Section B

Using the DSM-5 Legally and Ethically:
A Clinician’s Guide
2017

Anaheim Conference

Methods to Diagnose
Highlights of Diagnostic Changes

Diagnostic Uncertainty

Not Otherwise Specified” (NOS)

Eliminated

Two options replace NOS
Usually same code numbers for both
1. “Other Specified Disorder”
   • Clinician indicates specific reason full criteria not met
   • Example: – Insufficient symptoms

Two options replace NOS
Usually same code numbers for both
2. “Unspecified Disorder”
   • Clinician decides NOT to indicate why full criteria is not met
   • More likely in an emergency situation

Diagnostic Uncertainty

“Provisional Diagnosis”
   – A working diagnosis
   – Strong presumption all criteria will be met

Example: 300.4 (F34.1) Persistent Depressive Disorder (Provisional)

Methods to Diagnose

“Principal Diagnosis”
   – For inpatient diagnosing only
   – When more than one diagnosis is given
   – Responsible for the admission

Example: 300.4 (F34.1) Persistent Depressive Disorder (Dysthymia)
301.83 (F60.3) Borderline Personality Disorder (Principal Diagnosis)
Methods to Diagnose

“Reason for Visit”
– For outpatient diagnosing only
– When there are two diagnoses indicate which is the CURRENT focus of treatment

Example:
300.4 (F34.1) Persistent Depressive Disorder (Dysthymia)
308.3 (F43.0) Acute Stress Disorder (Reason for Visit)

Neurodevelopmental Disorders Chapter

• Autism spectrum disorder
• Social (pragmatic) communication disorder
• Specific learning disorder
• Attention-deficit/hyperactivity disorder
• Intellectual disability
  (Intellectual Developmental Disorder)

Highlights of Changes

Neurodevelopmental Disorders Chapter
Autism Spectrum Disorder
– Major Change:
– “Spectrum” encompassing:
  • Autistic Disorder
  • Asperger’s Disorder
  • Childhood Disintegrative Disorder
  • Pervasive Developmental Disorder NOS
Experts have known this for years…

Point of Concern
Thompson, 2013
Neurodevelopmental Disorders Chapter
Autism Spectrum Disorder (p. 50)
“The concern is people with autism will find themselves unable to receive services or treatment… particularly true for Asperger’s Syndrome, which has been eliminated.”
**Ethical Issue**  
*N. Neimeyer, 2014*  

**Point of Concern**  
Neurodevelopmental Disorders Chapter  
*Autism Spectrum Disorder*  
- **ETHICAL ISSUE:**  
- The other side:  
  - Asperger’s are more highly functioning  
  - Health care services will be spread  
  - Identity: “Aspie”  
  - “DSM-5 messing with my identity”

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**Highlights of Changes**  
*ApA, 2014*  

Neurodevelopmental Disorders Chapter  
*Social (Pragmatic) Communication Disorder*  
- Difficulty in social use of language  
  - Volume regulation, social norms of speaking  
- Impairment of ability to change communication  
  - Example:  
    - Speaking differently in a classroom than on playground  
    - Talking differently to a child than an adult

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**Highlights of Changes**  
*ApA, 2014*  

**Differential Diagnosis**  

- **Social Anxiety Disorder**  
- **Social Communication Disorder**  
  - Developed normal social communication  
  - Not being used due to anxiety  
  - Never developed normal social communication  
  - Never able to communicate effectively

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**Highlights of Changes**  
*Neurodevelopmental Disorders Chapter*  
*Attention-Deficit/Hyperactivity Disorder*  
- Persistent pattern of inattention and/or hyperactivity-impulsivity  
- Under 17 years: Requires six symptoms  
- Over 17 years: Requires five symptoms  
- Must be present in two or more settings  
  - Home  
  - School  
  - Work  
  - With friends or relatives

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**Highlights of Changes**  
*Neurodevelopmental Disorders Chapter*  
*Attention-Deficit/Hyperactivity Disorder*  
- Three ways to diagnose  
  1. Inattentive presentation  
  2. Hyperactivity/Impulsivity presentation  
  3. Combined presentation

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**Highlights of Changes**  
*Neurodevelopmental Disorders Chapter*  
*Attention-Deficit/Hyperactivity Disorder*  
- Age of onset from 7 years to 12 years  
- To allow for questions when diagnosing adults:  
  - What were you like in middle school easier to recall than prior to 7

**Rationale:**  
Numerous large-scale studies indicate that onset is not identified until after age 7 years, when challenged by school requirements. Recall of onset is more accurate at 12 years
Highlights of Changes
Frances, 2013, pp. 141-142

Caution not to over-diagnose
Neurodevelopmental Disorders Chapter
Attention-Deficit/Hyperactivity Disorder
• ETHICAL ISSUE:
  • “The Birthday Effect”
  • Best predictor of diagnosis of ADHD
  • Boys born January of previous year are eleven months older when school starts in Sept
    – 70% less likely to be diagnosed than boys born in December of previous year

Schizophrenia Spectrum and Related Disorders Chapter

• Delusional disorder
• Brief psychotic disorder
• Schizophreniform disorder
• Schizophrenia
• Schizoaffective disorder
• Schizotypal personality disorder

Highlights of Changes
Schizophrenia Spectrum and Other Psychotic Disorders Chapter

Delusional Disorder
• Elimination of required bizarre delusions
• Poor reliability:
  • Bizarre from non-bizarre
• Subtypes
  Erotomatic    Grandiose
  Jealous       Persecutory
  Somatic       Mixed

Highlights of Changes
Neimeyer, 2014

Schizophrenia Spectrum and Other Psychotic Disorders Chapter - Schizophrenia
• Eliminated schizophrenia subtypes
Rationale:
DSM-IV’s subtypes were shown to have very poor reliability and validity….. Treatment was unchanged among subtypes.

Obsessive-Compulsive and Related Disorders Chapter

• Obsessive-compulsive disorder
• Body dysmorphic disorder
• Hoarding disorder
• Trichotillomania (hair-pulling disorder)
• Excoriation (skin-picking) disorder
Highlights of Changes

Obsessive-Compulsive and Related Disorders Chapter

**Obsessive Compulsive Disorder**
- OCD work group objected to word “impulse”
  - Worried “impulse” would put them into Impulse and Conduct Disorders Chapter
  - Desired their own chapter
- Replaced word “impulse”
  - With “URGE”

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Highlights of Changes

Obsessive-Compulsive and Related Disorders Chapter

**Obsessive Compulsive Disorder**
- New specifiers:
  - With good or fair insight
    - Person believes OCD beliefs are not true
  - With poor insight
    - Person believes OCD beliefs may be true
  - With absent insight / delusional beliefs
    - Person believes OCD beliefs are absolutely true
  - Tic-related

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Highlights of Changes

OCD and Related Disorders Chapter

**Body Dysmorphic Disorder**
- Repetitive behaviors in response to appearance concerns
- Perceived defects or flaws in physical appearance
- Added:
  - Specifier: With Muscle Dysmorphia
  - Obsession: Body too small or not sufficiently muscular (“buff”)
Highlights of Changes

OCD and Related Disorders Chapter
New Diagnosis
Excoriation (Skin-Picking)
Children and adolescents:
• Onset with puberty
• Recurrent skin picking resulting in lesions
• Repeated attempts to stop
• Not attributable to another medical condition
• Most common: face, arms, hands

New Chapters Related to Depression
Coming up!
• Bipolar and Related Disorders Chapter
• Depressive Disorders Chapter

Depressive and Related Disorders Chapter
• Disruptive mood dysregulation disorder
• Major depressive disorder
• Persistent depressive disorder (dysthymia)
• Premenstrual dysphoric disorder

Highlights of Changes

Depressive Disorders Chapter
Disruptive Mood Dysregulation Disorder (DMDD)
• Temper outbursts:
  • Yelling, rages, or physical aggression
  • In at least 2 of 3 settings
• Overreacting to common stressors
• Limited to ages 6 to 18
• Valid: 7 to 18
• Considered “Temper Dysregulation D/O”

Legal / Ethical Issue
Neimeyer, 2014
Depressive Disorders Chapter
Disruptive Mood Dysregulation Disorder (DMDD)
• MOOD dysregulation
• Rather than behavioral acting out
Rationale:
• Addresses increase in pediatric bipolar
• Provides a diagnosis for children with extreme behavioral dys-control
• Decreases likelihood of inappropriate medication.
Highlights of Changes  
Neimeyer, 2014

Depressive Disorders Chapter
Disruptive Mood Dysregulation Disorder - DMDD
• “Depression Chapter” invites sympathy
  • “Child is depressed”
  • Versus a fire-starter or torturer of animals

Highlights of Changes  

Major Depressive Disorder
• Nine new specifiers
• DSM-IV bereavement exclusion eliminated after 33 years
• Bereavement now added to MDD
  – Bereavement is psychosocial stressor that can precipitate MDD
  – Generally beginning soon after the loss
  – Additional risk for suicide, suffering, worthlessness, poor interpersonal and work functioning, poor medical health

Highlights of Changes  

What is the Bereavement Exclusion?
in the DSM-IV there was an exclusion for a major depressive episode that was applied to depressive symptoms lasting less than 2 months following the death of a loved one (The Bereavement Exclusion).

The Bereavement Exclusion  
Kupfer, 2012

“As part of the ongoing study of major depression, the BE has been removed from DSM. This deletion from DSM-IV will be replaced by notes in the criteria and text that caution clinicians to differentiate between normal grieving associated with a significant loss and a diagnosis of a mental disorder.”

David Kupfer, Chair, DSM-5 Task Force:

The Bereavement Exclusion  
Kupfer, 2012; Neimeyer, 2014

Eliminated from major depressive episode (MDE) MDE is building block for MDD...

Rationale: In some individuals, major loss – including but not limited to loss of a loved one – can lead to MDE or exacerbate pre-existing depression. Individuals experiencing both conditions can benefit from treatment but are excluded from diagnosis under DSM-IV. Further, the 2-month timeframe required by DSM-IV suggests an arbitrary time course to bereavement that is inaccurate. Lifting the exclusion alleviates both of these problems.

ETHICAL ISSUE:
• At risk of being diagnosed “mentally ill” for grieving
• Pathologizing a normal reaction to a bad thing
Grief Major Depression

<table>
<thead>
<tr>
<th>Predominant affect</th>
<th>DSM-5 Criteria for Major Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emptiness and loss</td>
<td>Persistent depressed mood and the inability to anticipate happiness or pleasure</td>
</tr>
<tr>
<td>Decreases in intensity over days to weeks and occurs in waves; the so-called pangs of grief; waves associated with thoughts or reminders of the deceased</td>
<td></td>
</tr>
<tr>
<td>Accompanied by positive emotions and humor</td>
<td>Pervasive unhappiness and misery</td>
</tr>
</tbody>
</table>

Major Depression

<table>
<thead>
<tr>
<th>Thought content</th>
<th>Preoccupation with thoughts and memories of the deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-critical or pessimistic rumination</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self-esteem</th>
<th>Feels of worthlessness and self-soothing are common</th>
</tr>
</thead>
<tbody>
<tr>
<td>If self-derogatory ideation is present, it typically involves perceived failing the deceased (e.g. Not visiting enough)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicidal thoughts</th>
<th>Focused on the deceased and possibly about “joining” the deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focused on ending one’s own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression</td>
<td></td>
</tr>
</tbody>
</table>

Bereavement Exclusion

ETHICAL ISSUES:

- Depression
  - Expectable and culturally sanctioned response to a death
- Bereavement
  - Symptoms are not likely to recur
- Medicalizes sadness and grief
- Provides big pharma a bonanza

Objections to Bereavement Exclusion

Frances, 2013

Allen Frances, MD, Chair of the DSM-IV Task Force, upon hearing of the APA Board of Trustees final approval of the DSM-5, remarked:

"[This is] the saddest moment of my 45 year career of studying, practicing, and teaching psychiatry.”

(http://www.huffingtonpost.com/allenfrances/dsm-5 Chargers.html)
Caution: What is a “normal” reaction to the death of a loved one? When does it become MDD?

Caution not to over-use in cases of grief

Major Depressive Disorder
“MDD need not be diagnosed unless the bereaved becomes suicidal, or delusional, or suffers from symptoms that are severe, prolonged and incapacitating.” (p. 187)

When diagnosing Persistent Depressive Disorder:
- Do not give MDD and Persistent DD together
- MDD has four features not included in PDD
- Specifier when MDE exists with PDD diagnosis:
  - “With persistent MDE”
  - “With intermittent MDE…”

Depressive Disorders Chapter
Persistent Depressive Disorder (Dysthymia)
- Consolidation of DSM-IV chronic major depressive disorder and dysthymic disorder
- Depressed mood that occurs for most of the day
- No longer considered “milder” form of depression
- Do not diagnoses both MDD and PDD together

Premenstrual Dysphoric Disorder
- Appears in Depressive Disorders Chapter
- Promoted from Appendix B
- Now in primary text (Section II)

Premenstrual Dysphoric Disorder
- Moved from DSM-IV Appendix (for further study)
- Mood, irritability, dysphoria, anxiety symptoms occurring during the majority of menstrual cycles
Bipolar and Related Disorders Chapter

- Bipolar I disorder
- Bipolar II disorder
- Cyclothymic disorder

Bipolar Disorder HISTORY

- Manic-Depressive Psychosis
  - Focus on the psychotic behavior
- Bipolar Mood Disorders
  - Focus on the mood changes
  - With or without psychotic features
- Current
  - Bipolar and Related Disorders
  - Focus on energy and activity versus moods

Highlights of Changes

Bipolar II Disorder (pp. 132-135)

- At least one current or past
  Hypomanic episode
- At least one current or past MDE
- Average age of onset mid-20s

Bipolar I Disorder

Coding Based On Most Recent Episode

<table>
<thead>
<tr>
<th>DSM-IV Bipolar I Disorders</th>
<th>DSM-5 Bipolar I Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP I Disorder, Single Manic Episode</td>
<td>BP I Disorder, Current or Most Recent Episode Manic</td>
</tr>
<tr>
<td>BP I Disorder, Most Recent Episode, Hypomanic</td>
<td>BP I Disorder, Current or Most Recent Episode, Hypomanic</td>
</tr>
<tr>
<td>BP I Disorder, Most Recent Episode, Manic</td>
<td>BP I Disorder, Current or Most Recent Episode, Manic</td>
</tr>
<tr>
<td>BP I Disorder, Most Recent Episode, Mixed</td>
<td>BP I Disorder, Current or Most Recent Episode, Mixed</td>
</tr>
<tr>
<td>BP I Disorder, Most Recent Episode, Depressed</td>
<td>BP I Disorder, Current or Most Recent Episode, Depressed</td>
</tr>
<tr>
<td>BP I Disorder, Most Recent Episode, Unspecified</td>
<td>BP I Disorder, Current or Most Recent Episode, Unspecified</td>
</tr>
</tbody>
</table>

Specify if (clinical status features)

- With:
  - Anxious distress
  - Mixed features
  - Rapid cycling
  - Melancholic features
  - Atypical features
  - Psychotic features
  - Catatonia
  - Peripartum onset
  - Seasonal pattern

Severity / Course Specifiers

- Mild
- Moderate
- Severe
- In partial remission
- In full remission

Highlights of Changes

Bipolar I and II Disorders

- Changes in activity and energy as well as mood
- Removed: “Mixed Episode”
- Added: “With Mixed Features”
- Anxious Distress Specifier
Ethical Use of the DSM-5

Highlights of Changes

Bipolar and Related Disorders Chapter

**Cyclothymic Disorder**
- Both hypomanic and depressive periods
- No changes
- Hours of debate whether or not to leave it in
  **FINAL DECISION:**
  - Kept in for “tradition’s sake”
  - Not based upon science

Somatic Symptom and Related Disorders Chapter

**New Chapter**

- Somatic Symptom Disorder - NEW
  - Specify if with predominant pain (replaces pain disorder)
  - Specify if Persistent (6 months+)
  - Specify Severity (Mild, Moderate, Severe)
- Illness Anxiety Disorder - NEW
- Conversion Disorder
  (Functional Neurological Symptom D/O
- Psychological Factors Affecting
  Other Medical Conditions
- Factitious Disorder

**Somatic Symptom Disorder**
- Merger of two diagnoses
- Undifferentiated Somatoform Disorder
- Somatization Disorder
- Interface between mental health and medical symptoms
  - Attempt to avoid problematic overlap
  - Reinforces mind-body dualism

**Illness Anxiety Disorder**
- Replaced “Hypochondriasis”
- Preoccupation with having or acquiring an illness
- Distinction:
  - IAD = Somatic symptoms are **NOT** present
  - Illness Anxiety Disorder
  - SSD = Somatic symptoms **ARE** present
  - Somatic Symptom Disorder

Caution: Rule Out Medical Condition

**Somatic Symptom Disorder**
“The golden rule: An underlying medical illness has to be ruled out before ever deciding that someone’s symptoms are caused by a mental disorder.” (p. 196)
Anxiety Disorders Chapter

“The Biggest Losers…”
- Generalized anxiety disorder
- Specific phobia
- Panic disorder
- Agoraphobia
- Social anxiety disorder (social phobia)
- Separation anxiety disorder
- Selective mutism

Highlights of Changes

Anxiety Disorders Chapter
Generalized Anxiety Disorder

- Excessive anxiety and worry
  - Apprehensive expectation
  - Difficulty controlling worry
  - At least 6 months
- GAD vs. GAWD

Highlights of Changes

Anxiety Disorders Chapter
Generalized Anxiety Disorder

Three or more (One or more for children):
1. Restlessness
2. Fatigue
3. Difficulty concentrating
4. Irritability
5. Muscle tension
6. Sleep problems

Highlights of Changes

Anxiety Disorders Chapter
Unlinked:
- Panic Disorder and Agoraphobia
- Eliminated:
  - Panic Disorder with/without Agoraphobia
  - Agoraphobia without Hx of Panic Disorder
- Replaced with two separate disorders:
  - Panic Disorder
  - Agoraphobia

Note: Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual's presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned.

http://akfsa.org/

http://akfsa.org/

Social Anxiety Disorder
Andy Kukes Foundation
Highlights of Changes  

**Anxiety Disorders Chapter**
- Panic Attack Specifier
- Now a “free agent”
- “Can now be listed as specifier for all DSM-5 disorders” (p. 811)

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Ethical Issue  
Frances, 2013, pp. 152-153

**Caution not to over-use**  
Social Anxiety Disorder (Social Phobia)

**ETHICAL ISSUE:**
- Could simply be a personal style
- Simple shyness is not SAD
- Potential to become over used
- Open to use of psychiatric mediation when unnecessary

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Trauma- and Stress-Related Disorders Chapter

- Reactive attachment disorder
- Disinhibited social engagement disorder
- Posttraumatic stress disorder
- Acute stress disorder
- Adjustment disorders

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Highlights of Changes  

**Anxiety Disorders Chapter**
- Social Anxiety Disorder (Social Phobia)
  - Deleted:
    - Recognition anxiety is excessive or unreasonable
  - Added:
    - Anxiety out of proportion to the actual danger or threat (Criterion E)
    - Must consider cultural context

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Highlights of Changes  

**Anxiety Disorders Chapter**
- Social Anxiety Disorder (Social Phobia)
  - Children and adolescents
  - Median age 13 years
  - 75% have onset between 8 and 15 years
  - Can emerge out of childhood stressful or humiliating experience
    - Bullying
Highlights of Changes

Trauma- and Stressor-Related Disorders

1. Acute Stress Disorder – 3 days to 1 month
2. PTSD – More than one month

Exposure to actual or threatened death, serious injury, or sexual violation (violence)

1. Directly or witnessing in person
2. Learning the events occurred to someone close or family member – no need to experience
3. Experiences first-hand repeated exposure to aversive details or traumatic event

Rationale:
Direct and indirect exposure to trauma are still reflected in the criteria, but a review of the literature indicated more restrictive wording was needed such that military and other professionals could meet full criteria for PTSD.

Adjustment Disorders

Specify – each has separate F-Code:

- With Depressed Mood
- With Anxiety
- With Mixed Anxiety & Depressed Mood
- With Disturbance of Conduct
- With Mixed Disturbance of Emotions & Conduct
- Unspecified

Trauma- and Stressor-Related Disorders

Adjustment Disorders

Specify – each has separate F-Code:

- With Depressed Mood
- With Anxiety
- With Mixed Anxiety & Depressed Mood
- With Disturbance of Conduct
- With Mixed Disturbance of Emotions & Conduct
- Unspecified

Highlights of Changes

Trauma- and Stressor-Related Disorders

1. Acute Stress Disorder – 3 days to 1 month
2. PTSD – More than one month

Examples:
- Military or first responders cannot afford to let down defenses (examples)
- Collecting human remains
- Exposure to child abuse

Rationale:
"Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional six months.”
Highlights of Changes

**Neurocognitive Disorders Chapter**
- Delirium
- Major Neurocognitive Disorders
- Mild Neurocognitive Disorders

**Highlights of Changes**

**Major Neurocognitive Disorder**
- Cognitive decline from previous level of functioning
- One of six domains:
  1. Complex attention
  2. Executive function
  3. Learning and memory
  4. Language
  5. Perceptual motor
  6. Social cognition

**Mild Neurocognitive Disorder**
- Cognitive decline from previous level of functioning
- One of six domains:
  1. Complex attention
  2. Executive function
  3. Learning and memory
  4. Language
  5. Perceptual motor
  6. Social cognition

**Highlights of Changes**

**Major and Mild Neurocognitive Disorder**

**Major:**
- Decline in at least 1 of 6 neurocognitive domains
- **DOES** interfere with independence
- Specify etiology

**Mild:**
- Decline in at least 1 of 6 neurocognitive domains
- **NO** interference with independence
- Specify etiology

**Highlights of Changes**

Frances, 2013, 180-181

Caution not to over-diagnose

**Neurocognitive Disorders Chapter**

**Mild Neurocognitive Disorder**
- A “risk diagnosis
- Normal aging or precursor to neurocognitive disorder

**Practice Vignette**

Jonathan is an 11 year old 5th grader. His parents present you with his assessment results where the psychologist has diagnosed Jonathan with Asperger’s. Since the test results are from 2012, what diagnosis should be given to Jonathan now?

**Answer:**

**Sum Up Questions**

How does a General Medical Condition get coded, primarily by medical health care workers?

**Answer:**
**Sum Up Questions**

Name one area of **ETHICAL** concern related to the change to “Autistic Spectrum Disorder.”

**Answer:**

**Sum Up Questions**

Your patient has been a fire fighter for 12 years. Another good friend in the department, while fighting a fire two weeks ago, was unable to save the life of a young child. Your patient is now avoiding going to work, has lost concentration, has negative thoughts throughout the day, and has difficulty sleeping. What diagnoses would you consider?

**Answer:**

**Sum Up Questions**

What two elements replaced NOS in the DSM-5?

**Answer:**

**Sum Up Questions**

What is the “The Birthday Effect” and which diagnosis is effected by this **ETHICAL** issue?

**Answer:**

**Sum Up Questions**

Why did the authors use “Autism Spectrum Disorder” to replace four childhood disorders?

**Answer:**

**Sum Up Questions**

What is a potential **ETHICAL** issue raised by those who objected to Hoarding Disorder being added as a diagnosis?

**Answer:**
Sum Up Questions
What new diagnosis replaced the disturbing increase in diagnoses of childhood Bipolar Disorder?

Answer:

Sum Up Questions
What is the ETHICAL concern when diagnosing children with Bipolar Disorder?

Answer:

Sum Up Questions
What is the primary ETHICAL objection to eliminating the "Bereavement Exclusion to Major Depression?"

Answer:

Sum Up Questions
Name at least one of the diagnoses previously listed in Appendix B in the DSM-IV that has been promoted to Section II.

Answer:

Sum Up Questions
What was the thoughtfully considered diagnosis that required many months of debate to allow it to remain in the DSM-5? Why did the task force finally decide to keep it in the DSM-5?

Answer:

Sum Up Questions
What is a primary ETHICAL ISSUE related to the diagnosis of Social Anxiety Disorder?

Answer:
**Sum Up Questions**

*Why did the Schizophrenia “subtypes” get eliminated?*

*Answer:*

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**Bibliography**


First MB. *Current Opinion in Psychiatry*, 2011, 24:1–9