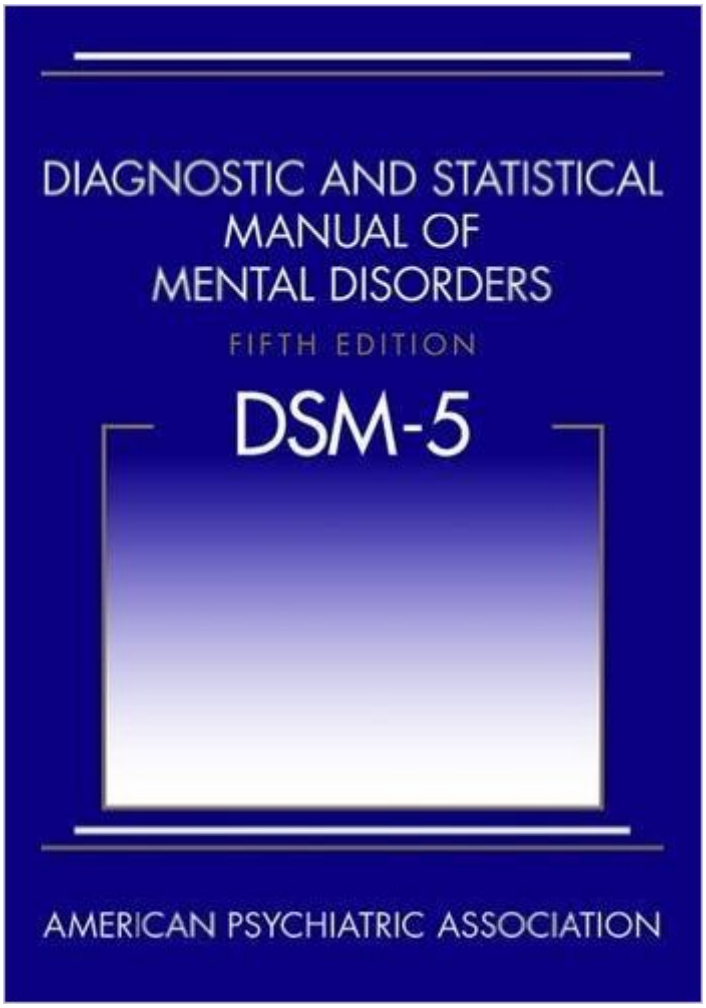
Diagnostic And Statistical Manual Of Mental Disorders, 5th Edition: DSM-5



Synopsis

This new edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5), used by clinicians and researchers to diagnose and classify mental disorders, is the product of more than 10 years of effort by hundreds of international experts in all aspects of mental health. Their dedication and hard work have yielded an authoritative volume that defines and classifies mental disorders in order to improve diagnoses, treatment, and research. This manual, which creates a common language for clinicians involved in the diagnosis of mental disorders, includes concise and specific criteria intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, is the most comprehensive, current, and critical resource for clinical practice available to today's mental health clinicians and researchers of all orientations. The information contained in the manual is also valuable to other physicians and health professionals, including psychologists, counselors, nurses, and occupational and rehabilitation therapists, as well as social workers and forensic and legal specialists. DSM-5 is the most definitive resource for the diagnosis and classification of mental disorders.

Book Information

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Customer Reviews

I ordered this book, and the book I received had about 40 pages that were upside down. This was disappointing. I would not recommend.Here is a picture of the book I received: [...]

There are a few minor and almost no major changes in DSM-5 that the patients and professional need to be aware of.1. The most remarkable structural change of the Fifth Edition is getting rid of 5-axial system. Good riddance!The old classification grouped diagnoses down into independent dimensions called axes:Axis I: all diagnoses except mental retardation and personality disorderAxis II: personality disorders and mental retardationAxis III: acute medical conditionsAxis IV: psychosocial and environmental factors making things worseAxis V: Global Assessment of Functioning (GAF), or a number between 0 and 100 that reflects patients' well-being.The new classification combines the axes together and let them rate the disorders by severity. In addition the NOS (not otherwise specified) label is changed to NED (not elsewhere defined).2. The diagnosis Mental Retardation is changed to intellectual disability (intellectual developmental disorder)3. Autism Spectrum Disorder is the new name and a single category for autistic disorder, Asperger disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS). Probably a bad idea, in my opinion, as the same diagnosis will be given to a child with mild social deficit and severely autistic, nonverbal, and not functional one. In addition, it would be impossible to find out that there might be more than one disorder in this group, as all of them will carry the same name.4. Binge Eating Disorder is a newcomer to the group - anorexia nervosa, bulimia nervosa, and eating disorder NOS - three different conditions which ended up in the Eating Disorders group only because they have something to do with food. There does not seems to be a good reason to add another one.5. Disruptive Mood Dysregulation Disorder (DMDD) is a new category and infact a welcome addition. Moodiness, anger, and emotional outbursts in children have been subject of diagnostic controversy for the last two decades. Unfortunately, the issue was hijacked by some unscrupulous members in academia in tandem with a couple of profit seeking pharmaceutical companies. Previous decade saw forty fold increase in diagnosis of pediatric bipolar disorders. While some children develop bipolar illness as they grow up, overwhelming majority do not. In children, common reason for "manic behavior" is immaturity of the brain, partly responsible for control of emotions (Executive Function Network located mostly, but not exclusively, in pre-frontal area of the brain), while emotions themselves are mild or moderate. By analogy, a car collision might be explained either by revved up engine or failed breaks, but rarely by two failures at a time. Children's "breaks" are commonly weak, while extremes of emotions (frequently diagnosed in adults as Intermittent Explosive Disorder or Mania) are relatively rare. DMDD brings "sanity" into the insane world of pediatric bipolar disorders and redirects our focus on weak inhibition vs. excessive "excitation".6. New to the DSM-5 is bringing together obsessive-compulsive and other

disorders previously found under category of Impulse Control Disorder (OCD, Body Dysmorphic Disorder, trichotillomania - hair pulling, Intermittent Explosive disorder, etc.) into a broader class of disorders. Two new conditions which also include adding excoriation (skin-picking) and hoarding disorder to the group. In my opinion, that was a premature move. Compulsion (an irresistible urge to behave in a certain way) and impulsiveness (acting suddenly on impulse without reflection) are not the same: one can have, the other, both, or neither one. Lumping these distinctly different disorders into one category is premature and unfounded.7. In personality Disorders category, all 10 original (DSM-IV) disorders remained, but the axes boundaries separating them from other psychiatric disorders were removed. Sharp division between personality disorders has always been seen as artificial, nevertheless, the committee, after long deliberation, left them intact. To my regret, Depressive Personality Disorder (DPD), so common in clinical practice was not resurrected. Originally included in DSM II, DPD was never recognized as a distinct entity in subsequent editions, and only showed up in the Appendix B of DSM-IV TR for consideration for later studies.8. The new umbrella category, or chapter, in DSM-5 is titled Trauma- and Stressor-Related Disorders and includes posttraumatic stress disorder (PTSD) and a new diagnostic sub-type for pre-school children. The significance and reliability of the new subtype will take time to validate.9. The new specifier "with mixed features" can be used now with bipolar disorders and Major Depressive disorder (MDD). Mood is divided into predominant (depression, mania, or hypomania) and secondary (subclinical). This development, in my view, will broaden the application of mood disorder diagnosis and will allow flexibility in description of nuances of mood fluctuation. Bereavement exclusion, reserved for depressive symptoms lasting less than 2 months after a loss, has been removed from MDD criteria in DSM-5. Although depression is almost universal and predictable reaction to death of a loved one, it is virtually impossible to separate it from a any other stress induced depressive episode.10. Substance abuse and substance dependency, separate criteria in the previous edition, were combined in to substance use in DSM-5, each substance use divided into mild, moderate, and severe subtypes.11. To avoid stigmatizing patients with dementia, DSM-5 introduced neurocognitive disorders in its place. The new edition distinguishes different types of these disorders: Alzheimer disease, Lewy body disease, Parkinson disease, HIV infection, and vascular disease. The disorders are divided into mild and major degree of impairment. I believe it is a move in the right direction. As the population ages, we need better understanding of various types of amnesia, cognitive decline and neuronal degeneration. Studying these diseases will allow better understanding and, prediction of natural course, prevention and treatment.12. DSM manual, probably in reverence to the psychoanalytical past, always paid excessive attention to sexual

perversions, disproportionate to their prevalence and impact. In this edition, while keeping criteria unchanged, the committee advised to discriminate between paraphilic behavior and paraphilic diseases.13. During the DSM -5 writing other disorders were considered. Among them were Relational disorder, Developmental Trauma Disorder, Parental Alienation Syndrome, Internet Addiction Disorder, Male-to-Eunuch Gender Identity Disorder, Disorders of Extreme Stress, Not Otherwise Specified, etc. Thankfully, they didn't make it.DSM, despite its new Arabic vs. Roman numeral - 5, is still the same hodge-podge of random symptoms, syndromes, and their clusters with various labels, grouped not by their intrinsic similarities but superficial likeness, e.g. having to do with eating, eliminating, having childhood onset, related to sex, happening soon after "an event", etc. Until the committee and the APA recognize fundamental weakness and confusion of their approach to classification, professionals and patients alike will keep using the document, as Allen Frances, M.D (the chair of the DSM-IV edition) put it, "cautiously, if at all."In conclusion, I would like share a classification from "certain Chinese Encyclopedia" from Jorge Luis Borges `s The Celestial Emporium of Benevolent Knowledge which, in my opinion, accurately reflects the DSM committee's attempt to organize psychiatric disorders:"The animals are divided into: those that belong to the Emperor, embalmed, those that trained, suckling pigs, mermaids, fabulous, stray dogs, those that are included in the present classification, those that tremble as if they were mad, innumerable ones, those drawn with a very fine camel hair brush, et cetera, those that have just broken a pitcher, those that from a long way off look like flies."

Ok, I have taken some time to actually read through DSM 5. While DSM has often been scrutinized--both for what it includes, as well as what it doesn't--the back-lash against the newest edition has been particularly pronounced these past few months. Part of this stems from the micro-analysis that happens with many things in our modern world, though we have to admit that ego, resentment, and a misunderstanding of the process also plays a part. In addition, historical debate over DSM typically took place in-house; that is, by clinicians. With DSM 5, this has broadened to people who have little- to no understanding of the diagnostic process, its purpose, and its strengths/limitations. Thus, there has been a lot of negative press about DSM 5 in Huffington Post, NY Times, and other sources, often by people with practically no understanding of mental health.Why 5 stars, you might ask? Because my review is based on DSM 5 as a book, not anything else having to do with DSM as a concept or tool. This particular edition 'reads' well, in that the text and lay-out is clear. In contrast to previous editions, the reader will be given more orientation to the book and how to use it. The diagnostic criteria is familiar and through the Table of Contents, Index,

and quick-view pages, it is easy to find the diagnosis or category you're looking for. Yes, it's bulky and expensive, but you should have the large edition in your library for now; later, when you're more familiar with the changes, you can buy the quick-reference guide.As a child psychologist who conducts psychological and neuropsychological evaluations--for social service agencies, schools, the courts, and for families--DSM plays a prominent role in my work. In addition, I have taught a course on DSM to masters-level graduate students for the past 10 years. In my role as a psychologist, I have witnessed first-hand how a DSM diagnosis is formulated, applied, and interpreted. I have also seen the benefits and limitations of assigning a DSM diagnosis to a client. In the end, however, most people are less concerned about the diagnosis, per se, and more about how to facilitate services, treatment or quality of life/education for the individual to whom it is assigned. This will still be the case now that DSM 5 is published.Through the years, DSM has attempted to reflect our understanding of mental health symptomatology and how it impacts people across the lifespan. This continues to be the case with DSM 5, though admittedly, mental health is a `young' science, and there is much about the human condition we don't fully understand (neither DSM nor any other classification system can help us account for the Sandy Hook shootings; the Cleveland kidnapping case; the Boston bombing; or many other actions our fellow human beings engage in).With DSM 5, there are some noteworthy modifications to how we code a mental health diagnosis. Thus, users will need to read the introductory chapter in order to make sure their work reflects these changes. In contrast to what has been hyped in the popular media, DSM 5 does not pathologize grief or childhood tantrums. It doesn't randomly lower thresholds, to make it such that more people will now be diagnosed with ADHD, depression, or Bipolar Disorder. And it doesn't eliminate most of the diagnoses that were previously applicable. Rather, DSM 5 reframes some criteria, clarifies various symptom presentations, and tries to shape our perspective on clinical diagnosis. In particular, DSM 5--in contrast to earlier editions--helps to reinforce that we should view most diagnoses from a lifespan perspective, while staying mindful of the fact that its presentation can vary in severity or magnitude. As with previous editions, DSM 5 provides a classification of mental health disorders, but it doesn't make inference about how these should be treated.In my opinion, DSM is simply one tool we as clinicians use to formulate an understanding of what is happening with a client at any given time. It also serves to provide us with a `common' language, since a diagnosis will be assigned to most of the clients with whom we work. Much of this language, as used in DSM 5, will be familiar, and those of you who have used DSM thus far won't find that the content has changed that much. When you skim the Table of Contents, for example, you won't see a lot of new diagnoses, but you will see a re-working of where some of them are placed (PTSD and

OCD, for example, are no longer in the Anxiety Disorders classification).In particular, I like the expansion we see portrayed in DSM 5 of neurodevelopmental disorders; better clarification for avoiding a mis-diagnosis of Bipolar Disorder with children; the placement of Autism on a spectrum; and distinctions of how PTSD manifests in young children versus adults. What we've previously known as Reactive Attachment Disorder is now split into two separate classifications (to reflect discriminate and indiscriminate manifestations, accordingly). DSM 5 no longer has the classification, `Disorders First Evidenced in Infancy and Early Childhood.' Instead, the classifications are supposedly arranged by manner in which they appear in the lifespan. This rationale doesn't really fit, however, as many of the kids I see in my practice have substance use and/or neurocognitive disorders, which--using this rationale--the authors put later on in the book.Overall, DSM 5 reflects the evolution we are all involved in, as we try to understand and account for the mental health symptomswhich impact large numbers of the population. People are much more complex than the diagnoses we assign to them, but DSM at least provides us with a place to start. What happens after that depends upon the skill of the clinician; ultimately, isn't that what most of our clients are concerned with?

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