An Overview of the *DSM-5*

Changes, Controversy, and Implications for Psychiatric Nursing

Margaret Jordan Halter, PhD, APRN; Donna Rolin-Kenny, PhD, APRN, PMHCNS-BC; and Laura Cox Dzurec, PhD, PMHCNS-BC

ABSTRACT

Scheduled for publication in May 2013, the *Diagnostic and Statistical Manual of Mental Disorders, fifth edition* (*DSM-5*), will guide clinical diagnoses, treatment plans, medication choices and protocols, insurance reimbursements, and research agendas throughout the United States. It will also serve as a reference manual for clinicians around the world. This primary diagnostic source used by psychiatric and mental health providers is undergoing significant change in organization and content relative to the previous edition. This article provides a general overview of what to expect in the *DSM-5*, highlighting major aspects of the revision. Included is a list of the proposed diagnostic categories and an overview of some of the debate and discussion accompanying the changes. Implications for psychiatric nurses and psychiatric nursing are presented.

chiatric and mental health providers, the *DSM-5* is undergoing significant change in organization and content relative to the previous edition.

This article provides a general overview of what to expect in the *DSM-5*. It collates information provided previously on the APA website, information available in recently published multi-disciplinary literature and discussion regarding the changes to the new manual, and APA's latest announcements. A table of contents included in a recent APA (2012a) news release provides a summary of final decisions about the contents and order of diagnostic categories included in the *DSM-5*. In early 2013, the APA launched a separate website devoted to the *DSM-5*, which contains essential preview information regarding final changes (APA, 2013).

THE REVISED FORMAT OF THE *DSM-5*

The *DSM-5* represents the first substantial revision to its clinical practice guidelines in more than 30 years. Changes to this updated version were structured in light of several overarching ideals. First, the manual was planned to be a living document, amenable to updates as knowledge about characteristics of psychiatric problems and approaches to their management improves. As a consequence, the bulky Roman numeral format (e.g., *DSM-I, DSM-II, DSM-IV-Text Revision [TR]*) that was previously used to indicate manual updates will be abandoned in favor of Arabic numerals (e.g., *DSM-5, DSM-5.1, DSM-5.2*), which will be easier to track over time. Ongoing revisions to individual diagnoses and diagnostic categories are planned to be based on current evidence. If changes are made electronically, as they are in the *Oxford English Dictionary* and in course catalogs in many universities, regular and frequent updates will become more feasible and affordable.

The 20 diagnostic categories in the revised manual are purported to be evidence-based (i.e., built on current best evidence informing decisions about care for individual patients). Although research-based diagnosis is not a new concept in the development of diagnoses and criteria, the emphasis in this manual was planned to be hard-hitting. The leadership at APA sought to provide diagnoses based on scientific evidence developed within the past two decades (APA, 2012a).

Building on that evidence, the *DSM-5* aimed for increased cross-cultural application. The *DSM-IV-TR* (APA, 2000) included an abbreviated list of "Culture-Bound Syndromes" in the appendix. The current revision expands cultural considerations, incorporating the Cultural Formulation Interview (CFI) (Bäärnhielm & Scarpinati-Rosso, 2009), a standard method for simple and efficient cultural assessment, into criteria for diagnosis. The 14-question CFI has the potential to improve patient-centered care while reducing racial and ethnic disparities in treatment. Furthermore, it may help providers screen and identify individuals who would benefit from the presence of language translators.

Most *DSM-5* disorder categories will incorporate dimensional assessments that will support appraisal of symptom severity for each individual client. Rather than a simple yes or no decision related to a symptom's existence, the clinician can now identify the severity of symptoms on a scale of 3 or more ordinal-level points, emphasizing patient self-assessment of symptom severity (Narrow & Kuhl, 2011). Dimensional assessments are drawn from tools already in use such as scales from the Patient-Reported Outcomes Measurement Information System (National Institutes of Health, n.d.). The *DSM-5* work groups also developed and tested other measures that will be included in the manual.

O n December 1, 2012, the American Psychiatric Association's (APA) Board of Trustees approved the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). The publication will debut at the APA's annual convention in May 2013. It will guide clinical diagnoses, treatment plans, medication choices and protocols, insurance reimbursements, and research agendas throughout the United States and will serve as a reference manual for clinicians around the world. The primary diagnostic source used by psy-

DIAGNOSTIC CATEGORIES IN THE *DSM-5*

1. Neurodevelopmental Disorders	11. Elimination Disorders
2. Schizophrenia Spectrum and Other Psychotic Disorders	12. Sleep-Wake Disorders
3. Bipolar and Related Disorders	13. Sexual Dysfunctions
4. Depressive Disorders	14. Gender Dysphoria
5. Anxiety Disorders	15. Disruptive, Impulse Control, and Conduct Disorders
6. Obsessive-Compulsive and Related Disorders	16. Substance Related and Addictive Disorders
7. Trauma and Stressor-Related Disorders	17. Neurocognitive Disorders
8. Dissociative Disorders	18. Personality Disorders
9. Somatic Symptom and Related Disorders	19. Paraphilic Disorders
10. Feeding and Eating Disorders	20. Other Disorders

Note. DSM = Diagnostic and Statistical Manual of Mental Disorders.
Adapted from American Psychiatric Association (2013).

Cross-cutting assessments are included as a psychiatric version of general medicine's "review of systems" and are meant to be conducted without regard to a specific diagnosis (Kuhl, Kupfer, & Regier, 2011). It is well known that some symptoms (e.g., sleep deprivation) are present across numerous disorders. Detailed, clinically significant assessments will prompt more in-depth follow up of the initial clinician- administered assessments.

Diagnostic categories and diagnoses included in the *DSM-5* incorporate objective measures based on knowledge emerging from recent innovations and advancements in neurodiagnostics, including measurements available through genetic work-ups, neuroimaging, or neurochemistry. Some sleep disorders categorized in the *DSM-5* will include a requirement for polysomnography prior to formal diagnosis (Gever, 2012). Narcolepsy/hypocretin deficiency (formerly known as narcolepsy) will require measurement of hypocretin in the cerebrospinal fluid. Such techniques may represent the dawn of a new era through which objective measurements validate the existence of underlying causes, illuminating previously unrecognized physical pathology. The potential for stigma reduction as a consequence of more exacting diagnostic criteria is an exciting prospect emerging from the changes in the *DSM-5*.

Additionally, across diagnostic groups, the use of functional impairment as a criterion for diagnosis has been reduced, but not eliminated. Diagnoses such as autism and other disorders involving neuropsychiatric deficits will retain functional diagnostic criteria, as functional impairment is a cornerstone of these disorders (Gever, 2012). For other conditions, functionality may be included in the dimensional assessments rather than in diagnostic criteria.

In the previous edition of the *DSM*, the not otherwise specified (NOS) diagnoses tended to be catchall categories. For example, more than half of all eating disorders were listed in the Eating Disorder NOS diagnostic classification (Gever, 2012). In the new manual, NOS will be replaced with not elsewhere classified (NEC). Although this sounds similar to the previous system, the inclusion of a requisite list of specifiers, each with a specific diagnostic code, refines and streamlines the process and conveys important, distinct clinical information. For example, depressive disorder NEC may involve any one or any combination of five specifiers, such as "short duration," that indicate the patient's clinical condition and provide rationale as to why the presenting condition does not meet criteria for one of the main depressive syndromes.

Finally, one of most notable changes in the forthcoming *DSM-5* pertains to the axis system. Beginning in 1980, the *DSM-III* (APA, 1980) adopted the following categories, or axes, to organize diagnostic conceptualization:

- Axis I: Major mental disorders.
- Axis II: Personality disorders and intellectual disabilities.
- Axis III: Acute medical conditions.
- Axis IV: Environmental factors contributing to the disorder.
- Axis V: Global Assessment of Functioning Scale (GAF).

DSM-5 authors concluded that there was no scientific basis for these categories; thus, the new version will retire the five axes. The categories in the *DSM-5* are at once simpler and more complex. Specifically, Axes I, II, and III will be collapsed into a single axis that contains all of the psychiatric and medical diagnoses. This approach is congruent with the system used by the *International Classification of Diseases* (ICD) (World Health Organization [WHO], 2010b). Additionally, the *DSM-5* will likely incorporate clinician use of a 15-page *ICD* checklist (WHO, 2010b) for assessment of psychosocial and contextual factors previously assessed on Axis IV.

The traditional Axis V GAF score has been criticized for mixing symptom severity with functional severity. It may be replaced by the WHO Disability Assessment Schedule (WHODAS) (WHO, 2010a). WHODAS is a 36-item measure that addresses six domains—cognition, mobility, self-

care, getting along with others, life activities, and participation. Self-administration takes 5 to 10 minutes, and clinician administration takes 20 minutes.

These conceptual changes to the manual's organization and method of content delivery provide the context for changes to specific diagnoses and diagnostic categories. The discussion that follows addresses each of the diagnostic categories in the *DSM-5* individually.

DIAGNOSTIC CATEGORIES AND THEIR SEQUENCING

The *DSM-5* lists approximately the same number of disorders as the *DSM-IV-TR*, roughly 300 across 20 diagnostic categories. The sequencing of the diagnostic categories specified in the new manual generally follows a neurodevelopmental life span approach, as do the disorders identified within category listings. In other words, categories generally follow a sequence from problems that typically are diagnosed in childhood through those typical of adolescents, adults, and finally, older adults.

The *DSM-5* authors also sought to arrange disorders by relatedness, taking into account similar vulnerabilities and characteristic symptoms for disorders listed within individual categories. For example, schizophrenia and bipolar disorder are listed in succession, as individuals affected by one of these two disorders may share common genetic variations and overlapping manifestations (Craddock, O'Donovan, & Owen, 2005). Likewise, depression is listed immediately before anxiety, reflecting the long-recognized interrelationship of these two disorders.

Finalized categories in the *DSM-5* are summarized in the **Table** (APA, 2013). The care and forethought characterizing development of the 20 diagnostic categories and the diagnoses within them does not imply that they have been met with universal agreement in the mental health community. The following discussion highlights some of the controversies accompanying the diagnostic changes in

the *DSM-5*, in addition to summarizing the diagnoses slated for inclusion within each diagnostic category.

Neurodevelopmental Disorders

As noted, diagnostic categories in the *DSM-5* are arranged across the life span, beginning with infancy. The Neurodevelopmental Disorders category was formerly identified as Disorders Usually First Evident in Infancy, Childhood, and Adolescence.

In the *DSM-IV-TR*, *intellectual developmental disorder* was called *mental retardation*. The revised name aligns the *DSM-5* with federal legislative language (Moran, 2013b). Impairment in adaptive functioning will be coupled with intelligence quotient to serve as the dual bases for diagnosis (Sederer, 2011). Severity measures for mild, moderate, severe, and profound intellectual disability will be included.

Specific learning disorders, formerly *learning disorders*, will group the neurodevelopmental disorders that previously stood alone—dyslexia, dyscalculia, and disorder of written expression—into a single problem. Problems will be grouped in diagnostic statements descriptive of the patient's presenting symptoms (i.e., a specific learning disorder with dyslexia). Opponents of this new system fear individuals with dyslexia, in particular, will be disadvantaged due to the absence of a freestanding diagnostic label. They believe that this change may limit treatment options, as well as restrict educational supports, legal rights, and continued insurance coverage (Burgess, 2012).

Autism spectrum disorders now combines the subcategories of autistic disorder, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder NOS, into one broad label. These changes are based on evidence from clinical field trials that suggest clinicians make diagnoses based on similar presenting problems quite differently (Moran, 2013b). The Neurodevelopmental Disorders Work Group concluded that distinctions

between the disorders tend to be in terms of overall severity rather than in terms of symptoms. Another change is removing the requirement of symptom onset before age 3; the new criterion is expanded to early childhood. Also, the *DSM-IV-TR* (APA, 2000) criteria included three separate behavioral dimensions—social reciprocity, deficits in communication, and restricted, repetitive behaviors and interests. The *DSM-5* collapses the three behavioral dimensions into two domains by combining communication and social interaction into a single domain of social communication or social reciprocity. The second is restrictive or repetitive behaviors that may be current or historical.

A significant controversy regarding autism spectrum disorders is that people with a previous diagnosis of Asperger's disorder may be stigmatized with an autism diagnosis, which might likely be termed *mild autism*. Opponents of the change suggest that this higher functioning subset could lose funding for services due to tighter diagnostic criteria (Willingham, 2012). There are disparities in services offered to affected individuals by diagnosis; a diagnosis of autism is eligible for speech, occupational, physical, and behavioral therapies, whereas funding for other diagnoses within the Neurodevelopmental Disorders category is significantly less.

In the *DSM-IV-TR*, attention-deficit/hyperactivity disorder symptoms were only significant if they occurred before age 7. Opponents of this criterion suggest that this age for symptom manifestation was arbitrary and not based on evidence. Many reports have shown symptom onset among children older than 7 (APA, 2010). *DSM-5* criteria thus extend diagnostic inclusion criteria to age 12.

Allen Frances (2012), chair of the *DSM-IV* Task Force, reinforced an argument posed by those in opposition to the new learning disorders characterizations. He suggests that changes to the *DSM* would result in inflation of children diagnosed with attention-deficit disorder. He contends that the altered age criterion

would result in an easier-to-gain adult diagnosis and increase the potential for psychostimulant drug abuse.

Schizophrenia Spectrum and Other Psychotic Disorders

Previously listed under the category of schizophrenia, disorders sharing schizophrenia-like symptoms and underlying causes are listed in the *DSM-5* as *schizophrenia spectrum disorders*, roughly arranged from least to most severe. This change is one of the least controversial in the new manual. Also, *catatonic*, *disorganized*, *paranoid*, *residual*, and *undifferentiated* have been removed as subtypes of schizophrenia; however, *catatonia* will be retained as a specifier throughout the *DSM-5* diagnostic categories.

Dimensional ratings for schizophrenia that would allow clinicians to rate symptoms in terms of severity on a 0 to 5 scale were developed. However, they were ultimately rejected as potentially burdensome and not adequately tested (Moran, 2013a). They will reside in Section 3, an area in the appendix reserved for diagnoses requiring further research (APA, 2012b) and may be used in clinical settings.

One disorder that was proposed, but not accepted, was attenuated psychosis syndrome. Individuals who develop attenuated psychotic symptoms accompanied by dysfunction at school and at home are thought to be more likely than individuals in the general population to develop schizophrenia or other psychotic disorders within 2 years of symptom onset (Carpenter & van Os, 2011). Proponents of making attenuated psychosis syndrome a specific disorder believe that early detection of symptoms and follow-up treatment are neuroprotective and helpful in reducing severity, neurobiological decompensation, and subsequent long-term disability. Opponents of the diagnosis noted that although 35% of individuals with prodromal psychotic states convert to psychosis within 2 years, 65% do not (Cannon et al., 2008). This proposed diagnosis could result in too many false positives that could broaden stigma. Early pharmacological treatment is argued by opponents to expose people to unnecessary and potentially damaging antipsychotic therapy. Consequently, the diagnosis was moved to Section 3 of the *DSM-5*.

Bipolar and Related Disorders

Previously listed under *mood disorders* along with *major depressive disorder*, the *bipolar and related disorders* now emphasize core symptoms of increased energy/activ-
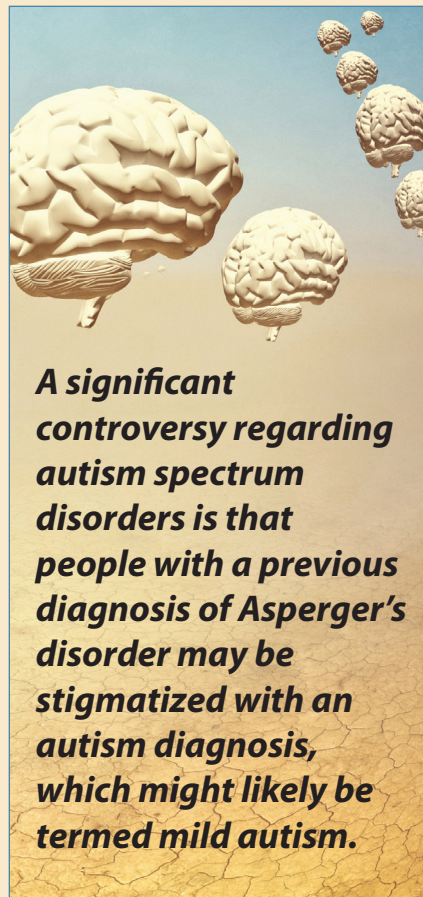

A significant controversy regarding autism spectrum disorders is that people with a previous diagnosis of Asperger's disorder may be stigmatized with an autism diagnosis, which might likely be termed mild autism.

ity for both hypomanic and manic episodes. The diagnosis will be made on the basis of a set of criteria that is consistent across the life span, despite arguments that the criteria are too stringent for children and adolescents (Kaplan, 2012).

Specifiers have been added to bipolar disorder. One is *anxious distress* (Moran, 2013a). The rationale for this addition is that anxiety is a serious complication of bipolar disorder and must be addressed. Also, a mixed state specifier replaces the fully mixed type of bipolar disorder, which was rarely seen. The mixed state specifier will apply to individuals who have major depression along with three manic symptoms, and to individuals who have mania along with three depressive symptoms.

Depressive Disorders

As noted above, depressive disorders were previously listed under the mood disorders. *Disruptive mood dysregulation disorder* is a new diagnosis within this revised category. Disruptive mood dysregulation is characterized by qualities similar to, but more severe than, those of oppositional defiant disorder. The diagnosis applies to 6- to 18-year-olds who have outbursts up to four times per week that are out of proportion to what is happening in the environment. Previously, persistent foul temper punctuated by bursts of rage was considered diagnostic of bipolar disorder (onset before age 10). Disruptive mood dysregulation is a response to criticism that bipolar disorder diagnoses were being made too frequently among children. The new diagnosis is viewed as an alternative to assigning a lifelong diagnosis of bipolar disorder, which often is accompanied by early and powerful drug treatment (Margulies, Weintraub, Basile, Grover, & Carlson, 2012).

Psychiatric care providers and the public alike have criticized the disruptive mood dysregulation disorder for its medicalization of temper tantrums (Frances, 2012). The new diagnoses may result in attributing psychiatric pathology where it is not appropriate.

Another controversial change is the removal of the bereavement exclusion for major depression. This exclusion previously prevented individuals with depressive symptoms from being diagnosed with major depression if their symptoms occurred within 2 months of losing a loved one. Criteria for major depressive disorder in the new manual support its diagnosis after

2 weeks of sadness and loss of interest in life events—along with reduced appetite, sleep, and energy—following the loss of a loved one. The *DSM-5* Task Force cites a lack of evidence to differentiate grief-related depressive episodes from major depression. They argue that treatment delay for severe grief increases the risk of suffering and impairment. Opponents of the change contend that medicalizing grief impairs the normal, dignified process of grief and may discourage the appropriate use of cultural rituals, religion, and the comfort of family and friends (Kleinman, 2012). A view that minimizes normal grief may result in a mental disorder label, stigma, and unnecessary treatment.

Formerly housed in the appendix, *premenstrual dysphoric disorder* (PMDD) is now a bona fide diagnosis. Its symptoms, including mood disturbance, are more severe than those identified in the previous manual and related role dysfunction is more pronounced, especially in the area of personal and family relationships. Controversy about this diagnosis 20 years ago was heated. Opponents suggested women's hormones were being blamed for mental illness and that the social implications were dangerous (Tavris, 1993). For this revision, controversy has been nearly absent. In fact, since the last manual was published, the U.S. Food and Drug Administration has approved drugs for the treatment of premenstrual dysphoria—Prozac® (fluoxetine) was repackaged by Eli Lilly as Sarafem®, and Yaz® (drospirenone and ethinyl estradiol) was introduced for those taking birth control medication.

Anxiety Disorders

There are two changes in the Anxiety Disorders category. The first is that *separation anxiety disorder* now includes adults. Adults may actually be at greater risk than children for the disorder, with a lifetime prevalence estimate of 6.6% compared to 4.1% for children (Shear, Jin, Ruscio, Walters, & Kessler, 2006).

The second change in this category is that *agoraphobia* is now a freestanding disorder and not necessarily a subset of panic disorder.

Changes to generalized anxiety disorder garnered the most interest within this category. The draft form of the *DSM-5* included a reduction of symptom duration from 6 to 3 months, and a reduction of the number of symptoms from three to one. Opponents to this change include Aaron Beck, the father of cognitive-behavioral therapy, who asserts that reducing the symptom threshold for anxiety will result in false positives (Starcevic, Portman, & Beck, 2012). Furthermore, increased diagnoses might encourage overuse of addictive anti-anxiety medications. It is possible that changes to this disorder will be discarded in the final version of the manual.

A disorder that was proposed and quickly rejected was mixed anxiety depression. Early in the development of the *DSM-5*, authors hoped to create a new diagnosis that included both anxiety and depression where neither clearly predominated, similar to the diagnosis included in the *ICD-10* (WHO, 2010a). This combined diagnosis did not test well in clinical field trials and the disorder was abandoned.

Obsessive-Compulsive and Related Disorders

Disorders within the Obsessive-Compulsive and Related Disorders category previously were listed across several other diagnostic groups. *Obsessive-compulsive disorder* was formerly included in anxiety disorders; *body dysmorphic disorder* was a somatoform disorder, and *hair pulling disorder* (*trichotillomania*) was listed under Impulse Control Disorders. All disorders in this category have the core symptom of abnormal and obsessive fixations.

Two new disorders have been added to the *DSM-5* in this category. The first is *excoriation disorder* (skin picking), which results in noticeable physical damage, emotional distress, and attempts to conceal the behavior (Odlaug & Grant, 2010). Second, *hoard-*

ing disorder makes its debut in the new manual. This devastating problem has been showcased on prime-time television and become part of common language. People who amass huge quantities of belongings and have extreme problems in parting with or discarding them may receive this diagnosis. Typically, the individual and the family suffer from chronic emotional, social, physical, financial, and even legal problems as a result of the hoarding (APA, 2012b).

Trauma and Stressor-Related Disorders

This category is new and all disorders share abnormal responses to external trauma and stress (Friedman et al., 2011). Four clusters of symptoms will define *posttraumatic stress disorder* (PTSD)—intrusion, persistent avoidance, arousal/reactivity, and negative mood and cognitions—rather than the three required in the last edition of the manual. Direct exposure or exposure of a close friend or relative to a traumatic event, or repeated exposure to the aversive details of trauma, such as that experienced by disaster workers or first responders, will meet the criteria for a PTSD diagnosis.

Friedman et al. (2011) noted that all 17 of the *DSM-IV* criteria for PTSD are slated for retention in the new version along with three new symptoms—specious (misleading or nearly believable) self- or other-blame in regard to the trauma, negative mood states, and reckless or maladaptive behavior. A subtype of PTSD was added to address the needs of children younger than 6 who have been subjected to traumatic events (Jagodzinski, 2011).

A new diagnosis for children is *disinhibited social engagement disorder*. These children demonstrate no normal fear of strangers, seem unfazed in response to separation from a primary caregiver, and are unusually willing to go off with people who are unknown to them.

Dissociative Disorders

Dissociative Disorders are purposefully listed immediately after Trauma

and Stressor-Related Disorders due to the link with trauma and disorganized attachment (Boysen, 2011). There is some debate over whether the two categories should be combined; the outline of the manual (APA, 2013) maintains them as separate categories.

Research indicates that patients with dissociative disorders do not respond well to standard exposure-based treatments designed for PTSD and that they leave treatment prematurely (Bland, Lanius, Vermetten, Lowenstein, & Spiegel, 2012). Experts in this field are optimistic that the *DSM-5* will stimulate future studies in the area of dissociative disorders.

Somatic Symptom and Related Disorders

This group was formerly known as Somatoform Disorders. The diagnosis of *somatic symptom disorder* subsumes the former diagnoses of *somatization disorder*, *hypochondriasis*, *undifferentiated somatoform disorder*, and *pain disorder*.

In the *DSM-IV-TR* (APA, 2000), somatization disorder required eight or more medically unexplained symptoms from four specified symptom groups. Criteria in the new manual include one of the following distressing reactions for a period of at least 6 months: (a) disproportionate thoughts about the seriousness of their symptom(s); (b) a high level of anxiety about their health; or (c) devoting excessive time and energy to symptoms or health concerns. Chapman (2012) stated that there is no research to support this change, opining that the change opens the gates to widespread diagnosis and treatment of people who would have been previously considered "worrywarts." Furthermore, individuals with established medical illness, such as cancer or heart disease, could be diagnosed with a mental illness.

Feeding and Eating Disorders

The category called Feeding and Eating Disorders was formerly known as Eating Disorders. It includes several problems originally listed in Disorders of Infancy, Childhood, or Adolescence. These include *pica*, *rumination disorder*, and *avoidant/restrictive food intake disorder*.

Symptoms of *anorexia nervosa* traditionally have included amenorrhea and a fear of gaining weight. New criteria include menstruating women along with individuals who are not fixated on weight gain. The twice-weekly binge and purge criterion previously required for a diagnosis of *bulimia nervosa* has been reduced to once per week.

Binge-eating disorder is the newcomer to this category; it has been moved from the appendix to inclusion as an actual disorder. One binge per week for 3 months, feeling out of control, and being distressed by the behavior characterizes this disorder. Affected individuals report that they eat too rapidly, feel too full, and eat when they are not hungry. Eating alone is common due to embarrassment. Opponents of the inclusion of this disorder note that while overeating is not healthy or good behavior, it should not be used to label a common eating behavior.

Elimination Disorders

The elimination disorders have not changed and include *enuresis* and *encopresis*.

Sleep-Wake Disorders

This category, formerly known as Sleep Disorders, has had a nearly complete overhaul in the *DSM-5*. The Sleep Disorders Work Group recommends that the term *primary* be dropped, with the currently named *primary insomnia disorder* listed simply as *insomnia disorder* (Reynolds, 2011). Dimensional measures will gauge severity and identify other contributing factors. Biological measures mentioned above (e.g., measuring hypocretin for narcolepsy) are also recommended.

Sexual Dysfunctions

Sexual Dysfunctions were formerly classified along with Sexual and Gender Identity Disorders. One disorder that was proposed but not accepted was hypersexual disorder. This disorder was to be characterized by intense, recurrent, and distressing sexual urges, fantasies, and behaviors lasting at least 6 months (Kafka, 2009). Hypersexual disorder is associated with personal distress and adverse consequences (sexually transmitted diseases, pregnancy, disturbed relationships, financial problems, and role impairment). Supporters of the diagnosis believed that its inclusion in the *DSM-5* could lead to effective treatment. Alternatively, detractors believed that there was not enough evidence to define this as a distinct disorder; studies have only included people seeking help for conditions other than those related to sexual dysfunction. Further research is necessary to define this problem and its criteria (Rettner, 2012).

Gender Dysphoria

This category was formerly listed under the category of Sexual and Gender Identity Disorders. For years, advocates lobbied the APA to redefine or remove *gender identity disorder* as a psychiatric diagnosis. Their work has been rewarded. To receive the new diagnosis and qualify for insurance coverage, one must experience a sense of mismatch between biological gender and personal gender identification and must experience related distress (dysphoria).

Disruptive, Impulse Control, and Conduct Disorders

This category now houses disorders that previously were included across diagnostic categories. *Oppositional defiant disorder* and *conduct disorder* were formerly classified alongside attention-deficit/hyperactivity disorder as disruptive behavior disorders. *Intermittent explosive disorder* was classified as an impulse control disorder NEC, and

dyssocial personality disorder was classified exclusively under personality disorders where it remains as a cross-listed diagnosis in the *DSM-5*.

Changes in the organization of these disorders have resulted in few comments in the literature. Anecdotally, there has been some discussion about a distinction between willful destruction or hurting another person and impulsive acts of violence, as the two motivations require different treatment approaches.

Substance Related and Addictive Disorders

This revised diagnostic category eliminates the hard-to-distinguish terms of *abuse* and *dependence*. With the rationale that addictions exist on a continuum, severity of diagnoses in this category will be rated as mild, moderate, or severe, based on standardized rating scales. In general, there are a reduced number of symptoms required for diagnosis of disorders listed in this category. Arguments in favor of the relaxed criteria suggest that early interventions could hinder the addiction problem, reduce or halt physical problems, and save money by reducing long-term disability. However, opponents of changes to this category express concern that its use may lead to inappropriate labeling and stigmatization among people with temporary problems (e.g., many college students who binge drink).

Gambling disorder broadens the definitions of addiction by including a behavioral, or process, addiction. Internet addiction was also considered, but there was not enough research support and it was moved to Section 3 for further study (APA, 2012b).

Neurocognitive Disorders

Disorders in this category were formerly listed under *delirium*, *dementia*, and *amnestic and other cognitive disorders*. Although the problems that are addressed in this revised category remain the same, using the term *neu-*

rocognitive was chosen to neutralize dementia-related stigma.

The Neurocognitive Disorders will be divided into major and mild types. Major neurocognitive disorders are characterized by substantial cognitive decline that results in curtailed independence and functioning among affected individuals. Mild neurocognitive disorders identify people whose symptoms place them somewhere in a gray zone between normal cognition and those with noticeably significant cognitive deterioration. Identifying early-presenting symptoms among those individuals may aid in earlier interventions at a stage when some disease-modifying therapies may be most neuroprotective (Sperling et al., 2011). Opponents of this revised diagnosis are concerned that the everyday characteristic of forgetting in old age will be pathologized and result in an alarming rate of false positives suggesting serious impairments of cognition (Frances, 2012). Additionally, why create anxiety when only limited, non-curative, non-reversing treatments exist for dementia?

Personality Disorders

In the *DSM-IV-TR* (APA, 2000), Personality Disorders were listed as problems on Axis II, suggesting that they were unique from Axis I, physically based psychiatric diagnoses. Removal of the Axis system eliminates the suggestion of a causal dichotomy between personality disorders and all other psychiatric diagnoses (Skodol, 2012).

A tremendous overhaul was planned for the personality disorders. Four disorders—*narcissistic*, *histrionic*, *dependent*, and *schizoid*—were slated for removal. The diagnostic process was planned to be a thorough, time-consuming process and to include a "Levels of Functioning Personality Scale." This scale included paragraph-length narrative descriptions for which clinicians would establish a description/patient match, as well as a 7-page severity scale that carefully rated negative affectivity, detachment, antagonism, disinhibition, and psychoticism among affected individuals. A last-minute decision was made to maintain all 10 *DSM-IV-TR* diagnoses and structure, minus the Axes. The more complicated trait-specific methodology is proposed for inclusion in Section 3 for further study (APA, 2012b).

Paraphilic Disorders

Paraphilias are disorders involving the patient's need for unusual sexual stimulation, such as sadism or masochism, to achieve sexual arousal or orgasm. This group of disorders was listed in the Sexual and Gender Identity

section of earlier versions of the *DSM*. In the *DSM-5*, each diagnosis within the Paraphilias category will include the word *disorder*. For example, exhibitionism will be labeled *exhibitionistic disorder*. The work group assigned to this category sought to distinguish the mild and socially harmless paraphilias from the severe paraphilias, which are distressing to those afflicted and/or are potentially dangerous to others (Dreger, 2010). Risk-assessing specifiers have been developed to indicate level of threat to others posed by individuals diagnosed with a paraphilic disorder, designating whether the individual is in a controlled environment, and if the individual is in remission. *Remission* is defined as having no distress, functional impairment, or recurring behavior for 5 years in an uncontrolled environment.

Other Disorders

Two disorders were proposed for this section. The first was *non-suicidal self-injury disorder*, a diagnosis intended to differentiate patients who engaged in intentional self-inflicted damage to the surface of the body from those mutilating with serious suicidal intent. Unsuccessful field trials resulted in the removal of this problem as an official disorder (Regier et al., 2012).

The other disorder, *suicidal behavior disorder*, was to be characterized by self-injurious behaviors that would result in death. This diagnosis would be given immediately following an attempt and would remain in place for 2 years, the time of greatest risk for reattempting suicide. Proponents believed that naming this disorder was a way to track risk, as a history of suicide attempts is the most predictive indicator of future suicidal behavior (Runeson, Tidemalm, Dahlin, Lichtenstein, & Långström, 2010). Opponents believed that the diagnosis was stigmatizing and unnecessary because being suicidal is almost always accompanied by other symptoms or clinical diagnoses, particularly major depression. Both of these proposed disorders were moved to Section 3 of the *DSM-5* for further study (APA, 2012b).

THE *DSM-5* AND ITS RELEVANCE TO PSYCHIATRIC NURSING

The *DSM-5* is a medical publication, yet the implications for advanced practice psychiatric and general psychiatric nurses alike are substantial. The accurate diagnosis of individuals with mental illness is essential to practicing nurses and is the foundation for treatment planning, management of psychotropic medications, and psychotherapeutic interventions. Nurse researchers will be involved in testing psychiatric diagnoses and developing relevant epidemiological and intervention studies. Nursing textbooks will be revised based on the new nomenclature. Nurse educators will incorporate the revised content into their classrooms.

CONCLUSION

A Google search with keywords "*DSM-5* + controversy" results in more than 600,000 citations that attest to the complicated nature of such an ambitious task. Opponents of the *DSM-5* changes assert that proposed revisions resulted in greater controversy than earlier editions. This may be true; however, it is likely that expanded public awareness and media interest were a product of electronic communication and exponentially increased instantaneous discussion and debate about the *DSM*. Hopefully, this same process will result in increased scrutiny and transparency in its continued development.

Predictions of epidemic numbers of people diagnosed with and stigmatized by psychiatric conditions will be tested in the years to come. Research of the categories and the disorders will be moved from clinical trials to evaluation in real-time clinical practice and applied by psychiatric nurses and other professionals in various settings. Future articles in the *Journal of Psychoso-cial Nursing and Mental Health Services* will likely address the implications and applications of changes in the *DSM-5* in greater detail and provide updates on how the new diagnostic criteria impact the clinical, research, and educational work of psychiatric-mental health nurses.

REFERENCES

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2010). DSM-5: *Options being considered for ADHD*. Retrieved from http://www.dsm5.org/Proposed%20Revision%20Attachments/APA%20Options%20for%20ADHD.pdf

American Psychiatric Association. (2012a). *American Psychiatric Association Board of Trustees approves* DSM-5 [Press release]. Retrieved from http://www.psychiatric-times.com/all/editorial/psychiatrictimes/pdfs/2012-apa-dsm5-final.pdf

American Psychiatric Association. (2012b). DSM-5 *development: Frequently asked questions*. Retrieved from http://www.dsm5.org/about/pages/faq.aspx

American Psychiatric Association. (2013). *DSM-5*. Retrieved from http://www.psychiatry.org/dsm5

Bäärnhielm, S., & Scarpinati-Rosso, M. (2009). The cultural formulation: A model to combine nosology and patients' life context in psychiatric diagnostic practice. *Transcultural Psychiatry, 46*, 406-428. doi:10.1177/1363461509342946

Bland, B.L., Lanius, R., Vermetten, E., Lowenstein, R.J., & Spiegel, D. (2012). Where are we going? An update on assessment, treatment, and neurobiological research in dissociative disorders as we move toward the *DSM-5*. *Journal of Trauma and Dissociation, 13*, 9-31. doi:10.1080/15299732.2011.620687

Boysen, G.A. (2011). The scientific status of childhood dissociative identity disorder: A review of published research. *Psychotherapy and Psychosomatics, 80*, 329-334. doi:10.1159/000323403

Burgess, T. (2012). *Steven Spielberg helps to bring dyslexia and legal rights into the news*. Retrieved from http://www.examiner.com/article/steven-spielberg-helps-to-bring-dyslexia-and-legal-rights-into-the-news

Cannon, T.D., Cadenhead, K., Cornblatt, B., Woods, S.W., Addington J., Walker, E.,…Heinssen, R. (2008). Prediction of psychosis in youth at high clinical risk: A multisite longitudinal study in North America. *Archives of General Psychiatry, 65*, 28-37. doi:10.1001/archgenpsychiatry.2007.3

Carpenter, W.T., & van Os, J. (2011). Should attenuated psychosis syndrome be a *DSM-5* diagnosis? *American Journal of Psychiatry, 168*, 460-463. doi:10.1176/appi.ajp.2011.10121816

Chapman, S. (2012). *Somatic symptom disorder could capture millions more under mental health diagnosis.* Retrieved from http://dxrevisionwatch.com/2012/05/26/somatic-symptom-disorder-could-capture-millions-more-under-mental-health-diagnosis/

Craddock, M., O'Donovan, M.C., & Owen, M.J. (2005). The genetics of schizophrenia and bipolar disorder: Dissecting psychosis. *Journal of Medical Genetics, 42*, 193-204.

Dreger, A. (2010, February 19). *Of kinks, crimes, and kinds: The paraphilias proposal for the DSM-5.* Hastings Center Bioethics Forum. Retrieved from http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=4494

Frances, A. (2012, December 3). DSM *is guide not bible: Simply ignore its ten worst changes.* Retrieved from http://www.psychologytoday.com/blog/dsm5-in-distress/201212/dsm-5-is-guide-not-bible-ignore-its-ten-worst-changes

Friedman, M.J., Resick, P.A., Bryant, R.A., Strain, J., Horowitz, M., & Spiegel, D. (2011). Classification of trauma and stressor-related disorders in the DSM-5. *Depression and Anxiety, 28*, 737-749. doi:10.1002/da.20845

Gever, J. (2012, May 10). DSM-5: *What's in, what's out.* Retrieved from http://www.medpagetoday.com/MeetingCoverage/APA/32619

Jagodzinski, M. (2011). *The study of the prevalence of Desnos symptoms in traumatized children* (Senior Honors Theses, paper 262, Eastern Michigan University). Retrieved from http://commons.emich.edu/honors/262

Kafka, M.P. (2009). Hypersexual disorder: A proposed diagnosis for *DSM-V. Archives of Sexual Behavior, 39*, 377-400. doi:10.1007/s10508-009-9574-7

Kaplan, S.L. (2012). *Your child does not have bipolar disorder.* Retrieved from http://www.psychologytoday.com/blog/your-child-does-not-have-bipolar-disorder/201212/small-unicornsupdate-dsm-5-bipolar-disorder--0

Kleinman, A. (2012). Culture, bereavement, and psychiatry. *Lancet, 379*, 608-609.

Kuhl, E.A., Kupfer, D.J., & Regier, D.A. (2011). Patient-centered revisions to the *DSM-5. Virtual Mentor, 13*, 873-879. doi:10.1001/virtualmentor.2011.13.12.stas1-1112

Margulies, D.M., Weintraub, S., Basile, J., Grover, P.J., & Carlson, G.A. (2012). Will disruptive mood dysregulation disorder reduce false diagnosis of bipolar disorder in children? *Bipolar Disorder, 14*, 488-496. doi:10.1111/j.1399-5618.2012.01029

Moran, M. (2013a). *DSM-5* fine-tunes diagnostic criteria for psychosis, bipolar disorders. *Psychiatric News, 48*(3), 10-11.

Moran, M. (2013b). *DSM-5* provides new take on neurodevelopment disorders. *Psychiatric News, 48*(2), 6-23. doi:10.1176/appi.pn.2013.1b11

Narrow, W.E., & Kuhl, E.A. (2011). Dimensional approaches to psychiatric diagnosis in *DSM-5. Journal of Mental Health Policy Economics, 14*, 197-200.

National Institutes of Health. (n.d.). *PROMIS: Dynamic tools to measure health outcomes from the patient perspective.* Retrieved from http://www.nihpromis.org/measures/measureshome

Odlaug, B.L., & Grant, J.E. (2010). Pathologic skin picking. *The American Journal of Drug and Alcohol Abuse, 36*, 296-303. doi:10.3109/00952991003747543

Regier, D.A., Narrow, W.E., Clarke, D.E., Kraemer, H.C., Kuramoto, S.J., Kuhl, E.A., & Kupfer, D.J. (2013). *DSM-5* field trials in the United States and Canada, Part II: Test-retest reliability of selected categorical diagnoses. *American Journal of Psychiatry.* Advance online publication. doi:10.1176/appi.ajp.2012.12070999

Rettner, R. (2012, December 7). Sex addiction not an official disorder, *DSM* says. *Huffington Post.* Retrieved from http://www.huffingtonpost.com/2012/12/07/sex-addiction-dsm-official-disorder_n_2258027.html

Reynolds, C.F. (2011). Troubled sleep, troubled minds, and *DSM-5. Archives of General Psychiatry, 68*, 990-991. doi:10.1001/archgenpsychiatry.2011.104

Runeson, B., Tidemalm, D., Dahlin, M., Lichtenstein, P., & Långström, N. (2010). Method of attempted suicide as predictor of subsequent successful suicide: National long term cohort study. *BMJ, 341*, c3222. Retrieved from http://www.bmj.com/content/341/bmj.c3222

Sederer, L.I. (2011). The *DSM-5*: The changes ahead (part 2). *Huffington Post.* Retrieved from http://www.huffingtonpost.com/lloyd-i-sederer-md/dsm-5_b_961966.html

Shear, K., Jin, R., Ruscio, A.M., Walters, E.E., & Kessler, R.C. (2006). Prevalence and correlates of estimated *DSM-IV* child and adult separation anxiety disorder in the National Comorbidity Survey Replication. *American Journal of Psychiatry, 163*, 1074-1083.

Skodol, A.E. (2012). Personality disorders in *DSM-5. Annual Review of Clinical Psychology, 8*, 317-344. doi:10.1146/annurev-clinpsy-032511-143131

Sperling, R.A., Aisen, P.S., Beckett, L.A., Bennett, D.A., Craft, S., Fagan, A.M.,…Phelps, C.H. (2011). Toward defining the preclinical stages of Alzheimer's disease: Recommendations from the National Institute on Aging–Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimer's Dementia, 7*, 280-292. doi:10.1016/j.jalz.2011.03.003

Starcevic, V., Portman, M.E., & Beck, A.T. (2012). Generalized anxiety disorder: Between neglect and an epidemic. *Journal of Nervous and Mental Disease, 200*, 664-667. doi:10.1097/NMD.0b013e318263f947

Tavris, C. (1993, November). Do you menstruate? If so, psychiatrists think you may be nuts. *Glamour*, p. 172.

Willingham, E. (2012). New *DSM* criteria for autism: Who will be left behind? *Forbes.* Retrieved from http://www.forbes.com/sites/emilywillingham/2012/10/11/new-dsm-5-criteria-for-autism-who-will-be-left-behind/

World Health Organization. (2010a). ICD-10: *Version 2010.* Retrieved from http://apps.who.int/classifications/icd10/browse/2010/en#/F40-F48

World Health Organization. (2010b). *Measuring health and disability: WHODAS 2.0.* Retrieved from http://whqlibdoc.who.int/publications/2010/9789241547598_eng.pdf

Dr. Halter is Associate Dean, Ashland University, Mansfield, Ohio; Dr. Rolin-Kenny is Assistant Professor, University of Texas at Austin, School of Nursing, Austin, Texas; and Dr. Dzurec is Dean and Professor, Kent State University, Kent, Ohio.