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Possibilities and limitations of DSM-5 in improving the classification and diagnosis of mental disorders

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Summary

Twenty years after publication of the previous version, the new and completely revised version of the US diagnostic system of psychiatric disorders, the Diagnostic and Statistical Manual of Mental Disorders – DSM-5, was introduced in 2013. Over the course of its preparation, which took many years, current knowledge was summarized and the respective consequences for the classification and diagnosis of psychiatric disorders were discussed in groups of high-ranking experts. In many regards, DSM-5 does not fulfil the original plans and expectations; however, for the most part it can be seen as an acceptable summary of current knowledge on mental disorders. Although universities and research groups throughout the world have shown great interest in DSM-5, in countries outside the USA the ICD-10 is still the mandatory classification system, until the official introduction of the ICD-11. From many perspectives, DSM-5 can be seen as a kind of predecessor model for ICD-11. However, ICD-11, despite the original plan for it to be very similar to DSM-5, will find many of its own solutions. This paper presents some important issues on DSM-5 that will be of interest to clinicians working in the field of mental disorders. In addition, it uses some examples to illustrate how DSM-5 operationally defines some disorders and how it differs from ICD-10 and DSM-IV.

Key words: diagnostics, DSM-5, classification, mental disorders

Introduction

The introduction of operationalized classification/diagnostics in the 1980s and 1990s (Diagnostic and Statistical Manual of Mental Disorders [DSM-III, DSM-IV] and the psychiatric section of the International Classification of Diseases [ICD-10) [1] significantly improved the classification of mental illnesses, which until then had been highly problematic. However, this progress did not solve all the associated problems. Furthermore, a classification system was needed that incorporated the empirical knowledge obtained since the publication of these systems. Improving the validity and

reliability of psychiatric classification/diagnostics is a constant concern in psychiatry. However, it is not an easy goal to achieve because most mental illnesses are not innately specified disease entities but rather constructs that have to be adapted, depending on the current state of knowledge. The introduction in 2013 of a new version of the DSM system, DSM-5, after long, comprehensive preparatory work and the expected introduction of a revised psychiatric section of the ICD, ICD-11, also after a long period of intensive work, represent attempts to fulfil this goal [2, 3].

DSM-5,published by the American Psychiatric Association (APA), is primarily tailored to the situation and needs of psychiatry in the USA. Similar to the previous versions, however, its high quality has led to it gaining international importance, although mainly in research settings. The introduction of DSM-5 thus also generated a lot of interest in many countries where the ICD system – currently the ICD-10 but in the near future the ICD-11 – is the mandatory classification system. Some of the approaches to and changes in psychiatric classification in DSM-5 are exemplary for the development of the psychiatric section of the ICD-11 (draft version 2016!) and provide general indications of the direction of the conceptual changes in psychiatric classification/diagnosis. Consequently, it seems relevant to take a look at these aspects. Because of its fundamental importance, DSM-5 has been translated into several languages, for example Polish [4].

Fundamental aspects of DSM-5

The structure and characterization of mental disorders in the recent diagnosis systems (DSM-IV, DSM-5, ICD-10, ICD-11) differs considerably in some parts from traditional pathological concepts. This is related among other things to the need for more precise concepts as part of the operationalization, the greater inclusion of recent research findings and, in particular in the ICD system, the necessity to make compromises on an international level. The overall objective is to improve the validity and reliability of psychiatric diagnostics.

DSM-5 is of such high quality because its development was very thorough, considered the latest scientific findings and included many renowned experts. It conveys the current status of international consensual knowledge about mental illnesses/disorders and is therefore an important reference source.

Noteworthy in this context is that in the course of the development of operationalized diagnostic systems in psychiatry the term ‘disorder’ has become increasingly preferred over the term ‘disease’ or ‘illness’, mainly because of the US literature. This term should convey the concept that these phenomena mostly do not correspond with what one refers to in medicine as a ‘disease’ or ‘illness’ (i.e., specific symptoms with a clear organic cause and a typical course) but rather to something that is not yet completely clear from a medical perspective and therefore can only be dealt with descriptively.

For reasons of space it is not possible to present all the relevant aspects of the voluminous DSM-5 here – the original English version is about 900 pages long! Therefore, this paper will just discuss important fundamental aspects and a few disorder-related aspects. For those interested in additional details, I recommend reading DSM-5 itself and some of the numerous publications that discuss DSM-5 descriptively or critically [e.g., 5, 6]. Guidance on implementing DSM-5 in practical clinical work can be found in the latest versions of psychiatric textbooks.

Contrary to the original intentions, DSM-5 is not as innovative as the initiators had planned [5, 6]. For example, the initially favored idea to introduce a primarily syndromal/dimensional diagnostic system, instead of the previous disease/disorder entities, was mostly abandoned for several scientific and pragmatic reasons. This was even the case with the personality disorders, where the syndromal/dimensional approach seemed particularly plausible and a meaningful concept was presented (published in Chapter 3 of DSM-5 as a 'condition for further study'). The intention to include biomarkers for the objectification of the diagnosis in many diseases/disorders was also not realized because of a lack of sufficient stable neurobiological findings.

Overall, the authors of DSM-5 did not manage to conceptualize mental illnesses/disorders as neurobiologically defined entities, even though that was the original objective. The neurobiological findings in the fields of genetics, molecular biology, imaging research, neuropathology, and others do not reveal clear or adequate associations with the traditional diseases/disorders. This state of empirical knowledge, although known for a long time, has greatly disappointed psychiatrists.

The preparation of DSM-5 and the discussions about the basic problems mentioned above have contributed to an improved overview of the status of knowledge in our specialty on both the conceptual and evidence-based levels.

The previous categorial and structural system was largely retained [2, 5], although some meaningful changes and additions were made. Table 1 gives a general overview of the structure of DSM-5.

Table 1. **General overview of the chapters in DSM-5 (abbreviated) [2]**

Neurodevelopmental Disorders Intellectual disabilities; Communication disorders; Autism spectrum disorder; Attention-deficit/Hyperactivity disorder; Specific learning disorder; Motor disorders
Schizophrenia Spectrum and Other Psychotic Disorders Schizotypal (personality) disorder; Delusional disorder; Brief psychotic disorder; Schizophreniform disorder; Schizophrenia; Schizoaffective disorder
Bipolar and Related Disorders Bipolar I disorder; Bipolar II disorder; Cyclothymic disorder; Other specified bipolar and related disorder
Depressive Disorders Disruptive mood regulation disorder; Major depressive disorder; Persistent depressive disorder

table continued on the next page

Anxiety Disorders Separation anxiety disorder; Selective mutism; Specific phobia; Social anxiety disorder (Social phobia); Panic disorder; Agoraphobia; Generalized anxiety disorder
Obsessive-Compulsive and Related Disorders Obsessive-compulsive disorder; Body dysmorphic disorder; Hoarding disorder; Trichotillomania (Hair-pulling disorder); Excoriation (Skin-picking) disorder
Trauma – and Stressor-Related Disorders Reactive attachment disorder; Disinhibited social engagement disorder; Posttraumatic stress disorder; Acute stress disorder; Adjustment disorders
Dissociative Disorders Dissociative identity disorder; Dissociative amnesia; Depersonalization/Derealization disorder
Somatic Symptom and Related Disorders Somatic symptom disorder; Illness anxiety disorder; Conversion disorder; Psychological factors affecting other medical conditions; Factitious disorder
Feeding and Eating Disorders Pica; Rumination disorder; Avoidant/Restrictive food intake disorder; Anorexia nervosa; Bulimia nervosa; Binge-eating disorder
Elimination Disorders Enuresis; Encopresis
Sleep-Wake Disorders Insomnia disorder; Hypersomnolence disorder; Narcolepsy; Breathing-related sleep disorders; Parasomnias
Sexual Dysfunctions Delayed ejaculation; Erectile disorder; Female orgasmic disorder; Female sexual interest/Arousal disorder; Genito-pelvic pain/Penetration disorder; Male hypoactive sexual desire disorder; Premature (early) ejaculation
Gender Dysphoria
Disruptive, Impulse-Control and Conduct Disorders Oppositional defiant disorder; Intermittent explosive disorder; Conduct disorder; Antisocial personality disorder; Pyromania; Kleptomania
Substance-Related and Addictive Disorders Use; Intoxication; Withdrawal (Related to alcohol, caffeine, cannabis, hallucinogen, inhalant, opioid, sedative, hypnotic, anxiolytic, stimulant or tobacco); Gambling disorder
Neurocognitive Disorders (NCD) Delirium; Major and mild NCD (due to Alzheimer's disease, frontotemporal NCD, NCD with Lewy bodies, vascular NCD, due to traumatic brain injury, due to HIV infection, due to prion disease, due to Parkinson's disease, due to Huntington's disease)

table continued on the next page

Personality Disorders
Cluster A personality disorders (paranoid, schizoid, schizotypal); Cluster B personality disorders (antisocial, borderline, histrionic, narcissistic); Cluster C personality disorders (avoidant, dependent, obsessive-compulsive)
Paraphilic Disorders
Voyeuristic disorder; Exhibitionistic disorder; Frotteuristic disorder; Sexual masochism disorder; Sexual sadism disorder; Pedophilic disorder; Fetishistic disorder; Transvestic disorder

For various reasons (e.g., lack of validity and practicability), the original plan to combine schizophrenic psychoses and bipolar disorders into a superordinate 'psychotic spectrum' group was not realized. This is seen as a problem by some experts, in particular with regard to the genetic overlap between these two disorder groups. Thus, DSM-5 still has a main capital devoted to schizophrenic disorders, entitled 'Schizophrenia spectrum and other psychotic disorders'. The symptom-related characterization of the schizophrenic psychoses was simplified even more than in DSM-IV. Because of a lack of validity or stability, neither the first-rank symptoms (according to Kurt Schneider) nor most of the traditional subtypes were included. Of these original subtypes, only catatonia remains, although no longer as a subtype of schizophrenia but as a cross-diagnosis 'specifier' for catatonic symptoms that can also be used in affective disorders, among others.

DSM-5 is the first edition of the manual to contain a chapter for bipolar disorders, 'Bipolar and related disorders'. This chapter includes both mania (as previously) and depression as part of a bipolar disorder. This is the first time that these two phenomenological main groups of bipolar disorders – mania and depression – have been presented together in an independent chapter. Most experts in bipolar disorders view this as a meaningful decision, although others who focus more on the entire field of affective disorders see the lack of an association with (unipolar) depression, and thus with this part of the spectrum of affective disorders, as problematic. Because of the implausible and frequently criticized frequency of a 'bipolar' diagnosis among children in the USA, the new diagnostic category 'disruptive mood dysregulation disorder' was introduced, although it was placed in the chapter on depressive disorders; this new category is supposed to better represent the phenomenon observed in children/adolescents. A 'mixed feature' specifier should draw attention to mixed forms of depression and mania and capture the admixture of the respective opposite pole, i.e., manic symptoms in depression and depressive symptoms in mania. This approach serves to provide a differentiated and quasi-dimensional representation of the previous concept of 'mixed states'. Furthermore, the category 'Other specified bipolar and related disorder' presents an array of mostly subsyndromal bipolar manifestations and thus expands the range of bipolar diagnostic options.

The depression chapter now only deals with (unipolar) depression ('major depressive disorder') and no longer with depression as part of bipolar disorder. Besides including major depression in its episodic and relapsing form, the depression chapter now combines the previous category 'dysthymia' with chronic forms of depression in the category 'persistent depressive disorder'. The chapter also contains 'premenstrual dysphoric disorder'. With regard to depression, close consideration is given to mild (subsyndromal) symptomatic indications for bipolarity and mixed forms between depression and mania (similarly, these transitional areas are focused on in the presentation of mania; see above). To capture these subsyndromal transitions, DSM-5 provides the specifier 'with mixed features'. An additional specifier – 'with anxious distress' – refers to the transitional area between depression and anxiety, another common area of either fully expressed or subsyndromal comorbidity.

Obsessive-compulsive disorders were removed from the chapter on anxiety disorders, a change that corresponds with traditional European psychopathology. These disorders have been expanded considerably by the addition of related disorders (such as pathological hoarding, pathological hair pulling, body dysmorphic disorder) and are now presented in their own chapter. This independent and significantly extended chapter 'Obsessive-compulsive and related disorders' does more justice to the prevalence and clinical relevance of these disorders than the previous classification systems. Additional codes allow a better differentiation between psychotic and non-psychotic obsessive-compulsive disorders.

Now that trauma – and stressor-related disorders have been removed from the chapter on anxiety disorders, the chapter only contains classical anxiety disorders, whereby the definition of generalized anxiety disorder in particular has been changed. The category 'mixed anxiety and depression disorder' is not used for the mixed form of mild depressive and anxious symptoms; instead, the overlap between depressive and anxious symptoms can be expressed by the specifier 'with anxious distress', which is included in the section on depressive disorders.

Trauma – and stressor-related disorders are now described in an independent chapter that, in addition to acute stress disorder, for example, also includes posttraumatic stress disorder. Many experts consider this an important improvement that makes sense from a phenomenological and pathogenetic perspective and does better justice to the growing importance of posttraumatic stress disorder in particular. The chapter 'Somatic symptom and related disorders' contains several disorders that were already included in DSM-IV and ICD-10, although some of the definitions have changed – despite similar diagnostic terms. Thus, DSM-5 uses the term 'somatic symptom disorder' for the important group referred to in ICD-10 as 'somatisation disorders' and in the diagnostic criteria, besides the somatoform symptoms, strongly emphasizes the aspect of stress or anxiety (see Table 2).

Table 2. **Diagnostic guidelines for somatization disorder according to ICD-10 and diagnostic criteria for somatic symptom disorder according to DSM-5 (excerpts) [1, 2]**

ICD-10
The main features are multiple, recurrent and frequently changing physical symptoms of at least two years duration. Most patients have a long and complicated history of contact with both primary and specialist medical care services, during which many negative investigations or fruitless exploratory operations may have been carried out. Symptoms may be referred to any part or system of the body. The course of the disorder is chronic and fluctuating, and is often associated with disruption of social, interpersonal, and family behavior.
Time criterion: at least two years duration.
DSM-5
One or more somatic symptoms that are distressing or result in significant disruption of daily life. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following: – Disproportionate and persistent thoughts about the seriousness of one's symptoms. – Persistently high level of anxiety about health or symptoms. – Excessive time and energy devoted to these symptoms or health concerns.

This results among other things in difficulties in defining the DSM-5 diagnosis 'Illness anxiety disorder', which is also in this chapter and is traditionally referred to in ICD-10 as 'hypochrondriacal disorder'. One really has to study these new definitions carefully. Although the presentation of this important group of disorders has improved in comparison with DSM-IV, it is still not quite successful not only from a clinician's perspective but also from that of experts in the field. This is related to the fundamental difficulties in classifying this range of phenomena into clear phenotypes and structuring it systematically. This aspect requires more work because this group of disorders is extremely prevalent and clinically important in the transitional area between mental and physical illnesses and is highly relevant in psychiatric-psychosomatic liaison services in particular.

The presentation of the disorders related to psychotropic substances avoids using the term 'dependence'. The reason for this decision by the DSM group is not a scientific but a psychological one: people do not want to feel dependent or be referred to as being dependent. This consideration of public attitudes and the avoidance of discriminations related to certain attitudes is characteristic of the DSM-5 'philosophy' and resulted, among other things, in avoidance of the term 'dementia' (see below). The presentation of disorders related to the use of psychotropic substances no longer differentiates between 'misuse' and 'addiction' but instead refers to the overall phenomenon. For example, in the case of alcohol it refers to 'alcohol use disorder', which is defined by 11 criteria. The disorder is then divided into mild, moderate and severe, depending on the number of criteria fulfilled, whereby 'severe' roughly corresponds to with alcohol dependence in the traditional sense.

As was the case with DSM-IV, DSM-5 also does not have a separate category for the mental illnesses traditionally referred to as 'organic'. If an identifiable organic

correlate is present, DSM-5 refers to it as ‘other medical condition’. Analogous to the substance-induced disorders (see below), disorders attributable to ‘other medical conditions’ are assigned to the main group that corresponds with the cardinal psychopathological symptoms.

Neurocognitive disorders, which usually have an organic basis, are presented in a separate chapter. However, the terms ‘dementia syndrome’ and ‘amnestic syndrome’ are no longer used and are replaced by the term ‘neurocognitive disorder’, which is then differentiated on the basis of different severities and etiopathogenetic factors. Besides ‘neurocognitive disorder’, ‘delirium’ – another ‘organic syndrome’ in the traditional sense – is now also an independent syndrome. For reasons of space, other approaches and changes, such as the new chapter on autism spectrum disorders and chapters that present various sexual disorders, cannot be further discussed here.

Insights into the clinical application of DSM-5

This chapter only has room to present a few examples of the clinical application of DSM-5, but the points presented here are typical for its approach.

Schizophrenia

As mentioned in the previous section, the symptom-related diagnostic criteria in DSM-5 are even simpler than those in DSM-IV. Consequently, they do not seem very discriminative compared, e.g., not only with first-rank symptoms according to Kurt Schneider but also with ICD-10, which still adheres closely to the traditional psychopathology of schizophrenia (Table 3). If one reads these criteria the characteristic clinical picture of a patient with a schizophrenic psychosis does not immediately come to mind. The DSM-5 authors decided to take this apparently radical step because they thought there was insufficient empirical evidence for the traditional theory, e.g., in terms of first-rank symptoms, although this decision has also been criticized [3].

Table 3. Diagnostic guidelines or criteria for schizophrenia spectrum disorders according to ICD-10 and DSM-5 [1, 2]

ICD-10
A diagnosis of schizophrenia requires at least one very clear symptom (or two or more if less clear-cut) from groups 1–4 below or symptoms from at least two of the groups 5–8.
1. Thought echo, thought insertion or withdrawal, etc.
2. Delusions of control, influence or passivity, delusional perception, etc.
3. Hallucinatory voices giving a running commentary or discussing among themselves.
4. Persistent, culturally inappropriate or completely impossible delusions.
5. Persistent hallucinations in any modality accompanied by fleeting or half-formed delusions without clear affective content or by persistent over-valued ideas, or when occurring every day for weeks or months on end.

table continued on the next page

6. Breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech or neologisms.

7. Catatonic behavior.

8. Negative symptoms such as marked apathy, paucity of speech, blunting or incongruity of emotional responses; it must be clear that these are not due to depression or to neuroleptic medication.

9. A significant and consistent change in the overall quality of some aspects of personal behavior, manifest as aimlessness, idleness, a self-absorbed attitude and social withdrawal.

The course of schizophrenic disorders can be either continuous, or episodic with progressive or stable deficit, or there can be one or more episodes with complete or incomplete remission. The diagnosis of schizophrenia should not be made in the presence of extensive depressive or manic symptoms unless it is clear that schizophrenic symptoms antedate the affective disturbance. Nor should schizophrenia be diagnosed in the presence of overt brain disease or during states of drug intoxication or withdrawal.

DSM-5

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2) or (3):

1. Delusions

2. Hallucinations

3. Disorganized speech (e.g., frequent derailment or incoherence)

4. Grossly disorganized or catatonic behavior

5. Negative symptoms (e.g., diminished emotional expression or avolition)

For a significant portion of time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational functioning).

Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms.

The symptom-related characterization of schizophrenic psychoses now appears to be relatively simple, which especially supporters of a discriminative psychopathology – in the sense of traditional phenomenology – consider to be unsatisfactory [5].

Because of insufficient validity and stability over time, the subtypes of schizophrenia have also been largely eliminated. Instead, DSM-5 offers the possibility to assess the severity of the primary schizophrenic symptoms – delusions, hallucinations, disorganized speech, psychomotor activity and negative symptoms – on a 5-level evaluation scale (0–4) and thus to personalize the description of individual patients. However, this specification is not a requirement for the diagnosis. In addition, a ‘catatonia specifier’ was introduced. This specifier is used to characterize catatonic symptoms, which are no longer perceived to be symptoms only of schizophrenia but also as possible symptoms of affective disorders, for example; the criteria for the specifier are as follows:

– Stupor;
– Catalepsy;
– Waxy flexibility;

- Mutism;
- Negativism;
- Posturing;
- Mannerism;
- Stereotypy;
- Agitation, not influenced by external stimuli;
- Grimacing;
- Echolalia;
- Echopraxia.

Catatonia is therefore not perceived as a specific subtype of schizophrenia but as a nosologically unspecific psychopathological syndrome. Kraepelin's postulate of a residual condition resulting from an unfavorable course is not included in DSM-5. Instead, DSM-5 lists several favorable and unfavorable disease courses that can be diagnosed as such. More generally, it provides a 'Clinician-rated dimensions of psychosis symptom severity' scale for use when assessing schizophrenic and affective psychoses (psychosis spectrum). The scale can be used to evaluate the severity (0–4) of eight symptom domains of psychoses:

- Hallucinations;
- Delusions;
- Disorganized speech;
- Abnormal psychomotor behavior;
- Negative symptoms;
- Impaired cognition;
- Depression;
- Mania.

Of interest is a 36-item, self-administered version of the Disability Assessment Schedule in DSM-5 (Section III), which was originally developed by the WHO as an observer-rating instrument. The schedule assesses several domains:

- Understanding and communicating;
- Mobility;
- Self-care;
- Dealing with other people;
- Life activities (Household);
- Life activities (School/Work);
- Participation in society.

The measure thus allows disease-related psychosocial impairments and consequences of schizophrenic psychoses and other mental illnesses to be assessed in a differentiated way and allows the clinician to produce an individual picture of a patient beyond the level of symptoms. It is well known that psychopathological symptoms can have different psychosocial consequences in different people and that the severity of the mental disorder is associated in different ways with the psychosocial consequences [7]. In Section III, DSM-5 also provides additional self – and observer-rating instruments, including instruments that are intended to support clinical decision-making in general. Noteworthy in this context is a self-assessment questionnaire that is offered as a screening instrument and covers 13 symptom domains (on a scale of 0–4).

Depression

The symptomatic and other criteria of major depression have not changed significantly in DSM-5 (Table 4). Additional specification is possible with regard to various symptomatic and course-related aspects, which are largely unchanged from earlier approaches.

Table 4. **Diagnostic guidelines for a depressive episode according to ICD-10 and diagnostic criteria for major depression according to DSM-5 [1, 2]**

ICD-10
Symptoms
Lowering of mood, reduced capacity for enjoyment, depression may be worst in the morning
Loss of interests
Marked tiredness after even minimum effort, reduced motivation and energy
Psychomotor retardation, agitation
Reduced concentration
Reduced self-esteem
Ideas of guilt or worthlessness
Negative and pessimistic thoughts about the future
Suicidal thoughts/acts
Disturbed sleep (early morning awakening)
Diminished appetite, weight loss
Loss of libido
Severities:
Mild depressive episode
Moderate depressive episode
Severe depressive episode without psychotic symptoms = major depression, melancholia
Severe depressive episode with psychotic symptoms, psychotic depression; also present: delusions (poverty, sin), depressive stupor

table continued on the next page

Minimum duration: 2 weeks

Course: relapsing (> 2 episodes)

DSM-5

Symptoms

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning.

Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others

Markedly diminished interest or pleasure in all, or almost all, activities

Significant weight loss when not dieting or weight gain or decrease or increase in appetite

Insomnia or hypersomnia

Psychomotor agitation or retardation

Fatigue or loss of energy

Feelings of worthlessness or excessive or inappropriate guilt

Diminished ability to think or concentrate, or indecisiveness

Recurrent thoughts of death

The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

The episode is not attributable to the physiological effects of a substance or to another medical condition.

Severities:

Mild

Moderate

Severe

With psychotic features

Minimum duration: Symptoms must persist for at least 2 consecutive weeks

Course: partial remission, full remission

The newly developed 'catatonia specifier' mentioned above can also be used for further description, if applicable. The traditional concept of melancholia can be depicted with the specifier 'with melancholic features':

A. One of the following is present during the most severe period of the current episode:
   – Loss of pleasure in all, or almost all, activities;
   – Lack of reactivity to usually pleasurable stimuli.

B. Three (or more) of the following:
   – A distinct quality of depressed mood;
   – Depression that is regularly worse in the morning;
   – Early-morning awakening;
   – Marked psychomotor agitation or retardation;

- Significant anorexia or weight loss;
- Excessive or inappropriate guilt.

In terms of the concept of an admixture of subsyndromal manic symptoms or a transition to manic symptoms, the 'mixed states' specifier is of particular relevance. The overlap with anxiety symptoms can be represented with the specifier 'with anxious distress'.

Alcoholism

As mentioned above, terms such as 'dependence' or 'addiction' are not used in DSM-5. In the case of alcoholism, DSM-5 instead uses the term 'alcohol use disorder'. A total of 11 diagnostic criteria are listed. At least two of the following, occurring within a 12-month period:

- Alcohol is often taken in larger amounts or over a longer period than was intended;
- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use;
- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol or recover from its effects;
- Craving or a strong desire or urge to use alcohol;
- Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school or home;
- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol;
- Important social, occupational or recreational activities are given up or reduced because of alcohol use;
- Recurrent alcohol use in situations in which it is physically hazardous;
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol;
- Tolerance.
- Withdrawal.

The disorder is divided into three severity levels, depending on the number of symptoms, whereby moderate (4–5) and severe (6 or more) are similar to the clinical picture of patients with a 'dependence' in the traditional sense.

Dementia

The neurocognitive disorders will be mentioned here as an additional example. DSM-5 uses the term 'severe neurocognitive disorder' in place of 'dementia', although it allows use of the term dementia in etiological subtypes where that term is standard, e.g., 'Alzheimer dementia'. Similar to the term 'dementia' in ICD-10, the term 'neurocognitive disorder' in DSM-5 focuses only on cognitive disorders. Criteria are provided that define severity levels and facilitate diagnosis. A distinction must be made between 'severe neurocognitive disorder' and 'mild neurocognitive disorder' (Table 5).

Table 5. **Diagnostic guidelines for dementia according to ICD-10 and diagnostic criteria for neurocognitive disorder (NCD) according to DSM-5 [1, 2]**

ICD-10
Symptoms
Decline in memory
Deterioration in thinking
Deterioration in judgement
Reduced flow of ideas
Impaired information processing
Decline in cognitive abilities causes impaired performance in daily living
Preserved awareness of the environment
Severities: mild, moderate, severe
Course: chronic, dementias can be reversible
DSM-5
Symptoms
Evidence of significant cognitive decline from a previous level in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor or social cognition) based on:
Concern of the individual, a knowledgeable informant or the clinician that there has been a significant decline in cognitive function; and
A substantial impairment in cognitive performance preferably documented by standardized neuropsychological testing. The cognitive deficits interfere with independence in everyday activities.
The cognitive deficits do not occur exclusively in the context of a delirium.
Severities: mild, moderate, severe
Course: Information that is similar in content to ICD-10 but more detailed is provided in the section 'Development and course'.

Evaluation and concluding remarks

As described above, DSM-5 is meaningful for clinical work because it facilitates differential diagnosis. With its various additional elements, such as associated features, specifiers and ratings, DSM-5 enables a differential assessment of symptoms and, if

applicable, psychosocial adaptation that goes beyond the simple diagnosis of a disorder. An individual patient's circumstances can thus be represented in a much more detailed way that goes far beyond the more or less categorial 'disorder diagnosis'. Unclear is whether these additional options will be made full use of in view of the time constraints of everyday clinical practice and the ever-present shortage of professionals. Despite such limitations, however, because of its various options DSM-5 should be viewed as an asset by dedicated clinicians, e.g., with regard to differential psycho – and pharmacotherapy.

The 'disorder entities' presented in DSM-5 correspond largely with those in DSM-IV. Some are new, however, and some are defined in a somewhat or considerably different way (often more detailed/precise); some are assigned to other main groups than before and some traditional names of disorders have been replaced by newer, supposedly less discriminatory terms. Overall DSM-5 takes into account the growing body of empirical knowledge, and most of the changes are understandable with regard to the evidence base or other conceptual considerations.

DSM-5 corresponds with the state-of-the-art of empirical knowledge about mental 'illnesses', even though in principle other conceptions and structural approaches could be made on the basis of the same body of knowledge. It is already clear that ICD-11 (draft version 2016) will follow some but not all of the changes in DSM-5 (i.e., the ICD-11), which will be the mandatory diagnosis system in all countries outside the USA, will remain distinct and will not merge with DSM-5. On the other hand, the enormous amount of scientific and conceptual preparatory work performed in the context of DSM-5 is of great importance for ICD-11, which is still under development.

Disappointing is that in many respects DSM-5 did not meet the original goals and expectations. Although DSM-5 incorporates the accumulated empirical knowledge, the hope could not be fulfilled that many disease/disorder entities would be conceived as neurobiologically defined entities, or at least validated by biomarkers, so that diagnoses could be objectified. This failure cannot be blamed on the respective DSM-5 commissions but was an unpleasant consequence of the unsatisfactory body of evidence. Although biomarkers (blood laboratory parameters, genetic parameters, imaging parameters, etc.) were repeatedly described for individual disorders in the last two decades, they could not be validated and replicated, or at least not well enough, and showed insufficient discriminatory power on the individual level. The question to what extent the criteria proposed by the NIMH for research purposes, the Research Domain Criteria (RDoC) – which are not associated with DSM-5 but represent an alternative concept from a primarily neurobiological perspective – will advance this attempt is currently unanswerable [5]. Because the RDoC do not refer to entities of traditional clinical diagnostics, they remain irrelevant for the process of making diagnoses in everyday clinical practice and are to be viewed as a purely research-related instrument.

The originally planned radical change to using a syndromal/dimensional diagnostic system that would mainly abandon traditional 'disease entities' was also not implemented. In the course of the respective efforts and discussions it became apparent that the 'disorder entities' (nosological level) clearly provide valuable additional information, particularly in clinical care, and that this information would be lost in a purely syndromal/dimensional system. Pragmatic considerations about clinical practice, such as the traditional (disease-related) indications for psychopharmaceuticals and traditional (disease-related) billing to health insurance companies with diagnosis codes, also played a role in the decision. The maneuvering between the traditional classification of personality disorders and the new/future-oriented draft of a syndromal/dimensional classification (published in Section III of DSM-5 as a 'condition for further study') is a particularly impressive example of this problem. For such pragmatic reasons, the decision was made almost at the last minute to retain the tradition approach. The combination of schizophrenic and bipolar diseases/disorders as a 'psychosis spectrum', which has been proposed and intensively discussed for over two decades, in particular on the basis of genetic findings, was also not implemented, partly for theoretical reasons, partly for pragmatic ones. The syndromal/dimensional approach was only introduced for additional information, i.e., as a sort of second level, e.g., in the form of transdiagnostic specifiers (e.g., the 'mixed features' specifier), and in the sense of simple, syndrome-related global ratings (e.g., for negative symptoms).

The specifiers underline the basic concept, which is apparent in many parts of DSM-5, that not every mental illness can be classified as a separate 'disease entity' and not even as a separate 'disorder entity' but that there are significant areas of overlap, e.g., between major depression and anxiety disorders (in particular generalized anxiety disorder) and between unipolar and bipolar disorder: varying degrees of manic symptoms are common in unipolar depression and, vice versa, depressive symptoms are often present in mania, with mixed states being the extreme case. DSM-5 attempts to take these problems of overlap into account with the respective 'specifiers'; this is a meaningful approach to capture the differing extent of the respective 'admixture'. Schizoaffective psychosis is another such area of overlap, in this case between affective disorders and schizophrenic psychoses. Interestingly, however, such a specifier approach was not chosen here and DSM-5 retained the traditional, categorial 'disease' concept of the schizoaffective psychosis (which, contrary to all expectations, achieved relatively good interrater reliability scores in field studies). Remarkably no specifier is provided to describe the transitions between depressive, manic, anxiety or other disorders on the one hand and schizophrenic/psychotic symptoms on the other. People familiar with DSM could argue that, instead of a specifier, the 'Clinician-rated dimensions of psychosis symptom severity' scale could be used for this purpose. However, this scale is only used as a descriptive dimensional 'assessment approach' that, unlike

the specifiers, does not provide the option to reach a quasi-categorial classification from the syndromal description by defining a specific threshold value, e.g., to determine a mixed state by using the 'mixed features' specifier.

From a psychometric perspective the differentiation between 'specifiers' and other 'scales' (e.g., the 'Clinician-rated dimensions of psychosis symptom severity' scale) is hard to understand. Why is the same assessment approach, i.e., a dimensional rating of severity, not used throughout? Clearly, the specifiers must still contain the remains of a categorial approach, even if encoded in a 'syndromal way'. This may also explain why the specifiers are more or less mandatory whereas the other symptom-/syndrome-related 'ratings' are only presented in an annex (DSM-5, Section III), where they will probably receive little attention. The question of the validity of this 'rating scale' has not yet been adequately studied and studies have only been performed in the USA. The proposed assessment approach of a global evaluation of specific clinical syndromes is questionable from a psychometric perspective because we know from research on scales how difficult it is to record complicated psychopathology, e.g., schizophrenic psychoses (and in particular negative symptoms) with sufficient reliability, even with differentiated scales. The proposed simple global evaluations seem to forget these problems and clearly originate from a very pragmatic approach. The tendency to favor only self-rating over observer rating in certain contexts (e.g., the form of the 'Disability Assessment Schedule' to assess psychosocial adaptation), which probably also stems from pragmatic considerations, must be addressed as a problem because of the known bias of self-ratings, especially in patients with severe mental illness. The pragmatism seems to be very far-reaching in this case, probably because the DSM authors feared that anything beyond this approach would not be accepted in everyday clinical practice, especially in the outpatient sector.

As discussed above, DSM-5 is an interesting development that shows the possibilities and limitations of modern psychiatric diagnostics. Because of the priority given to ICD-10, and in the future ICD-11, in countries outside the USA, in these countries DSM-5 will probably be used primarily in universities and as part of research projects (e.g., in studies of pharmaceuticals for regulatory submissions). It is an important precursor, however, for the solutions that need to be put forward in ICD-11, which will be similar to DSM-5 in some areas but also find its own solutions.

Experiences in clinical practice will show the extent to which the changes achieved in DSM-5 are actually useful. Initial practice-oriented field studies show that diagnostic agreement between doctors is still unsatisfactory for some of the diagnoses in most disorder groups. We do not know whether DSM-5 has achieved some increase in interrater reliability (i.e., the agreement between two doctors in diagnosing the same patient) because (unfortunately) no such direct comparisons have been performed [6].

In all these attempts at operationalizing diagnostics, we need to ensure that we avoid the risk of 'cookery book diagnostics' or even 'McDonalds psychiatry'.

The ideal approach in psychiatry must continue to combine sufficiently differentiated psychopathological diagnostics and empathetic conversations in the sense of an 'understanding psychiatry'.

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