The American Psychiatric Association (APA) finalized the content of the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM-5) at its December 2012 board of trustee’s meeting [1, 2] and decided to release the monograph to the public in May 2013. DSM-IV [3] was published in 1994. Nineteen years have been elapsed when DSM-5 is to be published. It is a big event in psychiatry in the world for its publication.

The APA used to post the proposed drafts of DSM-5 on the APA website for soliciting feedback from the membership. Now, APA’s commercial interest dictates to protect the news-worthiness of the complete final criteria and the texts. I think that the timing to write a brief summarized changes of its context on the eve of its publication is appropriate. The information in this editorial is all obtained from published scattered features in newsletters or articles. Contents of the final words should be referred to the contents of DSM-5.

Changes from DSM-IV in the Organization of the Manual

DSM-5 will have three sections [2]. Section 1 contains introductory information on using this manual. Section 2 lists the categorical diagnoses. Section 3 includes conditions that require further research before their acceptance as formal disorder as well as cultural concepts of distress, etc [2]. All five DSM-IV axes are eliminated in DSM-5 [2]. Section 2 lists childhood diseases first and later-life diseases at the end, being arranged in the order of lifespan developmental sequence [3].

Changes from DSM-IV in Contents of Mental Disorders

Intellectual developmental disorders

Intellectual Developmental Disorders (Intellectual Disability) in DSM-5 is a disease category replacing for DSM-IV mental retardation [4, 5]. The diagnoses would be based on measures of adaptive functioning, rather than solely sticking to the IQ scores [4, 5].

Specific learning disorders

DSM-5 no longer uses three separate learning disorders, but replace with a disease category Specific Learning Disorder (SLD) with seven “descriptive feature specifiers” in patients with learning disorder in specific area [4].

Motor disorders

Motor Disorder in DSM-5 are used for the DSM-IV motor skills disorders. DSM-5 criteria for Tourette Syndrome and Chronic Motor (or Vocal Tic Disorder) state that tics may “wax and wane in frequency but have persisted for more than one
year” [5] instead of that tics occur many times a day nearly every day in DSM-IV [3].

**Communication disorders**

Communication Disorders in DSM-5 are restructured to include Social Communication Disorder plus two diagnostic categories—Language Disorders and Speech Disorders. Each of the latter two categories each contains appropriate subtypes to cover Late Language Emergence, Specific Language Impairment, Voice Disorder, Speech-sound Disorder, Motor Speech Disorder, and Child Onset Fluency Disorder [5]. Social Communication Disorder is designed to diagnose children with severe deficits in social communication and interaction, but lack the restrictive and repetitive behavior patterns necessary for Autistic Spectrum Disorder [4].

**Autistic spectrum disorder**

In DSM-5, a new chapter Autistic Spectrum Disorder (ASD) contains four DSM-IV disease categories—autistic disorder, childhood disintegrative disorder, Asperger’s disorder, and pervasive developmental disorders not otherwise specified (NOS) [4]. ASD has two new criterion sets, “deficits in social communication and social interaction” and “restrictive and repetitive behavioral patterns” besides an expanded number of specifiers [5]. The above-listed two principal symptoms need to assess the levels of supportive service [5].

**Attention-deficit and hyperactivity disorder**

Attention-deficit and hyperactivity disorder (ADHD) in DSM-5 replaces 3 subtypes with 4 presentation specifiers—combined, predominantly inattentive, inattentive presentation (restrictive), and predominantly hyperactive/impulsive [5]. The age of onset is increased from 7 to 12 years of age, and the threshold for diagnosing an adult is adjusted to five symptoms in either domain [5].

**Schizophrenia and psychosis-related disorders**

In DSM-5, the diagnosis of Schizophrenia requires a least 1 of 3 core positive symptoms—delusions, hallucination, or disorganized thinking [6]. The weight of bizarre delusions is removed; a specifier is added to indicate bizarre or nonbizarre delusion [6]. DSM-5 eliminates all DSM-IV subtypes of Schizophrenia, but creates a specifier only for catatonia [6]. A dimensional ratings are needed to rate symptom severity scale of 0 to 5 [6]. Delusional Disorder no longer requires that the delusion must be nonbizarre [6].

Attenuated Psychosis Syndrome (APS) with dimensional ratings of severity is printed in Section 3 of the manual to indicate the need for further research [6].

**Bipolar disorders**

Besides mood, activity and energy are added in mania symptom criteria in DSM-5 [6]. Catatonia specifier is added, whereas mixed type in Bipolar Disorder I is eliminated with additions of “mixed state” and “catatonia” as specifiers [6].

**Depressive disorders**

In DSM-5, new additions are Disruptive Mood Dysregulation Disorder (DMDD) and Premenstrual Dysphoric Disorder (PMDD) [7, 8], which is to be removed from the appendix in DSM-IV [3] and described in Section 2 of DSM-5. Catatonia specifier is added for patients with depressive disorders [6]. “Mixed state” specifier is also included for patients who have both kinds of symptoms of mania and depressive disorder [7]. Severity rating such as suicidal risk is used [7].
“Grief exclusion” for Major Depressive Disorder (MDD) is eliminated, but a note is added to distinguish normal grief from a depressive disorder [7]. Dysthymia in *DSM-IV* is changed to Persistent Depressive Disorder in *DSM-5* [7].

**Anxiety disorders**

*DSM-5* keeps 3 of 6 *DSM-VI* anxiety disorders (Panic Disorder, Phobic Disorder, Generalized Anxiety Disorder) in new Anxiety Disorders, which further include Separation Anxiety Disorder and Selective Mutism [7]. Those two disease categories were classified as disorders of infancy, childhood, or adolescence in *DSM-IV* [3]. In addition, Agoraphobia and Panic Disorder are two separate diagnoses in *DSM-5* [7].

**Obsessive-compulsive and related disorders**

In *DSM-5*, a new chapter for Obsessive-compulsive and Related Disorders (OCRD) is designated to include extra four new disorders—Hoarding Disorder, Excoriation (Skin Picking) Disorder, Substance/Medication-induced OCRD, and OCRD due to a medical condition [7]. Body Dysmorphic Disorder and Trichotillomania are kept under OSRD [7].

**Trauma and stress-related disorders**

Posttraumatic Stress Disorder (PTSD) in *DSM-5* is no longer considered as only a disease category of anxiety disorders as listed in *DSM-IV* [3, 9]. In *DSM-5*, Trauma and Stress-related Disorder (TSRD) includes PTSD, Acute Stress Disorder (ASD), Adjustment Disorder, and Reactive Attachment Disorder [10].

Subjective response criterion “intense fear, helplessness or horror at the time of adverse event” in PTSD (Criterion A2 in *DSM-IV* [3]) is eliminated in *DSM-5* [9, 10]. Instead of having 3 symptom clusters in *DSM-IV*, 4 PTSD symptom clusters (re-experiencing, avoidance, persistent negative alternations in mood and cognition, and arousal) are required in *DSM-5* [10]. The diagnosis of PTSD is also applicable for children aged 6 years or younger [10]. ASD in *DSM-5* only needs 9 of 14 listed symptoms in these categories of intrusion, negative mood, dissociation, avoidance, and arousal [10]. The presence of *DSM-IV* dissociative symptoms [3] is no longer necessary in the diagnosis of ASD [10]. Two subtypes of *DSM-IV* childhood reactive attachment disorder [3] are modified to become two *DSM-5* disease entities—Reactive Attachment Disorder and Disinhibited Social Engagement Disorder [10].

**Feeding and Eating Disorders**

Binge Eating Disorder has been proposed to be added in *DSM-5* Feeding and Eating Disorders besides Pica and Ruminative Eating Disorder [11]. Frequency of bulimic episode is proposed to change from twice a week for three months in *DSM-IV* [3] to “once a month for three months” in *DSM-5* [11]. Amenorrhea is eliminated from symptom criteria for Anorexia Nervosa [11].

**Sleep-wake Disorders**

Sleep-wake Disorders in *DSM-5* are proposed to mainly consist of Insomnia and Hypersomnia (Major Hypersomnia Disorder) in addition to Narcolepsy/Hypocretin Deficiency, Obstructive Sleep Apnea/Hypopnea, Central Sleep Apnea, Sleep-related Hypoventilation, Circadian Rhythm Sleep-wake Disorder, Disorder of Arousal, Nightmare Disorder, Rapid Eye Movement Sleep Behavior Disorder, Restless Legs Syndrome, and Substance-induced Sleep Disorder (www.dsm5.org). Only first two disease categories (Insomnia and Hypersomnia) have “NOS” as nonqualifying separate disease entities (www.dsm5.org). The concepts of *DSM-IV* primary and secondary causes
Possible Changes in DSM-5

for sleep disorders have been proposed to be eliminated in DSM-5 (www.dsm5.org).

**Major Neurocognitive Disorder**

The diagnostic criteria of Major Neurocognitive Disorder in DSM-5 is similar to those for DSM-IV [3] dementia (www.dsm5.org).

**Minor Neurocognitive Disorder**

A criterion “memory impairment” for Minor Neurocognitive Disorder in DSM-5 is the same as in that of DSM-IV dementia [3]. But it does not need B criterion “cognitive impairment,” but requires supporting evidences in brain imaging, or biological or genetic markers (www.dsm5.org).

**Comment**

The descriptions in this editorial are not complete in highlighting all the changes from DSM-IV to DSM-5. For example, Personality Disorders, Somatic Symptom and Related Disordered, and what’s not are not included in this editorial due to space limitation. What’s more, I am not sure that all the information is correct in this writing.

In most horse racings, there are always abundant flyers of predicting for the final outcome of the races. As people always say, the best reliable information is from the “horse’s month.” The most accurate information of changes from DSM-IV is checking the monograph of DSM-5, which is scheduled to be published May 18-25, 2013 at the annual APA meeting in San Francisco. Pre-ordering for a copy of DSM-5 is now available at APA’s American Psychiatric Press, Inc. (www.appi.org).

Now I am inviting Taiwanese Journal of Psychiatry’s readers to turn in your valuable opinions in the format of letter-to-the editor on clinical implication in patient’s care from those changes in DSM-5. I am looking forward to receiving your comments.

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**References**


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