DSM-5: What Will Changes Mean for Patient Care?

William J. Lorman, PhD, MSN, PMHNP-BC, CARN-AP
V. P. & Chief Clinical Officer, Livengrin Foundation, Inc.
Assistant Clinical Professor, Graduate Nursing Dept., Drexel University
Adjunct Professor, Graduate Psychology Dept., Immaculata University
wlorman@livengrin.org

What's Happening and How Are We Affected?

A Brief History of Psychiatric Classification

Understanding the DSM

History of Psychiatric Classification

- Hippocrates (460-377 BC)
  - Identified 6 conditions based on the observed phenomenology of mental disorders
    - Phrenitis; Mania; Melancholia; Epilepsy; Hysteria; Scythian Disease (transvestitism)
  - Noted the 4 temperaments comparable to present-day personality traits:
    - Harm avoidance, reward dependence, novelty seeking, & persistence
- Philippe Pinel (1745-1820)
  - Proposed a simple classification consisting of only 4 fundamental clinical types:
    - Mania, melancholia, dementia, idiotism
- 3000 BC
  - Description of the syndrome of senile dementia attributed to Egyptian Prince Ptah-hotep
- 2600 BC
  - Sumerian and Egyptian references to melancholia and hysteria
- 1400 BC
  - Ayur-Veda: the oldest known attempt to systematically classify presentations of mental illness in India
- Emil Kraepelin (1856-1926)
  - Compiled a classification system whose structure forms the basis for our current psychiatric classification.
    - His fundamental approach was that mental disorders could be isolated by grouping together patients whose disorders had the same course and combination of clinical features.
- Sigmund Freud (1856-1939)
  - Diagnosis of neurotic conditions
History of Psychiatric Classification

1917
- Prior to WWI, the Committee on Statistics of the American Medico-Psychological Association (later became the American Psychiatric Association) introduced a 22-item list of disorders

1935-1945
- By the end of WWII – 10% of premature discharges during the war were for psychiatric reasons
- Four major competing systems
  - The 1935 Standard Classified Nomenclature
  - The U.S. Army Classification of Mental Illnesses
  - The U.S. Navy Classification of Mental Illnesses
  - The Veterans Administration System of Classification

1952 – The DSM-I
- Provided a glossary of definitions of the categories in addition to the names of the disorders
- The term ‘reaction’ was used throughout the classification, reflecting the perspective that mental disorders represented reactions of the person to psychological, social, and biological factors
- Psychoanalytic concepts were reflected in the frequent references to defense mechanisms as explanations for the neuroses and personality disorders

1968 – the DSM-II
- No longer used the term ‘reaction’
- Encouraged clinicians to make multiple diagnoses
- Goal was diagnostic accuracy

1980 – the DSM-III
- Provided comprehensive descriptions of the manifestations of disorders without regard to etiology
- Adoption of a multiaxial system of diagnosis
- Addressed the problem of interrater reliability
- Main problem: criteria sets were used in a mechanical or rigid manner – treating conditions, not people
- Became a guideline for insurance

1987 – The DSM-III-R
- Provided corrections of inconsistencies
- Contained substantive changes based on new evidence

1994 – the DSM-IV
- Major revision of criteria sets

2000 – the DSM-IV-TR
- No changes in criteria sets
- Changes made to text and wording to clarify information

Preparing for DSM-5
- Process began in 1999
- Many DSM-IV participants not invited
- Fifty percent from outside the US
  - Experts in twin studies genetics, neuroscience and behavioral science
- Significant disagreement in some diagnostics
- There will be a two year ‘grace period’

Definition of a Mental Disorder
- No available definition adequately specifies precise boundaries for the concept of mental disorder.
- Medical illnesses are defined on a widely varied conceptual basis. Based on:
  - Gross anatomy (mitral stenosis & ulcerative colitis)
  - Histopathology (Carcinomas)
  - Bacteriologic (tuberculosis)
  - Statistical deviance from the norm (hypertension; hypercholesterolemia; diabetes)
  - Symptom presentation [etiology unknown] (migraines)
Where Does Psychopathology End and the ‘wear-and-tear’ of Everyday Life Begin?

- Becomes more difficult because of the increasing number of new categories meant to describe the less impaired outpatient population
- Emphasis on the requirement that the condition cause clinically significant impairment or distress
  - The term *clinical significance* is not defined or operationalized
  - Depends on the clinician

### The Term Mental Disorder

**DSM-IV-TR current definition:**
- "Clinically significant behavioral or psychological or biological syndromes that are associated with present distress, disability, or significant impairment in important areas of functioning."

**DSM-5 additions to the definition:**
- "Must draw concern from others in a relational, social, occupational, or vocational setting that requires a referral for treatment. Behaviors may be primarily displayed in relationships."
- "Must incorporate respect for age, gender, and culture-specific factors and sensitivity to these factors when making a diagnosis."

### Descriptive Syndromal Diagnosis Versus Disease

- Some disorders have a sufficiently well-established pathogenesis to be considered diseases
  - E.g., Dementia of the Alzheimer’s type
- Some disorders are no more than symptom presentations
  - E.g., Specific Phobia
- Most disorders are clusters of correlated symptoms at a syndromal level that is somewhere between diseases and symptoms
  - A *syndrome* is a group or pattern of symptoms, affects, thoughts, and behaviors that tend to appear together in clinical presentations
Categorical Versus Dimensional Diagnosis

- A categorical strategy works best in situations where there are clear boundaries between the things named and all members of the class are homogeneous with regard to their defining features.
- Dimensional systems are used to describe continuous variables that are more accurately depicted with numbers, not names (e.g., height, weight, IQ)
- DSM remains basically categorical (but Axis 5 is dimensional)

Two important issues:
- There is considerable heterogeneity of the presentations encountered even within each disorder.
- The boundaries between disorders are often fuzzy; many patients have presentations that fall through the cracks and cannot be comfortably forced into any of the DSM categories.

Polythetic Versus Monothetic Criteria

- Polythetic criteria sets are those in which the diagnosis is made if the presentation includes only a proportion of the items that define the disorder
- There was an increased use in DSM-III-R
- Monothetic criteria sets are those in which all of the items must be present for the diagnosis to be made.
- Disadvantages of Polythetic Criteria Sets:
  - They may allow for more heterogeneity in the diagnosis than is desirable
  - E.g., there are more than 100 different ways for the criteria for Borderline Personality Disorder to be met;
  - Two patients may each have presentations that meet the criteria for OCD without sharing even a single criterion for the diagnosis

Multiple Diagnoses & Comorbidity

- The more diagnoses included in a system, the more clearly these are defined and the more multiple diagnoses there will be.
- DSM-I 106 different diagnostic categories
- DSM-II 182 different diagnostic categories
- DSM-III 265 different diagnostic categories
- DSM-III-R 292 different diagnostic categories
- DSM-IV 354 different diagnostic categories

Some of the Problems of DSM-IV That Have Emerged

- Symptoms overlap
- Diagnosis is reached by counting symptoms
- No treatment guidance is provided
- Outside pressures are placed on clinicians

DSM-IV Concerns

- Symptoms overlap
- Diagnosis is reached by counting symptoms
- No treatment guidance is provided
- Outside pressures are placed on clinicians
A large number of patients also meet criteria for multiple diagnoses

- There are clusters of disorders that co-occur at very high frequencies
  - Anxiety disorders often co-occur with a mood disorder
  - ASPD, ADHD, SUDs co-occur with each other at high frequency
  - Patients with personality disorders rarely receive a single PD diagnosis

**PLAN:**
- Recognize broader disorder spectra
- Conceptualize disorders in terms of quantitative dimensions

Use of ‘Not Otherwise Specified’ (NOS) Criteria

- For some diagnoses, ‘NOS’ is more prevalent than the specific disorder
  - Eating Disorder NOS
  - Personality disorder NOS
  - Autism Spectrum Disorders

- Approaches taken in DSM-IV to improve interrater reliability produced narrowly specified criteria and a large number of patients are excluded
  - E.g., for diagnosis of Schizophrenia, the vague, term ‘chronic’ was rejected in favor of the precise but arbitrary ‘6 months’ of illness.

DSM-IV Categories do not map well onto the genome

- Genetics research suggests that the problem will not be fixed by tweaking the boundaries of existing categories.
- The weight of findings from genetics fits more comfortably with broader disease spectra or the representation of psychopathology as interacting symptom dimensions.

**How is the DSM-5 Structured?**

Why was DSM revised now?

- Over the past two decades, there has been a wealth of new information in:
  - Neurology (how the brain functions)
  - Genetics (lifelong influences of genes and the environment)
  - Prevalence of mental disorders
- Introduction of scientific technologies:
  - Brain imaging techniques
  - Sophisticated new methods for mathematically analyzing research data

“Ultimately, the goal is to move away from a classification that focused on reliability while inadvertently sacrificing validity toward a classification that is far more clinically useful than that of DSM-IV and far more open to validation.”

- Carol A. Bernstein, MD
  Past President, APA
Guiding Principles in Revising the DSM

- Clinical Utility
  - Insuring the manual is useful to those who diagnose and treat patients
  - Recommendations guided by evidence
  - Maintain continuity with previous editions
  - No a priori restraints should be placed on the level of change permitted

Identified Areas for Improvement

- Reduce the use of medications
- Better assess the severity of symptoms
- Handling of psychiatric disorders that often occur together in the same patient
- Reduce diagnoses currently called ‘Not Otherwise Specified’
- Improve diagnostic criteria that are not precise
- Specify ‘treatment targets’ for clinicians
  - Identify symptoms that should be addressed in treatment and for which improvement may be possible.

DROPPING THE ROMAN NUMERALS

- The decision was made to no longer use Roman Numerals to designate new editions of the DSM
- The new edition – published in May, 2013 – will be known as DSM-5
- Future changes prior to the manual’s next complete revision will be signified as DSM-5.1, DSM-5.2, etc.

Organization of the DSM-5: 20 Classifications

1. Neurodevelopmental Disorders
2. Schizophrenia Spectrum & Other Psychotic Disorders
3. Bipolar & Related Disorders
4. Depressive Disorders
5. Anxiety Disorders
6. OCD & Related Disorders
7. Trauma & Stress Related Disorders
8. Dissociative Disorders
9. Somatic Symptom Disorders
10. Feeding & Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse Control and Conduct Disorders
16. Substance Use & Addiction Disorders
17. Neurocognitive Disorders
18. Personality Traits That Affect Treatment
19. Paraphilias
20. Other Disorders

Organization of the DSM-5: 20 Classifications

- The multiaxial format has been eliminated
Organization of the DSM-5: Additional Information

- Suicide Risk
  - There will be comments on each diagnosis vulnerability to suicide where appropriate.
  - Scales include impulsive behavior and heavy drinking in teens.
- Respect for Age, Gender & Culture
  - Each diagnostic definition, where appropriate, will incorporate "developmental symptom manifestations" related to the age of the client.
  - Gender specific disorders and cultural sensitivity in regard to certain behaviors will also be addressed.

Organization of the DSM-5: Additional Information

- Severity Index Across Time & Circumstances
  - Will be an essential specifier in all diagnostic categories.
  - Replaces the Axis V GAF.
    - 0 – GAF 71 – 100. No impairment
    - 1 – GAF 61 – 70. Mild impairment
    - 2 – GAF 31 – 60. Moderate impairment
    - 3 – GAF 1 – 30. Severe impairment
  - Specifier must indicate Level 1, 2 or 3 before a diagnosis is validated as a mental disorder.

Some Considerations

- Risk Syndromes Category
  - Information to help clinicians identify earlier stages of some serious mental disorders, such as neurocognitive disorder and psychosis
- Dimensional Assessments
  - Would permit clinicians to evaluate the severity of symptoms

Unwise & Arbitrary Decisions

- Disruptive Mood Dysregulation Disorder
  - Turns temper tantrums into a mental disorder.
  - Problem: Will exacerbate the already excessive and inappropriate use of medication in young children
    - During the past two decades, child psychiatry has already provoked three fads:
      - A tripling of ADD
      - A more than 20-times increase in autistic Disorder
      - A 40-times increase in childhood Bipolar Disorder
- Normal Grief will become MDD
- Minor Neurocognitive Disorder
  - The everyday forgetting characteristic of old age will now be pathologic.
  - Since there is no effective treatment, the label provides absolutely no benefit while creating great anxiety since there is no correlation with development of dementia.
### Unwise & Arbitrary Decisions

- **Somatic Symptom Disorder**
  - For patients worried about having a medical illness

- **Social Communication Disorder**
  - For persistent difficulties in the social uses of verbal and nonverbal communication.

### Unwise & Arbitrary Decisions

- **Adult Attention Deficit Disorder**
  - Will lead to widespread misuse of stimulant drugs for performance enhancement and recreation along with diversion

- **Binge Eating Disorder**
  - Excessive eating 12 times in 3 months is no longer just a manifestation of gluttony and the easy availability of really great tasting food

- **Schizophrenia**
  - Removal of all subtypes (e.g., Paranoid, catatonic, disorganized, undifferentiated, etc.)

### Unwise & Arbitrary Decisions

- **Substance Use Disorder**
  - First time substance abusers will be lumped definitionally with chronic, severe addiction despite their very different treatment needs and prognosis and the stigma this will cause.

- **Generalized Anxiety Disorder**
  - There already exists a fuzzy boundary between GAD and worries of everyday life. Small changes in definition will create millions of anxious new ‘patients’ and expand the already widespread practice of inappropriately prescribing addicting anti-anxiety medications.

### Other Changes

- **Autism Spectrum Disorder**
  - Incorporates Autistic Disorder, Asperger’s Disorder, Childhood Disintegrative Disorder and PDD
  - Insurance & services concerns

- **Name Change:**
  - Intellectual Developmental Disorder (Mental Retardation)
    - IQ at or below 70 in “culturally appropriate testing”
    - Requires assistance in vocational and/or occupational endeavors
    - The Severity Index is based on functioning and not on the IQ.
    - ‘General medical condition’ is replaced with ‘another medical condition’

### Some Real Dangers

- Diagnostic inflation causes overdiagnosis and overtreatment of patients who are essentially well.

- Drug companies will take marketing advantage of the loose DSM definitions by promoting the misleading idea that everyday life problems are actually undiagnosed psychiatric illness requiring a solution in pill form.

- New psychiatric diagnoses are now potentially more dangerous than new psychiatric drugs.

### Changes for ADHD

- Criteria for hyperactivity – addition of 4 more impulsivity criteria (must choose 6 out of 13):
  - interrupts or intrudes
  - act without thinking
  - often impatient
  - uncomfortable doing things slowly and systematically
  - difficult to resist temptations or opportunities

- Several noticeable inattentive or hyperactive-impulsive symptoms were present by age 12.

- **Note:** for older adolescents and adults (ages 17 and older), only 4 symptoms are required.
Bipolar Disorders
- Bipolar Disorder
  - Addition of Temper Dysregulation Disorder with Dysphoria
  - Removal of Mixed Episode
  - Removal of Single Manic Episode
  - Bipolar Conditions Not Elsewhere Classified
    - Subsyndromal Hypomania
  - Specifiers:
    - With Mixed Features
    - With Anxiety, mild to severe
    - With Suicide Risk Severity
    - With Seasonal Pattern
    - With Postpartum Onset

Depressive Disorders
- New additions:
  - Disruptive Mood Dysregulation Disorder
  - Premenstrual Dysphoric Disorder
  - Depressive CNEC
    - Minor Depressive Disorder
      - meets duration criteria but not symptom count criteria
    - Recurrent Brief Depressive Disorder
      - Meets symptom count criteria but not duration criteria
- Name Change:
  - Chronic Depressive Disorder (Dysthymic Dx)

Disinhibited Social Engagement Disorder
- Absent reticence approaching unfamiliar adults
- No boundaries in relationships
- Behavior is the consequence of inconsistent nurturing in five realms
- Symptoms displayed before the age of six

The Five Pathogenic Care Realms
1. Persistent disregard for child's emotional needs
2. Persistent disregard for child's physical needs
3. Repeated changes in primary caregivers
4. Raised in settings with limited opportunities for stable attachments
5. Persistent harsh punishment or other types of grossly inept parenting
One or more of these five essential specifiers for diagnosis.

Diagnosing Utilizing the 5 Pathogenic Care Realms
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- PTSD in Children
- Dissociative Mood Dysregulation Disorder
- Dissociative Disorders in Children
- Oppositional Defiant Disorder
- Conduct Disorder (Sociopathy Specifier)
- Dyssocial Personality
  - Self-gratification
  - No capacity for intimacy

Obsessive-Compulsive and Related Disorders
- New Additions:
  - Hoarding Disorder
  - Excoriation Disorder (Skin-Picking Disorder)
- Name Change:
  - Hair-Pulling Disorder (Trichotillomania)
  - Functional Neurological Symptom Disorder (Conversion Disorder)
Non-Suicidal Self Injury Syndrome

- Continuous behaviors of inflicting pain upon the body by cutting, scarring, burning, slashing or bruising for the purpose of gaining transient, temporary relief from psychological, emotional, psychiatric stress and/or distress.
- The intentional injury is goal oriented and not a behavior occurring during psychosis, delirium or intoxication.
- It is not socially or culturally sanctioned behavior (tattooing, body piercing, culturally sanctioned rituals) and has no correlation to suicide intent.

Non-Suicidal Self Injury Syndrome

- The behavior is the consequence of significant stressors.
- May present as either syntonic or dystonic depending on the clinically observed attitude of the client.
- There is a strong correlation to drug use during adolescence and adults.
- There is no correlation to suicide.
- Treatment should focus on the stressor and not the behavior.

Eating Disorders

- Anorexia Nervosa
  - Removal of amenorrhea requirement
- Bulimia Nervosa
  - Change frequency from once a week to twice a week
- Addition of Binge Eating Disorder

Additional Eating Disorders

- Feeding and Eating CNEC
  - Atypical Anorexia Nervosa
  - Subthreshold Bulimia Nervosa (low frequency or limited duration)
  - Subthreshold Binge Eating Disorder (low frequency or limited duration)
  - Purging Disorder
  - Night Eating Syndrome

Gender Dysphoria

- Types
  - Gender Dysphoria in children
  - Gender Dysphoria in adolescents & adults
  - CNEC
- Name change from Gender Identity Disorder
- Is a dystonic condition if the dysphoria has behavioral manifestations
- Serious questions if this is a ‘mental disorder’

Gender Dysphoria

- Gender Dysphoria in Children
  - A dysphoric experience is a state of sadness and is usually a symptom of depression or a reaction to life events.
  - It is manifested by persistent behaviors of a desire to be of the other gender.
  - In males, it is marked by a strong desire to cross dress, avoid typical male activities, engage with members of the other gender, dislike for sexual anatomy.
  - In females, it is marked by refusal to engage in female activities, preference for other gender attire and dislike for sexual anatomy.
**SUBSTANCE USE DISORDER**
(DSM-5)
(Dependence – DSM-IV-TR)

“A problematic pattern of substance use, leading to clinically significant impairment or distress, as manifested by at least 2 of 11 criteria, occurring in the same 12-month period.”

**Essential Features**

- A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.
- An underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders
  - Behavioral effects may be exhibited in the repeated relapses and intense drug craving when exposed to drug-related stimuli.

**SUD Criteria**

**Pathological Pattern of Behaviors**

- Impaired Control
- Social Impairment
- Risky Use
- Pharmacological Criteria

**SUD Criteria**

**IMPAIRED CONTROL:**

| 1) | The substance is often taken in larger amounts or over a longer period than was intended. |
| 2) | There is a persistent desire or unsuccessful efforts to cut down or control use. |
| 3) | A great deal of time is spent in activities necessary to obtain, use or recover from the effects. |
| 4) | Craving, or a strong desire or urge to use. |

**SUD Criteria**

**SOCIAL IMPAIRMENT**

| 5) | Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home. |
| 6) | Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the drug. |
| 7) | Important social, occupational or recreational activities are given up or reduced because of use. |

**Commentary:**

- The individual may withdraw from family activities and hobbies in order to use the substance.
SUD Criteria

**RISKY USE**

- (8) Recurrent use in situations in which it is physically hazardous.
- (9) Use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the drug.
  - **Commentary:**
    - The key issue in evaluating this criterion is not the existence of the problem, but the individual’s failure to abstain despite the difficulty it is causing.

**PHARMACOLOGICAL CRITERIA**

- (10) Tolerance
- (11) Withdrawal
  - **Commentary:**
    - The drug (or a closely-related substance) may be taken to relieve or avoid withdrawal symptoms. This now counts as the presence of withdrawal.
  - **NOTE:**
    - Neither tolerance nor withdrawal is necessary for a diagnosis of a substance use disorder.

Substance Use Disorder

- **Severity specifiers:**
  - Moderate: 2-3 criteria positive
  - Severe: 4 or more criteria positive
- Polysubstance Dependence has been eliminated.
- ‘Recurrent legal problems’ criterion has been deleted.
- Added: Cannabis w/d & caffeine w/d
- Added to Substance-Induced Disorders:
  - Obsessive Compulsive Disorder
  - Bipolar Disorder

Other Name Changes

- Functional Neurological Disorder (Conversion Disorder)
- Neurocognitive Disorder (Dementia)
- Illness Anxiety Disorder (Hypochondriasis)
- Childhood Onset Fluency Disorder (Stuttering)
- Speech Sound Disorder (Phonological Disorder)

Additional Conditions Being Considered

- Apathy Syndrome
- Body Integrity Identity Disorder
- Complicated Grief Disorder
- Developmental Trauma Disorder
- Disorders of Extreme Stress Not Otherwise Specified
- Fetal Alcohol Syndrome
- Depressive Personality Disorder
- Negativistic (passive-aggressive) Personality Disorder
- Relational Disorder
- Male-to-Eunuch Gender Identity Disorder
- Melancholia
- Parental Alienation Disorder
- Seasonal Affective Disorder
- Sensory Processing Disorder

*It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.*

— Charles Darwin, English naturalist
Questions? And Comments

Thank you!