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THEORETICAL STUDY

From DSM-IV-TR to DSM-5: Analysis of some changes



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Abstract The publication of the fifth edition of the DSM has intensified a debate begun some time ago with the announcement of the changes in diagnostic criteria proposed by the APA. This article analyzes some of these modifications. Some interesting points where it is right, such as the inclusion of dimensionality in both diagnostic classes and in some disorders, the inclusion of an obsessive-compulsive spectrum, and the disappearance of subtypes of schizophrenia. It also analyzes other more controversial points, such as the consideration of the attenuated psychosis syndrome, the description of a persistent depressive disorder, reorganization of the classic somatoform disorders as somatic symptom disorders, or maintenance of three large clusters of personality disorders, always unsatisfactory, along with an announced, but marginal, suggestion of the dimensional perspective of personality impairments. The new DSM-5 classification opens many questions about the diagnostic validity which it attempts to improve, this time taking an approach nearer to neurology and genetics than to clinical psychology.

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PALABRAS CLAVE

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Del DSM-IV-TR al DSM-5: análisis de algunos cambios

Resumen La publicación de la quinta edición del DSM ha avivado un debate iniciado tiempo atrás, desde el anuncio de los cambios en los criterios de diagnóstico propuestos por la APA. En este artículo se analizan algunas de estas modificaciones. Se plantean aspectos interesantes y acertados, como la inclusión de la dimensionalidad tanto en las clases diagnósticas como en algunos trastornos, la incorporación de un espectro obsesivo-compulsivo o la desaparición de los subtipos de esquizofrenia. También se analizan otros aspectos más controvertidos como la consideración del síndrome de psicosis atenuada, la descripción de un trastorno depresivo persistente, la reordenación en trastornos de síntomas somáticos los clásicos trastornos somatoformes, o el mantenimiento de los tres grandes grupos de trastornos de la personalidad,

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siempre insatisfactorios, junto con un planteamiento anunciado, pero marginal, de la perspectiva dimensional de las alteraciones de la personalidad. La nueva clasificación del DSM-5 abre numerosos interrogantes acerca de la validez que se pretende mejorar en el diagnóstico, en esta ocasión, asumiendo un planteamiento más cercano a la neurología y la genética que a la psicopatología clínica.

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To judge by the success of its sales (Blashfield, Keeley, Flanagan, & Miles, 2014), the publication of a new edition of the DSM has immediately become an event. This study is intended to analyze some aspects that the fifth edition of the DSM (American Psychiatric Association APA, 2013b) contributes. It is materially impossible to consider all its sections, at the same time that it requires an educational effort for its explanation: disappearance of hypochondria or of concepts such as somatization, substance dependence, appearance of spectra, new disorders, etc. Therefore, a selection has been made of what might be the most outstanding from a clinical, psychopathological viewpoint.

The Manual's presentation states its intention of improving the validity of previous editions and of being based on research. However, the sources to which it alludes are from neuroscience and genetics. Although the text considers psychological (and social) factors, it is not this type of research that structures the DSM-5. In fact, future contributions from the *Research Domain Criteria* (RDoC), the principles of which are directed at understanding mental disorders as cerebral disorders, dysfunctions of brain circuitry evaluable by the instruments of cognitive neuroscience, and of developing the biological basis for symptoms, are proposed for inclusion (Insel, 2013; Insel et al., 2010).

Needless to say, the DSM is not a psychopathology text, although, as it is a Manual that has to guide diagnosis (still clinical), treatment and research, it is quite relevant to underline the obvious: that the biologicist perspective (Adam, 2013) conditions the subject of study. As a matter of fact, we could start talking about a NeuroDSM, given the proliferation of the prefix: Neurodevelopmental disorders, Neurocognitive disorders, or Functional neurological symptom disorder. This seems to minimize or discard any contribution of psychological research from the start.

In view of the evidence accumulated (Blashfield et al., 2014), in addition to decreasing the unspecified categories, among the DSM-5 goals were development of clusters and dimensions of disorders. Dimensionality appears in some disorder spectra, in some disorders (scales for diagnostic criteria of intellectual disability, autism spectrum and schizophrenia), partially in others (domains are defined in neurocognitive disorders, but the structure is categorical), and in determining severity (not in all diagnoses). It is curious in this sense that in spite of following contributions from neuroscience and genetics, and although the data match much wider sets of disorders depending on their susceptibility and pathogenesis (Craddock & Owen, 2010; Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013), in reality the resulting clusters are much

more limited (e.g., schizophrenia spectrum, but separated from bipolar disorders and autism spectrum). And even within the schizophrenia spectrum, there would be no reason (by genetic criteria) for distinguishing schizophreniform disorder from schizophrenia, and by the way, harmonizing the DSM-5 with the ICD-10.

It is not a matter of forcing a choice between categorical and dimensional. As Wakefield and First (2013) point out, numerous dimensional variables end up generating a point of inflection (points of rarity) based on which categories are established. Perhaps the most difficult thing to accept is that mental disorders (or that all of them) are natural classes by definition. But it is deficient in that decisions are made in favor of some dimensions and not others which are also backed by research (e.g., related to personality), or that do not develop one of the crucial dimensions, the one establishing the level of distress (Sandín, 2013).

One of the questions that remain under discussion about the diagnostic classifications and their lack of validity has to do with the definition of mental disorder itself. Although we are not going to concentrate our analysis on this point, it is advisable to remember that to a large extent, diagnostic decisions do not depend so much on specific symptoms (None pathognomonic) (Malhi, 2013), and do on clinically significant distress and impairment in areas of functioning. So the doubt arises of whether what makes a person suffer is a mental disorder (this is where the issue related to bereavement arises), or whether it is a matter of processes and variations not coinciding with social demands and personal opportunities (e.g., Circadian rhythm sleep-wake disorders) (Wakefield, 2013). In this sense, the need of finding the precise point at which distress and significant clinical deterioration become unmanageable or disabling (Bolton, 2013) has been noted. Therefore, the new edition of the DSM has lost a perfect occasion for an indispensable dimension.

A first analysis of this work shows that the number of general diagnostic classes of mental disorders has increased to 21, when in the DSM-IV there were 16 (excluding the chapter on Other conditions that may be a focus of clinical attention). This increase in diagnostic classes seems right in some cases of disorders that have little to do with each other (e.g., paraphilic disorder and sexual dysfunctions) or in cases like the Obsessive-compulsive disorder and related disorders, taken out of the Anxiety disorders.

Apart from this, an apparently minor question like the number of diagnoses in each DSM edition mismatch in different analyses (Blashfield et al., 2014; Mayes & Horwitz, 2005; Sandin, 2013; Spitzer, 2001), as it depends on what categories are included: with description and criteria, forms

with another specification or unspecified, with diagnostic codes, with specification of severity, etc. In any case, to the contrary of what is often published, the number of diagnoses (with criteria) is slightly lower.

The new DSM diagnostic classification proposes a scheme of diagnostic classes placed by affinity of their characteristics, and with evolutionary criteria, from manifestations that seem to originate in neurodevelopment to neurocognitive disorders. In each class, the diagnostics follow a chronological criterion: whether they appear in childhood and adolescence or in adulthood. Some of the major DSM-5 diagnostic classes are analyzed below.

Neurodevelopmental disorders

It should be emphasized that of the neurodevelopmental disorders, the mental retardation concept must be replaced by Intellectual disability (intellectual development disorder). Apart from eluding the derogatory sense of the first term, the concept is much more in agreement with WHO classifications (such as the *International Classification of Functioning, Disability and Health*) (APA, 2013c). Included in Communication disorders are Language disorder, Speech sound disorder, Childhood-onset fluency disorder (stuttering), and Social (pragmatic) communication disorder (and being able to distinguish it as such from the autism spectrum).

The Autism spectrum disorder is a recluster of DSM-IV-TR manifestations headed by the concept of Pervasive developmental disorders: Autistic disorder (autism), Rett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified. Two major domains are indicated for diagnosis (formerly divided into three): Social communication and social interaction, and restricted, repetitive patterns of behavior, interests, or activities. The genetic risk study has not enabled categories to be discriminated (King, Navot, Bernier, & Webb, 2014), and it has been suggested that the new classification gains in specificity but not in sensitivity (Volkmar & McPartland, 2014).

With respect to Attention-Deficit/Hyperactivity Disorder (ADHD), it has been questioned whether the DSM-5 maintains the same systematic indicators without improving precision of the disability (reduces the number of symptoms necessary in adults), which it is suspected will increase false positives (Frances, 2010). In fact, in Criteria B and C, the presence of impairment or distress is unnecessary and only Criterion D alludes to them generically, so overdiagnosis is possible (Epstein & Loren, 2013). Furthermore, the neuroimaging study does not make it clear whether what is observed is rather extremes of normality (Shah & Morton, 2013).

While there are no relevant changes in the category that clusters Specific learning disorders (reading, written expression and mathematics disorders), several disorders that were scattered in the DSM-IV-TR, such as motor disorders, have been reclustered: Developmental coordination disorder, stereotypic movement disorder, and the various categories referring to tic disorders (mainly Tourette's disorder, persistent (chronic) motor or vocal tic disorder, temporary tic disorder).

Schizophrenia spectrum and other psychotic disorders

This chapter concentrates a series of relevant changes. On one hand, research has shown a more uniform view of this diagnostic class, qualifying it in this sense as a spectrum (Garety & Freeman, 2013), including Schizotypal personality disorder.

In schizophrenia, as already claimed, diagnostic subtypes (catatonic, disorganized, paranoid, undifferentiated and residual types) had to be eliminated due to limited diagnostic stability, low reliability, and poor validity (APA, 2013c). The relevance given in diagnostic criteria to Schneiderian first-rank symptoms and the consideration of bizarre delusions, traditionally linked to schizophrenia, has disappeared, thereby gaining in specificity (Keshavan, 2013). There are no changes in the consideration of the minimum of indicators for Criterion A (at least two symptoms), but it is emphasized that at least one has to be a positive symptom: hallucinations, delusions, and/or disorganized speech.

On the other hand, dimensions are included in the diagnosis (Barch et al., 2013). In the previous version of the DSM, a proposal was made concentrating on the three dimensional clusters of symptoms: psychotic (hallucinations/delusions), disorganized, and negative (deficit) dimensions. The idea then was to improve precision in identifying schizophrenia subtypes. The current proposal concentrates on symptom dimensions for reporters (or the patient himself), and about symptom severity (Likert-type scale from 0-4) (APA, 2013a) (other scales may be found in the official APA website). A separate mention should be made of the scale directed at the patient or informant, since of the two questions about psychotic symptoms, the one that has to do with delusions alludes to manifestations typical of Schneider's first rank symptoms. If, as mentioned, these symptoms are unspecific, and no instrument is dedicated exclusively to schizophrenia but to psychosis in general, there are doubts that it would be a useful tool.

In schizoaffective disorder, mood is made preponderant over disorder duration (including prodromes and residual phase), complying with Criterion A for schizophrenia. Although it is pointed out that it would gain in reliability, it diminishes the frequency of its diagnosis (Malaspina et al., 2013). What would have to be asked is whether the diagnosis of schizophrenia will then increase.

Concerning delusional disorder, one outstanding point stems from the possibility of including bizarre content in delusions (a specification). This question is on target considering the set of symptoms that accompanies such thought content, especially if there is no deterioration in functioning, nor any disorganized or bizarre behavior. But it is contradictory if the reasons given for exclusion of bizarreness in the case of delusions are considered in schizophrenia. It would be sufficient to mention this possibility for both diagnoses, or else, indicate it in the detailed description of this manifestation and not as a specification.

It is also foreseeable that the diagnosis of delusional disorder could decrease, since in both Obsessive-compulsive disorder and Corporal dysmorphic disorder, psychotic severity can be identified without requiring a double diagnosis (as in the DSM-IV-TR).

One of the most noteworthy inclusions in the DSM-5 Manual is the separation of catatonia from the specifications of other disorders. It is clarified that this is not an independent diagnostic class (p. 119), but it is given a privileged position, as it is identified as a specifier with the codes and section of a separate disorder. We do not know whether this relocation responds to its presence being as high as stated (10%) (Sienaert, Dhossche, & Gazdag, 2013), the definitive delimitation of its etiology (and stimulus for development of new drugs), or because better diagnostic precision is required (Tandon et al., 2013).

Shared psychotic disorder loses its classic name of *Folie à deux* and is relocated as the latest form of the residual category of Other specified schizophrenia spectrum and psychotic disorders, with the label "Delusional Symptoms in the partner of an individual with a delusional disorder". Apart from the term applied to this disorder not being very operative (think of the clinician making his report), and although it must be acknowledged that it is not a frequent diagnosis, it remains limited to cases in which the origin comes from persons with a delusional disorder.

Attenuated psychosis syndrome has been the subject of enormous controversy. It is cursorily placed within the wide category of Other specified schizophrenia spectrum and psychotic disorders. The arguments that support this concentrate on its diagnosis being situated in the context of asking for help. Most of these persons show identifiable symptomatology of anxiety, depression or substance abuse. The fact that help is requested for these symptoms justifies their being treated symptomatically and thereby avoids these persons confronting the more traumatic diagnosis of schizophrenia (Tsuang et al., 2013).

The heart of the issue with respect to this new diagnostic category is that it means increasing the number of diagnoses made without absolute certainty of what the consequences may be (e.g., stigma), but above all, because there is no certainty that antipsychotics will prevent the development of psychosis, although there is that atypical neuroleptics favor weight gain (Frances, 2010).

Emphasis has been placed on the significant probability of transition to psychosis (from 9 to 33%, depending on criteria and time lapse) based on the identification of "high-risk mental states" (high-risk or ultra-high-risk criteria): attenuated psychotic symptoms; brief limited intermittent psychotic symptoms, and trait-state risk factors (Schultze-Lutter, Schimmelmann, Ruhrmann, & Michel, 2013). It has also been highlighted that in some initiatives the presence of suicide has been reduced, although there is no proven concrete treatment (Carpenter & van Os, 2011).

From all of the above, it is understood that a general risk syndrome should rather be discussed (McGorry, 2010), one of the possibilities of which is psychosis (in particular, schizophrenia) but not the only one (Fusar-Poli, Carpenter, Woods, & McGlashan, 2014; Fusar-Poli, Yung, McGorry, & van Os, 2014; Van Os, 2013). So it is a premature category, and we think it is correctly included in proposals for further research.

Bipolar and related disorders

This is proposed as a bipolar spectrum. Even though there are shared specifiers and episodes in bipolar and depressive

disorders, in addition to much research data showing the proximity of the two diagnostic groups, they appear separately in the DSM-5. In the DSM-IV-TR, they were both under the wide Mood Disorders diagnostic class.

From the viewpoint of the description of hypomanic episodes with respect to Cyclothymic disorder, it is suggested that numerous periods of hypomanic symptoms do not meet the criteria of a hypomanic episode (or depressive). This was not expressly stated in the DSM-IV-TR and resolves a contradiction present in bipolar disorders not otherwise specified (p. 401). Among the specifiers given, the most novel are anxious distress, mixed features, mood-congruent and incongruent psychotic features.

In the DSM-IV-TR, there was a mixed episode, applicable exclusively to bipolar disorders. The importance of the mixed symptoms specifier has to be seen in its historical context (not exclusively bipolar). Classic mixed depression is observed in manifestations of early onset, with heavier family history loading, and clearer diagnosis of Bipolar Disorder II than Major Depressive Disorder (Benazzi, 2007). The Kraepelian idea is that recurrent depression is in reality in the bipolar sphere, although the DSM-III set this proposal aside when it included polarity (Ghaemi, 2013). Therefore, the mixed symptom specifier is a common area between two classes, which from this perspective, should be together. If this is coherent with this starting point, the error in the DSM-5 is in considering that the symptoms of this specifier are euphoria, impulsive behavior and grandeur, when they should really be irritability or reactivity (Koukopoulos, Sani, & Ghaemi, 2013).

One question that has been brought up is that an onset specifier, such as in the Persistent depressive disorder, is lacking. This is especially relevant, since about a third of the severest cases (more suicides, psychotic symptoms) begin before 18 years of age with wide comorbidity (Colom & Vieta, 2009).

Depressive disorders

One of the outstanding changes in this class of disorders is the incorporation of the specifier "with anxious distress", which is a clear acknowledgment of the anxio-depressive emotional combination (and perhaps makes up for the definitive withdrawal of the mixed anxiety depressive disorder, which in the DSM-IV-TR was under unspecified anxiety disorders).

Disruptive mood dysregulation disorder is described to limit overdiagnosis and treatment of bipolar disorder in children. Severe, non-episodic irritability is the organizing core compared to typically bipolar euphoria and grandiosity (and also brevity and recurrence; Axelson et al., 2011; Towbin, Axelson, Leibenluft, & Birmaher, 2013). This chronic irritability often overlaps with ADHD, and up to 85% with Oppositional defiant disorder (in which temper outbursts are described, but the opposite is much less coincident (Axelson et al., 2011). It is also suggested that this disorder may really be an acute version of Oppositional defiant disorder (Dougherty et al., 2014) (in Disruptive, impulse-control, and conduct disorders).

In the classic category of Major depressive disorder (MDD), the differentiation between the single and recurrent

episode disappears. It is based on the premise that both manifestations were etiologically different, with different vulnerabilities, although all the recurrent forms are not necessarily chronic. Priority is given to course, so chronic forms of MDD (over two years of continuous symptomatology) and Dysthymic disorder (DD) are integrated in the new Persistent depressive disorder (Dysthymia) (PDD). Regardless of its already having been known that most of those who met the diagnostic criteria for DD were also diagnosed with double depression (MDD plus DD), this reorganization brings up several problems. On one hand, MDD then becomes a provisional diagnosis (depending on whether the symptomatology becomes chronic or not), and in fact, Criterion D does not exclude PDD. It is in the specification where it indicates whether to treat dysthymia (pure dysthymic syndrome), a persistent major depressive episode, or two intermittent types depending on whether the major depressive episode is present at the time of assessment.

On the other hand, DD showed favorable course in the DSM-IV-TR in up to 50% of cases (even if it was double depression), so very heterogeneous conditions have been assembled under the sign of the PDD which impedes its study (Rhebergen & Graham, 2014). To summarize, the former concept of dysthymia has little time left (which is why it appears in parentheses), and the point on which this new disorder turns is the chronicity of the depressive manifestation, which is why all the specifiers available, most of which are inapplicable to pure dysthymic syndrome, are added. So do we then definitely reject study of depressive personality, the origin of DD?

Premenstrual dysphoric disorder already widens the first line of mental disorders (in the DSM-IV-TR, it was among the unspecified forms and research criteria). Arguments have been made against its inclusion, in the sense that it will point to and harm women and that it is a manifestation fabricated by pharmaceutical companies (Hartlage, Breau, & Yonkers, 2014). What is true is that research has not been sufficiently conclusive, that overvaluing of many indicators is favored (Gómez-Márquez, García-García, Benítez-Hernández, Bernal-Escobar, & Rodríguez-Testal, 2007), and that criteria that the symptoms appear in at least two cycles, but not consecutive, will increase diagnosis unnecessarily.

One of the most debated questions refers to bereavement and possible risk of overdiagnosis in what has been called medicalization of bereavement (Frances, 2010). The DSM-IV-TR was clear in excluding bereavement from major depressive episode (Criterion E). There was a possibility that a diagnosis of MDD was indicated if the symptoms were lasting (persisting for longer than two months) and especially, with aggravation of symptoms (e.g., suicidal ideation or marked psychomotor retardation) (APA, 2000; p. 741). More so, on page 373, it was suggested that MDD could take place starting with a severe psychosocial stressor, such as the death of a loved one or divorce, which made bereavement equivalent to other stressors. Therefore, bereavement is not a disorder and is diagnosed when the symptomatology is severe and characteristic of MDD.

But the heart of the problem is that in major depressive episode the DSM-5 does not specify the exclusion of bereavement, which gives us to understand that the figures for MDD identification will increase (Maj, 2013), when in reality, the

symptomatology comes from a normal reaction of bereavement (and even though bereavement is expressly excluded in the definition of a mental disorder, p. 20).

In the DSM-5 section on conditions for further study, criteria are given for a Persistent complex bereavement disorder. The essence of this proposal stems from suffering for the death of someone with whom he or she had a close relationship, with presence of clinically significant symptomatology on more days than not, and which persists for at least 12 months in adults (and at least six months in children). There would therefore be some continuity from the DSM-IV-TR (in the sense of dealing with a diagnosable condition), lengthening the time span (APA, 2013c). Some data suggest that around 10% of bereavements would fit in the description of a disorder (violent deaths, or traumatic, such as the death of a child) (Bryant, 2013). The problem comes from the DSM-5 criteria themselves: Reactive distress to the death, persistent yearning/longing for the deceased, social/identity disruption, which break with the idea of the previous edition of the DSM and pose terms of doubtful diagnostic validity since they refer rather to a process of bereavement that can be lengthy, but not pathological.

Anxiety disorders

Childhood characteristics such as selective mutism or separation anxiety disorder are studied in the diagnostic class related to Anxiety disorders. In this one, it is clearly specified by its possible presence in adults, although in reality the DSM-IV-TR did not exclude its diagnosis (p. 123). Perhaps the limitation of the previous edition is that it forced the onset to be before 18 years of age. Research shows that in some adults, onset is later (Bögels, Knappe, & Clark, 2013). In view of this, transitions between the various Anxiety disorders to which it can lead, as well as its relationship with Dependent personality disorder, question the validity of this category.

In the case of Specific phobia, and given the changes that include Illness anxiety disorder in another of the diagnostic classes, it is very deficient in that there are no explanations about it, e.g., in differential diagnosis for classic nosophobia.

The classic concept of Social phobia will disappear in future classifications due to the term used in the literature, Social anxiety disorder, with the specification of whether it refers exclusively to performance anxiety (talking or addressing a group).

Panic disorder and agoraphobia remain in this classification as independent disorders. Although it is true that by doing this it is desired to acknowledge that the origin of agoraphobia is not always panic, it is no less true that now there will be two frequent comorbid diagnoses.

In general terms, the role of panic attacks as a specifier, in reality an authentic subsyndrome present in all psychopathology, would have to be emphasized. It is now limited to two forms: expected and unexpected (APA, 2013c) (instead of unexpected, situationally bound (cued), and situationally predisposed in the DSM-IV-TR).

Generally, indicating over six months of symptomatology to avoid overdiagnosis in Anxiety disorders may be an adequate measure. Precisely because of it, the role of Limited symptom attacks (fewer than four indicators out of a total

of 13) must be shown in the forms of anxiety with another specification, and that seems to stabilize it as another risk syndrome.

Obsessive-compulsive and related disorders

Consideration of manifestations about the concept of obsession-compulsion may be acknowledged as true. It is bound to a tradition that began in the nineteen-nineties (Hollander, 1998; Hollander, Kim, Braun, Simeon, & Zohar, 2009; Hollander & Rosen, 2000), and was suggested as a spectrum that spans from the most compulsive to impulsive. It includes, e.g., impulse-control disorders, addictions, eating disorders, and hypochondria (Abramowitz, McKay, & Taylor, 2007; Phillips et al., 2010). This diagnostic class, half-way between anxiety and depressive disorders, is now made up of: Obsessive-compulsive disorder (OCD), Body dysmorphic disorder (BDD), Hoarding disorder (HD), Trichotillomania (which announces the following term proposal: hair-pulling disorder), Excoriation disorder (skin-picking), and so forth (e.g., Obsessional jealousy).

The specification insight (good or fair insight, poor insight, and absent insight/delusional beliefs) is introduced for OCD, BDD and HD. In BDD in particular, it was observed that there were few differences among cases with or without delusions, and identical response to drugs, so it was preferable to specify insight than give an additional diagnosis in the psychotic spectrum (Phillips, Hart, Simpson, & Stein, 2014). The specification With muscle dysmorphia is also added for this disorder, and those who show objective defects in appearance are placed in Other specified obsessive-compulsive and related disorders.

On the other hand, manifestations such as HD have been given backing (Mataix-Cols et al., 2010), and nevertheless, it clearly overlaps with Obsessive-compulsive personality disorder. The text points out that both diagnoses are possible, although HD is suggested for more severe cases. Therefore, and like manifestations qualified as body-focused Repetitive behavior disorder (nail-biting, lip-biting, or cheek chewing), these manifestations may not have sufficient entity and require more research to determine whether they should be considered isolated disorders.

Trauma and stressor-related disorders

For quite a long time it has been suggested that the classic posttraumatic stress and adaptive anxiety disorders be separated because of their different pathological mechanisms. This class of disorders includes Disinhibited social engagement disorder, Posttraumatic stress disorder (better differentiation of key symptoms of three to four indicators, especially for emotional response), Acute stress disorder (not only dissociative symptoms are emphasized), and Adjustment disorders. Forms with another specification are placed in persistent complex bereavement disorder.

Dissociative disorders

In this group we emphasize the inclusion of dissociative fugue as a specifier of Dissociative amnesia, and inclusion of the concept of possession among the criteria for Dissociative

identity disorder. Possession was already contemplated in the DSM-IV-TR under the unspecified forms among versions of the Dissociative trance disorder (Spiegel et al., 2013), but here it is given an appropriate place in the definition of dissociated identity.

Somatic symptom and related disorders

Profound transformations have been made in this chapter. It could be said that the organizing principle has been changed from somatization to the main reference of somatic symptoms, whether medically explained or not. The idea is that if it is medically unexplained, the patient's experience is delegitimized (Dimsdale & Levenson, 2013), but the consequences of considering anyone with at least one physical illness as a mental disorder may not be the best idea (Frances & Nardo, 2013).

Reclustering the Somatization disorder, Undifferentiated somatoform disorder, and Pain disorder categories makes sense because of the complexity of the criteria necessary for the first diagnosis, and lassitude with respect to the second, affecting validity of the diagnostic classification. However, this cluster is described very ambiguously under the name Somatic symptom disorder (SSD): At least one somatic symptom that is distressing or results in significant disruption of daily life, with excessive thoughts, feelings, or behaviors related to the somatic symptoms, and causing disproportionate thoughts, high level of anxiety, or excessive time devoted to these symptoms (p. 311). It is an imprecise definition from including any somatic symptom to referring vaguely to worry and anxiety.

Research has suggested that the total number of symptoms is more relevant than whether they are unexplained or not, which is related to disability and overuse of health-care services (Sharpe, 2013), even after having adjusted the emotional variables and with extensive samples (Tomenson et al., 2013). The importance of a larger number of indicators among the psychological symptoms supports the posture of the DSM-5 (Voigt et al., 2012; Wollburg, Voigt, Braukhaus, Herzog, & Löwe, 2013). However, this also means that a poly presentation is more relevant than a monosymptomatic one (it is unlikely that many symptoms respond to a reference illness) (Rief & Martin, 2014), and certain more detailed processes could improve the diagnostic pattern: selective attention to bodily signals, dysfunctional cognitions as catastrophizing interpretations of bodily signals, persistent attribution, excessive health-care use, avoidance and decreased activity, or functional impairment (Löwe et al., 2008). No examples are given in the criteria, so it is easy to predict that diagnoses in this category will increase.

Another question that attracts attention is the express mention made in the differential diagnosis of SSD in which it is stated that the presence of somatic symptoms is not sufficient to make this diagnosis, because it excludes irritable bowel syndrome or fibromyalgia (p. 314), and contradictorily, are later dealt with in Other conditions that may be a focus of clinical attention, such as manifestations with a defined etiology. Some authors, even in characterizing SSD, have suggested the presence of these disorders, as well as chronic fatigue syndrome or the forms of multiple chemical sensitivity (Rief & Martin, 2014).

Although the difference between SSD and Illness anxiety disorder (IAD) concentrates on the presence or not of illnesses (Starcevic, 2013), there is some overlapping among symptoms of both entities, because of imprecision in crucial measurable behavioral and cognitive symptoms (e.g., rumination) (Rief & Martin, 2014).

Another novelty of the DSM-5 is that many of the persons diagnosed with classic hypochondria will now be identified as SSD (APA, 2013b). The concept of hypochondria has been withdrawn because in addition to being derogatory, it could condition the therapeutic relationship. In the concept of hypochondria there are two contents: the belief in an unspecified disease (overvalued idea, even delusional), and fear of developing the disease (Noyes, Carney, & Langbehn, 2004). Research on IAD requires that what is considered normal functioning be well defined, since presence of hypochondria from 2-13% is recorded (Weck, Richtberg, & Neng, 2014) (5.72% life prevalence), far above 1%, and although it is true that classic hypochondria was infrequent and difficult to diagnose (Sunderland, Newby, & Andrews, 2013), is it not like diagnosing overweight instead of obesity? In a medicalized society with strong concern for health, are we not going to find an increase in persons who meet the diagnosis for IAD?

Medical emphasis is obvious in the Conversion disorder (Functional neurological symptom disorder), justified by a lower percentage of cases in which a neurological etiology has been found. The question of whether to locate conversion among the dissociative manifestations (such as dissociative sensorimotor disorder (Spiegel et al., 2013) or in relation to somatic symptoms, where paralysis fits well, but seizures worse, goes way back.

Psychological factors affecting other medical conditions is a controversial class. They were considered separately from Axis I disorders as a complement to them in the DSM-IV-TR. Many subjects studied by health psychology are thus understood as a mental disorder, e.g., the relationship between chronic stress and hypertension or anxiety and asthma. Functional syndromes such as migraine, irritable bowel syndrome, fibromyalgia, or idiopathic medical symptoms, such as pain, fatigue and dizziness are also located here (already indicated in SSD, p. 311).

Finally, we believe it is appropriate to include Factitious disorder in this diagnostic class because it also uses the body and illness as a vehicle for communicating distress.

Feeding and eating disorders

This section includes Pica, Rumination disorder, and Avoidant/restrictive food intake disorder. The last needs to be studied further to clarify its relationship with anorexia (may precede it) and conversion, given its link to concepts of functional dysphagia and globushystericus (p. 319), or its relationship to anxiety (avoidance, frequent traumatic origin, comorbidity). In fact, the same possibility of diagnosis is given in the description of phobias without explanation in the differential. Furthermore, many of these expressions may be limited and not require intervention (Attia et al., 2013), so their usefulness is not seen, but risk of overdiagnosis is.

Adjustments have been made in Anorexia nervosa (e.g., the requirement of amenorrhea has been withdrawn), and frequency of binges in Bulimia nervosa and Binge-eating disorder (they are equivalent: at least one binge per week for three months or more) (Call, Walsh, & Attia, 2013). Some studies concentrating on eating disorders with the new criteria back the modifications made (Stice, Marti, & Rohde, 2013), even a slight increase in binge eating (0.2% in men and women) (Hudson, Coit, Lalonde, & Pope, 2012). It has been proposed, however, that overvaluing shape and weight be included in this disorder, which would diminish its prevalence (Grilo, 2013) and make the group more coherent. It certainly seems strange that a description of a person who binge eats, does not compensate for it, and feels ill, and is neither anorexia nor bulimia.

Substance-related and addictive disorders

In this diagnostic class, the concept of dependence has been withdrawn, because it is derogatory, and abuse because it is not very reliable (it was sufficient for one indicator to be met) (Regier, Kuhl, & Kupfer, 2013). Research shows that although the Substance use disorder has no natural threshold, it agrees with the version in the DSM-IV-TR (Hasin et al., 2013; Peer et al., 2013). Inclusion of the concept of craving makes it possible to relate it to DSM and ICD classifications, and the set of changes made will differentiate compulsive behavior in seeking a substance better (Obiols, 2012).

Diagnosis of Gambling disorder is transferred from the chapter on impulse-control disorders to the present diagnosis class (same brain reward system). Reference is made to a Gambling disorder (and not pathological gambling as redundant and stigmatizing), and Criterion 8 in the DSM-IV-TR (illegal acts such as forgery, fraud, theft, etc.) disappears. Diagnosis goes from at least five to ten indicators to at least four to nine. It is suggested that although this modification may increase prevalence (or else the DSM-IV-TR underestimated it), the agreement between the DSM-IV-TR and the DSM-5 is over 99% (Petry, Blanco, Jin, & Grant, in press).

Neurocognitive disorders

The incorporation of Minor neurocognitive disorders (mNCD) has awakened controversy. It should be recalled, however, that it was already suggested in DSM-IV-TR, both in Appendix B (Criteria and axes provided for further study), and in the section on cognitive disorders not otherwise specified (mild neurocognitive disorder). Inclusion in the DSM-5 and its presentation along with Major neurocognitive disorder MNCD (due to Alzheimer's disease, frontotemporal, with Lewy bodies, etc.) is another example of continuation.

The problem is similar to the attenuated psychosis syndrome described above, since it is oriented by data on transition rates, in this case toward dementia (from 6-10% per year in epidemiological studies, higher in clinical samples) (Petersen et al., 2009), and therefore, mNCD is taken as a prodrome of dementias (mainly Alzheimer's disease) (Gauthier et al., 2006). Other data show that heterogeneity is the norm and that transition indicators with participants from the community are much lower (3%) (Decarli, 2003; Gauthier et al., 2006). Therefore, this incorporation in the

DSM-5 favors excessive medicalization (Frances, 2010) and confusion between aging, cognitive deterioration associated with aging, and the development of a neurodegenerative process. Research must find a way to make a precise distinction between decline and deterioration. But the most questionable, from a psychopathological viewpoint is that a mNCD is identified without any functional impairment, without any interference in the activities of daily life (Criterion B). In addition to its arguable validity for a diagnostic classification of mental disorders, what personal, social and even legal implications does this have?

We do consider appropriate the domains proposed for the study of NCD (Complex attention, executive function, learning and memory, expressive and receptive language, perceptual-motor, social cognition), adoption of a characteristic neuropsychological language (possible or probable illness), and integration of the classic amnesic disorder in NCD.

Personality disorders

The chapter on personality disorders (PD) is mentioned as an example of incorporation of dimensionality in the DSM-5. However, this novelty has become a step taken without conviction, a sort of yes but no. On one hand, the previous categorical classification was not backed by research (neither disorders nor their clusters) (Livesley, 2011; Pull, 2014; Tyrer, Crawford, & Mulder, 2011), and nevertheless, their basic criteria remain unchanged. On the other hand, the dimensional contribution appears in Section III of the Manual (among the emerging measures and models), so it is complementary and probably not secondary in the clinic.

This proposal fits the Big Five factor model (Krueger & Markon, 2014), and the Manual includes a complete version, another summarized for adults, and one for informants (APA, 2013d, 2013e, 2013f). It consists of five domains: negative affectivity/emotional stability, detachment/extraversion, antagonism/agreeableness, disinhibition/conscientiousness, psychoticism/lucidity, and 25 personality trait facets. However, some components analyzed do not show acceptable reliability (see in Krueger, Derringer, Markon, Watson, & Skodol, 2012), and Widiger (2011) criticizes the DSM-5 for developing an own dimensional system when others had already been established and consolidated. The truth is that this discourages its use.

It has often been suggested that this perspective is too complicated for daily use by the clinician (First, 2011; Tyrer et al., 2011), and however, doctors often analyze the results of a hemogram, for example, considering different dimensions and combinations. The psychometric tradition in psychology and the model of the broad factors is sufficiently solid to be able to understand and apply a model similar to the one described.

Another of the criticisms refers to the Manual offering characterization of some specific PDs (antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal disorders), but not others (they did not have sufficient backing). On the other hand, it is hardly mentioned that in the case of Antisocial personality disorder, there is a specification of psychopathic symptoms (in addition to its

definition), which could contribute to making the differences debated for so long about the antisocial personality concept more precise.

Final comments

The latest edition of the DSM was started before publication of the TR revision of the DSM-IV. It has been a very publicized, elaborate and long-awaited text (first as DSM-V and finally as DSM-5). Since then, criticisms have been varied, some coincide with past editions (e.g., tendency to reification of disorders or presence of marketing by the pharmacology industry) (Obiols, 2012; Reed, Anaya, & Evans, 2012); others have addressed poorly written text and lack of clarity in some criteria, plus the signs that will favor an increase in diagnoses with its application: the requirements for meeting some diagnoses are lowered, new disorders are incorporated, variants of normal behavior are included, among other arguments (Frances, 2010; George & Regier, 2013).

Doubtless, what exactly a risk syndrome is and how it should be approached will have to be well explained, since it could derive in the same treatment being applied for a disorder as its risk factor, and that says little in favor of intervention precision. At the same time, it would require an education to discriminate and balance prevention and stigma, a labor that compromises the science, and social agents. In this sense, mention has been made before of the attenuated psychosis syndrome (which in the end is proposed for later study) and the mNCD. But there are other examples: Suicidal behavior disorder and Nonsuicidal self-injury are proposed for further study. The first case attracts attention in that it is considered difficult to observe outside of the context of other disorders (bipolar disorders, depressive, etc.) (p. 803). In the second case, it seems that the greatest emphasis is on differentiating it from the first (Butler & Malone, 2013), although nothing indicates specific treatments in this sense, or that it makes sense to separate it from disorders such as borderline personality or posttraumatic stress. In fact, much of the content of the DSM-5 does not resolve doubts about whether the descriptions contained in the DSM-5 are valid, or whether or not the Manual's reliability has improved, so it is difficult to take this classification as a guideline for treatment (Timimi, 2014).

One of the decisions that we think has to do not only with its validity, but with the clinical usefulness of a diagnostic system, is the elimination of the multiaxial system in the DSM-5. Regardless of comorbidity between Axes I and II, in the daily clinic, the information from different contents is necessary. Although it is true that a disability scale is included (the *WHO Disability Assessment Schedule*, located in Appendix III), there is no express reference to its application in diagnosis. It has been suggested that there are numerous specifiers present throughout the classification that make up for this content (Harris, 2014), but neither does it guarantee it nor is it the same. It is also true that, as in earlier editions, the content includes other conditions that may be a focus of clinical attention (e.g., relational problems), of strong relevance along with everything else that makes up Axis IV and which should serve the clinician to contextualize a problem, and research

on delimiting participating variables, but there is no clear pattern combining the information.

It could be said, as a closing point, that this version of the DSM does not make anybody happy. For some, because it is obvious that the approach goes in the direction of biological reductionism (which does not fit in with what affects human beings), while for others the DSM-5 stops short, as it would require a larger number of biological markers, physiological risk factors and genetic results to determine mental illnesses (Kupfer & Regier, 2011).

Although we have not reviewed all the diagnostic classes, in some, there are details of interest (such as in Sexual dysfunctions) and even among the proposals for further study (such as the Internet gaming disorder), we propose some points that should be taken into account for the upcoming electronic version of the DSM (ver. 5.1, now being spoken of):

The validity of the diagnoses and their clusters needs more in-depth study (perhaps decreasing and integrating categories) and they need to be separated them from the variants of behavior. Just as terms are changed because they are derogatory, alternatives for action that minimize the stigma associated with diagnoses must also be studied and generated (Kapur, Cooper, O'Connor, & Hawton, 2013). It is imperative to study and dimension distress, and relate it to the characteristics of the context to offer a more integral view of human suffering. If one of the goals of the DSM-5 was alignment with the ICD-11 (Blashfield et al., 2014), it could be added that they should suggest integrative dimensional forms (Harkness, Reynolds, & Lilienfeld, 2014) from other spheres of knowledge.

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