorders are in fact simply extremes on personality trait dimensions found in everyone. The system of trait

evaluation that evolved within the work group was however adjusted to capture pathological features not adequately addressed in the normal-personality trait system, and the resulting proposal became so complex that it was eventually rejected and placed in the Manual's section 3 (see "Alternative DSM-5 Model for Personality Disorders"). However, it is being characterized as an "emerging" system and its use is encouraged nonetheless. Consequently, there is the sense that this is just a strategic retreat by the DSM-5 Task Force and that this proposal is destined to be brought back to replace the current categories.

Paraphilic Disorders

The paraphilic disorders caused enormous controversy because of proposals to add two categories of disorder representing sexual desire for adolescent youths ("hebephilia") and sexual arousal at coercive sex (in effect a "rape disorder"). These categories would have made it easier in forensic contexts to seek institutionalization of repeat sex offenders under federal and state "sexual predator" laws, which require the presence of a mental disorder. However, both of these specific proposals were defeated.

The primary "change" in this chapter is purely semantic. The term "paraphilia," which was originally introduced in DSM-III as a less stigmatizing label for what were traditionally labeled "perversions," has been used in all DSMs since then to label disorders. Correspondingly, the paraphilia's specific name, such as "exhibitionism," has referred to a disorder. In all recent DSM editions, diagnosis of a paraphilic disorder required satisfaction of two criteria, where Criterion A specifies the qualitative nature of the non-normative sexual desire that constitutes a dysfunction (e.g., sexual desire for children, or for exposing one's genitals to strangers), and Criterion B specifies the harmful consequences of having or acting on the desire (e.g., distress, role impairment, or inflicting sexual activity on an unwilling victim). The diagnostic criteria remain approximately the same in DSM-5, except that now the deviant sexual desire described in criterion A will be labeled a paraphilia, and so the paraphilia by itself will not be considered a disorder, whereas the entire condition of desire plus harm will be labeled a "paraphilic disorder." For example, whereas "exhibitionism" denotes the disorder in DSM-IV-TR, in DSM-5 it denotes only criterion A, a non-normative form of sexual desire that is not in itself a disorder, and only when there is additionally one of the specified forms of harm does it become "exhibitionistic disorder." If a paraphilia without harm emerges in a clinical interview, it is not to be a diagnosis, but merely a

non-normative sexual desire that is "ascertained" rather than "diagnosed."

There is a rather subtle but potentially important change in the nature of paraphilia criteria. DSM-IV generally required "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors" regarding the specific content of the paraphilia. However, it was argued that this was ambiguous and could allow behaviors alone (or behaviors associated with sexual arousal) to satisfy criterion A, and in "sexual predator" cases this could confuse opportunistic criminality with true paraphilic disorder and thus open the way for individuals to be mistakenly institutionalized (First and Halon 2008). Consequently, in DSM-5, in order to clarify that paraphilias involve the nature of desire and not just deviant behavior, criterion A was revised to require "recurrent and intense sexual arousal [from the specific paraphilic content] as manifested by fantasies, urges, or behaviors." This change in wording is intended to convey that the individual's sexual desire and arousal must be directed at the paraphilic content. Thus, sheer behavior is not a sufficient indicator of a paraphilia but rather it must be established that the behavior is due to a preexisting paraphilic sexual desire/arousal.

Depressive Disorders

This completes my survey of major DSM-5 changes and controversies, with the single exception of the chapter on depressive disorders. Depressive disorders experienced the most changes and the most controversy of any chapter, and deserves more extensive discussion. I now consider that chapter's changes and controversies in a bit more detail. These changes include elimination of the major depression bereavement exclusion, introduction of the new category of disruptive mood dysregulation disorder in children, introduction into the main listing of premenstrual dysphoric disorder, introduction for further study of the new category of persistent complex grief disorder, creation of a new category of persistent depressive disorder, and introduction of a new major depression specifier, "with anxious distress." In addition to surveying the changes themselves, I provide some background that explains what makes some of these changes so controversial or interesting.

Elimination of the Major Depression Bereavement Exclusion

The proposal to eliminate the bereavement exclusion to major depression in DSM-5 was the most controversial diagnostic proposal since depathologization of homosexuality in DSM-III. It seemed to fly in the face of common

sense and to pathologize something central to human experience, grieving over the lost of loved ones. Nevertheless, the proposal was accepted and the bereavement exclusion is eliminated in DSM-5, replaced by a vague note suggesting that clinical judgment is needed in distinguishing normal grief and reactions to other stressors from depressive disorder.

It is known that grief sometimes triggers a major depressive disorder (MDD) (Parkes 1964). However, it is also known from longitudinal studies of non-clinical samples that some of the symptoms used to identify depression (e.g., sadness, insomnia, lowered appetite, difficulty concentrating on usual tasks, lowered interest or pleasure in usual activities) are in fact general-distress symptoms that regularly occur in normal reactions to loss as well (Clayton et al. 1968). Because of the way DSM defines MDD—as having any 5 out of 9 symptoms lasting for more than 2 weeks—normal grievers may spuriously qualify for MDD if they have 5 of the general-distress symptoms. To avoid false positive diagnoses of the bereaved, the bereavement exclusion provided guidance for the clinician in distinguishing genuine depressive disorders during bereavement from grief's normal symptoms that might be mistaken for depressive disorder. Basically, it said that if a bereaved individual has only the general-distress type symptoms, that is likely normal grief, but if the depression includes any of 6 severe symptoms not usual in normal grief (i.e., lengthy duration, marked impairment, psychotic ideation, suicidal ideation, psychomotor retardation, sense of worthlessness), then, despite the loss, diagnose the patient as having MDD to be safe.

Proponents of eliminating the bereavement exclusion were concerned primarily about missing MDD cases rather than overdiagnosing normal grief. They cited evidence that they claimed supported their view that the excluded cases are just like other standard depression and contained many genuine MDD cases, but in fact the evidence they cited did not address this specific issue, and a published review found that no research base supported the proposal (Wakefield and First 2012). Proponents put forward many arguments nonetheless—for example, that suicidal patients are missed, and that medication works for excluded cases—and these proved persuasive to the American Psychiatric Association (APA).

However, research studies emerging both before and after the decision have strongly supported the exclusion's validity and persuasively suggested that this decision was mistaken. Excluded bereavement-related depressions are dramatically lower than standard MDD on many indicators of pathology (Wakefield et al. 2007; Wakefield and Schmitz 2013a). Followed for one to three years, those who had excluded depression do not have the recurrences typical of MDD—in fact, they have no more later depressive episodes or other negative sequelae such as anxiety

disorders than do those in the general population who never had MDD (Gilman et al. 2012; Mojtabai 2011; Wakefield and Schmitz 2012), whereas standard MDD has very high rates of recurrence and other negative outcomes. The claim that antidepressant medication works with these early uncomplicated grief reactions (Fawcett 2010) turns out to be based on one small study with uncontrolled data (Zisook et al. 2001), whereas grief normally sees major reductions in depressive symptoms during the same period without medication, so the study's results are scientifically spurious (Wakefield 2013b). The repeated claim that the exclusion misses suicidal individuals is equally spurious (Wakefield and Schmitz 2013a, b), which is expectable since “no suicidal ideation” is a requirement for exclusion.

A further central argument used by eliminationists is that depressive reactions to other, non-bereavement stressors (e.g., job loss, marital dissolution, romantic betrayal, financial ruin, negative medical diagnosis) are not currently excluded from MDD diagnosis, but research (Kendler et al. 2008; Wakefield et al. 2007) has established that when the same exclusion rules are applied, such reactions are similar to uncomplicated reactions during grief, so why should grief be treated specially? This was posed as a dilemma: to be consistent, either the bereavement exclusion must be eliminated or it must be extended to other stressors (Kendler 2010; Wakefield 2011, 2013a). The DSM-5 work group rejected the “extend” option out of hand as unacceptable and never evaluated it, so the only answer it allowed to the dilemma was elimination. Accumulating empirical evidence now answers the “eliminate or extend” challenge more scientifically, and the evidence strongly supports the “extend” option. The same results showing the validity of the bereavement exclusion emerge in parallel form when one studies depressive responses to other stressors, applying the same exclusion rules generally to all stressors. Excluded depressive reactions in general are dramatically lower in pathology levels than standard MDD (Wakefield and Schmitz 2013b; Wakefield et al. 2007). Moreover, excluded depressive stressor reactions in general do not recur at rates higher than the background rate of occurrence of MDD in those who never had a depressive disorder (Wakefield and Schmitz 2013c). In sum, the “eliminate or extend” question has been empirically answered with evidence that strongly support the validity of extending the exclusion to other stressors. The elimination of the bereavement exclusion will no doubt again arise as an issue when the DSM-5 engages in the planned interim online revision, DSM-5.1.

Disruptive Mood Dysregulation Disorder

DSM-5 depressive disorders include a controversial new child depressive disorder category, Disruptive Mood

Dysregulation Disorder (DMDD) (earlier labeled Temper Dysregulation Disorder With Dysphoria). DMDD can be diagnosed only between 6 and 18 years of age, and requires onset by age 10. DMDD diagnostic criteria require: temper outbursts on average at least 3 times a week that are inconsistent with developmental level and not proportional to environmental provocations; a generally irritable or other negative mood between outbursts; symptoms occurring in more than one setting and lasting for at least a year; and no manic episode. Diagnosis of DMDD precludes diagnosis of oppositional defiant disorder (ODD), although most DMDD cases would qualify for ODD.

This is a largely untested diagnosis without a strong research history. It was introduced to address an urgent and embarrassing problem for psychiatry—the excessive diagnosis of child bipolar disorder (estimated at between 6 and 40 times more frequently than a few decades ago), and the consequent overtreatment of children with heavy-duty medications such as mood stabilizers and antipsychotics with serious side effects and lack of long-term testing in children. Difficult children often present not with the classic cycling bipolar pattern but with chronic irritability and dysphoria punctuated by severely disruptive tantrums. The idea has been widely accepted that child bipolar disorder may present in this way, with the irritability representing mania, leading to bipolar diagnoses in many children presenting with angry defiance and tantrums.

However, research suggests that children presenting with a pattern of chronic irritability and frequent tantrums are in fact neither experiencing an early form of bipolar disorder nor a stable mood disorder. Many children with these symptoms are brought to treatment by desperate parents, but the children seem to outgrow these behaviors and almost all (96 %) are alternatively classifiable as ODD or CD (Axelson et al. 2012). Consequently, the new DMDD diagnosis means that children whose defiance and tantrums are causing distress to parents may now come to be illegitimately diagnosed as having a mood disorder.

The arguments in defense of this diagnosis are, first, that because this diagnosis falls under depressive rather than bipolar disorders, it has more benign medication implications and so improves the situation with regard to excessive bipolar diagnoses. Second, these cases are more severe than usual ODD or CD cases, and require the greater attention and treatment focus that a mood disorder diagnosis will suggest.

Yet, elevating ODD and CD cases with tantrums into mood disorders seems worrisome. Allen Frances observed, “we have no idea whatever how this untested new diagnosis will play out in real life practice settings.” He argued that the DMDD criteria are so loose that “DSM-5 will turn temper tantrums into a mental disorder” resulting in “a new fad and even more inappropriate medication use in vulnerable children,” making the problem worse than the

one it is designed to address (Frances 2011). A subsequent article in *Slate* ridiculed this as “the new temper tantrum disorder” (Dobbs 2012).

The “cons” for this category are, first, that DMDD does not appear to be a valid construct, having low stability over time and lack of relationship to other mood and anxiety disorders or to family history. It seems to replace one category that encourages antipsychotic use with another that is likely to encourage psychotropic use as well. An ODD specifier would have captured this group as well—but ODD is a category for which medication is not considered appropriate at present. Children tend to outgrow these temper tantrum problems, so treatment and stigma may be applied unnecessarily to large numbers of children.

Premenstrual Dysphoric Disorder

A new category of mood disorder for severe premenstrual symptoms, Premenstrual Dysphoric Disorder (PMDD), has been added to DSM-5 depressive disorders. The milder condition of “premenstrual syndrome” (PMS), in which a woman experiences an uncomfortable constellation of physical and emotional symptoms prior to menses onset, is quite common and not considered a disorder; 90 % of women experience one or more PMS symptoms, and 20–40 % suffer more significant difficulties (Halbreich 2004; Halbreich et al. 2003). However, some cases of mood variation during perimenses are so severe as to persuasively warrant classification as a mood disorder, comprising perhaps 8 % of all women (European Medicines Agency 2011). Because of each episode’s brevity, this condition does not qualify as major depression. Hence, PMDD is potentially a useful category.

Diagnostic criteria for PMDD specify that in most menstrual cycles during the past year at least five out of 11 specified symptoms have occurred during the week before onset of menses and subsided in the week following menses, with the symptoms including marked levels of emotional lability (e.g., mood swings, increased sensitivity, tearfulness), irritability or increased conflict, depressed mood, anxiety, decreased interest in usual activities, difficulty concentrating, fatigue, decreased or increased appetite or food cravings, sleep difficulties, feeling overwhelmed, and physical symptoms (e.g., breast tenderness or swelling, joint or muscle pain, a sensation of ‘bloating,’ weight gain). The criteria require that these symptoms must be confirmed over at least two cycles, and that the symptoms are associated with ‘clinically significant distress or interference with work, school, usual social activities or relationships with others (e.g., avoidance of social activities, decreased productivity and efficiency at work, school or home).’

PMDD has long been controversial due to concerns that the category would inevitably pathologize a common and natural female response that varies in intensity but is not a mental disorder except under very rare circumstances (Offman and Kleinplatz 2004). The DSM-III-R introduced the equivalent category of “late luteal phase disorder” to the appendix of conditions needing further study, noting that aside from validity concerns there were objections that the category has “high potential for misuse, particularly against women” (1987, p. xxi). The DSM-IV Task Force convened a special “premenstrual dysphoric work group” of six female experts on mood disorders to consider the proposal, but, faced with the same objections, they left the category (renamed PMDD) in the appendix—but also listed it as an example that could be diagnosed under the axis I category of “depressive disorder not otherwise specified.” The DSM-5 mood disorders work group proposed upgrading PMDD to full disorder status (American Psychiatric Association 2011), and this time the APA approved with surprisingly little controversy. A central consideration was the demonstrated effectiveness of medications, particularly SSRIs, in treating this condition (Brown et al. 2009; Shah et al. 2008).

However, one can argue that the current criteria do not clearly differentiate PMDD from normal-range PMS symptoms. Valid diagnosis seems to depend entirely on how PMDD’s ambiguous “marked” descriptor is interpreted. For example, sensitivity to rejection, being ‘on edge’, easy fatigability, specific food cravings, and breast tenderness qualify a woman for diagnosis, yet seem potentially within normal PMS range. Symptoms such as self-deprecating thoughts, decreased interest in usual activities, insomnia, and increased interpersonal conflicts could easily occur normally in women feeling edgy, fatigued, and physically uncomfortable. The ‘clinical significance’ criterion, designed to prevent false positives, has the obvious weakness that distress and interference with or avoidance of some usual activities commonly occur due to normal-range discomfort, emotional lability, or irritability during PMS. Clinical judgment will be crucial to this diagnosis.

In response to criticisms of potential overdiagnosis, the depressive disorders work group acknowledged on the DSM-5 website that “a disorder that focuses on the perimenstrual phase of the menstrual cycle may ‘pathologize’ normal reproductive functioning in women.” They answered: “We felt that the prevalence statistics clearly indicate that PMDD is a condition that occurs in a minority of women. As such, it would be inappropriate to generalize any disability to women in general. In fact, a DSM diagnostic category for women who experience marked symptoms and impairment perimenstrually highlights the fact that most women do not experience such symptoms”

(American Psychiatric Association 2011). The argument seems to be that labeling a minority as disordered implies that the majority are not disordered, so the diagnosis exonerates most women from being pathologized for their perimenstrual experiences. This rationale seems to take pathologizing all women as the baseline against which to judge the proposal. Any diagnosis that applies to less than half the population, no matter how invalid, will offer the same benefit. The question is instead whether substantial numbers of nondisordered individuals are likely to be among those who are classified as disordered, and this is a question that could use some further attention despite the several decades of debate.

Persistent Complex Bereavement-Related Disorder

Until DSM-5, there was no diagnostic category that evaluated pathology in non-depressive grief feelings, such as yearning for the lost person, being pained by reminders, or feeling disbelief that the person is gone. However, grief researchers have longed recognized that some individuals do not have the normal trajectory of adaptation to a loss and experience chronic intense grief feelings that can be impairing over lengthy periods of time. Researchers have worked to provide scientific support for the introduction of a DSM category, alternatively labeled “prolonged” or “complicated” grief disorder, for diagnosing intense, lengthy grief symptoms as a grief-specific pathology that can be present even when major depression, PTSD, and GAD are not diagnosable (Prigerson et al. 2009; Shear et al. 2011).

Arguments for the addition of this category rested either on the claim that when intense grief goes on for 6 months or more it has become frozen and interminable and thus the normal ability to adapt to loss has failed (Shear et al. 2011), or the claim that having intense grief for 6 months or more increases the risk of developing later physical and mental disorders (Prigerson et al. 2009). However, risk does not equal disorder, and the “frozen and interminable” claim was not particularly well supported by the evidence (Wakefield 2012).

The DSM-5 anxiety disorders work group (under which the grief proposal fell because this work group also handled traumatic disorders) resolved the conflict between the two research groups’ proposed criteria by creating its own original set of diagnostic criteria combining elements from both. This disorder is introduced into section 3 of DSM-5. The disorder is renamed “persistent complex grief disorder.” Unlike the researchers’ proposals which called for a 6-month disorder duration threshold, the duration requirement in DSM-5 is 12 months to allay fears of false positive diagnoses that pathologize normal grief. This is a more

defensible cut-point but likely still too short given evidence that many individuals are still on a healing trajectory at 1 year (Wakefield 2012).

Diagnostic criteria require at least one out of four “separation distress” symptoms (yearning/longing, intense sorrow, preoccupation with the deceased, preoccupation with the death’s circumstances) and at least six out of 12 additional symptoms including difficulty accepting, shocked/stunned/numb, difficulty positively reminiscing, bitterness/anger, self-blame, avoidance of reminders, difficulty trusting, wanting to join the deceased, loneliness/detachment, meaninglessness/emptiness, role confusion or feeling part of oneself died, and difficulty pursuing interests or plans. Note that all of these phenomena can occur normally during acute grief, so it is the prolonged intensity rather than a trajectory of resolution that suggests pathology. The new category remains controversial because this category has high potential for abuse, especially if grief becomes targeted for medication development.

“With Anxious Distress” Specifier for Major Depressive Disorder

A new anxious-distress specifier is being added to major depression in DSM-5. The aim is to address the problem of the extremely high comorbidity of depression and anxiety. The specifier will allow the clinician to diagnose anxious depression without having to provide two diagnoses for the depression and the subthreshold anxiety.

Although developed on an independent track, the anxiety specifier in effect partially addresses the aims of a rejected proposal for a new category of mixed anxiety/depression disorder. That proposal allowed diagnosis with just a few subthreshold symptoms each of anxiety and depression, and the symptoms were not very demanding; for example, the anxiety symptoms included “preoccupation with unpleasant worries,” “trouble relaxing,” and “fear that something awful may happen,” all of which can be normal and even adaptive responses under challenging circumstances. Concern about false positive diagnoses killed that proposal, and the anxiety specifier for depression remains to address the issue of anxiety during depression.

Clinicians have traditionally recognized anxiety as a core symptom of depression. For example Hippocrates defined melancholia as “fear and sadness lasting a long time” (Horwitz and Wakefield 2007). However, starting with DSM-III, an attempt was made to sharply distinguish depressive and anxiety syndromes (Horwitz and Wakefield 2012). This led to the elimination of anxiety as a symptom of major depression. Subsequently, psychiatric researchers “discovered” a remarkably high comorbidity between

depression and anxiety and that they have common genetic sources, as well as that they tend to transform one into the other over time. This relationship has become of even greater interest as studies have consistently shown that comorbid anxiety predicts worse depression outcomes. The anxiety specifier will allow conditions that satisfy depression criteria and that have subthreshold anxiety symptoms to be accurately diagnosed without a second diagnosis.

Persistent Depressive Disorder (Dysthymia)

A new “persistent depressive disorder (dysthymia)” category combines DSM-IV dysthymia with major depression lasting more than 2 years, to form one chronic depression category. Dysthymia as chronic subthreshold depression was originally added to reassure psychodynamic clinicians that neurotic depression was still in the Manual when “neurosis” was eliminated as a label. However, research suggests that very lengthy depressions share some negative characteristics, such as poor treatment response, whether full major depressions or subthreshold dysthymic conditions. Moreover, the core major depression construct has always been anchored in the notion of episodic remission and recurrence, not chronically enduring symptoms. Dysthymia currently includes subthreshold depression with depressed mood and at least two other symptoms lasting more than 2 years, but if symptoms reach the 5-symptom major depression level, there is an exclusion stating that this is no longer dysthymia and is major depression. Essentially, the new category simply eliminates the exclusion so that a chronic depression now falls into this category no matter how many symptoms it has. A problem is that the major depression criteria were not amended to indicate that if symptoms persist more than 2 years, then the condition should not be diagnosed as major depression but as persistent depression. Thus, in cases of major depression lasting 2 years or more, it remains unclear whether the clinician is supposed to provide two disorder codes (major depressive disorder and persistent depressive disorder) or just one. A further potential practical problem is that, although the criteria have been changed, the category’s code remains the ICD’s dysthymia code. This could initially lead to confusion over reimbursement if, for example, dysthymia is generally not reimbursed for hospitalization but a persistent major depression case now falling under the same code requires hospitalization. Many such matters will need to be sorted out as insurers become educated about the nature of DSM-5 changes.

Whatever one thinks of the DSM-5 revision process or of the various changes to the Manual, several conclusions seem defensible. First, the DSM-5 revision was in some

ways a flawed process and a missed opportunity, and we can look forward to a period of further turmoil in the field as a result. Second, the domain of mental disorder is enlarged by DSM-5, and the distinction between mental disorder and normal distress is blurred. Although in some respects this may be a positive development for clinicians, it has the downside that, in a “brain disease” era, this could lead to increased inappropriate medication. Nevertheless, third, the conversation triggered by DSM-5 among those with competing views of mental disorder has enlivened and invigorated the field, reminded us how little we know and how much we have yet to learn, and changed clinical diagnostic criteria from a rather dull set of prescriptions by work groups into an endlessly fascinating intellectual street fight over the future of our conceptions of pathology. Moreover, fourth, we now have the rapt attention and involvement of the public and the media, who have an enormous stake in our nascent science of mental disorder and its treatment. This should remind us of just how much these disputes about the esoterica of psychiatric diagnosis matter at a real human level, how much our theories and constructs can help or hinder us in understanding the problems of our clients, and what a privilege and responsibility it is to be entrusted with the challenge of understanding and improving our clients’ emotional lives. Even if DSM-5 does not provide an entirely satisfactory set of answers, it has effectively posed a provocative set of questions with which we will be grappling for some time.

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