“Weighing the Ethical and Practical issues of Lifestyle vs. Risk to Community Safety“

“Ethics & The Hoarding Dilemma”

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28th Annual
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Justice for All: Protecting Vulnerable Adults

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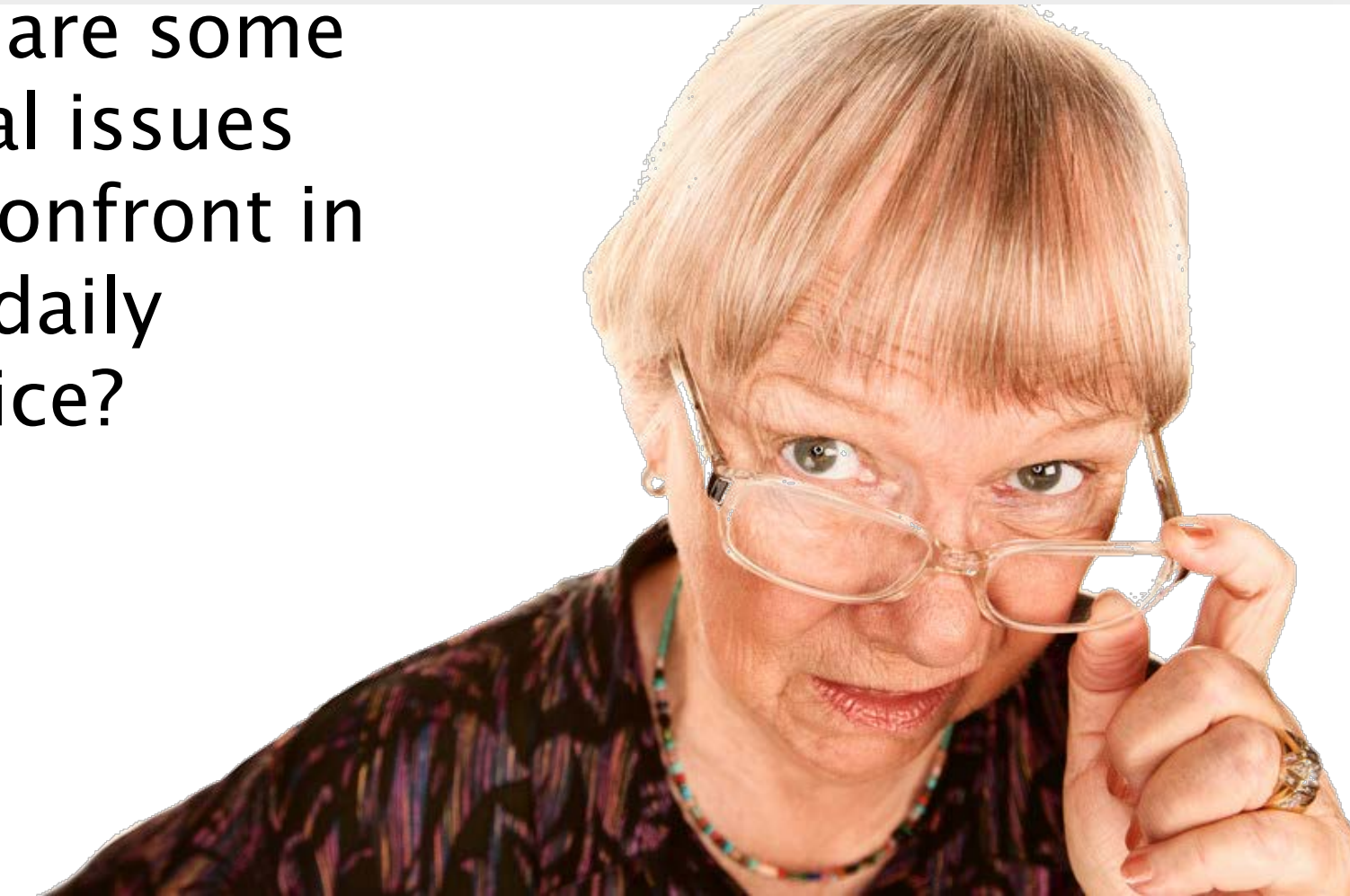
Objectives

- Determine specific ethical actions
- Identify at least five client rights
- Increase ethical self-knowledge.
- Commonly Hoarded Items
- Discovery
- Functional Impairment
- Impact of Clutter
- Decision Making

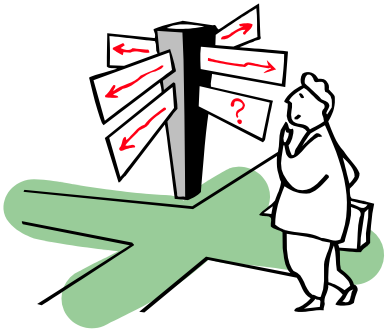
ACTIVE LEARNING #1: Large group

Brainstorming:

What are some ethical issues you confront in your daily practice?



Ethical Dilemmas



- Protection vs. autonomy
- Lifestyle vs. risk to community safety
- Treatment vs. Prevention

Rights of APS Clients

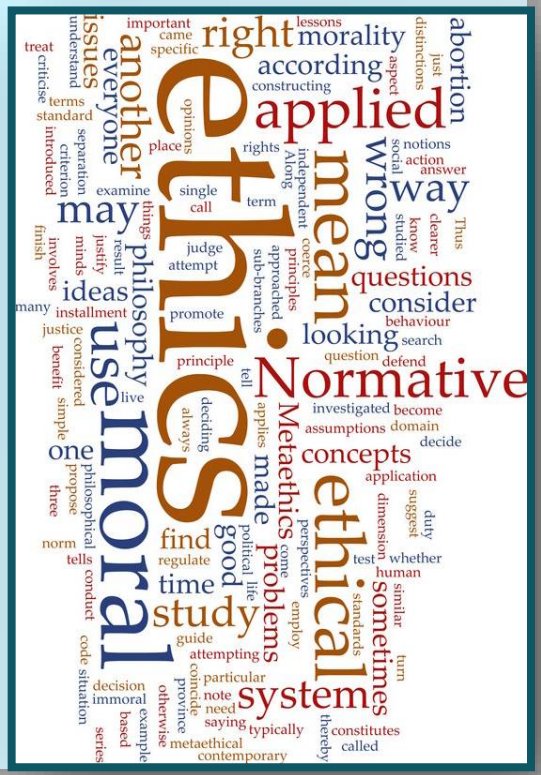
The client has the right to:

- decline adult protective services
- participate in all decisions
- least restrictive alternative
- decline medical treatment
- have a prompt and thorough investigation
- protection from abuse

Ethics and Values in APS practice

ETHICS: Defined

- "Good" or "right" conduct
- Branch of philosophy dealing with values of human conduct
- Useful in assessing the rightness of decisions and the fairness of the decision-making process



Ethics: code of ethics

- Why do we need them?
- How do they guide us professionally?

APS Guiding values

- Every action taken by APS must balance the duty to protect with the right to self determination
- Older people and people with disabilities who are victims of abuse, exploitation or neglect should be treated with honesty, caring and respect.

Napsa: aps ethical principles

- Adults have the right to be **safe.**
- **Adults retain all their civil and constitutional rights** unless some of these rights have been restricted by court action.
- **Adults have the right to accept or refuse services**
- **Adults have the right to make decisions** that do not conform with societal norms as long as these decisions do not harm others.
- **Adults are presumed to have decision-making capacity** unless a court adjudicates otherwise.

Ethical concepts: Autonomy

- Right of individuals to make choices as long as they have decision-making capacity and cause no harm to others. Decisions should be voluntary, intentional and not due to coercion, duress, or undue influence.

Ethical concepts: Beneficence

- Right to receive care by others that maintains and/or enhances the client's welfare.

Ethical concepts: Non-maleficence

- Right to expect others to “do no harm” in the maintenance or enhancement of the client’s welfare

Ethical concepts: privacy

- Right to maintain privacy regarding personal information, interpersonal relationships, physical environment, and lifestyle, as long as it does not infringe on the rights of others.

Ethical concepts: Fidelity

- Right to have others show loyalty or commitment to the client when they need help.
- Right and responsibility of family members to care for and assist one another (e.g. filial piety).
- **APS Workers**: Include and respect ideas of family members and significant others.

Ethical concepts: Accountability

- Right to expect others to tell the truth and be responsible for their actions.
- Right to expect others to expose the deception and irresponsibility of others.

Ethical concepts: Justice

- Right to be treated equitably whether they are a caregiver or care receiver.

ETHICAL DILEMMA

Ethical dilemma: definition

- An ethical dilemma presents a choice between two relevant sets of values, two good things.

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“Clutter to Chaos”

Persons whose lives revolve around hoarding

What are the Ethical Situations with Hoarding Clients?

- 1.
- 2.
- 3.
- 4.

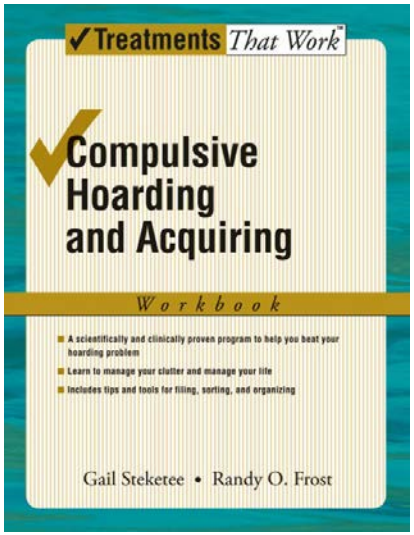
IT IS A HUGE PROBLEM!

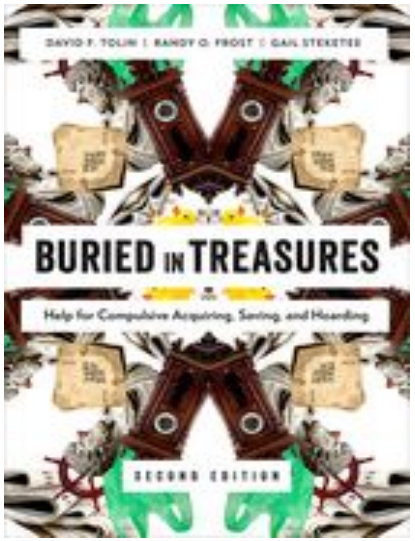
This is a much bigger problem than most people think!

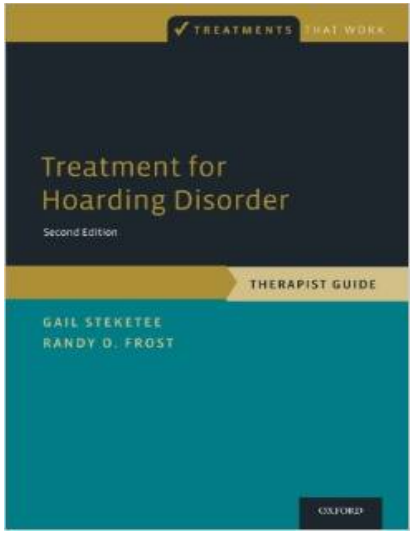
Hoarding

- 2012:
  - More than 75 Hoarding Task Forces in US & Canada
  - 3 Reality TV shows on hoarding
  - More than 2 dozen hoarding research labs across the world

Recent Books







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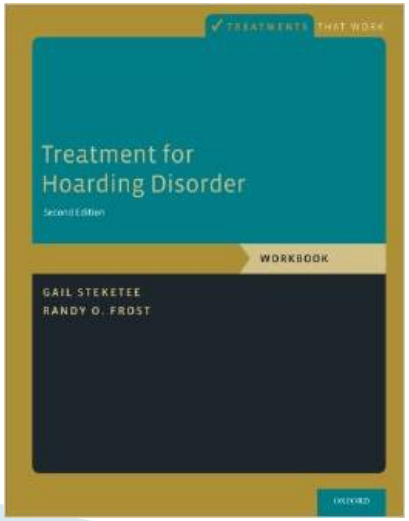


HOARDING IN ELDERS

- 15% of nursing home residents
- 25% of community day care elder participants hoarded small items

Rate of hoarding among elders in private and public housing :

- Elders at Risk Program, Boston 15%
- Visiting Nurses Assn., NYC 10-15%
- Community Guardianship, NC 30-35%

Discovery

- **APS/CPS – 40% hoarding complaints to local health departments are from elder services**

- **84% of hoarding cases come through discovery by another agency or neighbors or family - Landlords, property managers,– Fire or police departments**

Modern day cases

Hoarder Dies in Home; Removed Via Hole in Roof —

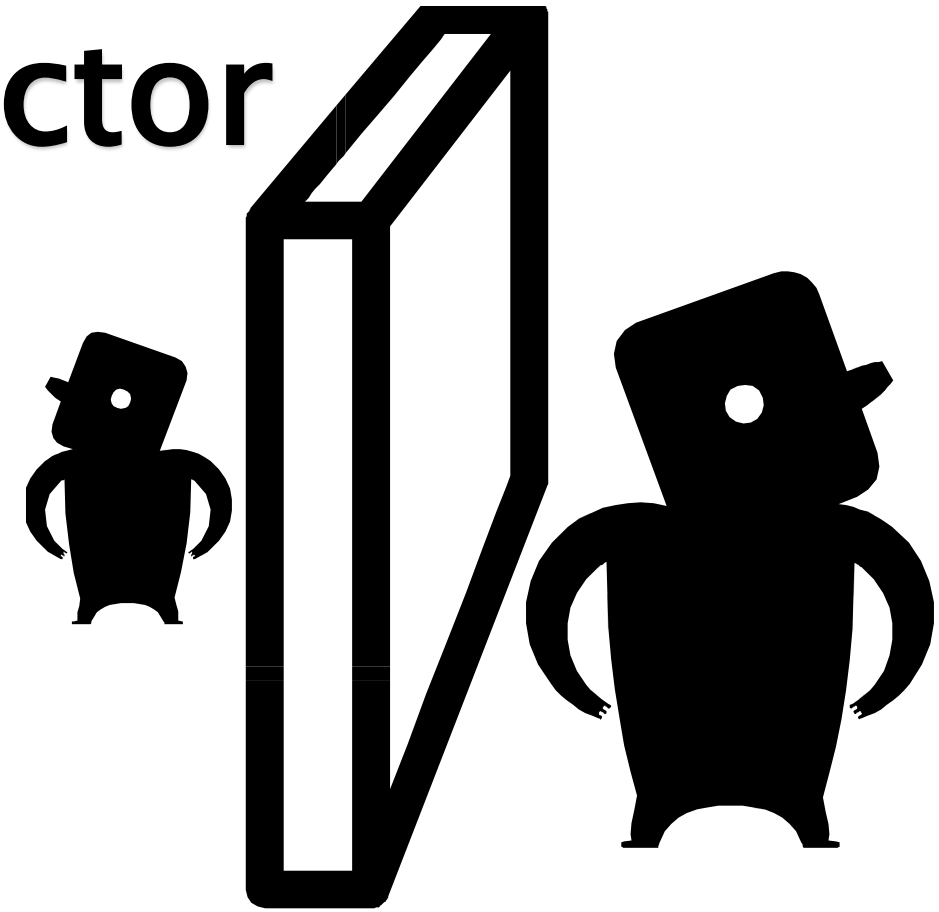
“A hoarder was stuck in so much garbage and debris and junk that when she died, she had to be removed through a hole cut into the roof of her hovel.”

CAUSES OF HOARDING

by: Dr Randy Frost

Hoarding as a Psychiatric Symptom

Collector



Hoarder

ACQUIRING BEHAVIORS

Differences in Acquiring process	Collectors	HD
Gather relevant information	95%	35%
Planning for acquiring specific objects	75%	35%
Getting attached	50%	35%
Searching for specific items	95%	18%
Feeling rewarded by purchase	95%	77%
Organize collected items	95%	47%

Mataix-Cols et al., 2012

REASONS FOR DIFFICULTY DISCARDING

	Collectors	HD
Useful in future	95%	100%
Sentimental attachment	90%	90%
Monetary value	50%	59%
Avoid waste	10%	55%**
Object is unique	55%	69%
Misuse of personal information	0%	31%**
Part of personal identity	80%	86%

Key Differentiating Features

Feature	Normative collecting	Hoarding Disorder
Onset & Course	Childhood; intermittent	Childhood; Chronic
Prevalence	70% children; 30% adult	1-5% adult
Use of Objects	Common	Rare
Object Content	Very focused	Unfocused
Acquisition Process	Structured	Unstructured
Excessive Acquisition	Possible, but less common	Very Common
Level of Organization	High	Low
Presence of Distress	Rare	Very Common
Social Impairment	Minimal	Severe
Occupational Impairment	Rare	Common

Diagnosis of Hoarding and the DSM-5

American Psychiatric Association DSM-5 Development

A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.

B. This difficulty discarding is due to a perceived need to save the items and distress associated with discarding them.

American Psychiatric Association DSM-5 Development

C. The symptoms result in accumulation of possessions that congest and clutter active living areas and substantially compromise their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).

American Psychiatric Association DSM-5 Development

E. The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi Syndrome).

F. The hoarding is not better accounted for by the symptoms of another DSM-5 disorder (e.g., hoarding due to obsessions in Obsessive-Compulsive Disorder, decreased energy in Major Depressive Disorder, delusions in Schizophrenia or another Psychotic Disorder, cognitive deficits in Dementia, restricted interests in Autism Spectrum Disorder).

American Psychiatric Association DSM-5 Development

Specify if: 'With Excessive Acquisition: If symptoms are accompanied by excessive collecting or buying or stealing of items that are not needed or for which there is no available space."

American Psychiatric Association DSM-5 Development

Specify if: **Good or fair insight:** Recognizes that hoarding- related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic.

Poor insight:

Absent insight:

American Psychiatric Association DSM-5 Development

Specify if:

Good or fair insight:

Poor insight: Mostly convinced that hoarding-related beliefs and behaviors are not problematic despite evidence to the contrary.

Absent insight:

American Psychiatric Association DSM-5 Development

Specify if:

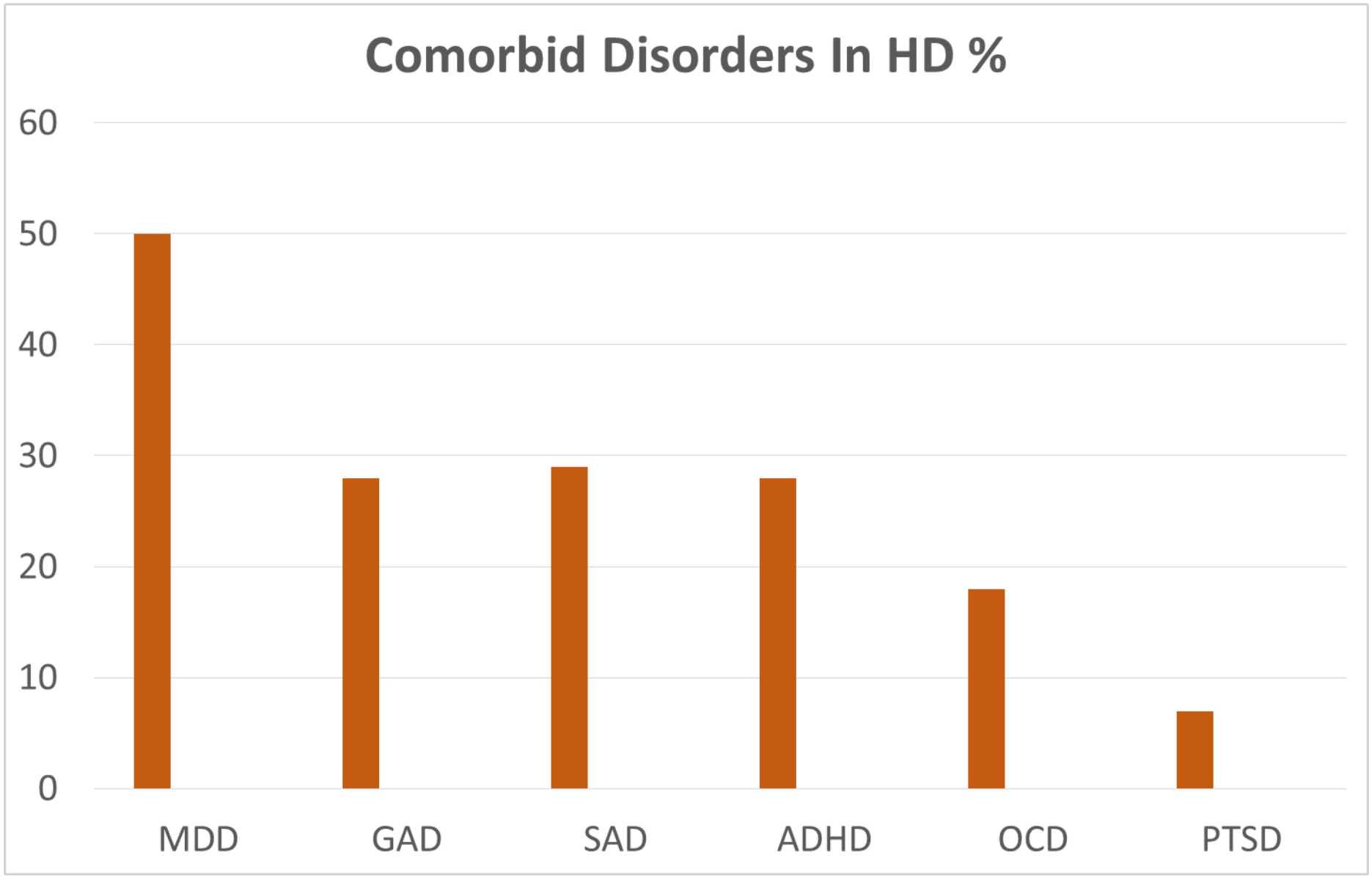
Good or fair insight:

Poor insight:

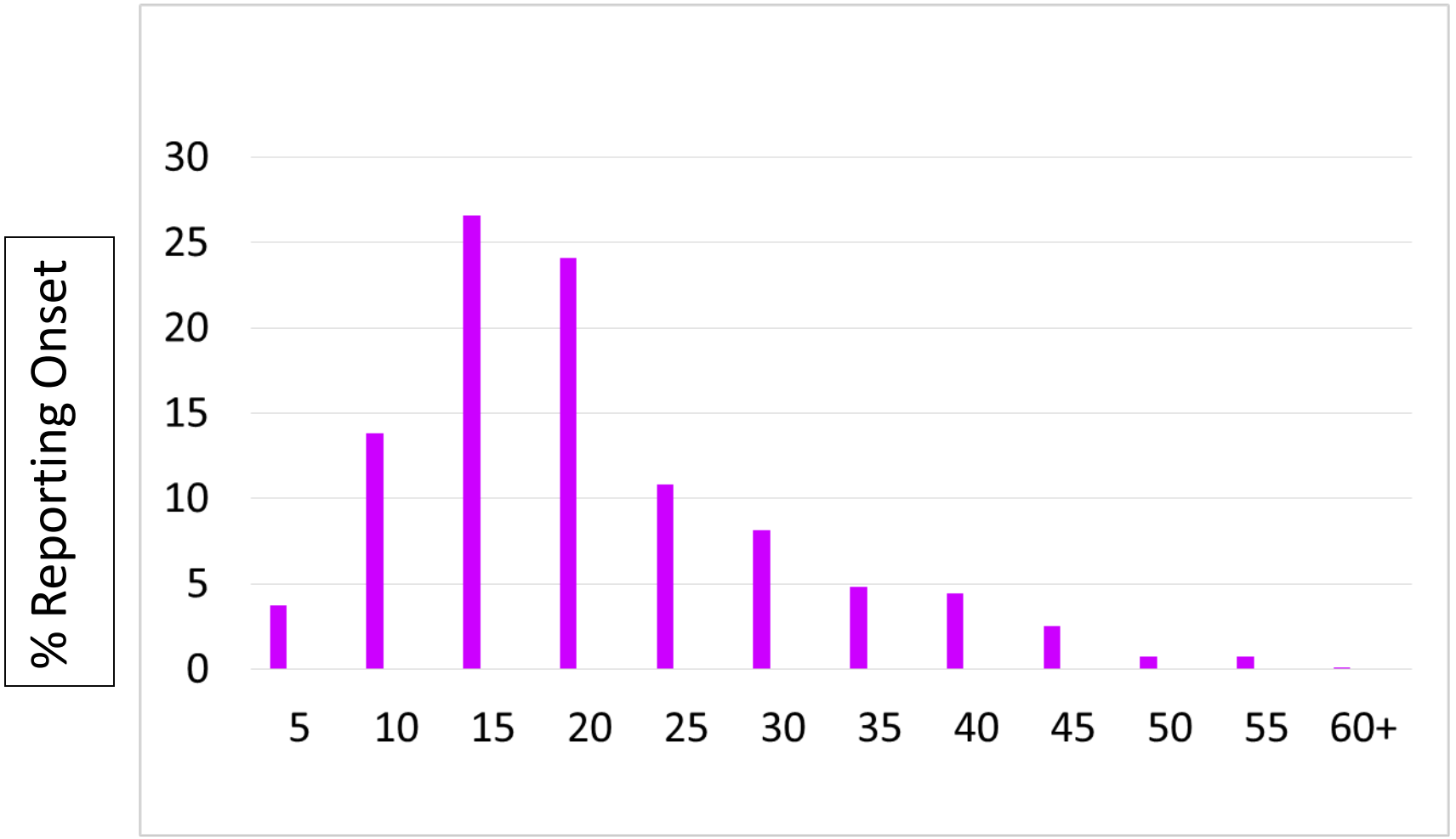
Absent insight (Delusional beliefs about hoarding): Completely convinced that hoarding-related beliefs and behaviors are not problematic despite evidence to the contrary.

PERCENTAGE WITH SIGNIFICANT ACQUISITION PROBLEMS

Frost et al., J A 639
Anxiety Disord 2009;23:632-


Comorbid Disorders In HD %
60
50
40
30
20
10
0
MDD
GAD
SAD
ADHD
OCD
PTSD

Age of Onset in Hoarding



COURSE OF COMPULSIVE HOARDING

- Saving begins in childhood or adolescence
- Clutter does not become severe until adulthood
- Chronic or worsening course

  |Insight begins later than the symptoms, and fluctuates

Intervention Differences: Elders vs. Younger Adults

- Strong ambivalence
- Need for strong relationship building
- Stronger emphasis on cognitive remediation: goal setting, list making, scheduling time, calendar
- Importance of socializing as a function of therapeutic intervention
- Need for in-home coaches to assist

Impact of Clutter-

- **98%** have at least moderate difficulty moving around the house
- **70%** unable to use furniture
- **50%** unable to use Stove tops or ovens
- **45%** unable to use refrigerator or freezer
- **42%** unable to use tubs or kitchen sinks
- **10%** unable to use toilets









HAZARDS OF HOARDING

Poor Sanitation | Mobility Hazard | Blocked Exits | Community Cost | Homelessness | Fire Hazard

Clinical Features Older Hoarders

90% have mild or no memory/cognitive deficits

85% have little or no insight that clutter is problem

30% have severe to substantial interference with self-hygiene because of clutter

77% have or may have mental disorder

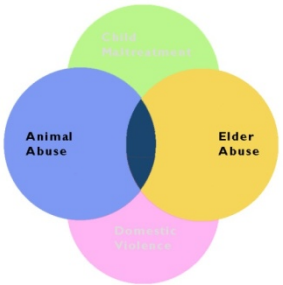
More often women

More often live alone and clutter more severe if never married

What Are the Links between Elder Abuse and Animal Abuse?

Key Statistics:

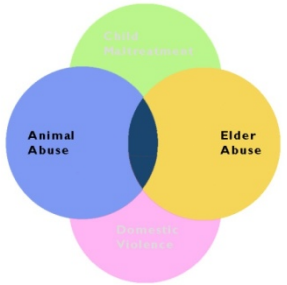
- 92% of Adult Protective Services case workers saw animal neglect co-occurring with clients' inability to care for themselves.
- 45% observed intentional animal abuse or neglect.
- 75% reported clients' concerns for animals' welfare impacted their decisions to accept interventions or services.



National Link Coalition
Working together to stop violence against people and animals

What Are the Links between Elder Abuse and Animal Abuse?

What Is Animal Hoarding?

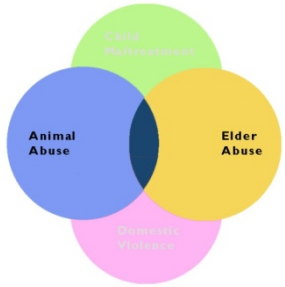


- Not a harmless eccentricity but a serious mental health, public health and environmental issue requiring multidisciplinary interventions.
- 100% recidivism rate.

National Link Coalition
Working together to stop violence against people and animals

What Are the Links between Elder Abuse and Animal Abuse?

Who Are Animal Hoarders?



- Many mental health disorders identified with animal hoarding.
- Current thinking: An Attachment Disorder stemming from early childhood traumas. Hoarders seek comfort in non-threatening, non-judgmental, non-humans.

National Link Coalition
Working together to stop violence against people and animals

Service Planning
&
Compulsive Hoarding

Who do you want on your team?

What can we do?

Service Planning is still what it has always been…..

Client centered

What two things will you take away with you from today's workshop?

Thanks Y'all !!!!

Mahalo!!!!

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Clutter and Hoarding

In 2003, an interdisciplinary **New York City Hoarding Task Force** was convened to address the complex behavioral disorder of hoarding in older adults and to develop practical tools and resources for community service providers.

As our population ages, hoarding has been increasingly recognized as a complex mental health problem that threatens the health, safety, and dignity of older adults. Although compulsive hoarding usually starts in young adulthood, it becomes particularly problematic later in life due to increased fall and fire risk. Moreover, the majority of older adults have multiple chronic health conditions, but necessary home care services may be denied until hoarding is resolved. Medicines can be buried under mounds of paper or clutter, and asthmatic conditions are exacerbated by dust and mold. Further, if the spouse dies who has been responsible for maintaining the home or if a person with advanced dementia loses the ability to organize or make rational judgments, then hoarding can spiral out of control.

A recent poll of ten Manhattan community service agencies that serve older adults revealed that approximately 10% of their clients are afflicted with hoarding behavior. Social workers reported of clients who lived in environments with

- Beds and bathtubs so filled with belongings there was no room for sleeping or bathing
- Kitchens that were unsafe and unusable due to cluttered stoves, sinks, and tabletops
- Large amounts of combustible materials blocking walking paths, radiators and fire exits
- No working toilets, sinks, heating and cooling appliances - afraid of eviction, they failed to get needed repairs
- Mounds of trash, rotten food, human and animal waste
- Insect and rodent infestation
- Many unkempt pets in need of care

These life-safety, quality-of-life and health issues not only affect the occupants but their neighbors as well. What makes hoarding so challenging is that people who hoard are usually oblivious to the problem and resist intervention. Factors such as extreme emotional attachment to possessions (including what appears to outsiders as useless junk), fear of loss, and the inability to discriminate (trash mixed with valuables) makes discarding items almost impossible.

Without a proper understanding of the psychosocial issues and reasons for hoarding, forced clean-outs, which can be costly, are often unsuccessful: dwellings revert back to an uninhabitable level within a relatively short period of time. Additionally, older adults may experience catastrophic emotional responses during forced cleanouts *requiring emergency psychiatric care*.

Understanding the reasons people hoard can help promote more therapeutic interventions, including on-going support and maintenance. It is our goal that the information contained in this section will help community agencies have a better understanding of, and more compassionate treatment for, older adults with hoarding behavior.

Best Practices

Top 20 Decluttering Tips

1. Let go of ideal notions of cleanliness. Your client may value items that appear to you as worthless or be rubbish. Parting with their belongings (even used paper cups) can cause severe emotional distress.

2. Listen to your client's ideas and plans for their belongings. Explore their hopes, both realistic and unrealistic, and accommodate them if possible. Clients have been helped to donate or sell their belongings. One woman even sent her "stuff" to relatives in her home country.

3. Work at the client's pace if you can. Start with short periods of time. Some clients cannot tolerate even a half hour in the beginning. Keep in mind, though, that a client's decluttering pace is usually slower than the eviction process.

4. Partner with a legal group, home care or nursing agency to find out what level of cleanliness your client needs to achieve in order to attain their goal, whether it be eviction prevention or home care services. You have to meet certain standards, but you *don't* have to exceed them.

5. Focus on fall prevention. Create pathways free of debris, loose cords or slippery rugs. Some frail clients hold onto furniture or other items while moving through the home; ask how your client gets around and preserve their "props" until other assistive devices (canes, walkers) can be introduced.

6. Focus on fire prevention. Make sure your client has a smoke alarm and test it monthly. Red flags include newspapers stored on top of or inside a gas stove or near working radiators. Help relocate their belongings from a hazardous area to a safe place.

7. Be creative and negotiate. Perhaps the client can keep the previous year's copy of a particular magazine, but throw away the prior twenty years' collection. Consider photographing belongings, as this may help the client part with them and preserve memories.

8. Begin by reorganizing, if time allows. Start with a small corner of a room, a single table, or just a section of the table.

9. Ask your client what they would like to do that currently they cannot do because of the clutter. For example, "Would you like us to help you to figure out how you can cook again?" or "How could you do this differently so you can use the stove?"

10. Motivate your client by helping them be realistic. Some clients will declutter only if told they face eviction or cannot be discharged home after a hospitalization. Gentle but firm pressure is appropriate if a client's home or health are at stake.

11. Create a limited number of categories for belongings. Large plastic crates or wicker baskets can help separate items into these categories.

12. Be resourceful in finding workers. Volunteers and other informal supports have been used with success, such as hired high school students who pack up agreed upon donations.

13. Have a social worker present during a major cleanout, preferably one who already has a supportive relationship with the client. Clean-outs can be overwhelming to people with severe hoarding behavior. Have a

back-up plan in case emergency psychiatric services are needed.

14. Discuss how to safeguard valuables in the cleaning process. Have a written contract. Agree on what to do with valuables that turn up, such as money, jewelry, checks, bonds, stock certificates, collectibles.

15. Call the ASPCA if you need help finding a temporary or permanent home for pets while the cleanout is being conducted.

16. Consider relocating an individual to a new apartment if the clutter is the result of physical or mental frailty. A new environment can provide a fresh start and enable the client to receive needed services sooner.

17. Encourage the client to participate even during a major cleanout. Get them involved so they can be part of the process and have some level of control. Ask them if you can help find something they might be looking for, or give them a box to help sort through.

18. Plan for a carefully orchestrated clean-up which can result in decreased client anxiety. Make sure you make arrangements

- with the building for entrance and egress when removing possessions and trash
- for use of the elevators
- for cost, rental and removal of dumpsters (***Do not*** *leave a dumpster or trash bags on the property after a cleanout, even overnight)*
- for storage if needed, including cost of transportation to storage facility

19. Communication is Vital. It is important for the client to communicate with the cleaning crew - making their concerns known. If the crew doesn't speak the same language as the client, there should be a supervisor/translator/advocate present so that the client can make his/her needs known and can feel as if he/she has some control over the situation.

20. Plan for on-going maintenance and supervision to maintain a decluttered environment.

Best Practices

Working With Individuals With Dementia Who Rummage and Hoard

People with dementia experience memory loss, mental confusion, disorientation, impaired judgment and behavioral changes, which may include rummaging and hoarding. The following information may be helpful to you when working with individuals who are experiencing these symptoms.

Rummaging

People with dementia may spend excessive amounts of time rummaging through their possessions. This may happen because they are searching for items they have misplaced or hidden. Oftentimes, people with dementia hide their possessions, forget where they have hidden them, and then blame others for stealing them.

Rummaging behavior may also result from boredom as people with dementia find it difficult to initiate activities and rely on others to keep them active. Quite often, redirecting individuals to activities that they enjoy, such as music, gardening, and/or meal preparation, can help distract them from engaging in distressing behaviors. For individuals in the later stages of dementia, certain repetitious activities, such as folding napkins or sorting colored socks, can satisfy the need to be active and engaged.

Hoarding

Some people will hoard or save numerous items, including dirty clothes, food, and papers. Keep in mind that individuals with dementia are continuously losing parts of their lives. Losing a meaningful role in life, an income, friends, family, and a good memory can have an impact on a person's need to hoard and or to "keep things safe". Hoarding in this population is oftentimes triggered by the fear of being robbed.

When working with persons who have dementia, it is essential that you keep their safety in mind as they become increasingly unable to protect themselves. Order, routine and simplicity are most helpful and a house or apartment that is relatively uncluttered is the ideal environment.

Tips to Consider

1. **Building trust** – Any changes you make in the home of a person with dementia could cause the person to become very anxious and agitated. It is essential, therefore, that you build a sense of trust between yourself and your client before you attempt to make any changes at all.

2. **Focus on fire prevention** – Check for papers stored on top of or inside a stove or microwave, and near working radiators. Make certain your client has a working smoke alarm and arrange for someone to test it monthly.

3. **Focus on preventing poisonous ingestion** – Be aware that people with dementia may not recognize that some things are not good to eat. Keep potentially dangerous materials such as cleaning fluids, plant soil, lotions, and medicines out of reach. Check the refrigerator on a regular basis to make sure that rotten food is thrown away.

4. **Focus on fall prevention** – Make certain that pathways are clear and that there are no slippery rugs that could cause falls. Keep in mind that some frail adults hold onto furniture while moving through the home. Observe how your client gets around and make sure that these supports are stable.

5. **Minimize the number of hiding places** by locking unused closets or doors Put signs that say "NO" or "STOP" on places that you want the person to stay out of. Note: This may not work for people who are advanced in the illness.

6. **Limit the amount of valuables** or cash that are within reach of the person with dementia.

7. **Keep the amount of junk mail to a minimum** so the person has less to manage. If possible, arrange for bills to be sent to some one else for payment.

8. **Remove non-essentials** such as out of season clothing to lessen the amount of clutter. Remember, however, that a person with dementia will experience increased anxiety if she/he believes that these possessions have been stolen.

9. **Understand coping mechanisms** – For example, some people with dementia keep their belongings, including clothing, out in the open otherwise they forget where they have placed them. This coping mechanism, with oversight by a caregiver, may help a person continue to function in the beginning or middle stages of the disease. Other individuals may be willing to put their belongings away if large signs or labels, such as "Socks" or "Blouses" help them identify the location of their possessions.

10. **Fill a drawer full of "odds and ends"** for the person to enjoy rummaging through.

11. **Check wastebaskets for "lost" items** before they are emptied.

12. **Provide support** such as home care for on-going maintenance.

13. **Learn their hiding places** – If a person hides things, learning where their favorite hiding places are will help you locate their important items. Items are often put in the same places, such as under carpets or mattresses and in shoes, handbags, coat pockets, or drawers.

14. **Keep duplicates of important items** such as glasses, hearing aids, keys, etc. as back-up. Have the client's doctor's name on hand if duplicate prescriptions need to be filled.

15. **Remove discarded items immediately** – If you are removing items from your client's home, it is best to remove them immediately from the premises or your client may rummage through the garbage and bring them back into the house.

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http://www.chipnyc.org/CHIP%20Advisor/archives/2004_archives.shtml

Hoarding Task Force

The first seminar on Hoarding was sponsored by the Hoarding Task Force on January 21 at Cardozo Law School. The seminar was attended by Social Workers, Property Owners and Landlord-Tenant attorneys. The seminar presented the findings of the task force, which was formed last year to deal with the unique situation of clutter in apartments with long-term renters.

Most people are familiar with famous case of the Collyer Brothers, who were both found dead in their Harlem Brownstone, buried under their own extensive collection of junk. However, this syndrome, known as compulsive hoarding can take many forms, less extreme than the Collyers- it is a growing concern as the New York City population ages. Rent regulation was acknowledged as a factor of the hoarding cases in the City due to the length of time people remain in apartments.

Compulsive hoarding has many dimensions; when a person becomes emotionally attached to objects and cannot part with them or when a person collects multiple items that others have discarded. The reasons for hoarding can be varied and may be exacerbated by both mental illness and the aging process. Previously, Property Owners with these situations had no choice but to commence costly legal proceedings.

The Hoarding Task Force has developed an intervention protocol which allows Owners to use the services of various Social Service Agencies to work with the Tenant in an attempt to control the behavior prior to commencing eviction proceedings.

Information regarding local contacts and Social Service Agencies is now available through the Hoarding Task Force website, http://www.cornellaging.com/gem/hoarding_index.html

HOARDING ASSESSMENT TOOL

By Randy Frost, Ph.D.

Telephone Screening:

Date referral received: _____

Worker receiving call: _____ Department: _____

Client name: _____ Age:_____

Address: _____

Type of dwelling: _____ Phone: _____

Referral Source (may be omitted to preserve confidentiality): _____
Phone: _(_____)_____-_____

Household members: _____

Pets/animals? _____ Own/Rent: _____

Family or other supports: (include names and phone numbers) _____

_____

Other Programs or private agencies involved: _____

_____

Physical or Mental Health Problems of client: _____

Are basic needs being met (i.e. food/shelter)? _____

Clients' attitude towards hoarding _____ Will client allow access:_____

Description of Hoarding Problem: (presence of human or animal waste, rodents or insects, rotting food, are utilities operational, are there problems with blocked exits, are there combustibles etc.)

_____

_____

_____

Other Problems/ Needs: _____

Initial Hoarding Severity Rating: None ___ Mild ___ Moderate ___ Severe ___

Others to Involve in Initial Assessment: _____
_____

*Modified after Arlington County, VA Hoarding Task Force's Assessment Tool

Condition of the Dwelling: (to be completed at the property)

Date: _____

Response Team Members and Phone numbers: _____

'Please indicate whether the following appliances/utilities are in working order.'

	Yes	No	Unknown			Yes	No	Unknown
Stove/Oven	1	2	9		Fridge/Freezer	1	2	9
Kitchen sink	1	2	9		Bathroom sink	1	2	9
Washer/Dryer	1	2	9		Toilet	1	2	9
Electricity	1	2	9		Water heater	1	2	9
Furnace/Heat	1	2	9		Shower/Tub	1	2	9

Other:

'Please indicate the extent of each of the following problematic living conditions.'

	none	somewhat	severe	Comments
Structural damage to house	0	1	2	
Rotten food in house	0	1	2	
Insect or rodent infestation in house	0	1	2	
Large number of animals in house	0	1	2	
Animal waste in house	0	1	2	
Clutter outside of the house	0	1	2	
Cleanliness of the house	0	1	2	
Other (e.g. human feces)	0	1	2	

'Please indicate the extent to which each of the following safety problems exist.'

	Not at all	Somewhat	Very Much	Description
Does any part of the house pose a fire hazard? (e.g. unsafe electrical cords, flammable object next to heat sources like furnace, radiator, stove)	0	1	2	
How difficult would it be for emergency personnel to move equipment through the home?	0	1	2	
Are the exits from the home blocked?	0	1	2	
Are any of your stairwells unsafe?	0	1	2	
Is there a danger of falling due to the clutter?	0	1	2	

'Please indicate the extent to which clutter interferes with the ability of the client to do each of the following activities.'

Activities of Daily Living	N/A	Can do	Can do with difficulty	Unable to do	Comments
Prepare food (cut up food, cook it)	0	1	2	3	
Use refrigerator	0	1	2	3	
Use stove	0	1	2	3	
Use kitchen sink	0	1	2	3	
Eat at table	0	1	2	3	
Move around inside the house	0	1	2	3	
Exit home quickly	0	1	2	3	
Use toilet (getting to the toilet)	0	1	2	3	
Use bath/shower	0	1	2	3	
Use bathroom sink	0	1	2	3	
Answer door quickly	0	1	2	3	
Sit in your sofas and chairs	0	1	2	3	
Sleep in your bed	0	1	2	3	
Clean the house	0	1	2	3	
Do laundry	0	1	2	3	
Find important things (e.g. bills)	0	1	2	3	
Care for animals	0	1	2	3	

Client Assessment: (to be completed during an interview with the client)

Mental Health Issues: (e.g., Dementia; see guidelines) _____

Frail/ elderly or disabled: _____

Family and other social supports: _____

Financial status/ ability or willingness to pay for services: _____

Hoarding Interview (questions to ask the client):

1. Because of the clutter or number of possessions, how difficult is it for you to use the rooms in your home?

   Not at all Difficult Mildly Moderately Extremely Difficult

2. To what extent do you have difficulty discarding (or recycling, selling, giving away) ordinary things that other people would get rid of?

   No Difficulty Mild Moderate Extreme Difficulty

3. To what extent do you currently have a problem with collecting free things or buying more things than you need or can use or can afford?

   No Problem Mild Problem Moderate Problem Severe Problem

4. To what extent do you experience emotional distress because of clutter, difficulty discarding or problems with buying or acquiring things?

No Distress	Mild Distress	Moderate Distress	Severe Distress

5. To what extent does the clutter, problems discarding, or problems with buying or acquiring things impair or interfere with your life (daily routine, job/school, social activities, family activities, financial difficulties)?

Not at all	Mildly	Moderately	Severely

Summary:

Level of risk: None Mild Moderate Severe
(Based on assessment of condition of the dwelling.)

Level of insight: None Mild Moderate Fully aware &cooperative

(Level of insight should be determined by comparing responses to the Hoarding Interview to the observed conditions of the dwelling.)

Complicating factors: (e.g., dementia, disabled) _____

_____

Recommendations:

Highlights of Changes from DSM-IV-TR to DSM-5

Changes made to the DSM-5 diagnostic criteria and texts are outlined in this chapter in the same order in which they appear in the DSM-5 classification. This is not an exhaustive guide; minor changes in text or wording made for clarity are not described here. It should also be noted that Section I of DSM-5 contains a description of changes pertaining to the chapter organization in DSM-5, the multiaxial system, and the introduction of dimensional assessments (in Section III).

Terminology

The phrase "general medical condition" is replaced in DSM-5 with "another medical condition" where relevant across all disorders.

Neurodevelopmental Disorders

Intellectual Disability (Intellectual Developmental Disorder)

Diagnostic criteria for intellectual disability (intellectual developmental disorder) emphasize the need for an assessment of both cognitive capacity (IQ) and adaptive functioning. Severity is determined by adaptive functioning rather than IQ score. The term mental retardation was used in DSM-IV. However, *intellectual disability* is the term that has come into common use over the past two decades among medical, educational, and other professionals, and by the lay public and advocacy groups. Moreover, a federal statue in the United States (Public Law 111-256, Rosa's Law) replaces the term "mental retardation with intellectual disability. Despite the name change, the deficits in cognitive capacity beginning in the developmental period, with the accompanying diagnostic criteria, are considered to constitute a mental disorder. The term *intellectual developmental disorder* was placed in parentheses to reflect the World Health Organization's classification system, which lists "disorders" in the International Classification of Diseases (ICD; ICD-11 to be released in 2015) and bases all "disabilities" on the International Classification of Functioning, Disability, and Health (ICF). Because the ICD-11 will not be adopted for several years, *intellectual disability* was chosen as the current preferred term with the bridge term for the future in parentheses.

Communication Disorders

The DSM-5 communication disorders include language disorder (which combines DSM-IV expressive and mixed receptive-expressive language disorders), speech sound disorder (a new name for phonological disorder), and childhood-onset fluency disorder (a new name for stuttering). Also included is social (pragmatic) communication disorder, a new condition for persistent difficulties in the social uses of verbal and nonverbal communication. Because social communication deficits are one component of autism spectrum disorder (ASD), it is important to note that social (pragmatic) communication disorder cannot be diagnosed in the presence of restricted repetitive behaviors, interests, and activities (the other component of ASD). The symptoms of some patients diagnosed with DSM-IV pervasive developmental disorder not otherwise specified may meet the DSM-5 criteria for social communication disorder.

Autism Spectrum Disorder

Autism spectrum disorder is a new DSM-5 name that reflects a scientific consensus that four previously separate disorders are actually a single condition with different levels of symptom severity in two core

domains. ASD now encompasses the previous DSM-IV autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. ASD is characterized by 1) deficits in social communication and social interaction and 2) restricted repetitive behaviors, interests, and activities (RRBs). Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRBs are present.

Attention-Deficit/Hyperactivity Disorder

The diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD) in DSM-5 are similar to those in DSM-IV. The same 18 symptoms are used as in DSM-IV, and continue to be divided into two symptom domains (inattention and hyperactivity/impulsivity), of which at least six symptoms in one domain are required for diagnosis. However, several changes have been made in DSM-5: 1) examples have been added to the criterion items to facilitate application across the life span; 2) the cross-situational requirement has been strengthened to "several" symptoms in each setting; 3) the onset criterion has been changed from "symptoms that caused impairment were present before age 7 years" to "several inattentive or hyperactive-impulsive symptoms were present prior to age 12"; 4) subtypes have been replaced with presentation specifiers that map directly to the prior subtypes; 5) a comorbid diagnosis with autism spectrum disorder is now allowed; and 6) a symptom threshold change has been made for adults, to reflect their substantial evidence of clinically significant ADHD impairment, with the cutoff for ADHD of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity. Finally, ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the DSM-5 decision to eliminate the DSM-IV chapter that includes all diagnoses usually first made in infancy, childhood, or adolescence.

Specific Learning Disorder

Specific learning disorder combines the DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified. Because learning deficits in the areas of reading, written expression, and mathematics commonly occur together, coded specifiers for the deficit types in each area are included. The text acknowledges that specific types of reading deficits are described internationally in various ways as dyslexia and specific types of mathematics deficits as dyscalculia.

Motor Disorders

The following motor disorders are included in the DSM-5 neurodevelopmental disorders chapter: developmental coordination disorder, stereotypic movement disorder, Tourette's disorder, persistent (chronic) motor or vocal tic disorder, provisional tic disorder, other specified tic disorder, and unspecified tic disorder. The tic criteria have been standardized across all of these disorders in this chapter. Stereotypic movement disorder has been more clearly differentiated from body-focused repetitive behavior disorders that are in the DSM-5 obsessive-compulsive disorder chapter.

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia

Two changes were made to DSM-IV Criterion A for schizophrenia. The first change is the elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing). In DSM-IV, only one such symptom was needed to meet the diagnostic requirement for Criterion A, instead of two of the other listed symptoms. This special attribution was

removed due to the nonspecificity of Schneiderian symptoms and the poor reliability in distinguishing bizarre from nonbizarre delusions. Therefore, in DSM-5, two Criterion A symptoms are required for any diagnosis of schizophrenia. The second change is the addition of a requirement in Criterion A that the individual must have at least one of these three symptoms: delusions, hallucinations, and disorganized speech. At least one of these core "positive symptoms" is necessary for a reliable diagnosis of schizophrenia.

Schizophrenia subtypes

The DSM-IV subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) are eliminated due to their limited diagnostic stability, low reliability, and poor validity. These subtypes also have not been shown to exhibit distinctive patterns of treatment response or longitudinal course. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia is included in Section III to capture the important heterogeneity in symptom type and severity expressed across individuals with psychotic disorders.

Schizoaffective Disorder

The primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder's total duration after Criterion A has been met. This change was made on both conceptual and psychometric grounds. It makes schizoaffective disorder a longitudinal instead of a cross-sectional diagnosis—more comparable to schizophrenia, bipolar disorder, and major depressive disorder, which are bridged by this condition. The change was also made to improve the reliability, diagnostic stability, and validity of this disorder, while recognizing that the characterization of patients with both psychotic and mood symptoms, either concurrently or at different points in their illness, has been a clinical challenge.

Delusional Disorder

Criterion A for delusional disorder no longer has the requirement that the delusions must be nonbizarre. A specifier for bizarre type delusions provides continuity with DSM-IV. The demarcation of delusional disorder from psychotic variants of obsessive-compulsive disorder and body dysmorphic disorder is explicitly noted with a new exclusion criterion, which states that the symptoms must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs. DSM-5 no longer separates delusional disorder from shared delusional disorder. If criteria are met for delusional disorder then that diagnosis is made. If the diagnosis cannot be made but shared beliefs are present, then the diagnosis "other specified schizophrenia spectrum and other psychotic disorder" is used.

Catatonia

The same criteria are used to diagnose catatonia whether the context is a psychotic, bipolar, depressive, or other medical disorder, or an unidentified medical condition. In DSM-IV, two out of five symptom clusters were required if the context was a psychotic or mood disorder, whereas only one symptom cluster was needed if the context was a general medical condition. In DSM-5, all contexts require three catatonic symptoms (from a total of 12 characteristic symptoms). In DSM-5, catatonia may be diagnosed as a specifier for depressive, bipolar, and psychotic disorders; as a separate diagnosis in the context of another medical condition; or as an other specified diagnosis.

Bipolar and Related Disorders

Bipolar Disorders

To enhance the accuracy of diagnosis and facilitate earlier detection in clinical settings, Criterion A for manic and hypomanic episodes now includes an emphasis on changes in activity and energy as well as mood. The DSM-IV diagnosis of bipolar I disorder, mixed episode, requiring that the individual simultaneously meet full criteria for both mania and major depressive episode, has been removed. Instead, a new specifier, "with mixed features," has been added that can be applied to episodes of mania or hypomania when depressive features are present, and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present.

Other Specified Bipolar and Related Disorder

DSM-5 allows the specification of particular conditions for other specified bipolar and related disorder, including categorization for individuals with a past history of a major depressive disorder who meet all criteria for hypomania except the duration criterion (i.e., at least 4 consecutive days). A second condition constituting an other specified bipolar and related disorder is that too few symptoms of hypomania are present to meet criteria for the full bipolar II syndrome, although the duration is sufficient at 4 or more days.

Anxious Distress Specifier

In the chapter on bipolar and related disorders and the chapter on depressive disorders, a specifier for anxious distress is delineated. This specifier is intended to identify patients with anxiety symptoms that are not part of the bipolar diagnostic criteria.

Depressive Disorders

DSM-5 contains several new depressive disorders, including disruptive mood dysregulation disorder and premenstrual dysphoric disorder. To address concerns about potential overdiagnosis and overtreatment of bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, is included for children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol. Based on strong scientific evidence, premenstrual dysphoric disorder has been moved from DSM-IV Appendix B, "Criteria Sets and Axes Provided for Further Study," to the main body of DSM-5. Finally, DSM-5 conceptualizes chronic forms of depression in a somewhat modified way. What was referred to as dysthymia in DSM-IV now falls under the category of persistent depressive disorder, which includes both chronic major depressive disorder and the previous dysthymic disorder. An inability to find scientifically meaningful differences between these two conditions led to their combination with specifiers included to identify different pathways to the diagnosis and to provide continuity with DSM-IV.

Major Depressive Disorder

Neither the core criterion symptoms applied to the diagnosis of major depressive episode nor the requisite duration of at least 2 weeks has changed from DSM-IV. Criterion A for a major depressive episode in DSM-5 is identical to that of DSM-IV, as is the requirement for clinically significant distress or impairment in social, occupational, or other important areas of life, although this is now listed as Criterion B rather than Criterion C. The coexistence within a major depressive episode of at least three manic symptoms (insufficient to satisfy criteria for a manic episode) is now acknowledged by the specifier "with mixed features." The presence of mixed features in an episode of major depressive disorder in-

creases the likelihood that the illness exists in a bipolar spectrum; however, if the individual concerned has never met criteria for a manic or hypomanic episode, the diagnosis of major depressive disorder is retained.

Bereavement Exclusion

In DSM-IV, there was an exclusion criterion for a major depressive episode that was applied to depressive symptoms lasting less than 2 months following the death of a loved one (i.e., the bereavement exclusion). This exclusion is omitted in DSM-5 for several reasons. The first is to remove the implication that bereavement typically lasts only 2 months when both physicians and grief counselors recognize that the duration is more commonly 1–2 years. Second, bereavement is recognized as a severe psychosocial stressor that can precipitate a major depressive episode in a vulnerable individual, generally beginning soon after the loss. When major depressive disorder occurs in the context of bereavement, it adds an additional risk for suffering, feelings of worthlessness, suicidal ideation, poorer somatic health, worse interpersonal and work functioning, and an increased risk for persistent complex bereavement disorder, which is now described with explicit criteria in Conditions for Further Study in DSM-5 Section III. Third, bereavement-related major depression is most likely to occur in individuals with past personal and family histories of major depressive episodes. It is genetically influenced and is associated with similar personality characteristics, patterns of comorbidity, and risks of chronicity and/or recurrence as non–bereavement-related major depressive episodes. Finally, the depressive symptoms associated with bereavement-related depression respond to the same psychosocial and medication treatments as non–bereavement-related depression. In the criteria for major depressive disorder, a detailed footnote has replaced the more simplistic DSM-IV exclusion to aid clinicians in making the critical distinction between the symptoms characteristic of bereavement and those of a major depressive episode. Thus, although most people experiencing the loss of a loved one experience bereavement without developing a major depressive episode, evidence does not support the separation of loss of a loved one from other stressors in terms of its likelihood of precipitating a major depressive episode or the relative likelihood that the symptoms will remit spontaneously.

Specifiers for Depressive Disorders

Suicidality represents a critical concern in psychiatry. Thus, the clinician is given guidance on assessment of suicidal thinking, plans, and the presence of other risk factors in order to make a determination of the prominence of suicide prevention in treatment planning for a given individual. A new specifier to indicate the presence of mixed symptoms has been added across both the bipolar and the depressive disorders, allowing for the possibility of manic features in individuals with a diagnosis of unipolar depression. A substantial body of research conducted over the last two decades points to the importance of anxiety as relevant to prognosis and treatment decision making. The “with anxious distress” specifier gives the clinician an opportunity to rate the severity of anxious distress in all individuals with bipolar or depressive disorders.

Anxiety Disorders

The DSM-5 chapter on anxiety disorder no longer includes obsessive-compulsive disorder (which is included with the obsessive-compulsive and related disorders) or posttraumatic stress disorder and acute stress disorder (which is included with the trauma- and stressor-related disorders). However, the sequential order of these chapters in DSM-5 reflects the close relationships among them.

Agoraphobia, Specific Phobia, and Social Anxiety Disorder (Social Phobia)

Changes in criteria for agoraphobia, specific phobia, and social anxiety disorder (social phobia) include deletion of the requirement that individuals over age 18 years recognize that their anxiety is excessive or unreasonable. This change is based on evidence that individuals with such disorders often overestimate the danger in "phobic" situations and that older individuals often misattribute "phobic" fears to aging. Instead, the anxiety must be out of proportion to the actual danger or threat in the situation, after taking cultural contextual factors into account. In addition, the 6-month duration, which was limited to individuals under age 18 in DSM-IV, is now extended to all ages. This change is intended to minimize overdiagnosis of transient fears.

Panic Attack

The essential features of panic attacks remain unchanged, although the complicated DSM-IV terminology for describing different types of panic attacks (i.e., situationally bound/cued, situationally predisposed, and unexpected/uncued) is replaced with the terms unexpected and expected panic attacks. Panic attacks function as a marker and prognostic factor for severity of diagnosis, course, and comorbidity across an array of disorders, including but not limited to anxiety disorders. Hence, panic attack can be listed as a specifier that is applicable to all DSM-5 disorders.

Panic Disorder and Agoraphobia

Panic disorder and agoraphobia are unlinked in DSM-5. Thus, the former DSM-IV diagnoses of panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder are now replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria. The co-occurrence of panic disorder and agoraphobia is now coded with two diagnoses. This change recognizes that a substantial number of individuals with agoraphobia do not experience panic symptoms. The diagnostic criteria for agoraphobia are derived from the DSM-IV descriptors for agoraphobia, although endorsement of fears from two or more agoraphobia situations is now required, because this is a robust means for distinguishing agoraphobia from specific phobias. Also, the criteria for agoraphobia are extended to be consistent with criteria sets for other anxiety disorders (e.g., clinician judgment of the fears as being out of proportion to the actual danger in the situation, with a typical duration of 6 months or more).

Specific Phobia

The core features of specific phobia remain the same, but there is no longer a requirement that individuals over age 18 years must recognize that their fear and anxiety are excessive or unreasonable, and the duration requirement ("typically lasting for 6 months or more") now applies to all ages. Although they are now referred to as specifiers, the different types of specific phobia have essentially remained unchanged.

Social Anxiety Disorder (Social Phobia)

The essential features of social anxiety disorder (social phobia) (formerly called social phobia) remain the same. However, a number of changes have been made, including deletion of the requirement that individuals over age 18 years must recognize that their fear or anxiety is excessive or unreasonable, and duration criterion of "typically lasting for 6 months or more" is now required for all ages. A more significant change is that the "generalized" specifier has been deleted and replaced with a "performance only" specifier. The DSM-IV generalized specifier was problematic in that "fears include most social situations" was difficult to operationalize. Individuals who fear only performance situations (i.e., speaking

or performing in front of an audience) appear to represent a distinct subset of social anxiety disorder in terms of etiology, age at onset, physiological response, and treatment response.

Separation Anxiety Disorder

Although in DSM-IV, separation anxiety disorder was classified in the section "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence," it is now classified as an anxiety disorder. The core features remain mostly unchanged, although the wording of the criteria has been modified to more adequately represent the expression of separation anxiety symptoms in adulthood. For example, attachment figures may include the children of adults with separation anxiety disorder, and avoidance behaviors may occur in the workplace as well as at school. Also, in contrast to DSM-IV, the diagnostic criteria no longer specify that age at onset must be before 18 years, because a substantial number of adults report onset of separation anxiety after age 18. Also, a duration criterion—"typically lasting for 6 months or more"—has been added for adults to minimize overdiagnosis of transient fears.

Selective Mutism

In DSM-IV, selective mutism was classified in the section "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence." It is now classified as an anxiety disorder, given that a large majority of children with selective mutism are anxious. The diagnostic criteria are largely unchanged from DSM-IV.

Obsessive-Compulsive and Related Disorders

The chapter on obsessive-compulsive and related disorders, which is new in DSM-5, reflects the increasing evidence that these disorders are related to one another in terms of a range of diagnostic validators, as well as the clinical utility of grouping these disorders in the same chapter. New disorders include hoarding disorder, excoriation (skin-picking) disorder, substance-/medication-induced obsessive-compulsive and related disorder, and obsessive-compulsive and related disorder due to another medical condition. The DSM-IV diagnosis of trichotillomania is now termed trichotillomania (hair-pulling disorder) and has been moved from a DSM-IV classification of impulse-control disorders not elsewhere classified to obsessive-compulsive and related disorders in DSM-5.

Specifiers for Obsessive-Compulsive and Related Disorders

The "with poor insight" specifier for obsessive-compulsive disorder has been refined in DSM-5 to allow a distinction between individuals with good or fair insight, poor insight, and "absent insight/delusional" obsessive-compulsive disorder beliefs (i.e., complete conviction that obsessive-compulsive disorder beliefs are true). Analogous "insight" specifiers have been included for body dysmorphic disorder and hoarding disorder. These specifiers are intended to improve differential diagnosis by emphasizing that individuals with these two disorders may present with a range of insight into their disorder-related beliefs, including absent insight/delusional symptoms. This change also emphasizes that the presence of absent insight/delusional beliefs warrants a diagnosis of the relevant obsessive-compulsive or related disorder, rather than a schizophrenia spectrum and other psychotic disorder. The "tic-related" specifier for obsessive-compulsive disorder reflects a growing literature on the diagnostic validity and clinical utility of identifying individuals with a current or past comorbid tic disorder, because this comorbidity may have important clinical implications.

Body Dysmorphic Disorder

For DSM-5 body dysmorphic disorder, a diagnostic criterion describing repetitive behaviors or mental

acts in response to preoccupations with perceived defects or flaws in physical appearance has been added, consistent with data indicating the prevalence and importance of this symptom. A "with muscle dysmorphia" specifier has been added to reflect a growing literature on the diagnostic validity and clinical utility of making this distinction in individuals with body dysmorphic disorder. The delusional variant of body dysmorphic disorder (which identifies individuals who are completely convinced that their perceived defects or flaws are truly abnormal appearing) is no longer coded as both delusional disorder, somatic type, and body dysmorphic disorder; in DSM-5 this presentation is designated only as body dysmorphic disorder with the absent insight/delusional beliefs specifier.

Hoarding Disorder

Hoarding disorder is a new diagnosis in DSM-5. DSM-IV lists hoarding as one of the possible symptoms of obsessive-compulsive personality disorder and notes that extreme hoarding may occur in obsessive-compulsive disorder. However, available data do not indicate that hoarding is a variant of obsessive-compulsive disorder or another mental disorder. Instead, there is evidence for the diagnostic validity and clinical utility of a separate diagnosis of hoarding disorder, which reflects persistent difficulty discarding or parting with possessions due to a perceived need to save the items and distress associated with discarding them. Hoarding disorder may have unique neurobiological correlates, is associated with significant impairment, and may respond to clinical intervention.

Trichotillomania (Hair-Pulling Disorder)

Trichotillomania was included in DSM-IV, although "hair-pulling disorder" has been added parenthetically to the disorder's name in DSM-5.

Excoriation (Skin-Picking) Disorder

Excoriation (skin-picking) disorder is newly added to DSM-5, with strong evidence for its diagnostic validity and clinical utility.

Substance/Medication-Induced Obsessive-Compulsive and Related Disorder and Obsessive-Compulsive and Related Disorder Due to Another Medical Condition

DSM-IV included a specifier "with obsessive-compulsive symptoms" in the diagnoses of anxiety disorders due to a general medical condition and substance-induced anxiety disorders. Given that obsessive-compulsive and related disorders are now a distinct category, DSM-5 includes new categories for substance-/medication-induced obsessive-compulsive and related disorder and for obsessive-compulsive and related disorder due to another medical condition. This change is consistent with the intent of DSM-IV, and it reflects the recognition that substances, medications, and medical conditions can present with symptoms similar to primary obsessive-compulsive and related disorders.

Other Specified and Unspecified Obsessive-Compulsive and Related Disorders

DSM-5 includes the diagnoses other specified obsessive-compulsive and related disorder, which can include conditions such as body-focused repetitive behavior disorder and obsessional jealousy, or unspecified obsessive-compulsive and related disorder. Body-focused repetitive behavior disorder is characterized by recurrent behaviors other than hair pulling and skin picking (e.g., nail biting, lip biting, cheek chewing) and repeated attempts to decrease or stop the behaviors. Obsessional jealousy is characterized by nondelusional preoccupation with a partner's perceived infidelity.

Trauma- and Stressor-Related Disorders

Acute Stress Disorder

In DSM-5, the stressor criterion (Criterion A) for acute stress disorder is changed from DSM-IV. The criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly. Also, the DSM-IV Criterion A2 regarding the subjective reaction to the traumatic event (e.g., "the person's response involved intense fear, helplessness, or horror") has been eliminated. Based on evidence that acute posttraumatic reactions are very heterogeneous and that DSM-IV's emphasis on dissociative symptoms is overly restrictive, individuals may meet diagnostic criteria in DSM-5 for acute stress disorder if they exhibit any 9 of 14 listed symptoms in these categories: intrusion, negative mood, dissociation, avoidance, and arousal.

Adjustment Disorders

In DSM-5, adjustment disorders are reconceptualized as a heterogeneous array of stress-response syndromes that occur after exposure to a distressing (traumatic or nontraumatic) event, rather than as a residual category for individuals who exhibit clinically significant distress without meeting criteria for a more discrete disorder (as in DSM-IV). DSM-IV subtypes marked by depressed mood, anxious symptoms, or disturbances in conduct have been retained, unchanged.

Posttraumatic Stress Disorder

DSM-5 criteria for posttraumatic stress disorder differ significantly from those in DSM-IV. As described previously for acute stress disorder, the stressor criterion (Criterion A) is more explicit with regard to how an individual experienced "traumatic" events. Also, Criterion A2 (subjective reaction) has been eliminated. Whereas there were three major symptom clusters in DSM-IV—reexperiencing, avoidance/numbing, and arousal—there are now four symptom clusters in DSM-5, because the avoidance/numbing cluster is divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood. This latter category, which retains most of the DSM-IV numbing symptoms, also includes new or reconceptualized symptoms, such as persistent negative emotional states. The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms. It also includes irritable or aggressive behavior and reckless or self-destructive behavior. Posttraumatic stress disorder is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents. Furthermore, separate criteria have been added for children age 6 years or younger with this disorder.

Reactive Attachment Disorder

The DSM-IV childhood diagnosis reactive attachment disorder had two subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. In DSM-5, these subtypes are defined as distinct disorders: reactive attachment disorder and disinhibited social engagement disorder. Both of these disorders are the result of social neglect or other situations that limit a young child's opportunity to form selective attachments. Although sharing this etiological pathway, the two disorders differ in important ways. Because of dampened positive affect, reactive attachment disorder more closely resembles internalizing disorders; it is essentially equivalent to a lack of or incompletely formed preferred attachments to caregiving adults. In contrast, disinhibited social engagement disorder more closely resembles ADHD; it may occur in children who do not necessarily lack attachments and may have established or even secure attachments. The two disorders differ in other important ways, including correlates, course, and response to intervention, and for these reasons are considered separate disorders.

Dissociative Disorders

Major changes in dissociative disorders in DSM-5 include the following: 1) derealization is included in the name and symptom structure of what previously was called depersonalization disorder and is now called *depersonalization/derealization disorder*, 2) dissociative fugue is now a specifier of dissociative amnesia rather than a separate diagnosis, and 3) the criteria for dissociative identity disorder have been changed to indicate that symptoms of disruption of identity may be reported as well as observed, and that gaps in the recall of events may occur for everyday and not just traumatic events. Also, experiences of pathological possession in some cultures are included in the description of identity disruption.

Dissociative Identity Disorder

Several changes to the criteria for dissociative identity disorder have been made in DSM-5. First, Criterion A has been expanded to include certain possession-form phenomena and functional neurological symptoms to account for more diverse presentations of the disorder. Second, Criterion A now specifically states that transitions in identity may be observable by others or self-reported. Third, according to Criterion B, individuals with dissociative identity disorder may have recurrent gaps in recall for everyday events, not just for traumatic experiences. Other text modifications clarify the nature and course of identity disruptions.

Somatic Symptom and Related Disorders

In DSM-5, somatoform disorders are now referred to as somatic symptom and related disorders. In DSM-IV, there was significant overlap across the somatoform disorders and a lack of clarity about their boundaries. These disorders are primarily seen in medical settings, and nonpsychiatric physicians found the DSM-IV somatoform diagnoses problematic to use. The DSM-5 classification reduces the number of these disorders and subcategories to avoid problematic overlap. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed.

Somatic Symptom Disorder

DSM-5 better recognizes the complexity of the interface between psychiatry and medicine. Individuals with somatic symptoms plus abnormal thoughts, feelings, and behaviors *may or may not* have a diagnosed medical condition. The relationship between somatic symptoms and psychopathology exists along a spectrum, and the arbitrarily high symptom count required for DSM-IV somatization disorder did not accommodate this spectrum. The diagnosis of somatization disorder was essentially based on a long and complex symptom count of medically unexplained symptoms. Individuals previously diagnosed with somatization disorder will usually meet DSM-5 criteria for somatic symptom disorder, but only if they have the maladaptive thoughts, feelings, and behaviors that define the disorder, in addition to their somatic symptoms.

In DSM-IV, the diagnosis undifferentiated somatoform disorder had been created in recognition that somatization disorder would only describe a small minority of “somatizing” individuals, but this disorder did not prove to be a useful clinical diagnosis. Because the distinction between somatization disorder and undifferentiated somatoform disorder was arbitrary, they are merged in DSM-5 under somatic symptom disorder, and no specific number of somatic symptoms is required.

Medically Unexplained Symptoms

DSM-IV criteria overemphasized the importance of an absence of a medical explanation for the somatic symptoms. Unexplained symptoms are present to various degrees, particularly in conversion disorder,

but somatic symptom disorders can also accompany diagnosed medical disorders. The reliability of medically unexplained symptoms is limited, and grounding a diagnosis on the absence of an explanation is problematic and reinforces mind -body dualism. The DSM-5 classification defines disorders on the basis of positive symptoms (i.e., distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms). Medically unexplained symptoms do remain a key feature in conversion disorder and pseudocyesis because it is possible to demonstrate definitively in such disorders that the symptoms are not consistent with medical pathophysiology.

Hypochondriasis and Illness Anxiety Disorder
Hypochondriasis has been eliminated as a disorder, in part because the name was perceived as pejorative and not conducive to an effective therapeutic relationship. Most individuals who would previously have been diagnosed with hypochondriasis have significant somatic symptoms in addition to their high health anxiety, and would now receive a DSM-5 diagnosis of somatic symptom disorder. In DSM-5, individuals with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder).

Pain Disorder
DSM-5 takes a different approach to the important clinical realm of individuals with pain. In DSM-IV, the pain disorder diagnoses assume that some pains are associated solely with psychological factors, some with medical diseases or injuries, and some with both. There is a lack of evidence that such distinctions can be made with reliability and validity, and a large body of research has demonstrated that psychological factors influence all forms of pain. Most individuals with chronic pain attribute their pain to a combination of factors, including somatic, psychological, and environmental influences. In DSM-5, some individuals with chronic pain would be appropriately diagnosed as having somatic symptom disorder, with predominant pain. For others, psychological factors affecting other medical conditions or an adjustment disorder would be more appropriate.

Psychological Factors Affecting Other Medical Conditions and Factitious Disorder
Psychological factors affecting other medical conditions is a new mental disorder in DSM-5, having formerly been included in the DSM-IV chapter "Other Conditions That May Be a Focus of Clinical Attention." This disorder and factitious disorder are placed among the somatic symptom and related disorders because somatic symptoms are predominant in both disorders, and both are most often encountered in medical settings. The variants of psychological factors affecting other medical conditions are removed in favor of the stem diagnosis.

Conversion Disorder (Functional Neurological Symptom Disorder)
Criteria for conversion disorder (functional neurological symptom disorder) are modified to emphasize the essential importance of the neurological examination, and in recognition that relevant psychological factors may not be demonstrable at the time of diagnosis.

Feeding and Eating Disorders

In DSM-5, the feeding and eating disorders include several disorders included in DSM-IV as feeding and eating disorders of infancy or early childhood in the chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence." In addition, brief descriptions and preliminary diagnostic criteria are provided for several conditions under other specified feeding and eating disorder; insufficient informa-

tion about these conditions is currently available to document their clinical characteristics and validity or to provide definitive diagnostic criteria.

Pica and Rumination Disorder
The DSM-IV criteria for pica and for rumination disorder have been revised for clarity and to indicate that the diagnoses can be made for individuals of any age.

Avoidant/Restrictive Food Intake Disorder
DSM-IV feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder, and the criteria have been significantly expanded. The DSM-IV disorder was rarely used, and limited information is available on the characteristics, course, and outcome of children with this disorder. Additionally, a large number of individuals, primarily but not exclusively children and adolescents, substantially restrict their food intake and experience significant associated physiological or psychosocial problems but do not meet criteria for any DSM-IV eating disorder. Avoidant/restrictive food intake disorder is a broad category intended to capture this range of presentations.

Anorexia Nervosa
The core diagnostic criteria for anorexia nervosa are conceptually unchanged from DSM-IV with one exception: the requirement for amenorrhea has been eliminated. In DSM-IV, this requirement was waived in a number of situations (e.g., for males, for females taking contraceptives). In addition, the clinical characteristics and course of females meeting all DSM-IV criteria for anorexia nervosa except amenorrhea closely resemble those of females meeting all DSM-IV criteria. As in DSM-IV, individuals with this disorder are required by Criterion A to be at a significantly low body weight for their developmental stage. The wording of the criterion has been changed for clarity, and guidance regarding how to judge whether an individual is at or below a significantly low weight is now provided in the text. In DSM-5, Criterion B is expanded to include not only overtly expressed fear of weight gain but also persistent behavior that interferes with weight gain.

Bulimia Nervosa
The only change to the DSM-IV criteria for bulimia nervosa is a reduction in the required minimum average frequency of binge eating and inappropriate compensatory behavior frequency from twice to once weekly. The clinical characteristics and outcome of individuals meeting this slightly lower threshold are similar to those meeting the DSM-IV criterion.

Binge-Eating Disorder
Extensive research followed the promulgation of preliminary criteria for binge eating disorder in Appendix B of DSM-IV, and findings supported the clinical utility and validity of binge-eating disorder. The only significant difference from the preliminary DSM-IV criteria is that the minimum average frequency of binge eating required for diagnosis has been changed from at least twice weekly for 6 months to at least once weekly over the last 3 months, which is identical to the DSM-5 frequency criterion for bulimia nervosa.

Elimination Disorders
No significant changes have been made to the elimination disorders diagnostic class from DSM-IV to DSM-5. The disorders in this chapter were previously classified under disorders usually first diagnosed in infancy, childhood, or adolescence in DSM-IV and exist now as an independent classification in DSM-5.

Sleep-Wake Disorders

Because of the DSM-5 mandate for concurrent specification of coexisting conditions (medical and mental), sleep disorders related to another mental disorder and sleep disorder related to a general medical condition have been removed from DSM-5, and greater specification of coexisting conditions is provided for each sleep-wake disorder. This change underscores that the individual has a sleep disorder warranting independent clinical attention, in addition to any medical and mental disorders that are also present, and acknowledges the bidirectional and interactive effects between sleep disorders and coexisting medical and mental disorders. This reconceptualization reflects a paradigm shift that is widely accepted in the field of sleep disorders medicine. It moves away from making causal attributions between coexisting disorders. Any additional relevant information from the prior diagnostic categories of sleep disorder related to another mental disorder and sleep disorder related to another medical condition has been integrated into the other sleep-wake disorders where appropriate.

Consequently, in DSM-5, the diagnosis of primary insomnia has been renamed insomnia disorder to avoid the differentiation of primary and secondary insomnia. DSM-5 also distinguishes narcolepsy, which is now known to be associated with hypocretin deficiency, from other forms of hypersomnolence. These changes are warranted by neurobiological and genetic evidence validating this reorganization. Finally, throughout the DSM-5 classification of sleep-wake disorders, pediatric and developmental criteria and text are integrated where existing science and considerations of clinical utility support such integration. This developmental perspective encompasses age-dependent variations in clinical presentation.

Breathing-Related Sleep Disorders

In DSM-5, breathing-related sleep disorders are divided into three relatively distinct disorders: obstructive sleep apnea hypopnea, central sleep apnea, and sleep-related hypoventilation. This change reflects the growing understanding of pathophysiology in the genesis of these disorders and, furthermore, has relevance to treatment planning.

Circadian Rhythm Sleep-Wake Disorders

The subtypes of circadian rhythm sleep-wake disorders have been expanded to include advanced sleep phase syndrome, irregular sleep-wake type, and non-24-hour sleep-wake type, whereas the jet lag type has been removed.

Rapid Eye Movement Sleep Behavior Disorder and Restless Legs Syndrome

The use of DSM-IV "not otherwise specified" diagnoses has been reduced by designating rapid eye movement sleep behavior disorder and restless legs syndrome as independent disorders. In DSM-IV, both were included under dyssomnia not otherwise specified. Their full diagnostic status is supported by research evidence.

Sexual Dysfunctions

In DSM-IV, sexual dysfunctions referred to sexual pain or to a disturbance in one or more phases of the sexual response cycle. Research suggests that sexual response is not always a linear, uniform process and that the distinction between certain phases (e.g., desire and arousal) may be artificial. In DSM-5, gender-specific sexual dysfunctions have been added, and, for females, sexual desire and arousal disorders have been combined into one disorder: female sexual interest/arousal disorder.

To improve precision regarding duration and severity criteria and to reduce the likelihood of overdiag-

nosis, all of the DSM-5 sexual dysfunctions (except substance-/medication-induced sexual dysfunction) now require a minimum duration of approximately 6 months and more precise severity criteria. These changes provide useful thresholds for making a diagnosis and distinguish transient sexual difficulties from more persistent sexual dysfunction.

Genito-Pelvic Pain/Penetration Disorder

Genito-pelvic pain/penetration disorder is new in DSM-5 and represents a merging of the DSM-IV categories of vaginismus and dyspareunia, which were highly comorbid and difficult to distinguish. The diagnosis of sexual aversion disorder has been removed due to rare use and lack of supporting research.

Subtypes

DSM-IV included the following subtypes for all sexual disorders: lifelong versus acquired, generalized versus situational, and due to psychological factors versus due to combined factors. DSM-5 includes only lifelong versus acquired and generalized versus situational subtypes. Sexual dysfunction due to a general medical condition and the subtype due to psychological versus combined factors have been deleted due to findings that the most frequent clinical presentation is one in which both psychological and biological factors contribute. To indicate the presence and degree of medical and other nonmedical correlates, the following associated features are described in the accompanying text: partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, and medical factors.

Gender Dysphoria

Gender dysphoria is a new diagnostic class in DSM-5 and reflects a change in conceptualization of the disorder's defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification per se, as was the case in DSM-IV gender identity disorder. In DSM-IV, the chapter "Sexual and Gender Identity Disorders" included three relatively disparate diagnostic classes: gender identity disorders, sexual dysfunctions, and paraphilias. Gender identity disorder, however, is neither a sexual dysfunction nor a paraphilia. Gender dysphoria is a unique condition in that it is a diagnosis made by mental health care providers, although a large proportion of the treatment is endocrinological and surgical (at least for some adolescents and most adults). In contrast to the dichotomized DSM-IV gender identity disorder diagnosis, the type and severity of gender dysphoria can be inferred from the number and type of indicators and from the severity measures.

The experienced gender incongruence and resulting gender dysphoria may take many forms. Gender dysphoria thus is considered to be a multicategory concept rather than a dichotomy, and DSM-5 acknowledges the wide variation of gender -incongruent conditions. Separate criteria sets are provided for gender dysphoria in children and in adolescents and adults. The adolescent and adult criteria include a more detailed and specific set of polythetic symptoms. The previous Criterion A (cross-gender identification) and Criterion B (aversion toward one's gender) have been merged, because no supporting evidence from factor analytic studies supported keeping the two separate. In the wording of the criteria, "the other sex" is replaced by "some alternative gender." Gender instead of sex is used systematically because the concept "sex" is inadequate when referring to individuals with a disorder of sex development.

In the child criteria, "strong desire to be of the other gender" replaces the previous "repeatedly stated desire" to capture the situation of some children who, in a coercive environment, may not verbalize the desire to be of another gender. For children, Criterion A1 ("a strong desire to be of the other gender or

an insistence that he or she is the other gender . . .)" is now necessary (but not sufficient), which makes the diagnosis more restrictive and conservative.

Subtypes and Specifiers

The subtyping on the basis of sexual orientation has been removed because the distinction is not considered clinically useful. A posttransition specifier has been added because many individuals, after transition, no longer meet criteria for gender dysphoria; however, they continue to undergo various treatments to facilitate life in the desired gender. Although the concept of posttransition is modeled on the concept of full or partial remission, the term remission has implications in terms of symptom reduction that do not apply directly to gender dysphoria.

Disruptive, Impulse-Control, and Conduct Disorders

The chapter on disruptive, impulse-control, and conduct disorders is new to DSM-5. It brings together disorders that were previously included in the chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" (i.e., oppositional defiant disorder; conduct disorder; and disruptive behavior disorder not otherwise specified, now categorized as other specified and unspecified disruptive, impulse-control, and conduct disorders) and the chapter "Impulse-Control Disorders Not Otherwise Specified" (i.e., intermittent explosive disorder, pyromania, and kleptomania). These disorders are all characterized by problems in emotional and behavioral self-control. Because of its close association with conduct disorder, antisocial personality disorder has dual listing in this chapter and in the chapter on personality disorders. Of note, ADHD is frequently comorbid with the disorders in this chapter but is listed with the neurodevelopmental disorders.

Oppositional Defiant Disorder

Four refinements have been made to the criteria for oppositional defiant disorder. First, symptoms are now grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness. This change highlights that the disorder reflects both emotional and behavioral symptomatology. Second, the exclusion criterion for conduct disorder has been removed. Third, given that many behaviors associated with symptoms of oppositional defiant disorder occur commonly in normally developing children and adolescents, a note has been added to the criteria to provide guidance on the frequency typically needed for a behavior to be considered symptomatic of the disorder. Fourth, a severity rating has been added to the criteria to reflect research showing that the degree of pervasiveness of symptoms across settings is an important indicator of severity.

Conduct Disorder

The criteria for conduct disorder are largely unchanged from DSM-IV. A descriptive features specifier has been added for individuals who meet full criteria for the disorder but also present with limited prosocial emotions. This specifier applies to those with conduct disorder who show a callous and unemotional interpersonal style across multiple settings and relationships. The specifier is based on research showing that individuals with conduct disorder who meet criteria for the specifier tend to have a relatively more severe form of the disorder and a different treatment response.

Intermittent Explosive Disorder

The primary change in DSM-5 intermittent explosive disorder is the type of aggressive outbursts that should be considered: physical aggression was required in DSM-IV, whereas verbal aggression and nondestructive/noninjurious physical aggression also meet criteria in DSM-5. DSM-5 also provides more

specific criteria defining frequency needed to meet criteria and specifies that the aggressive outbursts are impulsive and/or anger based in nature, and must cause marked distress, cause impairment in occupational or interpersonal functioning, or be associated with negative financial or legal consequences. Furthermore, because of the paucity of research on this disorder in young children and the potential difficulty of distinguishing these outbursts from normal temper tantrums in young children, a minimum age of 6 years (or equivalent developmental level) is now required. Finally, especially for youth, the relationship of this disorder to other disorders (e.g., ADHD, disruptive mood dysregulation disorder) has been further clarified.

Substance-Related and Addictive Disorders

Gambling Disorder

An important departure from past diagnostic manuals is that the substance-related disorders chapter has been expanded to include gambling disorder. This change reflects the increasing and consistent evidence that some behaviors, such as gambling, activate the brain reward system with effects similar to those of drugs of abuse and that gambling disorder symptoms resemble substance use disorders to a certain extent.

Criteria and Terminology

DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Rather, criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant. The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5, and a new criterion, craving or a strong desire or urge to use a substance, has been added. In addition, the threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria, in contrast to a threshold of one or more criteria for a diagnosis of DSM-IV substance abuse and three or more for DSM-IV substance dependence. Cannabis withdrawal is new for DSM-5, as is caffeine withdrawal (which was in DSM-IV Appendix B, "Criteria Sets and Axes Provided for Further Study"). Of note, the criteria for DSM-5 tobacco use disorder are the same as those for other substance use disorders. By contrast, DSM-IV did not have a category for tobacco abuse, so the criteria in DSM-5 that are from DSM-IV abuse are new for tobacco in DSM-5. Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed: 2–3 criteria indicate a mild disorder; 4–5 criteria, a moderate disorder; and 6 or more, a severe disorder. The DSM-IV specifier for a physiological subtype has been eliminated in DSM-5, as has the DSM-IV diagnosis of polysubstance dependence. Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without criteria (except craving). Additional new DSM-5 specifiers include "in a controlled environment" and "on maintenance therapy" as the situation warrants.

Neurocognitive Disorders

Delirium

The criteria for delirium have been updated and clarified on the basis of currently available evidence.

Major and Mild Neurocognitive Disorder

The DSM-IV diagnoses of dementia and amnestic disorder are subsumed under the newly named entity

major neurocognitive disorder (NCD). The term dementia is not precluded from use in the etiological subtypes where that term is standard. Furthermore, DSM-5 now recognizes a less severe level of cognitive impairment, mild NCD, which is a new disorder that permits the diagnosis of less disabling syndromes that may nonetheless be the focus of concern and treatment. Diagnostic criteria are provided for both major NCD and mild NCD, followed by diagnostic criteria for the different etiological subtypes. An updated listing of neurocognitive domains is also provided in DSM-5, as these are necessary for establishing the presence of NCD, distinguishing between the major and mild levels of impairment, and differentiating among etiological subtypes.

Although the threshold between mild NCD and major NCD is inherently arbitrary, there are important reasons to consider these two levels of impairment separately. The major NCD syndrome provides consistency with the rest of medicine and with prior DSM editions and necessarily remains distinct to capture the care needs for this group. Although the mild NCD syndrome is new to DSM-5, its presence is consistent with its use in other fields of medicine, where it is a significant focus of care and research, notably in individuals with Alzheimer's disease, cerebrovascular disorders, HIV, and traumatic brain injury.

Etiological Subtypes

In DSM-IV, individual criteria sets were designated for dementia of the Alzheimer's type, vascular dementia, and substance-induced dementia, whereas the other neurodegenerative disorders were classified as dementia due to another medical condition, with HIV, head trauma, Parkinson's disease, Huntington's disease, Pick's disease, Creutzfeldt-Jakob disease, and other medical conditions specified. In DSM-5, major or mild vascular NCD and major or mild NCD due to Alzheimer's disease have been retained, whereas new separate criteria are now presented for major or mild NCD due to frontotemporal NCD, Lewy bodies, traumatic brain injury, Parkinson's disease, HIV infection, Huntington's disease, prion disease, another medical condition, and multiple etiologies. Substance/medication-induced NCD and unspecified NCD are also included as diagnoses.

Personality Disorders

The criteria for personality disorders in Section II of DSM-5 have not changed from those in DSM-IV. An alternative approach to the diagnosis of personality disorders was developed for DSM-5 for further study and can be found in Section III. For the general criteria for personality disorder presented in Section III, a revised personality functioning criterion (Criterion A) has been developed based on a literature review of reliable clinical measures of core impairments central to personality pathology. Furthermore, the moderate level of impairment in personality functioning required for a personality disorder diagnosis in DSM-5 Section III was set empirically to maximize the ability of clinicians to identify personality disorder pathology accurately and efficiently. With a single assessment of level of personality functioning, a clinician can determine whether a full assessment for personality disorder is necessary. The diagnostic criteria for specific DSM-5 personality disorders in the alternative model are consistently defined across disorders by typical impairments in personality functioning and by characteristic pathological personality traits that have been empirically determined to be related to the personality disorders they represent. Diagnostic thresholds for both Criterion A and Criterion B have been set empirically to minimize change in disorder prevalence and overlap with other personality disorders and to maximize relations with psychosocial impairment. A diagnosis of personality disorder—trait specified, based on moderate or greater impairment in personality functioning and the presence of pathological personality traits, replaces personality disorder not otherwise specified and provides a much more

informative diagnosis for patients who are not optimally described as having a specific personality disorder. A greater emphasis on personality functioning and trait-based criteria increases the stability and empirical bases of the disorders.

Personality functioning and personality traits also can be assessed whether or not an individual has a personality disorder, providing clinically useful information about all patients. The DSM-5 Section III approach provides a clear conceptual basis for all personality disorder pathology and an efficient assessment approach with considerable clinical utility.

Paraphilic Disorders

Specifiers

An overarching change from DSM-IV is the addition of the course specifiers "in a controlled environment" and "in remission" to the diagnostic criteria sets for all the paraphilic disorders. These specifiers are added to indicate important changes in an individual's status. There is no expert consensus about whether a long-standing paraphilia can entirely remit, but there is less argument that consequent psychological distress, psychosocial impairment, or the propensity to do harm to others can be reduced to acceptable levels. Therefore, the "in remission" specifier has been added to indicate remission from a paraphilic disorder. The specifier is silent with regard to changes in the presence of the paraphilic interest per se. The other course specifier, "in a controlled environment," is included because the propensity of an individual to act on paraphilic urges may be more difficult to assess objectively when the individual has no opportunity to act on such urges.

Change to Diagnostic Names

In DSM-5, paraphilias are not ipso facto mental disorders. There is a distinction between paraphilias and paraphilic disorders. A paraphilic disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not automatically justify or require clinical intervention.

The distinction between paraphilias and paraphilic disorders was implemented without making any changes to the basic structure of the diagnostic criteria as they had existed since DSM-III-R. In the diagnostic criteria set for each of the listed paraphilic disorders, Criterion A specifies the qualitative nature of the paraphilia (e.g., an erotic focus on children or on exposing the genitals to strangers), and Criterion B specifies the negative consequences of the paraphilia (distress, impairment, or harm—or risk of harm—to others).

The change for DSM-5 is that individuals who meet both Criterion A and Criterion B would now be diagnosed as having a paraphilic disorder. A diagnosis would not be given to individuals whose symptoms meet Criterion A but not Criterion B—that is, to those individuals who have a paraphilia but not a paraphilic disorder.

The distinction between paraphilias and paraphilic disorders is one of the changes from DSM-IV that applies to all atypical erotic interests. This approach leaves intact the distinction between normative and nonnormative sexual behavior, which could be important to researchers or to persons who have nonnormative sexual preferences, but without automatically labeling nonnormative sexual behavior as

psychopathological. This change in viewpoint is reflected in the diagnostic criteria sets by the addition of the word disorder to all the paraphilias. Thus, for example, DSM-IV pedophilia has become DSM-5 pedophilic disorder.

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. For more information, go to www.DSM5.org.

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org. For more information, please contact Eve Herold at 703-907-8640 or press@psych.org.