Changes in the DSM–5

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Disclosures

- None
- Thanks to Don Black, MD for use of his slides
Goals

- Short history of DSM and thinking behind its creation and changes
- General overview of changes that may affect most clinical practice
- Resources to help answer your questions
The DSM through Time
The DSM Through Time

- **DSM–I (1952) – 132 pages**
  - Mental disorders resulted from a “reaction” of personality to psychological, social, and biological factors.
  - Definitions were simple, brief paragraphs.

- **DSM–II (1968) – 134 pages**
  - Term “reaction” dropped; users encouraged to record multiple psychiatric diagnoses.

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- DSM–III was transformative
- Process led by Robert Spitzer, MD
- Descriptive and neutral with regard to etiology.
- Introduced
  - diagnostic criteria
  - multiaxial classification
- Major goal was to introduce the biometric concept of reliability.

Robert Spitzer, MD

- DSM–IV (1994) had several important changes (886 pages):
  - Inclusion of a clinical significance criterion to almost half of all the categories.
  - New disorders introduced (e.g., Acute Stress Disorder, Bipolar II Disorder, Asperger’s Disorder).
  - Other disorders deleted (e.g., Cluttering, Passive–Aggressive Personality Disorder).
- DSM–IV–TR (2000) had text changes (943 pages), but none to the criteria; some specifiers added.

The March to DSM–5

- Began in 1999 at a meeting with APA leadership (Steve Mirin, Steve Hyman, David Kupfer).
- In 2000, Darrel Regier, MD recruited to coordinate the development of DSM–5.
- In 2006, the DSM–V Task Force created to oversee process.
  - Darrel Regier and David Kupfer appointed to lead the process.
  - 13 diagnostic Work Groups and chairs named.
  - Conflict of interest rule implemented.
Darrel Regier, MD (l) and David Kupfer, MD (r) appointed to lead Task Force.

The March to DSM–5

- Work Groups asked to consider ways to:
  - incorporate dimensional measures
  - consider culture/gender issues
- Field trials organized to assess reliability of proposed criteria
- Scientific reviews written
- Over 1000 members and consultants involved
- Aimed to be transformative
Multi–Stage Review

- Proposed changes undergo revision with input from APA members and others via three Internet postings.
- A Scientific Review Committee created to review the science validating the evidence for revisions.
- A Peer Review process involving hundreds of experts developed to consider clinical/public health risks and benefits of proposed changes.
- Approved by:
  - APA Assembly (November 2012)
  - Board of Trustees (December 2012)

Criticism of the DSM–5 Process

- Started early and continued unabated.
- Concerns that DSM–5:
  - was rushed
  - lacked transparency
  - authors were riddled with conflicts of interest
  - authors did not seek input of APA membership/public
  - Focus placed on controversial topics/diagnoses: Bereavement exclusion; Disruptive Mood Dysregulation Disorder, and Autism Spectrum Disorder.
Major Changes in DSM–5

- The organization of chapters follows the developmental lifespan.
  - Disorder chapters are arranged so that those typically diagnosed in childhood are listed first.
  - Related categories placed in close proximity.
- New diagnostic categories. Examples:
  - Obsessive–Compulsive and Related Disorders
  - Trauma– and Stressor–Related Disorders
- Reformulated diagnostic categories. Examples:
  - Neurodevelopmental Disorders
  - Somatic Symptom Disorders
Major Changes in DSM-5

- New and reformulated diagnoses. Examples:
  - Autism Spectrum Disorder (ASD)
  - Disruptive Mood Dysregulation Disorder (DMDD)
- Discontinuation of multiaxial classification
- Demise of NOS categories (replaced by “other specified” or “unspecified”)
- New dimensional scales in Section III.

Section III: Tools for clinical decision making

- Measures and assessments to help capture a more comprehensive assessment. They are included in Section III to encourage their testing and use by clinicians as part of the evolving diagnostic process.
- Cross-cutting symptom self-rated measures
  - Focus on more general mental function and severity measures that are disorder specific
  - Reflect increasing scientific evidence about the diagnostic and treatment limitations of a strictly categorical construct
  - By contrast, a more dimensional approach considers aspects of symptom presentation important for treatment planning and monitoring but that can be captured quantitatively, such as symptom count or the intensity, duration and change in symptoms.
  - Help to sort out intermediate categories such as schizoaffective DO
- WHODAS 2.0 for disability rating, greater exploration of responses to Level I
- Cultural Formulation Interview: instructions and guidance for culturally sensitive interviews
- New model for diagnosis of personality DO
During the development of DSM-5, several proposed revisions were drafted that would have significantly changed how clinicians diagnose individuals with personality disorders. Based on feedback from a multilevel review of proposed revisions, the APA ultimately retained the current categorical approach with the same 10 personality disorders.

But one of those alternative methods—a hybrid dimensional–categorical model—was included in Section III to prompt continued research. This model calls for evaluation of impairments in personality.

Section III functioning (how an individual typically experiences himself or herself as well as others) and characterizes five broad areas of pathological personality traits. It identifies six personality disorder types, each defined by a specific pattern of impairments and traits: • Borderline Personality Disorder • Obsessive–Compulsive Personality Disorder • Avoidant Personality Disorder • Schizotypal Personality Disorder • Antisocial Personality Disorder • Narcissistic Personality Disorder

Changes in Specific DSM Disorder Numbers (net difference = −15)

<table>
<thead>
<tr>
<th>Specific Mental Disorders*</th>
<th>DSM–IV</th>
<th>DSM–5</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>172</td>
<td>157</td>
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*NOS (DSM-IV) and Other Specified/Unspecified (DSM-5) conditions are counted separately.
### New and Eliminated Disorders in DSM-5
**New Disorders**
1. Social (Pragmatic) Communication Disorder
2. Disruptive Mood Dysregulation Disorder
3. Premenstrual Dysphoric Disorder *(DSM-IV appendix)*
4. Hoarding Disorder
5. Excoriation (Skin-Picking) Disorder
6. Disinhibited Social Engagement Disorder *(split from Reactive Attachment Disorder)*
7. Binge Eating Disorder *(DSM-IV appendix)*
8. Central Sleep Apnea *(split from Breathing-Related Sleep Disorder)*
9. Sleep-Related Hypoventilation *(split from Breathing-Related Sleep Disorder)*
10. Rapid Eye Movement Sleep Behavior Disorder *(Parasomnia NOS)*
11. Restless Legs Syndrome *(Dyssomnia NOS)*
12. Caffeine Withdrawal *(DSM-IV Appendix)*
13. Cannabis Withdrawal
14. Major Neurocognitive Disorder with Lewy Body Disease *(Dementia Due to Other Medical Conditions)*
15. Mild Neurocognitive Disorder *(DSM-IV Appendix)*

**Eliminated Disorders**
1. Sexual Aversion Disorder
2. Polysubstance-Related Disorder

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### Combined Specific Disorders in DSM-5
**net difference = -28**
1. Language Disorder *(Expressive Language Disorder, Mixed Receptive Expressive Language Disorder)*
2. Autism Spectrum Disorder *(Autistic Disorder, Asperger’s Disorder, Childhood Disintegrative Disorder, Rett’s disorder)*
3. Specific Learning Disorder *(Reading Disorder, Math Disorder, Disorder of Written Expression)*
4. Delusional Disorder *(Shared Psychotic Disorder & Delusional Disorder)*
5. Panic Disorder *(Panic Disorder Without Agoraphobia, Panic Disorder With Agoraphobia)*
6. Dissociative Amnesia *(Dissociative Fugue, Dissociative Amnesia)*
7. Somatic Symptom Disorder *(Somatization Disorder, Undifferentiated Somatoform Disorder, Hypochondriasis, Pain Disorder)*
8. Insomnia Disorder *(Primary Insomnia, Insomnia Related to Another Mental Disorder)*
9. Hypersomnia Disorder *(Primary Hypersomnia, Hypersomnia Related to Another Mental Disorder)*
10. Non-Rapid Eye Movement Sleep Arousal Disorders *(Sleepwalking Disorder, Sleep Terror Disorder)*
Combined Specific Disorders in DSM-5 (Continued) (net difference = -28)

11. **Genito-Pelvic Pain/Penetration Disorder** (Vaginismus, Dyspareunia)
12. **Alcohol Use Disorder** (Alcohol Abuse, Alcohol Dependence)
13. **Cannabis Use Disorder** (Cannabis Abuse, Cannabis Dependence)
14. **Phencyclidine Use Disorder** (Phencyclidine Abuse, Phencyclidine Dependence)
15. **Other Hallucinogen Use Disorder** (Hallucinogen Abuse, Hallucinogen Dependence)
16. **Inhalant Use Disorder** (Inhalant Abuse, Inhalant Dependence)
17. **Opioid Use Disorder** (Opioid Abuse, Opioid Dependence)
18. **Sedative, Hypnotic, or Anxiolytic Use Disorder** (Sedative, Hypnotic, or Anxiolytic Abuse, Sedative, Hypnotic, or Anxiolytic Dependence)
19. **Stimulant Use Disorder** (Amphetamine Abuse; Amphetamine Dependence; Cocaine Abuse; Cocaine Dependence)
20. **Stimulant Intoxication** (Amphetamine Intoxication, Cocaine Intoxication)
21. **Stimulant Withdrawal** (Amphetamine Withdrawal, Cocaine Withdrawal)
22. **Substance/Medication-Induced Disorders** (aggregate of Mood (+1), Anxiety (+1), and Neurocognitive (-3))

Section II: Chapter by Chapter Review
Neurodevelopmental Disorders

- MR replaced by Intellectual Disability (Intellectual Developmental Disorder).
  - Emphasis on adaptive functioning not IQ.
  - Rated as mild, moderate, severe, profound
- Autism Spectrum Disorder consolidates four conditions:
  - Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder.

Schizophrenia Spectrum and Other Psychotic Disorders

- Schizophrenia:
  - Subtypes dropped (paranoid, disorganized, catatonic, undifferentiated)
  - 2 Criterion A symptoms: delusions, hallucinations, disorganized speech, disorganized behavior, negative symptoms, diminished emotional expression, avolition
  - Must have at least one: delusions, hallucinations, disorganized speech
- Schizoaffective disorder:
  - Major mood DO plus criterion A
  - requires mood symptoms for a majority (≥50%) of the lifetime duration of the illness
- Shared psychotic disorder dropped
Mood Disorders

- Bipolar and Related Disorders:
  - Mixed episode (full criteria for both mania and MD episode) dropped; replaced by "with mixed symptoms" specifier
  - Includes both changes in mood and emphasizes changes "increased energy/activity" (Criterion B) as a defining feature of mania and hypomania

- Depressive Disorders, now include:
  - Disruptive Mood Dysregulation Disorder (new, children under 18 with persistent irritability, extreme dyscontrol - restrict use of BPD diagnosis in kids)
  - Premenstrual Dysphoric Disorder (new)
  - "Bereavement exclusion" for MDD dropped (Criterion E).
  - Persistent Depressive Disorder (new) includes previous Dysthymic Disorder and Chronic MDD.

Anxiety Disorders

- Moved to other chapters:
  - Obsessive–Compulsive Disorder (new chapter)
  - Acute Stress Disorder (trauma and stressor related DO chapter)
  - Posttraumatic Stress Disorder trauma and stressor related DO chapter)
- Separation Anxiety Disorder, Selective Mutism added.
- Panic Disorder and Agoraphobia are "unlinked."
- Panic attack specifier may apply to any disorder ("with panic attack").
Obsessive–Compulsive and Related Disorders

- New chapter – acknowledges the existence of the obsessive–compulsive spectrum
- Includes:
  - Obsessive–Compulsive Disorder
  - Body Dysmorphic Disorder (from Somatoform chapter)
  - Hoarding Disorder (new)
  - Trichotillomania (Hair-pulling Disorder) (from ICDNEC chapter)
  - Excoriation (Skin-Picking) Disorder (new)

Trauma– and Stressor–Related Disorders

- New chapter – brings together disorders that result from stressful/traumatic events:
  - Reactive Attachment Disorder
  - Disinhibited Social Engagement Disorder (new)
  - Acute Stress Disorder
  - Posttraumatic Stress Disorder
  - Adjustment Disorders
- PTSD
  - No longer requires subjective experience at the time of the event (“fear, helplessness, horror”) (Criterion A)
  - No longer requires that the event happen to the person, can be a close individual
**Somatic Symptom and Related Disorders**

- “Somatic Symptom Disorder” replaces Somatization Disorder, Hypochondriasis, Pain Disorder, and Undifferentiated Somatic Disorder.
  - No specific number of symptoms is required
  - Medically unexplained symptoms is eliminated—Can have somatization with a medically explained illness.
- Illness Anxiety Disorder (new) for individuals with high health-related anxiety.
- Conversion Disorder no longer requires a psychological stressor. Criteria are modified to emphasize the importance of Neuro exam.

**Feeding and Eating Disorders**

- Feeding Disorders (Pica, Rumination Disorder) now included with the Eating Disorders
  - All involve disturbed eating behaviors.
- Amenorrhea dropped for Anorexia Nervosa.
- Bulimia – fewer binge/purge cycles needed (weekly for 3 months).
- Binge Eating Disorder (new)
### Substance Use and Other Addictive Disorders

- No distinction made between **abuse** and **dependence** – merged into single “use disorder.”
  - Use disorders rated **mild** (2–3 sxs), **moderate** (4–5 sxs), **severe** (6+ sxs)
- **Gambling Disorder** added as a “Non-Substance-Related Disorder.”
- Other new disorders: Caffeine Withdrawal and Cannabis Withdrawal.

### Neurocognitive Disorders

- The term “dementia” subsumed under the new diagnosis **Major Neurocognitive Disorder**.
- **Mild Neurocognitive Disorder** is new – included as a less severe level of cognitive impairment.
- Etiologic subtypes now independent disorders (e.g., major neurocognitive disorder due to Alzheimer’s disease).
Gender Dysphoria

- New diagnostic class
- Based on conceptualization of gender incongruence rather than cross gender identification
- Different criteria for adults and adolescents and children
- Post-transition specifier

Personality Disorders

- The PD’s are unchanged:
  - 3 clusters
  - 10 disorders
- A hybrid categorical–dimensional scheme developed by the work group was rejected by the Board of Trustees, but is included in Section III.
Other changes

- Sexual Dysfunctions
- Sleep–Wake DO
- Paraphilic DO and Conduct DO

Resources

- [http://psychcentral.com/blog/archives/2013/05/18/dsm-5-released-the-big-changes/](http://psychcentral.com/blog/archives/2013/05/18/dsm-5-released-the-big-changes/)
- [https://www.aatbs.com/pdf/DSM_CC_Sample.pdf](https://www.aatbs.com/pdf/DSM_CC_Sample.pdf)
Conclusions

1) DSM–5 was 14 years in the making and most changes are not controversial.
2) The goal to move toward dimensions gained traction for many disorders.
3) The multiaxial system is history.
4) Three years out the full impact of DSM–5 remains uncertain.

References