

The DSM-5: classification and criteria changes

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The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) marks the first significant revision of the publication since the DSM-IV in 1994. Changes to the DSM were largely informed by advancements in neuroscience, clinical and public health need, and identified problems with the classification system and criteria put forth in the DSM-IV. Much of the decision-making was also driven by a desire to ensure better alignment with the International Classification of Diseases and its upcoming 11th edition (ICD-11). In this paper, we describe select revisions in the DSM-5, with an emphasis on changes projected to have the greatest clinical impact and those that demonstrate efforts to enhance international compatibility, including integration of cultural context with diagnostic criteria and changes that facilitate DSM-ICD harmonization. It is anticipated that this collaborative spirit between the American Psychiatric Association (APA) and the World Health Organization (WHO) will continue as the DSM-5 is updated further, bringing the field of psychiatry even closer to a singular, cohesive nosology.

Key words: DSM-5, ICD-11, diagnosis, classification

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The Diagnostic and Statistical Manual of Mental Disorders (DSM) provides the standard language by which clinicians, researchers, and public health officials in the United States communicate about mental disorders. The current edition of the DSM, the fifth revision (DSM-5) (1), was published in May 2013, marking the first major overhaul of diagnostic criteria and classification since the DSM-IV in 1994 (2).

Historically, the World Health Organization (WHO) has offered its own system of mental disorder classification in Chapter V of the International Classification of Diseases (ICD), largely used for reimbursement purposes and compiling national and international health statistics. However, following a 1982 international conference on mental disorder classification in Copenhagen (3), there was worldwide agreement for the ICD to adopt more explicit diagnostic criteria to define mental disorders that adhered to the 1980 model of DSM-III (4). What followed was a decade of consultation between the American Psychiatric Association (APA) developers of the DSM-IV and the WHO developers of the ICD-10, that was facilitated by a cooperative agreement between the National Institute of Mental Health and the WHO (5).

Although the official ICD-10 (6) contains only a brief definition of each disorder, the WHO Division of Mental Health obtained an agreement with the APA to publish similar Diagnostic Criteria for Research (7) to those in the DSM-IV, as well as more general Clinical Descriptions and Diagnostic Guidelines (8) as part of the ICD-10 Classification of Mental and Behavioural Disorders. Having similar but separate research criteria resulted in a major international convergence of clinical practice communication and research on mental disorders – although the seemingly slight differences in diagnostic criteria for research did produce some differences in prevalence rates and correlates of mental disorders (9,10). Based on this experience, the latest DSM-5 and ICD-11 development processes offered a further opportunity to not only advance the field in terms of diagnostic utility and validity, but to also increase compatibility with

ICD-11 clinical guidelines and the global psychiatric community at large.

DEVELOPMENT OF THE DSM-5

Details of the research development and the review and approval process for DSM-5 are described elsewhere (1,11-14); but briefly, the DSM-5 was constructed with the goal of addressing limitations in the DSM-IV while integrating the latest scientific and clinical evidence on the empirical basis of psychiatric disorders. The priority was to ensure the best care of patients possible and, in the process, improve usability for clinicians and researchers. Through the contribution of more than 400 experts from 13 countries, representing disciplines of psychiatry, psychology, neurology, pediatrics, primary care, epidemiology, research methodology and statistics, a series of 13 international research conferences was held (2003–2008), in cooperation with the WHO Division of Mental Health and Substance Abuse – with support from a 5-year National Institutes of Health (NIH) cooperative agreement with the American Psychiatric Institute for Research and Education, the research component of the APA (15). The resulting monographs were produced to identify gaps in the then-current nosology and diagnostic criteria, providing a starting point from where members of the DSM-5 Task Force and Work Groups would begin building their proposals for DSM-5.

One of these monographs, jointly produced by the APA and the WHO, was specifically focused on public health considerations in psychiatric diagnosis and classification in the United States and internationally (16), but nearly all of the monographs included explicit discussion of cultural implications of assessment and nosology, including cultural influences on the expression of anxiety and depression (17), the classification of psychotic disorders in Western and non-Western countries (18), and socio-cultural factors relevant to somatic syndromes (19). The additional monographs developed

under this cooperative agreement were used by the specific Work Groups responsible for the relevant disorders covered (20-25).

Membership in the DSM-5 Task Force and Work Groups was determined in part by the range of knowledge needed and also by diversity of representation. Nearly every DSM-5 Work Group included at least one international member. To ensure that cultural factors were included in early revision proposals, a DSM-5 Culture and Gender Study Group was appointed to provide guidelines for the Work Group literature reviews and data analyses that served as the empirical rationale for draft changes. Recommendations to the Work Groups included consideration of possible evidence of racial, ethnic, or gender bias in diagnostic criteria; the emergence of new data about gender or cultural differences, like discrepancies in prevalence or symptom presentations; and the presence of gaps in the literature signaling the need for field trial testing or secondary data analyses. Given his unique knowledge of international diagnostic issues from his leadership of the ICD-10 development, the former Director of WHO's Division of Mental Health, Norman Sartorius, was nominated and served as an international consultant to the DSM-5 Task Force.

Although the subfield of transcultural psychiatry has firmly established the relevance of culture and social context to individual help-seeking behaviors, clinical presentation, and response to treatment, the DSM leadership recognized that these issues would only increase in importance for both clinical care and research applications. As the social environment becomes more strongly linked to epigenetic mechanisms, heritability, disease risk, and resiliency factors, attention to these matters in the DSM-5 text was encouraged. As a result, in developing the chapter outline of text accompanying each diagnostic criteria set, it was determined that culture, as well as age and gender, warranted separate discussion of variances in symptom expression, risk, course, prevalence, and other aspects of diagnosis, where evidence was available. Although not included for every disorder, a substantial proportion of disorders include text that references such findings. This is a notable improvement from the DSM-IV, which more explicitly recognizes cultural context than the DSM-III (4), but relegates culture, gender, and age to sporadic discussion and collectively, rather than as separate topics. Symptom expression among different cultures is also referenced in revisions of certain disorder criteria. For instance, the B criterion for social anxiety disorder (Criterion A in the DSM-IV) has been expanded beyond just fear of embarrassment or humiliation of oneself to now include anxiety symptoms about offending others – a nod to the cultural syndrome *taijin kyofusho* and an acknowledgment of the fact that this presentation might be observed more in individuals from non-Western cultures (particularly Japan and Korea).

DSM-5 CLASSIFICATION

Despite the fact that the DSM is a US classification system for the diagnosis of mental disorders, in conjunction with the

use of official ICD statistical code numbers, international interest in the manual has flourished since the DSM-III was published in 1980. The DSM-5 is based on explicit disorder criteria, which taken together constitute a “nomenclature” of mental disorders, along with an extensive explanatory text that is fully referenced for the first time in the electronic version of this DSM. Although there is a more limited ICD-10 set of criteria for research, the current WHO proposal for ICD-11 will be to provide more general clinical descriptions and guidelines without the adoption of separate research criteria. The intent of joint APA and WHO collaborative efforts to date has been to develop a common research base for the revision of both DSM-5 and ICD-11, through the NIH supported conference meetings and a series of “harmonization meetings”. The developers of the DSM-5 sought to maintain and, where possible, enhance the consistency of DSM and ICD revisions for clinical guidance – a challenging task given that revisions to each were not entirely concurrent (the publication of the ICD-11 is projected for 2015). However, a DSM-ICD harmonization coordinating group was organized early in the development process, under the direction of Steven Hyman, chair of the WHO's International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders and a DSM-5 Task Force member. The group convened by teleconference and at several in-person meetings to facilitate the sharing of information on development processes for each publication and reduce discrepancies between the two. Of note, several of the chairs or members of the ICD revision Working Groups were also DSM-5 Work Group members.

At the outset, it was clear that one of the primary strategies would be to develop a joint approach to organizing the “metastructure” or organizational framework by which disorders are grouped into similar clusters based on shared pathophysiology, genetics, disease risk, and other findings from neuroscience and clinical experience. The DSM-IV's descriptive and phenomenological approach to classification was outdated and, in the framework of research from science that had emerged over the previous two decades, also inaccurate. Likewise, the organizational structure for the ICD-10 was open to a major restructuring, with the expectation that a new numbering system for ICD-11 codes would be initiated to accommodate a major expansion in the number of codes available for all medical disorders.

As a result, a DSM-5 initiative to develop a more valid basis for the organization of a mental disorder classification was rapidly converted into a joint effort of the DSM-5 Task Force and the ICD-10 revision (ICD-11 development) Advisory Committee. Using an expanded set of “validity criteria” from those originally proposed by Robins and Guze in 1970 (26), a series of analyses and papers were developed that were published in an international psychiatric journal (27-34). It was rapidly recognized that the application of such “validators” was much more meaningful for larger groups or disorder spectra than for individual categorical diagnoses. This resulted in a new organizational

Table 1 DSM-5 diagnostic chapters

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 and related disorders
Feeding and eating disorders
Elimination disorders
Sleep-wake disorders
Sexual dysfunctions
Gender dysphoria
Disruptive, impulse-control, and conduct disorders
Substance-related and addictive disorders
Neurocognitive disorders
Personality disorders
Paraphilic disorders
Other mental disorders

structure for the DSM-5 and the ICD-11, that is reflected in Table 1. The linear structure of this organization is intended to better reflect the relative strength of relationships between disorder groups, whereas the internal organization of disorder groups is intended to reflect more of a child-adult developmental perspective.

Much of the research from genetics and psychiatry over the past 20 years points to an overlapping genetic liability between psychotic and mood disorders, particularly bipolar disorder, that belie DSM-IV's separation of these as distinctive (35). In the DSM-5 classification, the chapter on schizophrenia and other psychotic disorders is sequenced with that of bipolar and related disorders (which are now separated from unipolar mood disorders), which is then followed by the chapter on depressive disorders. This also is consistent with recent findings from the largest genome-wide study of mental disorders to date (36), which identified shared polymorphisms between select neurodevelopmental disorders (autism spectrum disorder, ASD and attention-deficit/hyperactivity disorder, ADHD), schizophrenia, bipolar disorder, and major depressive disorder. Incidentally, these comprise the first four chapters of the DSM-5.

A similar pattern – grouping based more so on neuroscience and less on symptom expression – also occurs within the diagnostic categories. As noted above, ASD and ADHD are now grouped together in neurodevelopmental disorders, with some of the former DSM-IV “disorders first diagnosed in

infancy, childhood, or adolescence” distributed throughout DSM-5. In the obsessive-compulsive and related disorders chapter are body dysmorphic disorder (previously classified in DSM-IV's “somatoform disorders”) and trichotillomania (hair-pulling disorder), which belonged to DSM-IV's chapter on “impulse-control disorders not elsewhere classified”. For trichotillomania, similarities to obsessive-compulsive disorder and to other body-focused, repetitive pathologies (e.g., excoriation [skin-picking] disorder) in terms of symptom expression, comorbidity, and familial patterns suggested a closer resemblance to the obsessive-compulsive and related disorders than to its DSM-IV neighbors of pathological gambling, intermittent explosive disorder, kleptomania, or pyromania (37). Like the pediatric disorders, DSM-IV's anxiety disorders too are distributed into separate chapters of fear circuitry-based anxiety disorders (e.g., phobias); anxiety disorders related to obsessions and compulsions (e.g., obsessive-compulsive disorder); those that arise from trauma or extreme stress (e.g., post-traumatic stress disorder, PTSD); and those characterized by dissociation (e.g., dissociative amnesia).

Furthermore, the DSM-5 organization also reflects a broader clustering among groups of diagnostic categories, with those that tend to have similar premorbid personality traits and/or co-occur being placed proximally to one another, including neurodevelopmental disorders, schizophrenia and other psychotic disorders. As indicated in the series of “metastructure” papers, bipolar disorder occupies an intermediary position between the schizophrenia and other psychotic disorders and the emotional or internalizing disorders – exhibiting high levels of disinhibition, psychoticism, and negative affectivity (31). The internalizing disorders, with high levels of negative affectivity, include depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders, and dissociative disorders. Somatic disorders also frequently co-occur with the emotional or internalizing disorders, that include somatic symptom and related disorders, feeding and eating disorders, sleep-wake disorders, and sexual dysfunctions. Externalizing disorders include disruptive, impulse control, and conduct disorders, and the substance-related and addictive disorders (38).

INTEGRATION OF DIMENSIONS

Despite the statement in the DSM-IV that “there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders” (2, p. xxxi), the use of strict categorical boundaries has given the impression of psychiatric disorders as unitary, discrete phenomena. Throughout general medicine, conditions are frequently conceptualized on a continuum from “normal” to pathological, without relying on a singular threshold to distinguish the presence or absence of disease, as in serum cholesterol and glycated hemoglobin. In evolving toward a structure that more closely follows this

approach, the DSM-5 includes dimensional aspects of diagnosis along with categories. Although, ultimately, diagnosis is still largely dependent on a “yes or no” decision, use of specifiers, subtypes, severity ratings, and cross-cutting symptom assessments help clinicians better capture gradients of a disorder that might otherwise be hindered by a strict categorical approach.

For instance, the new “with anxious distress” specifier, applied to depressive disorders and bipolar and related disorders, includes symptoms that are not a part of the criteria for most mood disorders (e.g., difficulty concentrating because of worry) but nonetheless may describe a particular variant of mood disorder that causes impairment and/or distress and warrants intervention. It also yields clinically useful information for treatment planning and tracking outcomes that would likely be masked under a residual diagnosis of “not otherwise specified” in the DSM-IV, and may bring greater awareness to clinicians and researchers about the importance of assessing anxiety in the presence of mood symptoms. The DSM-5’s inclusion of severity specifiers contributes important details about the presentation and may be particularly informative for promoting more appropriate treatment, as treatment for certain mild disorders should differ from treatment regimens for moderate-to-severe presentations (39).

Some DSM-IV disorders were combined to form spectra disorders in the DSM-5. The most notable example is ASD, which includes symptoms that characterize previous DSM-IV autism disorder, Asperger’s disorder, child disintegrative disorder, and pervasive developmental disorder NOS. This proposed revision was developed because of the presence of very poor reliability data, that failed to validate their continued separation (40). Although the DSM-5 describes all of these presentations under one rubric, specifiers are provided to account for ASD variations, including specifiers for the presence or absence of intellectual impairment, structural language impairment, co-occurring medical conditions, or loss of established skills. A child previously diagnosed with Asperger’s disorder under the DSM-IV could therefore be diagnosed under the DSM-5 with ASD, with the specifiers “without intellectual impairment” and “without structural language impairment”.

Finally, integration of dimensions in the DSM-5 is encouraged for further study and clinical experience. Such dimensional assessment can be applied *across* disorders through use of cross-cutting quantitative assessments. These patient/informant- and clinician-completed measures prompt clinicians to assess symptom domains relevant to most, if not all, mental disorders, like mood, anxiety, sleep, and cognition, with a second level of measures specified for more in-depth assessment when a particular domain is endorsed. If criteria for a diagnosis are fulfilled, a third level of dimensional assessment can help establish severity. For example, the first level of cross-cutting assessment of a given patient indicates the presence of depressed mood; the clinician then administers the Patient-Reported Outcomes Measurement Information System (PROMIS) Emotional Distress – Depression –

Short Form. The score suggests the possible presence of major depressive disorder, and after a clinical interview that assesses the presence of diagnostic criteria, a depression diagnosis may be given. The Nine-Item Patient Health Questionnaire can then be administered to establish baseline severity, with repeated administration at regular intervals as clinically indicated for monitoring course and treatment response. While the first level cross-cutting measure is provided in the printed DSM-5, all three levels of dimensional measures are provided in the electronic version of the manual for downloading and clinical use without additional charge.

REVISIONS TO DIAGNOSTIC CRITERIA

By and large, there were not sweeping changes in the diagnostic criteria for most disorders. An abbreviated description of the major deviations from the DSM-IV can be found in the Appendix of the manual itself, with a more detailed version online (www.psychiatry.org/dsm5). What follows below is a select summary of revisions.

Combining and splitting DSM-IV disorders

Some disorders were revised by combining criteria from multiple disorders into a single diagnosis, as in instances where there was a lack of data to support their continued separation. The most publically discussed example of this is ASD. As noted previously, the addition of behavioral specifiers indicates variants of ASD that account for the DSM-IV disorders it subsumed. Somatic symptom disorder largely takes the place of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder, although many individuals previously diagnosed with hypochondriasis will now meet criteria for illness anxiety disorder (new to DSM-5). Substance use disorder is a combination of DSM-IV’s substance abuse and substance dependence, the latter of which was deemed inappropriate due to the pejorative nature of the term *dependence* used to describe normal physiological responses of withdrawal from certain substances and medications. Further, the addition of severity ratings for substance use disorder enables a diagnosis of mild substance use disorder, that will be coded separately (with the ICD code for substance abuse in DSM-IV) from moderate-to-severe levels (coded with the ICD codes previously used for substance dependence).

Alternately, in some instances, a DSM-IV disorder was split into independent disorders under the DSM-5. DSM-IV’s reactive attachment disorder included the subtypes “emotionally withdrawn/inhibited” and “indiscriminately social/disinhibited”. Despite a shared etiology (i.e., lack of a consistent, emotionally supportive caregiving environment), the reactive attachment subtype (reactive attachment disorder) is a manifestation of incomplete, insecure social attachments and is more similar to internalizing disorders, like

major depressive disorder, whereas the social disinhibition subtype (disinhibited social engagement disorder) is evident in children without secure social attachments but is more similar to externalizing disorders, including ADHD. The two subtypes also demonstrate disparities in course and treatment response; thus, each was elevated to a separate full disorder in the DSM-5 (41). Similarly, the DSM-5 now lists the DSM-IV subtypes of breathing-related sleep disorder as independent disorders with separate criteria (i.e., obstructive sleep apnea hypopnea syndrome, central sleep apnea, and sleep-related hypoventilation), which is more consistent with the International Classification of Sleep Disorders, 2nd Edition.

Specifiers and subtypes

Specifiers and subtypes delineate phenomenological variants of a disorder indicative of specific subgroupings, which impact, among other outcomes, on treatment planning and treatment developments. The numbers of specifiers and subtypes in the DSM-5 has been expanded to account for efforts to dimensionalize disorders more so than in the DSM-IV. Within the depressive disorders and bipolar and related disorders, a specifier of “with mixed features” replaces the diagnosis of bipolar I, mixed episode in the DSM-IV, given that subthreshold mixed states of major depressive and manic episodes are much more common and may have specific treatment implications (42,43) but would be excluded from diagnosis by continuing DSM-IV’s requirement that full criteria are met for both syndromes. The “with mixed features” specifier, therefore, now applies to unipolar as well as bipolar conditions. A specifier of “with limited prosocial emotions” is added to conduct disorder for children displaying extreme callousness and negative affectivity, different severity (e.g., more frequent and severe patterns of aggression), and poorer treatment response than children who do not qualify for the specifier (44). Specific treatment interventions have been developed that are more successful with this subgroup.

DSM-5’s major neurocognitive disorder (NCD) is roughly equivalent to DSM-IV’s dementia, although criteria for dementia have been revised to also form a separate and new diagnosis of mild NCD, representing the presence of neurocognitive disturbance that has not risen to the level of severity to warrant significant impairment or disruption in functioning, akin to DSM-IV’s mild cognitive impairment that was included in the Appendix. In addition to the core criteria for major and mild NCD, ten etiological subtypes are now provided, with separate criteria and text for each. Other than the explicit link to specific known etiologies, most of these subtypes’ criteria are largely similar to one another. However, there are important and often subtle differences between these disorders, as greater information on post-mortem laboratory correlations and clinical progression have become available over the past two decades. Many, but not all, of these subtypes were described briefly in the DSM-IV, but

the DSM-5 recognizes each separately and in greater detail to give clinicians more guidance in determining possible etiology.

New disorders

A rigorous review process was established for assessing all proposed revisions to the DSM-5, and those suggesting inclusion of new disorders were among the most stringently assessed. Based on a review of existing evidence from neuroscience, clinical need, and public health significance, a handful of new disorders are included, many of which were elevated from DSM-IV’s chapter on “conditions for further study”. Hoarding disorder addresses the excessive collection of often useless items, including garbage, which frequently results in hazardous living conditions for patients and/or dependents. Disruptive mood dysregulation disorder (DMDD) was proposed in response to a decade-long debate about whether or not chronic irritability in children is a hallmark symptom of pediatric bipolar disorder. With the prevalence of childhood bipolar disorders growing at an alarming rate, the DSM-5 Childhood and Adolescent Disorders Work Group compared evidence from natural history and treatment studies of classic bipolar disorder versus bipolar disorder diagnosed using non-episodic irritability as a criterion, and determined that separate disorders based on episodic versus persistent irritability were justified (45). Therefore, children with extreme behavioral dyscontrol but non-episodic irritability no longer qualify for a diagnosis of bipolar disorder in the DSM-5 and instead would be considered for DMDD. Other notable new disorders (which were elevated from DSM-IV’s appendix) include binge eating disorder, premenstrual dysphoric disorder, restless legs syndrome, and REM sleep behavior disorder.

Removal from DSM-IV

One of the most controversial proposals for the DSM-5 concerned the removal of the bereavement exclusion for major depressive episodes. Under the DSM-IV, individuals exhibiting symptoms of major depressive disorder were excluded from diagnosis if also bereaved within the past 2 months. The intention was to prevent individuals experiencing normal grief reactions to loss of a loved one from being labeled as having a mental disorder. Unfortunately, this also prevented bereaved individuals who were experiencing a major depressive episode from being appropriately diagnosed and treated. It also implied an arbitrary time course to bereavement and failed to recognize that experiences of major loss – including losses other than the death of a loved one, like job loss – can lead to depressive symptoms that needed to be distinguished from those associated with a major depressive disorder. Although symptoms of grief or other losses can mimic those of depression and do not necessarily suggest a mental disorder, for the subset of individuals

whose loss *does* lead to a depressive disorder (or for whom a depressive disorder was already present), appropriate diagnosis and treatment may facilitate recovery. As a result, the bereavement exclusion was lifted and replaced with much more descriptive guidance on the distinction between symptoms characteristic of normal grief and those that are indicative of a clinical disorder (46).

Changes in naming conventions

Revisions in commonly used terminology required an evaluation of the most appropriate terms for describing some mental disorders – an issue of particular concern for consumer-advocate organizations. The term “mental retardation” underwent several draft changes before the name “intellectual disability (intellectual developmental disorder)” was approved. The joint naming convention reflects use of the term “intellectual disability” in US law (47), in professional journals, and by some advocacy organizations, while the parenthetical term maintains language proposed for ICD-11 (48). As described previously, the terms “substance abuse and substance dependence” have been removed and are now replaced jointly by “substance use disorder”. The name of the substance chapter itself (“substance-related and addictive disorders”) was altered to include the term “addictive”, matching a proposed ICD-11 naming convention, which refers to inclusion of gambling disorder as a behavioral syndrome with symptoms and pathophysiology (e.g., reward system activation) largely mirroring those in substance-related disorders. Also in keeping with ICD language, the “not otherwise specified” categories in the DSM-IV have been renamed and reconceptualized as “other specified” and “unspecified” categories in the DSM-5.

CONCLUSIONS

Final determination of DSM-5’s impact must await judgment until after the manual has been in use for some time. Epidemiological studies will aid in detecting changes in prevalence and comorbidities from the DSM-IV, including implementation of cross-national surveys of disorders with high public health relevance worldwide, such as schizophrenia, major depressive disorder, and substance use disorders. The more immediate next steps for the DSM-5 include the development of materials that may assist in its use in primary care settings, adaptation of assessment instruments to DSM-5, and documenting the evidence base for revision decisions in the DSM-5 electronic archives. There will also be further testing and development of the dimensional assessments in the manual, including that of a pediatric version of the internationally used WHO Disability Assessment Schedule 2.0.

By continuing collaboration with the WHO in future editions of the DSM, we can assure a more comparable international statistical classification of mental disorders and move

closer to a truly unified nosology and approach to diagnosis. Such a collaborative effort should assist the 200,000 psychiatrists worldwide to better care for individuals with these life-altering and potentially destructive conditions, and advance a more synergistic and cumulative international research agenda to find the causes and cures for these disorders.

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