

THE CONCEPTUAL EVOLUTION OF DSM-5



EDITED BY
Darrel A. Regier, M.D., M.P.H.
William E. Narrow, M.D., M.P.H.
Emily A. Kuhl, Ph.D.
David J. Kupfer, M.D.

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Washington, DC
London, England

Note: The authors have worked to ensure that all information in this book is accurate at the time of publication and consistent with general psychiatric and medical standards, and that information concerning drug dosages, schedules, and routes of administration is accurate at the time of publication and consistent with standards set by the U.S. Food and Drug Administration and the general medical community. As medical research and practice continue to advance, however, therapeutic standards may change. Moreover, specific situations may require a specific therapeutic response not included in this book. For these reasons and because human and mechanical errors sometimes occur, we recommend that readers follow the advice of physicians directly involved in their care or the care of a member of their family.

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<i>David J. Kupfer, M.D.</i>	

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	<i>Sing Lee, M.B., B.S., F.R.C.Psych.</i>	
	<i>Michael Schoenbaum, Ph.D.</i>	
	<i>T. Bedirhan Üstün, M.D.</i>	
	<i>Ronald C. Kessler, Ph.D.</i>	
	<i>Ronny Bruffaerts, Ph.D.</i>	
	<i>Guilherme Borges, M.Sc., Dr.Sc.</i>	
	<i>Giovanni de Girolamo, M.D.</i>	
	<i>Oye Gureje, M.D., Ph.D., D.Sc.</i>	
	<i>Josep Maria Haro, M.D., M.P.H., Ph.D.</i>	
	<i>Stanislav Kostyuchenko, M.D.</i>	
	<i>Viviane Kovess Masféty, M.Sc., M.D., Ph.D.</i>	
	<i>Daphna Levinson, Ph.D.</i>	
	<i>Herbert Matschinger, Ph.D.</i>	
	<i>Zeina Mneimneh, M.P.H., M.Sc.</i>	
	<i>Mark Oakley Browne, Ph.D.</i>	
	<i>Johan Ormel, Ph.D.</i>	
	<i>José Posada-Villa, M.D.</i>	
	<i>Soraya Seedat, M.B.Ch.B., F.C.Psych., Ph.D.</i>	
	<i>Hisateru Tachimori, Ph.D.</i>	
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Rachel G. Klein, Ph.D.
Judith L. Rapoport, M.D.
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Charles H. Zeanah, M.D.

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Contributors

Jamie M. Abelson, M.S.W.

Institute for Social Research, University of Michigan, Ann Arbor, Michigan

Sergio Aguilar-Gaxiola, M.D., Ph.D.

Professor of Internal Medicine and Director, Center for Reducing Health Disparities, University of California, Davis School of Medicine, Sacramento, California

Jordi Alonso, M.D., Ph.D.

Senior Investigator and Head, Health Services Research Group, IMIM-Institut de Recerca, Hospital del Mar, Parc de Salut Mar

Gavin Andrews, M.D.

Professor of Psychiatry, Clinical Research Unit for Anxiety and Depression, University of New South Wales at St. Vincent's Hospital, Sydney, NSW, Australia

Katja Beesdo, Ph.D.

Assistant Professor, Institute of Clinical Psychology and Psychotherapy, Technische Universitaet Dresden, Dresden, Germany

Patricia A. Berglund, M.B.A.

Institute for Social Research, University of Michigan, Ann Arbor, Michigan

Guilherme Borges, M.Sc., Dr.Sc.

Professor, Department of Epidemiological Research, Division of Epidemiological and Psychosocial Research, National Institute of Psychiatry (Mexico) & Metropolitan Autonomous University

Mark Oakley Browne, Ph.D.

Professor, Discipline of Psychiatry, School of Medicine, University of Tasmania

Ronny Bruffaerts, Ph.D.

Associate Professor, Department of Neurosciences, Katholieke Universiteit Leuven

Giovanni B. Cassano, M.D.

Professor and Chair, Department of Psychiatry, Neurobiology, Pharmacology, and Biotechnology, University of Pisa, Pisa, Italy

Lee Anna Clark, Ph.D.

Professor, Department of Psychology, University of Notre Dame, Notre Dame, Indiana

Diana E. Clarke, Ph.D.

Research Statistician, American Psychiatric Association; Adjunct Assistant Professor, Johns Hopkins School of Public Health, Baltimore, Maryland

E. Jane Costello, Ph.D.

Professor, Department of Psychiatry and Behavioral Sciences, Center for Developmental Epidemiology, Duke University Medical School, Durham, North Carolina

Michelle G. Craske, Ph.D.

Professor, UCLA Anxiety Disorders Research Center, Department of Psychology, UCLA, Los Angeles, California

Ron Dahl, M.D.

Professor of Psychiatry and Pediatrics, University of Pittsburgh School of Medicine, Western Psychiatric Institute & Clinic, Pittsburgh, Pennsylvania

Giovanni de Girolamo, M.D.

Scientific Director, IRCCS—St. John of God, Clinical Research Centre

Madeleine Delves

Clinical Research Unit for Anxiety and Depression, University of New South Wales at St. Vincent's Hospital, Sydney, NSW, Australia

Michael Dewey, Ph.D.

Professor, Health Service and Population Research Department, Institute of Psychiatry, London, United Kingdom

Nicholas R. Eaton, M.A.

Graduate Student, Department of Psychology, University of Minnesota, Minneapolis, Minnesota

Warachal Eileen Faison, M.D.

Medical Director, Primary Care Neuroscience, Pfizer Inc., New York, New York

Ellen Frank, Ph.D.

Professor, Departments of Psychiatry and Psychology, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania

Richard Gater, M.D.

Mental Health and Neurodegeneration Research Group, University of Manchester, Manchester, England

Andrew T. Gloster, Ph.D.

Assistant Professor, Institute of Clinical Psychology and Psychotherapy, Technische Universitaet Dresden, Dresden, Germany

Nick Glozier, Ph.D.

Associate Professor, Disciplines of Psychiatry and Sleep Medicine, Sydney Medical School, The University of Sydney, Brain and Mind Research Institute, Camperdown, NSW, Australia

David Goldberg, D.M., F.R.C.P.

Professor Emeritus, Institute of Psychiatry, London, England

Oye Gureje, M.D., Ph.D., D.Sc.

Professor and Head of Department, Department of Psychiatry, University of Ibadan, University College Hospital

Josep Maria Haro, M.D., M.P.H., Ph.D.

Director of Research, Parc Sanitari Sant Joan de Déu

John E. Helzer, M.D.

Professor Emeritus, Department of Psychiatry, University of Vermont College of Medicine, Burlington, Vermont

Michael Höfler, Ph.D.

Researcher, Institute of Clinical Psychology and Psychotherapy, Technische Universitaet Dresden, Dresden, Germany

Steven E. Hyman, M.D.

Provost, Harvard University, Cambridge, Massachusetts

James S. Jackson, Ph.D.

Director and Research Professor, Institute for Social Research, and Daniel Katz Distinguished University Professor of Psychology, University of Michigan, Ann Arbor, Michigan

Regina James, M.D.

Director, Division of Special Populations, National Institute of Child Health & Human Development, Bethesda, Maryland

Ronald C. Kessler, Ph.D.

Professor, Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts

Rachel G. Klein, Ph.D.

Fascitelli Family Professor of Child and Adolescent Psychiatry, New York University Child Study Center, New York, New York

Stanislav Kostyuchenko, M.D.

Assistant, Department of Psychiatry, National Medical Academy of Postgraduate Education

Robert F. Krueger, Ph.D.

Hathaway Distinguished Professor, Department of Psychology, University of Minnesota, Minneapolis, Minnesota

Emily A. Kuhl, Ph.D.

Science Writer, Division of Research, American Psychiatric Association, Arlington, Virginia

David J. Kupfer, M.D.

Thomas Detre Professor, Department of Psychiatry, University of Pittsburgh and Western Psychiatric Institute & Clinic, Pittsburgh, Pennsylvania; Chair, DSM-5 Task Force

James F. Leckman, M.D.

Neison Harris Professor of Child Psychiatry and Pediatrics, Yale University School of Medicine, Yale Child Study Center, New Haven, Connecticut

Sing Lee, M.B., B.S., F.R.C.Psych.

Professor, Department of Psychiatry, The Chinese University of Hong Kong

Ellen Leibenluft, M.D.

Chief, Section on Bipolar Spectrum Disorders, Emotion and Development Branch, Mood and Anxiety Program, National Institute of Mental Health, Bethesda, Maryland

Daphna Levinson, Ph.D.

Director, Research and Planning, Ministry of Health, Mental Health Services

Viviane Kovess Masféty, M.Sc., M.D., Ph.D.

Professor and Directrice, Département of Epidémiologie; Directrice, Fondation MGEN; Head, L'Université Paris Descartes Research Unit, Ecole des Hautes Études en Santé Publique, Paris, France

Herbert Matschinger, Ph.D.

Senior Researcher, Department of Psychiatry and Psychotherapy, University of Leipzig

Briana Mezuk, Ph.D.

Department of Epidemiology and Community Health, Virginia Commonwealth University School of Medicine, Richmond, Virginia

Zeina Mneimneh, M.P.H., M.Sc.

Survey Director, University of Michigan/Survey Research Center, Institute for Social Research, Ann Arbor, Michigan

William E. Narrow, M.D., M.P.H.

Associate Director, Division of Research, American Psychiatric Association, Arlington, Virginia; Research Director of the DSM-5 Task Force

Johan Ormel, Ph.D.

Professor of Psychiatric Epidemiology, University Medical Center Groningen

Daniel S. Pine, M.D.

Chief of Developmental Studies, Mood and Anxiety Disorders Program, National Institute of Mental Health, Bethesda, Maryland

José Posada-Villa, M.D.

Professor, Instituto Colombiano del Sistema Nervioso, Clinica Montserrat

Martin Prince, M.D.

Professor, Centre for Public Mental Health, Health Service and Population Research Department, Institute of Psychiatry, London, United Kingdom

Judith L. Rapoport, M.D.

Chief, Child Psychiatry Branch, National Institute of Mental Health, Bethesda, Maryland

Darrel A. Regier, M.D., M.P.H.

Executive Director, American Psychiatric Institute for Research and Education and Director, Division of Research, American Psychiatric Association, Arlington, Virginia; Vice-Chair, DSM-5 Task Force

Paola Rucci, Dr.Stat.

Visiting Research Assistant Professor, Department of Psychiatry, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania; Fellow, Department of Medicine and Public Health, University of Bologna, Bologna, Italy

Norman Sartorius, M.D., Ph.D., F.R.C.Psych.

President, Association for the Improvement of Mental Health Programmes, Geneva, Switzerland

Michael Schoenbaum, Ph.D.

Senior Advisor, Office of the Director, Division of Services & Intervention Research, National Institute of Mental Health, Bethesda, Maryland

Susan K. Schultz, M.D.

Professor of Psychiatry, University of Iowa Carver College of Medicine, Iowa City, Iowa

Soraya Seedat, M.B.Ch.B., F.C.Psych., Ph.D.

Co-Director, Medical Research Council Unit on Anxiety and Stress Disorders, Cape Town, South Africa

David Shaffer, M.D.

Irving Philips Professor of Child Psychiatry and Professor of Pediatrics, Child & Adolescent Psychiatry, New York State Psychiatric Institute, New York, New York

Leonard J. Simms, Ph.D.

Associate Professor, Department of Psychology, University at Buffalo, The State University of New York, Buffalo, New York

Renata Sousa, Ph.D.

Psychologist and Researcher, Health Service and Population Research Department, Institute of Psychiatry, London, United Kingdom

Susan C. South, Ph.D.

Assistant Professor, Department of Psychological Sciences, Purdue University, West Lafayette, Indiana

Hisateru Tachimori, Ph.D.

Section Chief, National Institute of Mental Health, National Center of Neurology and Psychiatry

Eric Taylor, M.A., M.B.

Emeritus Professor, King's College London, Institute of Psychiatry, London, United Kingdom

Myriam Torres, M.S.

Institute for Social Research, University of Michigan, Ann Arbor, Michigan

Adley Tsang, B.So.Sci.

Senior Research Assistant, Hong Kong Mood Disorders Center, Prince of Wales Hospital

T. Bedirhan Üstün, M.D.

Coordinator Classifications Terminologies & Standards, World Health Organization, Geneva, Switzerland

Michael Von Korff, Sc.D.

Senior Investigator, Group Health Research Institute, Seattle, Washington

Philip S. Wang, M.D., Dr.P.H.

Deputy Director, National Institute of Mental Health, Bethesda, Maryland

Hans-Ulrich Wittchen, Ph.D.

Chairman and Director, Institute of Clinical Psychology and Psychotherapy, and Professor, Technische Universitaet Dresden, Dresden, Germany

Kimberly A. Yonkers, M.D.

Professor, Department of Psychiatry, Yale School of Medicine, New Haven, Connecticut

Charles H. Zeanah, M.D.

Professor, Department of Psychiatry, Tulane University, New Orleans, Louisiana

Rong Zhang, Ph.D.

Blue Cross Blue Shield of Michigan

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Darrel A. Regier, M.D., M.P.H.—The author, as Executive Director of the American Psychiatric Institute for Research and Education, oversees all federal and industry-sponsored research and research training grants in APIRE but receives no external salary funding or honoraria from any government or industry.

Lee Anna Clark, Ph.D.—The author receives research support and royalties from the University of Minnesota Press for the Schedule for Adaptive and Non-adaptive Personality (SNAP) measure.

Warachal Eileen Faison, M.D.—The author is a full-time employee at Pfizer Inc. and owns stock in Pfizer Inc.

Ellen Frank, Ph.D.—The author receives royalties from Guilford Press. The author is on the Advisory Board for Servier International.

Nick Glozier, Ph.D.—The author has received research support from the Australian Research Council, the National Health and Medical Research Council, Servier Laboratories, BOHRF, Beyond Blue, and the Heart Foundation. The author conducts medico-legal disability assessments for NSW Fire Brigades, NSW Police, RailCorp, the Worker's Compensation Commission, and several law firms, both appellant and respondent. The author is a member of the NSW Worker's Compensation Commission medical appeal panel for disability compensation.

Steven E. Hyman, M.D.—The author is a member of the Novartis Science Board but does not receive direct payment of honorarium.

Ronald C. Kessler, Ph.D.—The author has been a consultant for GlaxoSmithKline, Kaiser Permanente, Pfizer Inc., Sanofi-Aventis, Shire Pharmaceuticals, and Wyeth-Ayerst. The author has served on the advisory boards for Eli Lilly & Company and Wyeth-Ayerst. The author has received research support from Bristol-Myers Squibb, Eli Lilly & Company, GlaxoSmithKline, Johnson & Johnson, Ortho-McNeil Pharmaceuticals Inc., Pfizer Inc., and Sanofi-Aventis.

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Soraya Seedat, M.B.Ch.B., F.C.Psych., Ph.D.—The author has received research support from GlaxoSmithKline, Lundbeck, Astra-Zeneca, and Servier.

Michael Von Korff, Sc.D.—The author receives research support from Johnson and Johnson.

Kimberly A. Yonkers, M.D.—The author has received research support from Eli Lilly. The author has received publishing royalties from Up to Date Inc.

Charles H. Zeanah, M.D.—The author has received royalties from Guilford Press.

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Jamie M. Abelson, M.S.W.

Sergio Aguilar-Gaxiola, M.D., Ph.D.

Jordi Alonso, M.D., Ph.D.

Gavin Andrews, M.D.

Katja Beesdo, Ph.D.

Patricia A. Berglund, M.B.A.

Guilherme Borges, M.Sc., Dr.Sc.

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Herbert Matschinger, Ph.D.
Briana Mezuk, Ph.D.
Zeina Mneimneh, M.P.H., M.Sc.
William E. Narrow, M.D., M.P.H.
Johan Ormel, Ph.D.
Daniel S. Pine, M.D.
José Posada-Villa, M.D.
Martin Prince, M.D.
Judith L. Rapoport, M.D.
Norman Sartorius, M.D., Ph.D., F.R.C.Psych.
Michael Schoenbaum, Ph.D.
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Leonard J. Simms, Ph.D.
Renata Sousa, Ph.D.
Susan C. South, Ph.D.
Hisateru Tachimori, Ph.D.
Eric Taylor, M.A., M.B.
Myriam Torres, M.S.
Adley Tsang, B.So.Sci.
T. Bedirhan Üstün, M.D.
Philip S. Wang, M.D., Dr.P.H.
Hans-Ulrich Wittchen, Ph.D.
Rong Zhang, Ph.D.

Introduction

Darrel A. Regier, M.D., M.P.H.
William E. Narrow, M.D., M.P.H.
Emily A. Kuhl, Ph.D.
David J. Kupfer, M.D.

Over the past 30 years, there has been a continuous testing of multiple hypotheses that are inherent in the *Diagnostic and Statistical Manual of Mental Disorders*, from the third edition (DSM-III; American Psychiatric Association 1980) to the fourth (DSM-IV; American Psychiatric Association 1994). Although DSM-III was the first official classification from the American Psychiatric Association (APA) to embrace these hypotheses, their intellectual origin is more properly attributed to Eli Robins and Samuel Guze's landmark 1970 article on the establishment of diagnostic validity in psychiatric illness (Robins and Guze 1970) and the subsequent 1972 release of the St. Louis "Feighner diagnostic criteria" (Feighner et al. 1972). These formed the basis for the 1978 Research Diagnostic Criteria (Spitzer et al. 1978), which were used in the longitudinal collaborative study on the psychobiology of depression supported by the National Institute of Mental Health (Rice et al. 2005) and ultimately were the prototypical diagnoses adopted in DSM-III in 1980.

The expectation of Robins and Guze (1970) was that each clinical syndrome described in the Feighner criteria, Research Diagnostic Criteria, and DSM-III would ultimately be validated by its separation from other disorders, common clinical course, genetic aggregation in families, and further differentiation by future laboratory tests—which would now include anatomical and functional imaging, molecular genetics, pathophysiological variations, and neuropsychological testing.

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To the original validators Kendler (1990) added differential response to treatment, which could include both pharmacological and psychotherapeutic interventions.

After almost 40 years of testing these hypotheses, we are impressed by the remarkable advances in research and clinical practice that were facilitated by having explicit diagnostic criteria that produced greater reliability in diagnosis across clinicians and research investigators in many countries. The benefit of using explicit criteria to increase reliability in the absence of etiological understanding was an outcome predicted by the British psychiatrist Ervin Stengel (1959). However, as these criteria have been tested in multiple epidemiological, clinical, and genetic studies through slightly revised DSM-III-R (American Psychiatric Association 1987), DSM-IV, and DSM-IV-TR (American Psychiatric Association 2000) editions, the lack of clear separation of these syndromes became apparent from the high levels of comorbidity that were reported (Boyd et al. 1984; Regier et al. 1990). A particularly clear discussion of the inability to identify “zones of rarity” between mental disorders was presented by Kendell and Jablensky (2003). In addition, treatment response became less specific as selective serotonin reuptake inhibitors were found to be effective for a wide range of anxiety, mood, and eating disorders and atypical antipsychotics received indications for schizophrenia, bipolar disorder, and treatment-resistant major depression.

More recently, it was found that a majority of patients with entry diagnoses of major depression in the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study had significant anxiety symptoms, and this subgroup had a more severe clinical course and was less responsive to available treatments (Howland et al. 2009). The lack of clear separation between current disorders defined by DSM-IV-TR was clearly illustrated in a survey of primary care patients (Lowe et al. 2008), which found that among individuals with the most severe ratings of depression, anxiety, or somatization, more than one-half in each syndrome group also had at least one, if not both, of the other two disorders. Furthermore, the combined influence of the three syndromes on functional impairment was far more significant than any of their individual effects. Likewise, we have come to understand that we are unlikely to find single gene underpinnings for most mental disorders, which are more likely to have polygenetic vulnerabilities interacting with epigenetic factors (that switch genes on and off) and environmental exposures to produce disorders.

In retrospect, it is interesting that there was such a strict separation of mood, anxiety, psychotic, somatic, substance use, and personality disorder symptoms for the original Feighner diagnoses (Regier et al. 2005). It is clear that an hierarchy was present that tended to suppress the significance of lower-order symptoms in the syndrome definitions in order to achieve such pure types. This hier-

archical arrangement of disorders was implicit in the Kraepelinean classification tradition of ranking organic mental disorders, nuclear schizophrenia, manic-depressive illness, and neurotic illnesses from higher- to lower-order conditions (Surtees and Kendell 1979). It was followed by an explicit statement of Jaspers (1963): “The principle of medical diagnosis is that all the disease-phenomena should be characterized within a single diagnosis...in any one person” (p. 611). Although the idea of a strict hierarchy, in which the presence of any disorder could cause manifestations of disorders lower in the hierarchy, was explicitly abandoned for DSM-III-R after publication and review (Regier 1987) of the article by Boyd et al. (1984), the strict separation of symptoms and disorder types has persisted through DSM-IV-TR. Some remnants of the hierarchy persist in a few areas, such as the diagnosis of autistic disorder (299.00), in which there is still an explicit exclusion of a diagnosis of attention-deficit/hyperactivity disorder (ADHD) if autistic disorder is present. The practical effect of this exclusion is that insurance reimbursement is often denied for co-occurring symptoms of ADHD in the presence of a diagnosis of autism. To support this strict separation, we now have a plethora of comorbidity—because patients do not usually have only mood, somatic, or anxiety symptoms but tend to come with a mix from multiple symptom groups. Hence, we have heterogeneous conditions within single diagnostic groups, a remarkably high rate in specialty mental health settings of “not otherwise specified” diagnoses that do not quite fit the existing criteria, as well as high rates of “subsyndromal” mixed anxiety-mood-somatic disorders in primary care settings.

How then are we to update our classification to recognize the most prominent syndromes that are actually present in nature, rather than in the heuristic and anachronistic pure types of previous scientific eras? A serious consideration from the aforementioned study by Lowe et al. (2008) is that some patients with clinically significant distress and impairment might have only a few symptoms from mood, anxiety, and somatic diagnostic criteria sets that do not qualify for a formal diagnosis in any one disorder, although the aggregate burden requires a not-otherwise-specified diagnosis and treatment. A more important clinical consideration is that the clinical course and treatment response for anxious depression, posttraumatic stress disorder with depression, and other mixed disorders cannot be predicted from clinical trials of medications or psychosocial interventions that are based on outcomes with patient groups selected for pure categorical disorders or that contain an unknown heterogeneous mix of comorbid conditions. In addition, supraordinate dimensional measures may provide better phenotypic expressions for linkage to illness susceptibility substrates identified by neuroimaging and genetic studies. Common genetic determinants of schizophrenia and bipolar disorder have resulted in calls for a reappraisal of

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