The New DSM-5®: What Administrators Need to Know

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EVOLUTION OF THE DSM®
Pre-DSM

- United States Census Bureau
  - 1840 = "idiocy" & "insanity"
  - 1880 = mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy
- 1917 Committee on Statistics
  - Statistical Manual for the Use of Institutions for the Insane
- Standard Classified Nomenclature of Disease (1928 conference, 1933 pub)
- WW-II (1943): Medical 203

DSM®

DSM-I: 1952
  - 106 disorders, 130 pages
DSM-II: 1968
  - 182 disorders, 134 pages
DSM-III: 1980
  - 265 disorders, 494 pages
DSM-III-R: 1987
  - 292 disorders, 567 pages
DSM-IV: 1994
  - 297 disorders, 886 pages
DSM-IV-TR: 2000
DSM-5: 2013

Focus of Later DSMs: Diagnostic Reliability

- Communication
  - Common language
  - Documentation
  - Billing
- Research
- Service Planning
  - Prevalence rates
Why Revise?

- Grouping of disorders in DSM-IV not empirically supported
- High rates of comorbidity
  - Within and across groupings
- Overreliance on “NOS” disorders
- Lack of empirical support for diagnostic categories

Making the DSM-5®

- 12-year process
  - 1999: Current DX demarcations not supported by research
  - 2002: A Research Agenda for DSM-V
  - 2003-2008: Conferences & Reports
    - 13 planning conferences
    - 400 participants from 39 countries
  - 2006: Diagnostic work groups developed
  - 2006-2012:
    - Proposals for revisions
    - Field Trials
    - Review by the Public & Professionals
    - Expert Review
    - Executive “summit committee” session

CONFLICTS OF INTEREST

Guiding Principles for Revisions

- Focus on use and feasibility in routine clinical practice
- Revisions should be based in research evidence
- Maintain continuity with DSM-IV®, whenever possible
- Amount of change should not be restricted

Factors considered for revisions and new diagnoses

- Does the revision:
  - Help or hurt clinical practice or public health?
  - How strong is the evidence supporting a revision?
  - How big is the change?
- Can a new diagnosis:
  - Be reliability measured?
  - Be useful clinically?
  - Have strong validity?
How is the DSM-5® Organized?

Section I: DSM-5 Basics

Section II: Diagnostic Criteria & Codes

Section III: Emerging Measures & Models

Section I: Background & Basics of the DSM-5®

• History of DSM
• Process of Revising the DSM-5
• Structure of the DSM-5
• Cultural & Gender Concerns in Diagnosis
• The New Approach to “NOS” Disorders
• Saying Goodbye to the Multiaxial System
• From Print to Online

Section II: DSM-5® Diagnoses

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Section III: The Future of Measurement and Modeling

- New Strategies and Tools for Decision Making
- Symptom Measurement
- Cultural Formulation Interview
- Personality Disorder Alternative
- Conditions Requiring Additional Research

Why DSM-5® instead of DSM-V?

What Qualifies as a Mental Disorder?

- Syndrome
- Disturbance in:
  - Cognition
  - Emotion
  - Behavior
- Significant Distress or Disability (usually)
- Not:
  - Normative response to a stressor or loss
  - Politically or socially deviant behavior
  - Conflicts between individuals and society
Are DSM-5® Disorders Valid?

- Types of Validity:
  - Antecedent
  - Concurrent
  - Predictive

Validity Concerns

Problems with Categorical Diagnoses

- Prior DSMs:
  - Numerous and narrow diagnostic categories
    - Intermediate and combined diagnoses

- Clinical Implications:
  - Few "text-book" patients
  - Comorbidity
  - Not Otherwise Specified
  - Arbitrary cutoffs: Healthy vs. Disordered
  - Limited treatment specificity

- Research failed to support categories
  - Shared Genetic and Environmental Risk Factors
  - Symptom Heterogeneity within categories
  - Symptom Overlap across categories
Dimensional Approach: Benefits of Dimensions

- Acknowledges Human Variation
  - Normalcy to Pathology
- Provides a Symptom Profile
  - Regardless of Diagnostic Criteria
- More informative than a yes/no diagnosis
  - Characterizes severity
- Integrates Multiple Forms of Data:
  - Self-Report
  - Pathophysiology
  - Neurocircuitry,
  - Genetics
  - Environment
  - Lab tests

Progressive Subtypes of Bipolar Disorder

Bipolar I disorder
- Manic Episode
- Hypomania/MDD

Bipolar II disorder
- Hypomanic Episode
- Major Depression

Cyclothymic disorder
- Hypomanic Symptoms
- Depression Symptoms

Other Specified Bipolar
- Short durations
- Insufficient symptoms
- Nor prior MDD

Unspecified Bipolar

So where are the dimensions?

- “Scientifically Premature”
- Most Evident in Regrouping of Mental Disorders
- Regrouping based on:
  - Shared neural substrates
  - Family traits
  - Genetic risk factors
  - Specific environmental risk factors
  - Biomarkers
  - Temperamental antecedents
  - Abnormalities of emotional or cognitive processing
  - Symptom similarity
  - Course of illness
  - High comorbidity
  - Shared treatment response
“Cross-Cutting Symptom Measures”

- Review of Mental Functioning
  - General Medicine’s Review of Systems?
- Not necessarily specific to a diagnosis
- 2 Levels of assessment:
  - Level 1 Survey
    - Adults = 23 questions, 13 symptom domains
    - Child & Adolescents = 25 questions, 12 symptom domains
  - Level 2 Surveys
    - In-depth assessments
  - Initial, ongoing, and outcome assessment

Measures of Symptom Severity

- Specific to diagnostic criteria
- Designed for subclinical or full diagnosis

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CHANGES IN HOW DIAGNOSIS WILL APPEAR
Single-Axis System

- List everything
  - All Mental Disorders
  - Relevant Medical Diagnoses
  - Relevant Psychosocial & Contextual Factors
    - V codes & Z codes
- Disability & Functioning
  - Goodbye GAF
  - Hello WHO Disability Assessment Schedule (2.0)

Example: Multiaxial System

Axis I: Dysthymic Disorder (300.4)
  - Alcohol use disorder (303.9)
  - Cannabis use disorder (304.3)
Axis II: Diagnosis Deferred
Axis III: Migraine with aura (346.0)
Axis IV: Problems with primary support group; Problems related to interaction with the legal system/crime
Axis V: 58

Example: Single-Axis System

Diagnoses:
- 300.4 (F34.1) Persistent depressive disorder (dysthymia);
- 303.90 (F10.20) Alcohol use disorder, moderate;
- 304.30 (F12.20) Cannabis use disorder, moderate;
- V61.03 (Z63.5) Disruption of Family by Divorce (two years ago)
- V62.5 (Z65.0) Conviction in civil or criminal proceedings without imprisonment: Probation.

General Disability (WHODAS 2.0) = 2.9 (Moderate)
Diagnostic Specifics

• Order the diagnoses
• Add necessary Subtypes
• Indicate Severity, if possible
• Add Specifiers
• Add Provisional, if applicable
• Not Present = V71.09
• Diagnosis Deferred = 799.9

Not Otherwise Specified

• No more NOS!
  • Sort of...
• If patient does not fit existing criteria:
  • Other Specified Disorder
  • Unspecified Disorder

Assessing Impairment: WHODAS

• World Health Organization Disability Assessment Schedule (2.0)
  • Self-report (and Informant), 36 item survey
  • Adults
  • 6 Domains:
    • Understanding and communicating
    • Getting around
    • Self-care
    • Getting along with people
    • Life activities (i.e., household, work, and/or school activities)
    • Participation in society.
DIAGNOSES: MAJOR CHANGES IN DSM-5®

A Few Words of Caution

- Not an exhaustive overview
- Focus on:
  - Major Changes
  - Moderate Changes
- Diagnostic criteria are NOT provided verbatim from the DSM-5® in this presentation!
- You need to read the actual DSM-5® to make DSM-5® diagnoses!

Neurodevelopmental Disorders

- Intellectual Disability (intellectual Developmental Disorder)
- Communication Disorders
- Autism Spectrum Disorders (ASD)
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Specific Learning Disorder
- Motor Disorders
Intellectual Disability (Intellectual Developmental Disorder)
• Deficits in:
  • Intellectual functioning
  • Adaptive functioning
• Severity based on adaptive functioning, not IQ
  • Conceptual
  • Social
  • Practical
• Terminology:
  • Mental retardation replaced with Intellectual disability
• Onset during childhood or adolescence

Communication Disorders: Name Changes
• Speech sound disorder
  • Previously Phonological Disorder
• Childhood-onset fluency disorder
  • Previously Stuttering

Language Disorder
• Inclusive of expressive & receptive language
• Diagnosis:
  • Language Acquisition problems:
    • Vocabulary
    • Grammar & Morphology
    • Discourse
  • Below Expectations
  • Impaired functioning
Social Communication Disorder
• Primary problem with the use of language and communication for social means, including:
  • Socially appropriate communication (e.g., greeting)
  • Adapting communication style to situational demands.
  • Following standards of conversing and telling stories
  • Understanding indirect, abstract, and contextually-specific communication

Autism Spectrum Disorder (ASD)
• Replaces Autistic disorder (autism), Asperger’s disorder, Childhood Disintegrative Disorder, and PDD-NOS
• Persistent problem with:
  • Social reciprocity
  • Communication
  • Interaction
  • Restricted and repetitive behaviors, interests, or activities
• 3 Severity levels:
  • Requiring Support
  • Requiring Substantial Support
  • Requiring Very Substantial Support

Attention-Deficit/Hyperactivity Disorder
• What stayed the same?
  • Symptoms criteria
  • Structure of symptoms & # of symptoms:
    • Inattentive
    • Hyperactive/Impulsive
• What is different?
  • Criterion examples are applicable to adults
  • Adults: only 5 symptoms
  • Several symptoms required across settings
  • Age of onset changed to 12 years (from 7)
    • Impairment required
  • Subtypes changed to “presentation” specifiers
  • ASD can be comorbid
Specific Learning Disorder

- Combines reading, mathematics, written expression and learning NOS disorders
- Essential features:
  - Persistent (>6 months) difficulties in the acquisition of reading, writing, arithmetic, or mathematical reasoning
  - In spite of intervention!
  - Academic performance is well below average
  - Begin during school-age years
  - Measured intelligence is not required
- Specifiers in Reading, Writing, and Math

Motor Disorders

- Developmental Coordination Disorder
- Stereotypic movement disorder
- Tourette’s disorder
- Persistent motor or vocal tic disorder

Anxiety Disorders

- OCD, PTSD, Acute Stress in a separate sections
- Agoraphobia, Specific Phobia, and Social Anxiety
  - Removed requirement of insight for over 18 years
  - Must last 6 months or longer
  - “Generalized” specifier replaced with “Performance Only” for Social Anxiety.
- Panic
  - Improved terminology
  - Separated from Agoraphobia
- Separation Anxiety
  - More inclusive of adults
- Selective Mutism
  - Moved to Anxiety
Trauma- & Stressor-Related Disorders

- Adjustment disorder included
- PTSD & Acute Stress
  - More explicit stressor criterions
  - Subjective reaction removed
  - Avoidance/numbing cluster separated into:
    - Avoidance
    - Persistent negative alterations in cognitions and mood.
- PTSD includes developmentally sensitive thresholds
  - Separate criteria for age 6 or younger

Trauma- & Stressor-Related Disorders

- Reactive Attachment Disorder
  - Separated from a now distinct Disinhibited Social Engagement Disorder
  - RAD = internalizing
  - DSED = externalizing (ADHD-like)

Eating Disorders

- Anorexia Nervosa
  - Amenorrhea eliminated
- Bulimia Nervosa
  - Reduced minimum average frequency of binging/compensatory to 1 time a week
- Binge-Eating Disorder
  - New Disorder
  - Recurrent episodes binge eating
  - Lack of control over eating
**Disruptive Mood Dysregulation Disorder**

- Primary Feature: chronic, severe persistent irritability
  - Frequent, reactive temper outbursts
  - Chronic and persistent irritability or angry mood
- Must not meet criteria for a manic or hypomanic episode
- Must not occur only during major depressive episodes

**Substance Use Disorders**

- Essential Feature:
  - Continued use of substance(s) in the face of substance-related problems and impairments
  - Includes, but does not require tolerance or withdrawal symptoms
  - Eliminated the abuse vs. dependence distinction
  - Includes 10 separate classes of drugs
  - Also includes Gambling disorder
  - Excludes repetitive behaviors:
    - Sex, exercise, shopping, internet, gaming

**FINAL THOUGHTS**
DSM-5: the Bible of Mental Disorders?

While DSM has been described as a “Bible” for the field, it is, at best, a dictionary, creating a set of labels and defining each.

-Tom Insel, M.D.
NIMH Director

What about Validity?

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Thank you!
Questions? Concerns? Comments?

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