

## DSM IV – DSM 5

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## 1. Generelle Fakten zum DSM

- Diagnostic and Statistical Manual of Mental Disorders
- Herausgeber des DSM ist die Amerikanische Psychiatrische Vereinigung (American Psychiatric Association oder APA).
- Erstausgabe USA 1952
- Aktuell DSM IV TR (Text Revision) Das DSM-IV ist ein Ersatz und/oder eine Ergänzung für die jeweiligen Passagen im ICD 10, welches wiederum das internationale Klassifikationssystem der Weltgesundheitsorganisation der Vereinten Nationen (World Health Organization oder WHO) darstellt.
- Deutschland diagnostiziert nach ICD, jedoch starker Einfluss durch die APA und dem DSM (enge Zusammenarbeit wird auch durch die APA selbst gepflegt und nach außen suggeriert)
- Momentan gilt der ICD 10 – ICD 11 ist für 2015 geplant <- starke Beeinflussung (Übernahme der Passagen durch den DSM 5 ist anzunehmen)
- Gegenüberstellung ICD 10 – DSM IV (Verwendung in Deutschland)

	ICD-10	DSM-IV
<b>Vollständiger Name: Aufbau</b>	<i>International Classification of Diseases</i>	<i>Diagnostisches und statistisches Manual psychischer Störungen</i>
<b>Herausgeber:</b>	WHO	APA
<b>Verwendung (u.a.):</b>	Krankenkassen	Forschung
<b>Abdeckungsbereich:</b>	Störungen / Erkrankungen aller Art	Nur psychische Störungen
	Gliederung in 21 Kapitel;  Psychische Störungen in Kapitel V ("F-Codes");  10 Hauptgruppen	Multiaxial ausgelegt; Achse I: Klinische Störungen und „Andere Klinisch Relevante Probleme“ Achse II: Persönlichkeitsstörungen und Geistige Behinderung Achse III: Medizinische Krankheitsfaktoren (im Zusammenhang mit der psychischen Störung) Achse IV: Psychosoziale und Umgebungsbedingte Probleme Achse V: globale Beurteilung des Funktionsniveaus (Skala von 1-100)

- DSM 5 geplant in Englisch für Mai 2013 (braucht ca. 2-4 Jahre um auf Deutsch zu erscheinen)

## **2. Generelle formale Unterschiede DSM IV – DSM 5**

- Formal:  
Wechsel von römischen zu numerischen Zählsystem um überarbeitete Nachauflagen einfacher zu benennen (Im Internet durch Einheitlichkeit suchbarer zu machen) – geplant DSM 5.1; DSM 5.2 etc.
- Aufbau:  
Der Aufbau nach Achsen soll (soweit ich herauslesen konnte) beibehalten werden – es steht zur Diskussion, ob einzelne Diagnosen „umziehen“ von Achse 1 zu 2. Ansonsten soll sich der Aufbau der Kapitelstruktur stark verändern (Kapitelbenennung DSM IV s. unten „Aktueller Aufbau DSM IV“):

Proposed DSM-5 Organizational Structure (Links führen zur offiziellen DSM 5 Seite der APA)

Neurodevelopmental Disorders

Schizophrenia Spectrum and Other Psychotic Disorders

Bipolar and Related Disorders

Depressive Disorders

Anxiety Disorders

Obsessive-Compulsive and Related Disorders

Trauma- and Stressor-Related Disorders

Dissociative Disorders

Somatic Symptom Disorders

Feeding and Eating Disorders

Elimination Disorders

Sleep-Wake Disorders

Sexual Dysfunctions

Gender Dysphoria

Disruptive, Impulse Control, and Conduct Disorders

Substance Use and Addictive Disorders

Neurocognitive Disorders

Personality Disorders

Paraphilic Disorders

Other Disorders

Aktueller Aufbau DSM IV:

Das DSM, zurzeit in der vierten Version erhältlich (DSM-IV-TR, 2000), systematisiert psychiatrische Diagnosen seit der dritten Version (DSM-III, 1980) in fünf Achsen. Zu einer Diagnose gehört die Angabe des Zustandes auf jeder dieser fünf Achsen:

- Achse I: Klinische Störungen und andere klinisch relevante Probleme. Hauptsächlich Zustandsstörungen, schwere mentale Fehlstörung und Lernunfähigkeit (Beispiele: Schizophrenie, Angststörungen, Störungen der Impulskontrolle, Essstörungen).

- Achse II: Persönlichkeitsstörungen (Beispiele: Borderline-Persönlichkeitsstörung, schizoide oder paranoide Persönlichkeitsstörungen, Antisoziale Persönlichkeitsstörung) und geistige Behinderungen.
- Zu Achse I und II Zusatz siehe Anhang
- Achse III: Medizinische Krankheitsfaktoren. Diese Achse umfasst körperliche Probleme, die bedeutsam für die Psychische Störung sein können.
- Achse IV: Psychosoziale und umgebungsbedingte Probleme (Beispiele: Wohnungsprobleme, Berufliche Probleme, Probleme im sozialen Umfeld)
- Achse V: Globale Beurteilung des Funktionsniveaus anhand der GAF-Skala.

Auf einzelnen dieser Achsen kann die Angabe auch "keine" oder eine mehrfache sein.

Insgesamt hat das DSM für die Achsen I und II 16 diagnostische Kategorien/ 17 Kapitel:

- 1. Störungen, die gewöhnlich zuerst im Kleinkindalter, in der Kindheit oder Adoleszenz diagnostiziert werden (Seite 71-163 im DSM-IV-Buch)
- 2. Delir, Demenz, amnestische und andere kognitive Störungen (S. 163-209)
- 3. Psychische Störungen aufgrund eines medizinischen Krankheitsfaktors (209-221)
- 4. Störungen im Zusammenhang mit psychotropen Substanzen (221-327)
- 5. Schizophrenie und andere psychotische Störungen (327-375)
- 6. Affektive Störungen (375-453)
- 7. Angststörungen (453-509)
- 8. Somatoforme Störungen (509-537)
- 9. Vorgetäuschte Störungen (537-543)
- 10. Dissoziative Störungen (543-559)
- 11. Sexuelle und Geschlechtsidentitätsstörungen (559-613)
- 12. Essstörungen (613-627)
- 13. Schlafstörungen (627-691)
- 14. Störungen der Impulskontrolle, nicht andernorts klassifiziert (691-705)
- 15. Anpassungsstörungen (705-711)
- 16. Persönlichkeitsstörungen (711-761)
- 17. Andere klinisch relevante Probleme (761-773)

### **3. Generelle inhaltliche Unterschiede DSM IV – DSM 5**

- Einarbeitung von „Dimensionen“ in die Diagnosen (Diagnose Schweregrad z.B. Persönlichkeitsstörungen Skalen zum „Personality Functioning – auch Gesundheitszustand wird hier definiert) im Gegensatz zum starren binären System von DSM IV (Diagnose ja/nein)
- „Aufweichung“ und Umstrukturierung verschiedener Diagnosen: Stärkere Flexibilität
- Stärkere Einarbeitung/ Berücksichtigung von Alter-, Geschlecht- und (sozio)kulturellen Aspekten (Fungieren z.B. als Auschlusskriterium bei BPS s. Kapitel zu Persönlichkeitsstörung)
- Annäherung an die Neurologische, „biologische“ Sichtweise z.B. Biomarker (Dimensionen Skalen ebenfalls aus der „Medizin“ entlehnt)

Wichtiges zusammenfassendes Zitat hierzu aus „The Conceptual Development of DSM-V“  
(Anm.: Achtung es müsste richtig DSM-5 heißen)

- “Mental disorder syndromes will eventually be redefined to reflect more useful diagnostic categories (“to carve nature at its joints”) as well as dimensional discontinuities between disorders and clear thresholds between pathology and normality. However, our immediate task is to set a framework for an evolution of our diagnostic system that can advance our clinical practice and facilitate ongoing testing of the diagnostic criteria that are intended to be scientific hypotheses, rather than inerrant Biblical scripture. The single most important precondition for moving forward to improve the clinical and scientific utility of DSM-V will be the incorporation of simple dimensional measures for assessing syndromes within broad diagnostic categories and supraordinated dimensions that cross current diagnostic boundaries. Thus, we have decided that one, if not the major, difference between DSM-IV and DSM-V will be the more prominent use of dimensional measures in DSM-V.

The readiness of biological markers to serve as associated features, risk factors, or diagnostic criteria will be of major concern. Likewise, the clinical utility and validity of age-, gender-, and culture-related specifiers or subtypes of disorders will need to be assessed. Measurement-based approaches for field-testing new criteria sets will need to be reviewed and selected as part of the field-test procedures.”

### **4. Inhaltliche Unterschiede DSM IV – DSM 5 – Persönlichkeitsstörungen ( Beispiel Borderline)**

- Multidimensionale Struktur im Gegensatz zum DSM IV binären System ( x Kriterien von y müssen erfüllt sein – bzw. ja/nein Diagnose)
- Struktur basiert auf pathologische „Personality Traits“ und Graden von Beeinträchtigung im Bereich des sogenannten „Personality Functioning“ (Hier werden auch der gesunde Zustand und die verschiedenen Beeinträchtigungsgrade genauer definiert s.u.)

- Reduktion auf 6 übergeordnete Gruppen + Personality Disorder Trait Specified (antisocial, avoidant, borderline, narcissistic, obsessive/compulsive and schizotypal); vormals 11 + NOS (not otherwise specified): paranoide, schizoide, schizotypische, Borderline, histrionische, dissoziale, narzisstische, selbstunsichere, dependente, passiv-aggressive, & zwanghafte Persönlichkeitsstörung (DSM IV)
- Einführung der Personality Disorder Trait Specified für „gemischt“ Diagnosen – wenn keine PD Diagnose passt, wird das Raster nach pathologischen „Personality Traits“ aufgeschlüsselt

Wann liegt eine PD laut DSM 5 vor?

- Es muss eine signifikante Beeinträchtigung in den zwei Bereichen des „Personality Functioning“ (selbst und zwischenmenschlich) vorliegen. Die Skala anhand derer die Beeinträchtigung bestimmt werden soll reicht von schwach – extrem
- Zusätzlich muss mindestens eine pathologische „Personality Trait“ gegeben sein – von 5 möglichen Bereichen
- “Critically, a person must have significant impairment in the two areas of personality functioning – self and interpersonal. Self is defined as how patients view themselves as well as how they identify and pursue goals in life. Interpersonal is defined as whether an individual is able to understand other people’s perspectives and form close relationships. The scale by which these will be judged ranges from mild to extreme.  
In addition, the work group determined that pathological personality traits must be present in at least one of five broad areas – such as whether a person is antagonistic versus able to get along with others, or impulsive versus able to think through possible consequences of action.”

### Direkt aus dem DSM-5: Leitfragen

A standard approach to the assessment of personality pathology using the DSM-5 model could be the following:

1. Is impairment in personality functioning (self and interpersonal) present or not?
2. If so, rate the level of impairment in self (identity or self-direction) and interpersonal (empathy or intimacy) functioning on the Levels of Personality Functioning Scale.
3. Is one of the 6 defined types present?
4. If so, record the type and the severity of impairment.
5. If not, is PD-Trait Specified present?
6. If so, record PDTS, identify and list the trait domain(s) that are applicable, and record the severity of impairment.
7. If a PD is present and a detailed personality profile is desired and would be helpful in the case conceptualization, evaluate the trait facets.
8. If neither a specific PD type nor PDTS is present, evaluate the trait domains and/or the trait facets, if these are relevant and helpful in the case conceptualization.

## Direkt aus dem DSM 5: Revised General Criteria for Personality Disorder

The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose a personality disorder, the following criteria must be met:

- A. Significant impairments in self (identity or self-direction) and interpersonal (empathy or intimacy) functioning.
- B. One or more pathological personality trait domains or trait facets.
- C. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.
- D. The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment.
- E. The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).

## Personality Functioning

### Self and Interpersonal Functioning Dimensional Definition

A review of the empirical literature on the dimensional models pertinent to individuals' mental representations of self and others (Bender et al., in press), and subsequent empirical analyses (Morey et al., in press), suggest that the following components are most central in comprising a personality functioning continuum:

#### Self:

**Identity:** Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience

**Self-direction:** Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively

#### Interpersonal:

**Empathy:** Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding of the effects of own behavior on others

**Intimacy:** Depth and duration of positive connections with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior

### Self and Interpersonal Functioning Continuum

Although the degree of disturbance in the self and interpersonal domains is continuously distributed, it nonetheless is useful to consider levels of impairment in functioning for efficient clinical characterization and for treatment planning and prognosis. Patients' understanding of self and others affects the nature of interaction with mental health professionals and can have a significant impact on treatment efficacy and outcome. The following continuum uses each of the dimensions listed above to differentiate five levels of self-interpersonal functioning impairment, ranging from no impairment, i.e., healthy functioning (Level = 0) to extreme impairment (Level = 4).

Please indicate the level that most closely characterizes the patient's functioning in the self and interpersonal domain:

Level	SELF		INTERPERSONAL	
	Identity	Self-Direction	Empathy	Intimacy
0	<ul style="list-style-type: none"> <li>-Ongoing awareness of a unique self; maintains role-appropriate boundaries.</li> <li>-Consistent and self-regulated positive self-esteem, with accurate self-appraisal.</li> <li>-Capable of experiencing, tolerating and regulating a full range of emotions.</li> </ul>	<ul style="list-style-type: none"> <li>-Sets and aspires to reasonable goals based on a realistic assessment of personal capacities.</li> <li>-Utilizes appropriate standards of behavior, attaining fulfillment in multiple realms.</li> <li>-Can reflect on, and make constructive meaning of, internal experience.</li> </ul>	<ul style="list-style-type: none"> <li>-Capable of accurately understanding others' experiences and motivations in most situations.</li> <li>-Comprehends and appreciates others' perspectives, even if disagreeing.</li> <li>-Is aware of the effect of own actions on others.</li> </ul>	<ul style="list-style-type: none"> <li>-Maintains multiple satisfying and enduring relationships in personal and community life.</li> <li>-Desires and engages in a number of caring, close and reciprocal relationships.</li> <li>-Strives for cooperation and mutual benefit and flexibly responds to a range of others' ideas, emotions and behaviors.</li> </ul>
	<ul style="list-style-type: none"> <li>-Relatively intact sense of self, with some decrease in clarity of boundaries when strong</li> </ul>	<ul style="list-style-type: none"> <li>-Excessively goal-directed, somewhat goal-inhibited, or conflicted about</li> </ul>	<ul style="list-style-type: none"> <li>-Somewhat compromised in ability to appreciate and understand others'</li> </ul>	<ul style="list-style-type: none"> <li>-Able to establish enduring relationships in personal and community life, with some limitations on</li> </ul>

1	<p>emotions and mental distress are experienced.</p> <p>-Self-esteem diminished at times, with overly critical or somewhat distorted self-appraisal.</p> <p>-Strong emotions may be distressing, associated with a restriction in range of emotional experience.</p>	<p>goals.</p> <ul style="list-style-type: none"> <li>-May have an unrealistic or socially inappropriate set of personal standards, limiting some aspects of fulfillment.</li> <li>-Able to reflect upon internal experiences, but may overemphasize a single (e.g., intellectual, emotional) type of self-knowledge.</li> </ul>	<p>experiences; may tend to see others as having unreasonable expectations or a wish for control.</p> <ul style="list-style-type: none"> <li>-Although capable of considering and understanding different perspectives, resists doing so.</li> <li>-Inconsistent is awareness of effect of own behavior on others.</li> </ul>	<p>degree of depth and satisfaction.</p> <ul style="list-style-type: none"> <li>-Capacity and desire to form intimate and reciprocal relationships, but may be inhibited in meaningful expression and sometimes constrained if intense emotions or conflicts arise.</li> <li>-Cooperation may be inhibited by unrealistic standards; somewhat limited in ability to respect or respond to others' ideas, emotions and behaviors.</li> </ul>
2	<p>-Excessive dependence on others for identity definition, with compromised boundary delineation.</p> <p>-Vulnerable self-esteem controlled by exaggerated concern about external evaluation, with a wish for approval. Sense of incompleteness or inferiority, with compensatory inflated, or deflated, self-appraisal.</p> <p>-Emotional regulation depends on positive external appraisal. Threats to self-esteem may</p>	<p>-Goals are more often a means of gaining external approval than self-generated, and thus may lack coherence and/or stability.</p> <p>-Personal standards may be unreasonably high (e.g., a need to be special or please others) or low (e.g., not consonant with prevailing social values).</p> <p>Fulfillment is compromised by a sense of lack of authenticity.</p> <p>-Impaired capacity to</p>	<p>-Hyper-attuned to the experience of others, but only with respect to perceived relevance to self.</p> <p>-Excessively self-referential; significantly compromised ability to appreciate and understand others' experiences and to consider alternative perspectives.</p> <p>-Generally unaware of or unconcerned about effect of own behavior on others, or unrealistic</p>	<p>-Capacity and desire to form relationships in personal and community life, but connections may be largely superficial.</p> <p>-Intimate relationships are largely based on meeting self-regulatory and self-esteem needs, with an unrealistic expectation of being perfectly understood by others.</p> <p>-Tends not to view relationships in reciprocal terms, and cooperates predominantly for personal gain.</p>

	engender strong emotions such as rage or shame.	reflect upon internal experience.	appraisal of own effect.	
3	<ul style="list-style-type: none"> <li>-A weak sense of autonomy/agency; experience of a lack of identity, or emptiness. Boundary definition is poor or rigid: may be over identification with others, overemphasis on independence from others, or vacillation between these.</li> <li>-Fragile self-esteem is easily influenced by events, and self-image lacks coherence. Self-appraisal is unnuanced: self-loathing, self-aggrandizing, or an illogical, unrealistic combination.</li> <li>-Emotions may be rapidly shifting or a chronic, unwavering feeling of despair.</li> </ul>	<ul style="list-style-type: none"> <li>-Difficulty establishing and/or achieving personal goals.</li> <li>-Internal standards for behavior are unclear or contradictory. Life is experienced as meaningless or dangerous.</li> <li>-Significantly compromised ability to reflect upon and understand own mental processes.</li> </ul>	<ul style="list-style-type: none"> <li>-Ability to consider and understand the thoughts, feelings and behavior of other people is significantly limited; may discern very specific aspects of others' experience, particularly vulnerabilities and suffering.</li> <li>-Generally unable to consider alternative perspectives; highly threatened by differences of opinion or alternative viewpoints.</li> <li>-Confusion or unawareness of impact of own actions on others; often bewildered about peoples' thoughts and actions, with destructive motivations frequently misattributed to others.</li> </ul>	<ul style="list-style-type: none"> <li>-Some desire to form relationships in community and personal life is present, but capacity for positive and enduring connection is significantly impaired.</li> <li>-Relationships are based on a strong belief in the absolute need for the intimate other(s), and/or expectations of abandonment or abuse. Feelings about intimate involvement with others alternate between fear/rejection and desperate desire for connection.</li> <li>-Little mutuality: others are conceptualized primarily in terms of how they affect the self (negatively or positively); cooperative efforts are often disrupted due to the perception of slights from others.</li> </ul>
	<ul style="list-style-type: none"> <li>-Experience of a unique self and sense of agency/autonomy</li> </ul>	<ul style="list-style-type: none"> <li>-Poor differentiation of thoughts from actions, so goal-</li> </ul>	<ul style="list-style-type: none"> <li>-Pronounced inability to consider and understand others'</li> </ul>	<ul style="list-style-type: none"> <li>-Desire for affiliation is limited because of profound disinterest or expectation of</li> </ul>

4	<p>are virtually absent, or are organized around perceived external persecution. Boundaries with others are confused or lacking.</p> <p>-Weak or distorted self-image easily threatened by interactions with others; significant distortions and confusion around self-appraisal.</p> <p>-Emotions not congruent with context or internal experience. Hatred and aggression may be dominant affects, although they may be disavowed and attributed to others.</p>	<p>setting ability is severely compromised, with unrealistic or incoherent goals.</p> <p>-Internal standards for behavior are virtually lacking. Genuine fulfillment is virtually inconceivable.</p> <p>-Profound inability to constructively reflect upon own experience. Personal motivations may be unrecognized and/or experienced as external to self.</p>	<p>experience and motivation.</p> <p>-Attention to others' perspectives virtually absent (attention is hypervigilant, focused on need-fulfillment and harm avoidance).</p> <p>-Social interactions can be confusing and disorienting.</p>	<p>harm. Engagement with others is detached, disorganized or consistently negative.</p> <p>-Relationships are conceptualized almost exclusively in terms of their ability to provide comfort or inflict pain and suffering.</p> <p>-Social/interpersonal behavior is not reciprocal; rather, it seeks fulfillment of basic needs or escape from pain.</p>
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### Am Beispiel Borderline

#### Alte DSM IV Diagnosekriterien:

#### Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- (3) identity disturbance: markedly and persistently unstable self image or sense of self
- (4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.

- (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- (6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- (7) chronic feelings of emptiness
- (8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- (9) transient, stress-related paranoid ideation or severe dissociative symptoms

**Neue DSM 5 Diagnosekriterien:**

The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose borderline personality disorder, the following criteria must be met:

A. Significant impairments in **personality functioning** manifest by:

- 1. Impairments in **self functioning** (a or b):
  - a. **Identity:** Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
  - b. **Self-direction:** Instability in goals, aspirations, values, or career plans.

AND

2. Impairments in **interpersonal functioning** (a or b):

- a. **Empathy:** Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.
- b. **Intimacy:** Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between over involvement and withdrawal.

B. Pathological personality traits in the following domains:

- 1. **Negative Affectivity**, characterized by:
  - a. **Emotional lability:** Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
  - b. **Anxiousness:** Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant

- experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.
- c. **Separation insecurity:** Fears of rejection by – and/or separation from – significant others, associated with fears of excessive dependency and complete loss of autonomy.
  - d. **Depressivity:** Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feeling of inferior self-worth; thoughts of suicide and suicidal behavior.
2. **Disinhibition**, characterized by:
- a. **Impulsivity:** Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.
  - b. **Risk taking:** Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger.
3. **Antagonism**, characterized by:
- a. **Hostility:** Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.
- C. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time and consistent across situations.
- D. The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment.
- E. The impairments in personality functioning and the individual's personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).

## **5. Kleine Übersicht der diskutierten inhaltlichen Unterschiede**

- Verschiedene neue Diagnosen z.B. Hoarding (Messie) oder Binge-Eating
- Änderungen – hinzugefügte Unterkategorien und Umstrukturierung bei bereits bestehenden Diagnosen z.B. bei Schizophrenie/ Psychosen.  
DSM 5: Neue Kategorie: Attenuated Psychosis Syndrome (abgeschwächte Psychose)  
Welche quasi eine Diagnose für Risikogruppen ist. Argumente der APA:  
“Young people at risk for later manifestation of a psychotic disorder can be identified. It has been established in follow-back studies that early signs and symptoms of schizophrenia, for example, are present years before diagnosis is established [e.g., Haffner's longitudinal study] and can be predicted even in infants [Walker's home movies study]. However, it is the work of multiple groups of investigators in several countries over the past 15 years that has produced evidence for the effectiveness of

detecting at risk individuals. The validity of criteria for identifying individuals as at risk has been published [see Scott et al, below]. An approach to this issue in the DSM-V framework has been published [Heckers, see below and Carpenter, see below]. And also widely debated [see Schizophrenia Research Forum for presentations and commentary by many participants].

Critical issues to consider include sensitivity, specificity, positive predictive power and negative predictive power; the evidence for effective intervention, and issues related to stigma and potential harm of excessive treatment.

The potential benefit of establishing a category involves the evidence that psychotic illness is most effectively treated early in the course raising the potential that early intervention may have long lasting benefit that is not achievable with later therapeutic intervention. Also, as clarified in a recent IOM report, prevention science requires application. It seems reasonable to anticipate that mental disorders will gradually develop interventions for primary and secondary prevention associated with a number of disorders

For these reasons, a risk syndrome for psychosis is being considered for either the appendix or possibly the list of disorders. Immediate issues relate to the unanswered question as to whether ordinary users of DSM-V in ordinary settings will be able to reliably and validly identify cases based on criteria developed and validated by expert investigators. Any movement forward with this proposal will depend on affirmative answers to this issue in field trials. A second problem relates to the absence of an evidence-based intervention which has demonstrated benefit in reducing conversion to psychosis. Finally, more information regarding the potential negative effect on false positive identification is needed.”

- Folgende Unterkategorien aus dem Bereich Schizophrenie sollen gelöscht werden:
  - 295.30 Schizophrenia - Paranoid Type
  - 295.10 Schizophrenia - Disorganized Type
  - 295.20 Schizophrenia - Catatonic Type
  - 295.90 Schizophrenia - Undifferentiated Type
  - 295.60 Schizophrenia - Residual Type
  - 297.3 Shared Psychotic Disorder
- Mehr Unterkategorien bei der Bipolaren Störung
- Asperger soll als eigenständige Diagnose gelöscht und in den „autism spectrum disorders (ASD)“ eingegliedert werden

## **6. Kritikpunkte (Auszug)**

- Die Aufweichung von verschiedenen Diagnosen – gerade auch die neue Diagnose der abgeschwächten Psychose sorgen für reichlich Kritikstoff (siehe Finzen unten im Internetartikel)
- Die APA bzw. deren Mitglieder stehen teilweise unter Verdacht von den Pharmafirmen beeinflusst zu sein (mussten zwar Verträge unterschreiben indem eine „bestimmte Grenze“ an Abhängigkeit von wirtschaftlichen und

- Pharmainteressen (z.B. auch Aktien und dergleichen) nicht überschritten werden darf, wie die Grenze genau aussieht ist fraglich (ob sie eingehalten wird auch)
- Umdenken von strengem, binären System auf eine dimensionale Herangehensweise ist zwar auch positiv, andererseits gibt es weite Bereiche, bei der es Definitionssache bleibt z.B. bei Psychosen oder Persönlichkeitsstörungen

## 7. Anhang

### Achse I und II:

- Diagnose und Codierung nach Kriterienlisten (Typ: XXX.YY)
- Möglichkeit von Mehrfachdiagnosen (Achse I - Diagnose = Hauptdiagnose, wenn nicht anders vermerkt)
- Zusatzcodierungen für Schweregrad und Verlauf (an Stelle 4 oder 5 der Codierung): Leicht, Mittelschwer, Schwer, Teilremitiert, Voll remittiert, In der Vorgesichte
- Vorläufige und unsichere Diagnosen (Zustände, die nicht einer psychischen Störung zuordnbar sind, aber Anlass zur Behandlung oder Beobachtung geben), z.B. 799.9 = Diagnose zurückgestellt, 300.9 = unspezifische psychische Störung (nicht psychotisch), 298.9 = nicht näher bezeichnete psychotische Störung
- V-Kodierungen (für andere klinisch relevante Probleme), z.B. V61.20 = Eltern-Kind-Problem, V62.82 = Einfache Trauer, V65.2 = Simulation.

### **DSM-IV: Numerische Systematik der Schlüsselzahlen**

- **Allgemein:**  
Unter 300 = Organische und psychotische Störungen, Wahn und Autismus  
über 300 = Neurosen, und (fast) alles andere
- **Interpretation der 2. Stelle (300-319):**  
0 = nicht organisch, neurotisch, reaktiv in der Genese  
1 = (vermuteter) leichter organischer Verursachungsfaktor
- **Interpretation der 3. Stelle:**  
290 = Alzheimer  
291-2 = Substanzentzug oder -intoxikation mit Delir, Wahn, organischen Störungen  
293 = Störungen aufgrund eines medizinischen Krankheitsfaktors  
294 = andere Demenzen  
295 = Schizophrenien und schizoaffektive Störung  
296 = Affektive Störungen (nicht neurotisch)  
297 = Wahn  
298 = reaktive und atypische Psychosen  
299 = Autismus und andere Entwicklungsstörungen (nicht näher bezeichnet)
- 300 = Neurosen (im klassischen Sinn)  
301 = Persönlichkeitsstörungen  
302 = Sexualstörungen (ohne medizinischen Krankheitsfaktor)  
303 = Alkoholabhängigkeit und -intoxikation  
304 = Abhängigkeit von psychotropen Substanzen  
305 = Substanzmißbrauch und -intoxikation  
306 = Vaginismus

- 307 = spezielle Entwicklungs- und Schlafstörungen
- 308-9 = Anpassungs- und Belastungsstörungen
- 310 = organisch bedingte Persönlichkeitsstörungen
- 311 = depressive Störungen (nicht näher bezeichnet)
- 312 = Störungen der Impulskontrolle, Monomanien
- 313 = Bindungs- und Kontaktstörungen bei Kindern
- 314 = Aufmerksamkeitsstörungen und Hyperaktivität
- 315 = Sprach-, Rechen- und Motorikstörungen bei Kindern
- 316 = körperliche Zustände bei denen psychische Faktoren eine Rolle spielen
- 317-9 = Oligophrenien
- **Spezielle Codierungen (Auswahl):**
- 332-3 = Neuroleptikanebenwirkungen und -folgen
- 347 = Narkolepsie
- 607-25 = sexuelle Funktionsstörungen aufgrund eines medizinischen Krankheitsfaktors
- 780 = Schlafstörungen aufgrund eines medizinischen Krankheitsfaktors
- 780.09 = Delir (nicht näher bezeichnet)
- 780.9 = altersbedingter kognitiver Abbau
- 787 = Enkopresis mit Verstopfung und Überlaufinkontinenz
- 799.9 = Diagnose zurückgestellt

## **8. Quellen**

[Taskforce der American Psychiatric Association \(APA\)](#)

[Psychiatrie Verlag News: »DSM-5: Der Wahnsinn der Normalität«](#)

[DocCheck News »Ganz normal verrückt«](#)

[Der Tagesspiegel »Was ist schon normal?«](#)

[Ärzteblatt.de »Psychosen verkürzen das Leben«](#)

[Webseite von Prof. Asmus Finzen »Länger leben mit Neuroleptika?«](#)

[Psychcentral »Personality Disorders Shakeup in DSM-5«](#)

[Wikipedia](#)

[The American Journal of Psychiatry](#)

[International Journal of Methods in Psychiatric Research](#)

[International Journal of Methods in Psychiatric Research 2](#)

[DSM-5 Revisions for Personality Disorders Reflect Major Change \(APA\)](#)