I have been talking about DSM-5 for awhile, but I must say that this is at least going to be for me the most fun in terms of doing grand rounds at home base. We’ve been talking about DSM for along time and many of you in the room have knowingly contributed in terms of work members and advisors to the DSM-5 process and many of you have probably unknowingly contributed in terms of often the kinds of questions or even comments that I have made over really the past 5 or 6 years in chatting with house staff and chatting with individual residents and groups of residents on this sort of road to the DSM-5. The other thing I would like to point out and probably may come up in some questions at the end is that again in developing the DSM-5 and why I find it so important in terms of issues of education and training and dealing with specifically resident training, is that I was able to convince the APA to spend a day here in terms of having 2 focus groups with a variety of house staff which you’d be surprised considerably contributed to the if you will array of different books and strategies especially in the area of electronic versions of the DSM-5 so again I do want to thank all of you for participating in this development.

Now you can see that the title is not the road to DSM-5, not that the road is over, people are already talking about perhaps the road to DSM-6 or something in between and maybe we’ll get a chance to talk about that a little bit also, but DSM-5 has arrived. I had just returned as I mentioned yesterday at research day from a conference in London and England is one of these depression, not depression but DSM-5 free zones, and yet everybody was talking about the book. I have been told by my colleagues that it is already in its fourth printing and that something akin to raising the whole set of issues around mental health, mental illness, the need for more research, the need for an increased workforce or sophistication around dealing with mental health issues regardless of what specialty
we’re talking about, I think is all on the table again. And I don’t think we can attribute it to DSM-5 per se, but I think we can attribute it to the fact that it is a very important public health set of issues for all of us to recognize and deal with and in a sense you’re saying sort of it’s a beginning, it may very well mark a change. I think any book that is already sold over 900,000 copies within 2 weeks of release hopefully is not an inferno, but maybe something akin to leading us to both recognize and also move the whole area of what we think needs to happen in psychiatry over the next couple of decades, perhaps a little faster.

So with that let me find my clicker and I do have to report my Caesar’s disclosure, I’ve had no real contact with industry or the pharmaceutical industry now for 7 years, they wouldn’t recognize me. The only disclosure I have is that I served as a consultant to the APA for the past 7 seven years. If you are in a mood to either go to sleep or finish your lunch there’s a fast look, if you don’t want to look at the DSM, simply an article in JAMA that appeared at the end of April and I think it’s a nice summary, a quick read of what really is contained in the DSM-5. So you might want to look at that or if anybody asks for a quick read that’s probably what I would suggest.

Just for a little part of history, not too much because otherwise we won’t have time to really go through this in detail and I’m giving you probably the 8 hour master course in one hour so we can leave time for some questions. When we began this journey and the journey really began in a series of conferences and white papers around 1999-2000 or so when actually Steve Hyman was then the director of the NIMH, and we put together several groups to see what we could learn from what was already there in terms of research that could be applicable in a diagnostic revision. And the
expectation was that we would move beyond where we were and that that movement would be on the basis of a foundation built on empirical findings from the variety of scientific disciplines. Remember we’re talking about the fact that the last DSM came out in sort of 92-94 and here we are almost 19 years later coming out with the next version and obviously a lot has gone on. In order to get there as quickly as possible, we employed a number of if you will, opportunities. One was to make sure that this was not a small group of clinical psychiatrists getting together at a fancy restaurant or what not and making decisions as much as really a group of multi-disciplinary individuals and also taking advantage of the fact that a lot of work was going on overseas that might be very, very relevant to the development of a DSM-5. So with the sponsorship really of the WHO, NIH, actually 3 different NIH agencies as well as the American Psychiatric Association, we held the total of 13 conferences really around the world. And as you can see the participation was representative of the fact that there were conferences taking place in China, in Mexico, in England and the like. Out of that came 10 monographs which you can see in front of you and they were not necessarily always if you will, disorder driven. Some of them as you can see an example would be deconstructing psychosis and again a number of people in this room were involved in participating in these conferences. There were a lot of journal articles that came out of it and it really represented a very good foundation of giving us a sense of where we were around 2007-2008. A number of monographs were published as I’ve indicated and those are just the titles of 3 of them. Now we’re gradually moving up we’re now in 2006-2007, we establish the same number of work groups that we had previously in DSM-4 and what you see in front of you is really the titles of those work groups and also the individuals who were actually the heads of those particular work groups. And not surprisingly since we’ve always had a special love for sleep medicine in this department, Chip
Reynolds was the head of the sleep wake disorder work group and again in terms of kind of succession that we were hearing from Chip yesterday, I chaired that work group in DSM-4. So we kept that one in the family. A number of the other work groups also had as I’ve indicated already, members and advisors from this department as well.

So we took those work groups and we began moving ahead and in moving ahead there were a number of what I would call major issues around the revision and some rationales for some of the changes that you will see when you take a look at the DSM-5. So the first one is something that I never paid attention to and to be honest I never paid very much attention to DSM-4 except for the sleep group report, even though I was a member of the task force. And I was hoping as I said to the task force members this time around that they’d pay more attention to the whole book than certainly I paid in DSM-4. But one of the striking things is if you take a look at the actual organizational framework of the DSM-4 it was hard to tell a very coherent story. I do know one thing that was kind of interesting about it. There was this first chapter which dealt with all these childhood disorders which appeared very, very early in childhood and to me that was sort of, that’s what child psychiatry needed, they didn’t need the rest of the book, they could take the first 40 pages and run. And in many ways that was just symbolic of the fact that there wasn’t really a level of coherence that we felt that we really needed and so the DSM-5 itself reflects I think much better interrelationships, across different clustering of disorders and within the chapters the disorders themselves begin to make better, if you will, coherence with each other.
Another issue was that not surprisingly again thinking about what one learns from a wonderful department like this is I pushed very hard for them to develop a developmental, life span approach to the entire DSM-5. And I think you’ll find that this time around and it’s in every which way. Another thing again that comes I think from a broad experience that many of the members had is we did not pay enough attention to gender differences in terms of expression of different disorders and even prevalences that might be taking place in some of these disorders. And finally even within the United States when we talk about the issues of cultural diversity, we did not pay enough attention to that previously, and as you will see all 3 of those things I think really are reflective of a much greater emphasis in terms of whether you’re reading the text itself, whether you’re looking at the criteria, that you will see those changes in age and development and you certainly see those changes in terms of some of the cultural issues and cross cultural issues discussed much more explicitly. And even a set of guidelines that I will mention toward the end, that are in the book if you wanted to take a look at what you might use as an interview in terms of dealing with an greater level of cultural diversity.

Now another issue which certainly has become more popular in the last month is where is DSM in neuroscience? Does it reflect neuroscience? Does it lead neuroscience? Does it disregard neuroscience? What were we doing? Now if you looked at the actually CDs and sort of dossiers of all the people who were involved in the work groups you might, if you were a clinician complaint, that there were too many academics involved, whether they were academics in the area of psychology or psychiatry, or just even straight neuroscience. So if anything there was a purposeful overload of what I would call much of the best talents that could reflect any of the findings that we would have in genetics, neuroscience, cognitive psychology and many of the other important
disciplines where a lot of findings have been accrued over the last 20 years. What we sought to do was wherever possible you will find a lot more if you will, quote neuroscience in the text. You will find discussions of risk factors and issues that lead to prevention. You will not find however, at the end of the day, many criteria that are able to use the data from genetics and neuroscience. And that’s because when you think about the fact that all of us as clinicians are trying to make diagnoses, we need to think about issues of sensitivity and specificity and not necessarily group findings of finding changes whether they be imaging changes or the like. What we’ve done at the end of the day in terms of the organizational framework, is made it much easier for the findings that hopefully we will have relatively soon to be put right into the DSM-5 than we were previously able to do. And that’s one of the reasons why we pushed for a notion of a living document where one doesn’t have to wait another 19-20 years to make some changes. So if there are findings be they in schizophrenia, be they in autism, be they in bipolar disorder and the like, we will be able to put those in and hopefully they will even be diagnostic criteria, perhaps even for sub types or sub groups that we will be able to put into certainly an electronic version of a 5.1 or a 5.2.

Now something that may interest you only if you’re busy putting something together not necessarily for just a good assessment, but you have to do it for if you will, recording purposes. The multi axial system is sort of old stuff with respect to the DSM. It almost got excommunicated in the DSM-4, but as I was told they were, if you will, politically not wanting to take up a possible fight if they removed it. Since this was a much more aggressive group of people in DSM-5, one of the first things we decided to do was to dump it. And so the multi axial system is no longer with us in the way that it was thought previously. If I quizzed all of you and I have quizzed residents, most people
don’t know the different components of the multi-axial system which to me was another good reason to make it leave us. Axis II consisted of personality disorders and mental retardation as part of a test. Now those are 2 groups of things I hope in most cases you don’t think go together. Axis III consisted of medical conditions and basically what we did was make everything an equal opportunity disorder and so there really is only one axis whether it be a psychiatric disorder or a medical disorder in terms of DSM-5. Axis IV consisted of a discussion of, if you will, psychosocial and stressor factors and what we are doing basically is adopting what the WHO has and ICD which is really a use of their VNZ codes which I think gives us a very nice list and you’ll find them in those actually in section 2 of the DSM-5.

And finally something I grew up with which most of you may know about but not really, is something called the GAS or the GAF which we always needed to use to determine issues of so called functional status. But in reality we had to give it a score in order to get somebody from the emergency room into the hospital or in turn from the hospital outside again. And what we have really decided is not that functional impairment or disability is not important, it is vitally important but we are looking to establish a better, if you will, foundation of using assessment tools like what the WHO has developed in terms of dealing with functional status.

Now I can’t go every, I can’t go over in the time we have every even major change we’ve made so I’m going to give you really a bit of what I would think of as a small tasting menu. It’s a menu that I have used actually when I had an opportunity to talk to some of the child and adolescent psychiatry group here, and there’s a great emphasis on changes in childhood and adolescence than there is in
other areas and you know why, because more is needed there. It was very interesting in reviewing potential changes and looking at the difficulties in our current nomenclature and not surprisingly we found if you will, more confusion, more NOS if you will, in the child and adolescent area and that’s where certainly we have spent more time and tried to develop some proposals which we think we hopefully improve things not only in child and adolescent psychiatry but really across the life span since many of these disorders as we know and deal with here, are chronic disorders. Autism often doesn’t go away, ADHD is not something that you don’t have at the age of 18 and one month, conduct disorder is not something that you automatically, if you will, give up at the age of 18 and for that matter I would say you probably can have a personality disorder before the age of 18. So things like these arbitrary age differentials really have very little to do with, if you will, reality. We briefly mention something about the DSM structure this time. I’ve already eluded to the fact that it’s different than the DSM-4, there was a strong attempt to make it a better read, to make it a better teaching tool, to make it better if you will, in terms of the fact that it’s not something you simply put on your shelf and never look at again, or if you don’t want to use any other kind of hypnotic you simply open it up and look at a page or two randomly.

So section 1 of this time around is a relatively short section of maybe 20-25 pages. If you don’t read the rest of the book read that. And the reason I suggest that you do that is it does tell you how we got to where DSM-5 is, how to use it, it gives you a variety of things that some of you I think will find important such as definition of a mental disorder, issues that relate to when it should or should not be used in terms of forensic issues and the like and so there are important things in those first 25-30 pages.
The second section is something that really has appeared previously and that’s really the essential elements that deals with all the diagnostic criteria and the text for those disorders and it deals with some issues around coding, not surprisingly.

Section 3 is an interesting read. Most of section 3, at least even in the contents, have never appeared before. And it deals with some emerging measures that have been tested in some of the field trials as well as other kinds of measures many of which you’ll find much more explicitly laid out in the electronic version. And it also deals with models and it particularly deals with models of personality which I’ll come back to in a little while.

And finally it deals with a variety of disorders which if you will did not make the cut those are the disorders that it was felt at the end of the day were important to look at but did not have, if you will, sufficient amount of data and persuasion that they should be in a sense, in the main part of the book. So there are a number of disorders there that are still sitting in what I call the children’s table at Thanksgiving. Nevertheless, children are important and I think you may want to look at those and hopefully individuals will work with those disorders and gather more data.

And finally there’s a traditionally appendix and I’ll just briefly mention what’s in there as well as an index. The index is very long this time because it lists about 1,200 people and those are the 1,200 people who had something to do with the DSM-5. So one of the things that I want to especially in this audience make it clear is please don’t think about the DSM as a bible, don’t think about it as a
dictionary, it’s a guide primarily for clinical use but it is the beginning if you will of assessment. And even the first section of the book discusses an approach to clinical case formulation, and that’s why I’m including that particular point because I don’t want you simply to think of it as an old fashioned Chinese menu and you simply come up with these criteria and aha you know what to do, you know how to intervene. It is really to give you the elements or the beginning elements of a diagnosis and I think it requires a lot more judgment than just reading the appropriate page on a disorder.

Now Section 2 I think the main thing that I want to leave you with is that Section 2 there is a revision of the chapter structure, there is a revision for several reasons. One, we were – we were presented with a unique opportunity with respect to the next ICD or International Classification of their entire nomenclature that deals with all their medicine, basically where our coding comes from. And one of the questions that’s always out there not so much in the United States but in the rest of the world is why are there two different sets of criteria for mental disorder? There is the DSM which somehow became important everywhere and then there is the ICD that’s used for coding and it’s used in many other parts of the world. Why couldn’t they get their act together and have basically one set of criteria or disorder list? We’ve sought to do that this time around and so you will find out when ICD 11 comes out in 2015 or ’16 that the organizational structure, the chapter structure are both along the lines of 20 chapters and there will be a harmonization that never existed previously. There will be some differences, but the differences will be quite minimal on individual disorders and I think the bulk of what’s happened is that we’ve managed to influence each other quite a bit this time and I think it’s actually quite positive.
Now obviously our book is out, the chapters are out. In working with the WHO we really tried to think about the clustering of some of these chapters and so not surprisingly there are a number of clusters that come up from work that has either gone on in the area of genetics or other areas of psychology that may make some sense. And so you see in sort of some of these clustering ideas internalizing disorders, externalizing disorders, somatic disorders, neurodevelopmental disorders, neurocognitive disorders and personality disorders. And even within there one could say that you could have a kind of cross-clustering. But what we did was take our 20 chapters that we have and they do layout and relate a lot more to each other than previously. And so when you look at the neurodevelopmental disorders you’ll see not surprisingly autism, you’ll see ADHD and you’ll see other childhood disorders or at least disorders that begin in childhood. You move over and then you see psychosis and then you begin to see some independence that has taken place. Rather than submerging all the quote psychoses, that is schizophrenia and bipolar disorders together, bipolar disorders has its own chapter and it’s laid next to, not surprisingly, depression. And then of course you move into the anxiety area.

But let me just mention one example of why I think this structure may be more important for us. Even a couple of months ago or I guess it is a couple of months ago now Lancet published a major GWAS study once again showing the fact that there was a lot of if you will clustering of at least some of the genetic findings that cut across autism spectrum, schizophrenia, bipolar disorder, depression and not surprisingly one might say we took a good guess but we had some inside
information even about a year ago that it might get laid out that way, so that’s an example of where some of the genetics if you will have influenced the organizational structure.

The work that goes on in the anxiety disorder area where there were really 3 or 4 groups working very closely together and the question is should they have their own chapter, one wonderful example which I always tell the story because it’s true, the obsessive-compulsive group had a lot of work, they had their own particular international conference that related to the need and the importance and the brain circuitry that was different in OC compared to say anxiety disorders or the fear circuitry and then when we gave each of these groups an opportunity to declare independence and have their own chapter this was the group that took the longest to decide that they would have their own chapter. And once again I felt very, very good that we had clearly picked the right people for each of the work groups in terms of particular areas.

If you move onto sort of the next section you can see that what lays out there are if you will the somatic symptom disorders. Nobody wanted the elimination disorder group and so they are still by themselves. The sleep-wake area actually has expanded in many ways to include a lot of what we think of as all – really all across sleep medicine at this point. And finally as you move more to the external area you have not surprisingly some of the disruptive impulse control and substance related groups next to each other, then neurocognitive personality and the like. That represents really the 20 chapters.
Now let me drill down just a little bit watching the clock with some of the disorders where you will read about and have read about that there have been lots of changes. So one obvious one that received a lot of attention has been autism spectrum disorder and what essentially has been replaced by this one if you will, dimensional diagnosis has been autistic disorder, Asperger’s and pervasive developmental disorder not otherwise specified. And I’ll mention in a second one of the major changes and why that was important. Other disorders in the neurodevelopmental chapter include intellectual disability which is quite an improvement on what we had in the DSM-4. There have been some changes in the ADHD area, less than some people if you will speculated and also it was in part to try to capture much more the fact that ADHD is also a disorder certainly of young adults. We worked hard in the area of specific learning and I think again it moves us a little closer to what really goes on in education and learning areas ala 2013.

Now going back to autism spectrum for a second, I’ve already indicated that we have a single diagnosis and the reason we did that is because it was mushy in many areas. People were not necessarily – everybody that was quote labeled Asperger’s if you went back and looked at the diagnostic criteria of Asperger’s that was in DSM-4, all these people didn’t even meet that diagnostic criteria. So we knew that we needed to really make a better set of changes. These changes were first proposed actually some 3 years ago and it’s given us an opportunity to learn much more about them even as the book came out. We know that there will not be significant changes in prevalence rates, we also know and it has been tested and there have been some major journal articles really within the last couple of months that have strongly pointed to the fact that we are capturing most of the individuals that had any of these 4 diagnoses previously and the major point
here was the concern, not inappropriately, of the fact whether individuals would be able to continue to receive the kinds of treatment and educational services they had done – they had received previously. And I think we have pretty convincingly shown this to be the case, certainly we have seen many of the advocacy groups including autism speakers and the like to become very much aligned with what we are doing in this area. It also by the way, and I think we can see that in the sense even now in the neurobiology of autism is lending itself to a much more coherent structure to pursue research in this area.

In schizophrenia relatively little happened at the end of the day. There were some changes that related to getting rid of a special treatment for bizarre delusions. We went back to the old notion of course that in many ways psychosis must include delusions, hallucinations or disorganized speech to be labeled that. We got rid of some subtypes that only those of you interested in history of psychiatry would know about, they basically have not been used for a long, long time. The issue of catatonia was a very interesting one because some people argued it’s a special disorder, others argued that maybe it’s in just psychosis but clearly it’s been recognized in many emergency rooms which ultimately have wound up with an ultimate diagnosis that has ranged in mood disorders, schizophrenia and the like. And so what we’ve really done is as you can see we have made it basically a specifier for a number of different disorders and we think that will work best.

Now in the area of bipolar disorders, which again is something that a number of us in this department have long been interested along with really many of our European colleagues, part of what was going on was that many of us realized that changes in energy and activity were as much
essential features of bipolar disorder as mood. And so consequently based on a various set of interesting databases it has now been changed to include increased energy activity as a criterion A of hypomania or mania and we already know that if anything this tightens the criteria and will certainly not increase the prevalence of bipolar disorders. We have talked many times in this auditorium about mixed diagnoses and mixed episodes for mania and bipolar disorder, and you needed to fulfill both sets of criteria for depression and for mania to have a mixed episode. Those of us involved in this area never saw a patient who fulfilled that criteria, but nevertheless that was part of DSM. And so what we’ve done is developed as part of a push to develop better specification we’ve removed the mixed episode and we’ve replaced it with mixed features. And I think you’ll find that when you look at that, that will be very useful. In the same way that we’ve added anxious distress as a specifier both in bipolar disorder and then also in depression again giving one a greater level of precision with respect to assessment of patients with perhaps a single disorder but we are trying to make it a much more comprehensive assessment.

Now I mentioned to you about we relocated sort of bipolar and depression had its own chapter, but I can’t not go by without talking about bereavement because this was another one that received a good bit of media attention from our most prestigious scientific journals, the New York Times, the Wall Street Journal and the like with many Letters to the Editor and everybody basically saying these guys were just doing one more, and gals, were doing one more silly thing, they were making sadness and bereavement a disorder and that was terrible. So now as part of the truth squad here is actually what we did and here is actually what you will find when you open up the book. The first thing to realize is that sadness, grief and bereavement are not disorders, please don’t think of them as disorders, they
are part of fortunately or unfortunately if you will part of what we consider the normal kinds of things that happen to us across our lifespan. On the other hand, not to have – and by the way, these things don’t last two months; they can last a year, they can last a lifetime but at any point in time when you have had a loss whether it is the loss of a significant one, whether it is the loss of a job or any other tragic kind of loss you are entitled if necessary to be suffering from clinical depression, you are entitled to have your family bring you get a clinical assessment. We as clinicians ought to be able to perform a clinical assessment and decide whether we want to intervene or not intervene at any point of time. That’s all that’s been done. Now to make it even clearer you will find in the book a much if you will intense exposition around sadness and grief to make this delineation even more clear.

Some other things that we’ve done is we tried to deal with issues that relate to an inappropriate and perhaps even over-diagnosis of bipolar NOS or bipolar disorder in children and adolescents, hence one of the new diagnoses, disruptive mood dysregulation disorder. And you will also see that a number of other disorders have been either changed or added, premenstrual dysphoric disorder which was in the Appendix in DSM-4 for political reasons has finally moved to the main part of the book. And I’ve already indicated that we’ve done some issues around mixed features and anxious distress.

Let me come back to disruptive mood dysregulation disorder. There has been a lot of discussion about whether in pursuing an aim to reduce confusion about whether severe chronic irritability should be considered characteristic of mania in children, which has happened, and what can we do
about that? And whether coming up with a disorder that has features such as non-episodic irritability with some very tight thresholds of chronicity, frequency, time over a year, whether that disorder which in many cases followed longitudinally becomes anxiety or depression will help clean up the confusion about over-diagnosis of bipolar disorder. It’s an open question and we will have to see what happens over the next couple of years using that diagnosis to see whether it works. A lot of people have debated about it and I think that’s quite important but I think the most important thing is though is that people work with this diagnosis, work with the other diagnoses that are in the child mood area and see what we really come up with at the end of a couple of years. This is one of the several reasons why those of us are very enthusiastic if there are changes that need to be made we can make them in 3 or 4 years in the DSM-5.1 if this solution is not working.

With respect to anxiety disorders we really allowed the fact that panic attacks is not panic disorder, panic attacks accompany other disorders and by making it a specifier we really allowed that possibility across disorder groups to take place. I’ve already mentioned something about the independence of obsessive-compulsive disorders, there are some new disorders in there which I’d like you to take a look at. Hoarding disorder had a tremendous amount of research data and clinical experience and treatment strategies that we felt it was important to put in there, the response so far has been very, very positive about that. You can see that wherever possible we’ve tried to put in specifiers, and here is another example in this area to give a greater level of precision.

Given the amount of if you will attention and appropriate attention given the PTSD and the like, whether it be coming from issues relating to war or whether it be coming from issues relating to
children and adolescents and young adults unaffected if you will directly by war we felt that it needed its own chapter. There are a number of changes in the PTSD criteria that you will find and I think the other thing that I think is important is that there is a separate set of criteria that takes into account the developmental nature with respect to children who may be suffering from PTSD. And I think that’s an important change. Also in relating to children, subtypes of reactive attachment disorder really we’ve decided were two distinct disorders, and this again is something that is very specific to children.

In the feeding and eating dis area what we’ve done is we’ve made some changes. We think already from what we’ve been able to test that this reduces the amount of NOS disorders in the eating area, and brings it down from where at one point 50% of the diagnoses in the eating areas were being called NOS to a much cleaner array of distinct disorders.

In the sleep-wake area quite a bit of work has been done to try to bring that along based on a lot of the research and clinical experience over the past 20 years, and you could see that a good number of changes have been made again aligning very much with the International Classification of sleep disorders. I should also mention that that’s one of the few places where we did have enough biology particularly in the area of narcolepsy that some of the criteria themselves do include what we would think of as biological criteria. So it’s a start, it’s certainly not something that we’re happy that we can’t expand that to other disorders.
Gender dysphoria is an interesting one. The name as you can see has been changed from the previous name and part of that interestingly enough was to reduce the stigma if you will that has been considered previously with having a gender identity disorder and a lot of people felt very strongly about this. It’s unclear by the way where this will fall out in the International Classification, it may get moved entirely out of the mental disorder chapter.

Coming very quickly to conduct disorder, not much got changed there but other than the recognition of callous being an important subtype since there is always a huge debate and should be about language and labeling. The specifier is actually labeled with limited pro social emotions but in reality this is a short term if you will for what you see there as lack of remorse, callous, etc. And that’s one of the major changes that we’ve done.

Substance – the substance area got some major changes. It’s pulled together in a set of criteria and symptoms that cut across all of substance use and I think is better certainly. The group that worked with the data sets over the past 6, 7 years feel very strongly about removing some of the DSM-4 criteria, if you will getting rid of some of the terms that related to issues of substance dependence and creating really a continuum that very nicely lays out mild, moderate and severe and here again the advertisement that quote we were going to increase the prevalence by 40% and it was much easier to get a diagnosis of substance disorder. I mean it’s an interesting set of propositions, it just happens to be totally false, the criteria have actually tightened things and our estimates so far in terms of the data that’s available is that the prevalence of anything may very well go down. You can also see at the bottom of that slide the addition of craving and we think that’s important not only
from a clinical point of view of thinking about it but it does connect very much to the neurobiology in some of the basic translational science that has been going on for quite a while in addiction research.

Personality disorders, here is an interesting one. The work group spent a long time coming up with really a hybrid model of what they thought if you will the assessment of personality disorders using traits and the like would work out better. At the end of the day what happened was the major section, Section II, retained the 10 personality disorders that we had in DSM-4 but of course moved it now obviously to Access I, but in Section III you will find an alternate trait based diagnostic approach to personality disorders which I strongly suggest that you take a look at. And those of you who work in this area will want to improve your assessment expertise may find that this is a very good way to work with some of these issues around personality disorder. You will also find that some of the assessment tools will also be found electronically as well.

Now Section III has a kind of interesting thing, so Section III is a place where there is some support, but it’s not being officially recommended as part of the main body of the manual. And so there is a bit if you will of a kind of barrier between using it routinely and using it certainly using it, but not feeling that you can automatically code for that specific disorder. So what’s in Section III? Well Section II contains a variety of assessment measures. One of the things we wanted to do was to bring patients and families and even clinicians much more into the picture. And so there are a lot of interesting cross-cutting assessment measures that you will find there. There is also this cultural
formulation which I think is a very useful short read for you to take a look at. There is this alternative model for personality disorders and conditions for further study.

Conditions for further study are those that did not make it, if you will, to the main table. Perhaps the most interesting one is this whole issue of what we think of as prodromes for psychosis, it is now called attenuated psychosis syndrome and we hope that a lot more work will continue. There is a number of other disorders that are listed there, really for the first time we wanted to pay as much attention to suicide and suicidal behavior as we could. There is a lot of specifiers and assessment things throughout the book. There is also two disorders, suicidal behavior disorder and non-suicidal self-injury which we hope individuals will spend time thinking about.

The Appendix for those of you who have read the rest of the book and are up to page 900 or so, it has a much more intensive set of highlights of changes between this version and the previous version, it has a number of interesting but short glossaries and then a lot of what I call cross-walk between the DSM and the ICDs because the ICD-9-CM is still in effect in the United States until October 14th and then 10-CM comes into play. I have no idea when if you will 11-ICD will be adopted in the United States, it may be a long time.

This is what the book looks like. Many people thought that we decided on lots of things 5 years ago and everything was a done deal. Frankly 5 years ago the only thing we decided on was the cover of the book. And since then I think that there has been a lot going on.
I want to thank Mary Ganguli for this, she has sent me some interesting slides about DSM-5. For those of you who don’t want to read the whole book this is the abridged version I guess and it says DSM-5 Abridged Version, don’t worry, be happy. So that’s one way of dealing with it. I hope you’ll be happy with the book. Now again coming out of the fact that many of you in this room encouraged the idea that there ought to be if you will some accompanied guides and they may be hard to read but literally as we begin to think about it there is a DSM Guidebook, there is a Study Guide, there are going to be basically there is a Case Book that is coming out which I think you will find very useful. I’m hoping that we can develop some apps for some of these things and so this will be very, very useful for you in the Emergency Room or anywhere else to be able to take a look at some of these cases. Some people have described this as they did DSM-4 that this is kind of a, a cottage industry. I don’t think it’s a cottage industry anymore, I think it’s real. I leave it up to you to you know decide what you might want to use.

I do want to end and emphasize the fact that there is going to be a series of electronic products and they may be even more useful for you going forward in terms of the kinds of things that are happening. The publisher of the American Psychiatric Press if you will has some advanced ideas which are very positive and she is somebody who is not only receptive to moving this more electronically but clearly has helped to lead the way. You will find on the electronic version for example DSM-5 for the first time has references. You will not find the references themselves in the book, but you will find it on the electronic version and of course not surprisingly you ought to be able to find then the hyperlinks to the actual papers. And I think it’s important that what’s in the
DSM-5 is backed up by the actual references rather than necessarily again the notion that this was something that a few people decided in the back room.

So it’s a big book, it’s taken a long time to develop it. It is unlikely that you can read it in one night, I don’t recommend it as a old fashioned sleep expert, I don’t think it’s a good idea to stay up all night and read it. But you may find again parts of it worth reading rather to simply use it as a reference.