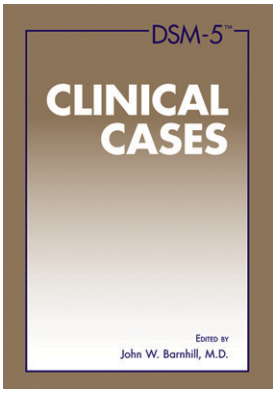

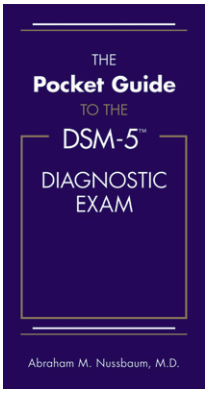

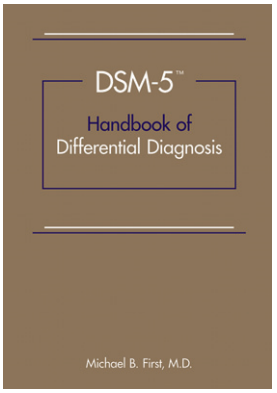

***DSM-5 Clinical Cases**, edited by John W. Barnhill, M.D. Washington, DC, American Psychiatric Publishing, 2014, 402 pp., $89.00.*

DSM-5 Clinical Cases makes the rather overwhelming DSM-5 much more accessible to mental health clinicians by using clinical examples—the way many clinicians learn best—to illustrate the changes in diagnostic criteria from DSM-IV-TR to DSM-5. More than 100 authors contributed to the 103 case vignettes and discussions in this book. Each case is concise but not oversimplified. The cases range from straightforward and typical to complicated and unusual, providing a nice repertoire of clinical material. The cases are realistic in that many portray scenarios that are complicated by confounding factors or in which not all information needed to make a diagnosis is available. The authors are candid in their discussions of difficulties arriving at the correct diagnoses, and they acknowledge the limitations of DSM-5 when appropriate.

The book is conveniently organized in a manner similar to DSM-5. The 19 chapters in *DSM-5 Clinical Cases* correspond to the first 19 chapters in section 2 of DSM-5. As in DSM-5, *DSM-5 Clinical Cases* begins with diagnoses that tend to manifest earlier in life and advances to diagnoses that usually occur later in life. Each chapter begins with a discussion of changes from DSM-IV. These changes are further explored in the cases that follow.

Some of the key changes illustrated in this book are:

• Autism spectrum disorder is used to describe symptoms previously broken into separate categories.

• The age limit prior to which attention deficit hyperactivity disorder symptoms must be present has been changed from 7 to 12 years, and adults must only meet five criteria from each dimension rather than six.

• Schizophrenia subtypes have been eliminated.

• "Other specified" is used for those patients who have symptoms in a particular diagnostic category but do not meet full criteria (e.g., other specified bipolar and related disorder).

• "Unspecified" is used for those patients who have significant symptoms consistent with a particular diagnostic category but in whom adequate history cannot be obtained (e.g., unspecified schizophrenia spectrum and other psychotic disorder).

• Disruptive mood dysregulation disorder is a new diagnosis for children in the depressive disorders diagnostic category.

• Bereavement is no longer an exclusion to the diagnosis of major depressive disorder.

• Obsessive-compulsive disorder (OCD) and posttraumatic stress disorder are now considered in their own sections rather than grouped with anxiety disorders.

• Hoarding disorder is new.

• Hypochondriasis has been eliminated and replaced by two separate disorders, somatic symptom disorder and illness anxiety disorder.

• Avoidant/restrictive food intake disorder is a new diagnosis to describe people with symptoms of restricting or avoiding food in a manner that leads to impairment but do not meet criteria for anorexia nervosa.

• Gender identity disorder has been eliminated and replaced with gender dysphoria.

• Substance use disorders are no longer split into abuse and dependence but rather are specified by course and severity.

Each case vignette is titled with the presenting problem. The cases are formatted similarly throughout and include history of present illness, collateral information, past psychiatric history, social history, examination, any laboratory findings, any neurocognitive testing, and family history. This is followed by the diagnosis or diagnoses and the case discussion. In the discussions, the authors highlight the key symptoms relevant to DSM-5 criteria. They explore the differential diagnosis and explain their rational for arriving at their selected diagnoses versus others they considered as well. In addition, they discuss complicating factors that make the diagnoses less clear and often mention what additional information they would like to have. Each case is followed by a list of suggested readings.

As an example, case 6.1 is titled Depression. This case describes a 52-year-old man, "Mr. King," presenting with the chief complaint of depressive symptoms for years, with minimal response to medication trials. The case goes on to describe that Mr. King had many anxieties with related compulsions. For example, he worried about contracting diseases such as HIV and would wash his hands repeatedly with bleach. He was able to function at work as a janitor by using gloves but otherwise lived a mostly isolative life. Examination was positive for a strong odor of bleach, an anxious, constricted affect, and insight that his fears and behaviors were "kinda crazy." No laboratory findings or neurocognitive testing is mentioned.

The diagnoses given for this case are "OCD, with good or fair insight," and "major depressive disorder." The discussants acknowledge that evaluation for OCD can be difficult because most patients are not so forthcoming with their symptoms.

DSM-5 definitions of obsessions and compulsions are reviewed, and the changes to the description of obsessions are highlighted: the term *urge* is used instead of *impulse* so as to minimize confusion with impulse-control disorders; the term *unwanted* instead of *inappropriate* is used; and obsessions are noted to *generally* (rather than always) cause marked anxiety or distress to reflect the research that not all obsessions result in marked anxiety or distress. The authors review the remaining DSM-5 criteria, that OCD symptoms must cause distress or impairment and must not be attributable to a substance use disorder, a medical condition, or another mental disorder. They discuss the two specifiers: degree of insight and current or past history of a tic disorder. They briefly explore the differential diagnosis, noting the importance of considering anxiety disorders and distinguishing the obsessions of OCD from the ruminations of major depressive disorder. They also point out the importance of looking for comorbid diagnoses, for example, body dysmorphic disorder and hoarding disorder.

This brief case, presented and discussed in less than three pages, leaves the reader with an overall understanding of the diagnostic criteria for OCD, as well as a good sense of the changes in DSM-5.

DSM-5 Clinical Cases is easy to read, interesting, and clinically relevant. It will improve the reader's ability to apply the DSM-5 diagnostic classification system to real-life practice and highlights many nuances to DSM-5 that one might otherwise miss. This book will serve as a valuable supplementary manual for clinicians across many different stages and settings of practice. It may well be a more practical and efficient way to learn the DSM changes than the DSM-5 itself.

RACHEL A. DAVIS, M.D.

Dr. Davis is affiliated with the Department of Psychiatry, University of Colorado Health Sciences Center, Denver.

The author reports no financial relationships with commercial interests.

Book review accepted for publication February 2014 (doi: 10.1176/appi.ajp.2014.14020214).

Guía de Consulta de los Criterios Diagnósticos del DSM-5: Spanish Edition of the Desk Reference to the Diagnostic Criteria From DSM-5*, by the American Psychiatric Association. Washington, DC, American Psychiatric Publishing, 2014, 490 pp., $69.00.*

Spanish is the second most commonly spoken language in the world, with over 400 million people using it as their first language, making it second only to Mandarin. In the United States alone, 60 million people speak Spanish currently, 40 million as a first language and 20 million as a second or "foreign" language (1). While the DSM system was designed primarily for the United States and Canada, starting with DSM-III, this set of criteria has had ample diffusion all over the world, and the manual has been translated into many languages. Spanish translations of DSM-III-R and DSM-IV have been completed mainly in Spain, and these have had limitations given the linguistic and idiomatic differences between the Spanish spoken in Spain and that of Latin American countries.

Translation is a complex process, as well described in a passage from the Spanish novel *Don Quixote*, by Miguel de Cervantes: "Translating from one language to another … is like looking at Flemish tapestries from the wrong side, for although the figures are visible, they are covered by threads that obscure them and cannot be seen with the smoothness and color of the right side." A contemporary scholar referring to cross-cultural translation stated that the process "requires a keenness of insight surpassing that of most mortals" (2). Since DSM is often called "psychiatry's bible," it is befitting to mention the *Bible*, the most translated document in the world, starting with the translation of the Old Testament from the original Hebrew into the Greek Septuagint and then the New Testament from the original Greek to the Latin Vulgate, followed by the multiple translations into most world languages. In the preface of the 1611 edition of the King James version, the first English translation of the *Bible*, the translators included the following passage:

> Translation is that openeth the window, to let in the light; that breaketh the shell, that we may eat the kernel; that putteth aside the curtain, that we may look into the most Holy place; that removeth the cover of the well, that we may come by the water, even as Jacob rolled away the stone from the mouth of the well, by which means the flocks of Laban were watered [Gen 29:10]. Indeed without translation into the vulgar tongue, the unlearned are but like children at Jacob's well (which is deep) [John 4:11] without a bucket or something to draw with; or as that person mentioned by Isaiah, to whom when a sealed book was delivered, with this motion, "Read this, I pray thee," he was fain to make this answer, "I cannot, for it is sealed" [Isa 29:11].

Bible translations undergo revision after revision by theologians and scholars, some of them validated with the *nihil obstat* of some superior authority. Interestingly, the English missals used by the 78 million U.S. Catholics were recently retranslated from Latin in efforts to recapture the essence of the original version, diluted more than 40 years ago by lax translations resulting from the notion of "dynamic equivalence."

While literary translations may allow for a good deal of freedom, as evidenced by Gregory Rabassa's English translations of works by Latin American authors (Rabassa, "one of the best translators who ever drew breath," according to William Kennedy, is so gifted that even Gabriel Garcia Márquez, author of *One Hundred Years of Solitude*, said he preferred Rabassa's English translation to his own original), technical translations, such as the translation of survey or measuring instruments, involve a more tedious and methodic routine and need to adhere to specific guidelines. Decades ago, our research group learned the complexities and nuances of this exercise when we did the first Spanish translation of the Diagnostic Interview Schedule, a structured interview for diagnosing DSM-III disorders in the Epidemiologic Catchment Area Study (3), and confronted the difficult task of translating documents developed for one culture/language into another. We also learned that it is quite difficult, if not impossible, to obtain a version that fits all the Spanish-speaking people in Latin America and Spain. Brislin et al. (4) articulated the state-of-the-art methodology and guidelines for cross-cultural translation of instruments since the 1970s. The process needs to take into account cultural, conceptual, and structural equivalence and should make use of back translation, bilingual subjects' testing, and expert panels. Moreover, it is recommended that the source instrument to be translated employ simple