Preparing for DSM-5

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Disclosure Information

NO RELEVANT FINANCIAL CONFLICTS OF INTEREST

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Program Outline

• Introduction
  – Evolution of DSM and Why DSM-5

• Major Changes in DSM-5
  – Structure
  – Content
  – Implications for Clinical Practice
What Characteristics Must A Medical Disorder Have?

- **VALIDITY**
  - Must define a “Real” entity with distinctive etiology, pathophysiology, clinical expression, treatment, & outcome

- **UTILITY**
  - Must be useful in addressing needs of various stakeholders
  - Must predict treatment response, guide treatment selection, and predict course and outcome
  - Must be simple and easy to apply

- **RELIABILITY**
  - Different groups of people who need to diagnose this condition must be able to do so in a consistent manner

History of Classifying Mental Disorders

- **1800s-1940**
  - 1 condition in 1840 ("idiocy/insanity")
  - 7 in 1880 (mania, melancholia, monomania, paresis, epilepsy, dementia, dipsomania)
  - 22 in 1917 for use in Institutions for the Insane

- **Currently Two Major Systems**
  - International Classification of Diseases (ICD); 1st time as Section 5 in ICD-6 in 1949
  - Diagnostic and Statistical Manual of Mental Disorders (DSM); 1st time in 1952

Conceptual Development of DSM

- DSM-I 1952
- DSM-II 1968
- DSM-III 1980
  - Reconceptualization
  - Emphasis on Reliability
  - Operational Criteria
- DSM-IV 1994
  - Dimensional Spectra
  - Clinical Utility
  - Validity
- DSM-III-R 1987
  - Most hierarchies dropped

Perceived Shortcomings in DSM-IV

- High rates of comorbidity
- High use of NOS category
- Incredible Complexity
- Unclear distinctions between several different disorders
- Only modestly guide treatment selection
- Impeding research progress
Key Objectives for DSM-5

- Incorporate research into the revision and evolution of the classification
- IMPROVE VALIDITY
- Maintain (when possible, improve) Reliability
- IMPROVE CLINICAL UTILITY
  - Reduce NOS
  - Reduce Artificial Comorbidity
  - Simplify
  - Specific issues in different disorders

Revisions to DSM-5

Major Changes

DSM-5

- Task Force
  - Workgroup chairs
  - Health professionals from stakeholder groups

13 Workgroups

- Members work in specific diagnostic areas
- Advisors for workgroups

Review & Oversight Groups

ITERATIVE PROCESS

- Task Force
  - Initial and Ongoing review of All Proposals
- Scientific Review Committee
  - Review of validity of recommendations
- Clinical and Public Health Committee
  - Impact on public health and clinical practice
- Forensic Committee
  - Clarity of language with regard to forensic implications
- Summit Group
  - Chairs and Co-Chairs of Various Initial Review Groups
- Board of Trustees
  - Final Approval
**Overall Changes**

- **Removal of Multi-axial system**
- **Changes in Overall Structure**
  - Addition of Section 3
  - Section 2: Twenty sections organized to describe inter-relationship
- **Dimensional assessments emphasized within and across sections**

**Removal of Multi-axial System**

- Move to a non-axial documentation of diagnosis
- Combines Axes 1-3
- Psychosocial and contextual factors (formerly Axis 4) captured via V codes (Z codes in ICD-10) or in narrative
- Disability (formerly Axis 5) now described separately via WHODAS-II and/or in narrative
- Partly replaced by additional of dimensional component and addition of severity measures to diagnostic categories

**Overall Changes**

- **Restructuring Overall Organization**
  - Sections 1-3
    - 1: Introduction, guidance on use, definition of mental disorder
    - 2. Various Chapters (20)
      - Chapter organization which incorporates our understanding of the underlying vulnerabilities as well as symptom characteristics of disorders (how genes and environment interact to influence mental health and behavior)
      - Chapter order reflecting above
      - Content may be clinically useful and warrants attention, but not yet part of official diagnosis
  - Appendix

**Section III: Content**

- Section III: Emerging Measures and Models
  - Assessment Measures
    - Level 1 and 2 cross-cutting measures
    - Diagnosis-specific severity measures
  - Cultural Formulation
  - Alternative DSM-5 Model for Personality Disorders
  - Conditions for Further Study
Section 2
Definitions of Disorders

Section II:
Chapter Structure
A. Neurodevelopmental Disorders
B. Schizophrenia Spectrum and Other Psychotic Disorders
C. Bipolar and Related Disorders
D. Depressive Disorders
E. Anxiety Disorders
F. Obsessive-Compulsive and Related Disorders
G. Trauma- and Stressor-Related Disorders
H. Dissociative Disorders

Section II:
Chapter Structure
J. Somatic Symptom and Related Disorders
K. Feeding and Eating Disorders
L. Elimination Disorders
M. Sleep-Wake Disorders
N. Sexual Dysfunctions
P. Gender Dysphoria

Section II:
Chapter Structure
Q. Disruptive, Impulse-Control, and Conduct Disorders
R. Substance-Related and Addictive Disorders
S. Neurocognitive Disorders
T. Personality Disorders
U. Paraphilic Disorders
V. Other Disorders
Medication-Induced Movement Disorders and Other Adverse Effects of Medication
Other Conditions That May Be a Focus of Clinical Attention
### Structure of Disorder Chapters

- Criteria
- Subtypes and/or specifiers
- Severity
  - Codes and recording procedures
- Explanatory text *(new or expanded)*
  - Diagnostic and associated features; prevalence; development and course; risk and prognosis; culture- and gender-related factors; diagnostic markers; functional consequences; differential diagnosis; comorbidity

### Neurodevelopmental Disorders in DSM-5

- Intellectual Disabilities
- Communication Disorders
- Autism Spectrum Disorder
- Attention Deficit / Hyperactivity Disorder
- Specific Learning Disorders
- Motor Disorders
- Other Neurodevelopmental Disorders
  - Other Specified Neurodevelopmental Disorder
  - Other Unspecified Neurodevelopmental Disorder

### Intellectual Disability (Intellectual Developmental Disorder)

- IQ > 2SD below mean on standardized test
- Coding of Severity
  - Based on adaptive functioning considering degree of needed assistance and support
  - Age-relevant descriptors for different severity levels provided for each domain
    - Conceptual: ability to learn; information processing, approach to problem-solving;
    - Social: social interaction, communication, social cues, emotional regulation, social judgment
    - Practical: personal care, daily living tasks, ability to perform age-appropriate roles

### Autism Spectrum Disorder

- Replaces DSM-IV’s autistic disorder, Asperger’s disorder, childhood disintegration disorder, and pervasive developmental disorder NOS
  - Extremely poor reliability for distinctions, in part because clinicians have been applying DSM-IV criteria inconsistently and incorrectly

#### Two Dimensions

- Deficits in social communication and interaction
- Restrictive and repetitive behavior patterns
Autism Spectrum Disorder

- Specifiers
  - With or without accompanying intellectual impairment
  - With or without accompanying structural language impairment
  - Associated with known medical or genetic condition or environmental factor (e.g., Rett’s)
  - Associated with another neurodevelopmental, mental, or behavioral disorder
  - With catatonia

Three Levels of Severity (based on Need for Supportive Services: Support/Substantial Support/Very Substantial Support)

Psychotic Disorders

Changes from DSM-IV

- Concept
  - Definition of psychosis
  - Relationship between different psychotic disorders
  - Dimensions of psychosis and their measurement

- Addition and Deletion of Disorders
  - Catatonia NEC;
  - Schizophrenia subtypes; Shared psychotic disorder

- Changes in Criteria
  - Schizophrenia, Schizoaffective Disorder; Delusional Disorder;

Definition of Psychosis

- Core Features
  - Delusions
  - Hallucinations
  - Disorganized speech (thought disorder)

- Accompanying Features
  - Catatonia
  - Disorganized behavior
  - Negative symptoms
  - Mood Symptoms

Psychotic Disorders in DSM-5

Schizophrenia & Related Disorders

- Add dimensional measures to assessment
- Eliminate current subtypes of schizophrenia
- Modify criteria for Schizoaffective Disorder
- Treat catatonia uniformly across the manual
- "Attenuated Psychosis Syndrome" as condition for further study
**DIMENSIONS OF SCHIZOPHRENIA**

- **Positive symptoms**
  - Disorganization
  - Motor symptoms
  - Mood symptoms
  - Reality distortion (delusions, hallucinations)
  - Negative symptoms
  - Impaired cognition
  - Disorganization
  - Psychomotor symptoms, including catalepsy

**Key Changes in Criterion A**

- Eliminate special treatment of Schneiderian “first-rank” symptoms
  - Poor reliability of diagnosing “bizarre” delusions
  - No special prognostic or diagnostic value

- Add requirement that at least one characteristic symptom be a core psychotic symptom
  - Delusions, hallucinations, disorganized speech

**Schizophrenia Subtypes in DSM-V**

- **ELIMINATE SUBTYPES**
  - No long-term stability
  - No diagnostic utility
  - No research utility
  - Poor reliability and validity

- **INTRODUCE DIMENSIONS** (To be rated on 0-4 scale)
  - Reality distortion (delusions, hallucinations)
  - Negative symptoms
  - Disorganization
  - Impaired cognition
  - Depression
  - Mania
  - Psychomotor symptoms, including catalepsy

**Mood Disorder Now Two Sections**

1. Bipolar & 2. Depressive Disorders

**Bipolar and related disorders**

- Bipolar disorder now a free standing category
  - Taken out of the broad mood disorder category

- Emphasis on changes in activity and energy (equivalent in importance to mood)

- Addition of an anxious distress specifier

- Elimination of “Mixed episode” category

- Replaced by “mixed features” specifier
Mania and Hypomania

• “Mixed episode” is replaced with a “with mixed features” specifier for manic, hypomanic, and major depressive episodes
  – Rationale: DSM-IV criteria excluded from diagnosis the sizeable population of individuals with subthreshold mixed states who did not meet full criteria for major depression and mania, and thus were less likely to receive treatment.

Depressive Disorders

• Elimination of bereavement exclusion
• Multiple specifiers added
  – Mixed
  – Anxious distress
• Dysthymia now called Persistent Depressive Disorder
• Added Premenstrual Dysphoric Disorder
• Added Disruptive Mood Dysregulation Disorder

Bereavement Exclusion (Depressive Disorders)

• Eliminated from major depressive episode
  – Rationale: In some individuals, major loss – including but not limited to loss of a loved one – can lead to MDE or exacerbate pre-existing depression. Individuals experiencing both conditions can benefit from treatment but are excluded from diagnosis under DSM-IV. Further, the 2-month timeframe required by DSM-IV suggests an arbitrary time course to bereavement that is inaccurate. Lifting the exclusion alleviates both of these problems.

Disruptive Mood Dysregulation Disorder (DMDD)- New Addition

– Rationale: This addresses the disturbing increase in pediatric bipolar diagnoses over the past two decades, which is due in large part to the incorrect characterization of non-episodic irritability as a hallmark symptom of mania. DMDD provides a diagnosis for children with extreme behavioral dyscontrol but persistent, rather than episodic, irritability and reduces the likelihood of such children being inappropriately prescribed antipsychotic medication. These criteria do not allow a dual diagnosis with oppositional-defiant disorder (ODD) or intermittent explosive disorder (IED), but it can be diagnosed with conduct disorder (CD). Children who meet criteria for DMDD and ODD would be diagnosed with DMDD only.
Anxiety Disorders

• Separation of DSM-IV Anxiety Disorders chapter into four distinct chapters
  – Rationale: Neuroscience, neuroimaging, and genetic data suggest differences in heritability, risk, course, and treatment response among fear-based anxiety disorders (e.g., phobias); disorders of obsessions or compulsions (e.g., OCD); trauma-related anxiety disorders (e.g., PTSD); and dissociative disorders. Thus, four anxiety-related classifications are present in DSM-5, instead of two chapters in DSM-IV.

Anxiety Disorders

• No longer has PTSD in this category
• No longer has OCD in this category
• Social Phobia now called Social Anxiety Disorder
• Panic Disorder delinked from Agoraphobia
• Separation Anxiety Disorder and Selective Mutism are included here
• Minor changes in criteria for various conditions

Obsessive-Compulsive and Related Disorders

OCD is now a stand alone category

• Delusional specifier included
• Body Dysmorphic Disorder listed under OCD
  – Repetitive behaviors are the key feature of BDD
• Added Hoarding under category of OCD
• Trichotillomania now called Hair-Pulling Disorder is listed under OCD
• Skin Picking Disorder (Excoriation) moved under OCD

Trauma and Stressor Related Disorders

Trauma related disorders are now a stand alone category

• Reactive Attachment Disorder is now listed here
• Added Disinhibited Social Engagement Disorder
• Added PTSD in Preschool Children
• Acute Stress Disorder is now listed here
• PTSD is now listed here
  – Diminished emphasis on dissociative symptoms
  – Need ≥9 of 14 symptoms across four clusters: avoidance/numbing/altered arousal/persistent negative emotional state
• Adjustment Disorders are now listed here
Posttraumatic Stress Disorder
(Trauma- and Stress-Related Disorders)

- Stressor criterion (Criterion A) is more precise
  - (elimination of “non-violent death of a loved one” as a trigger)
  - subjective reaction (Criterion A2) is eliminated

  Rationale: Direct and indirect exposure to trauma are still reflected in criteria, but a review of the literature indicated more restrictive wording was needed. Criterion A2 is not well-supported by the data and rarely endorsed by military and other professionals who otherwise would meet full criteria for PTSD.

Posttraumatic Stress Disorder (cont’d)

- Expansion to four symptom clusters (intrusion symptoms; avoidance symptoms; negative alterations in mood and cognition; alterations in arousal and reactivity), with the avoidance/numbing cluster divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood

  Rationale: Confirmatory factor analyses suggest PTSD is best conceptualized by four factors rather than three. Further, active avoidance and emotional numbing have been shown to be distinct; thus they have been separated here (with numbing expanded to include negative mood and cognitive symptoms).

Somatic Symptom and Related Disorders

- The central focus of medically unexplained symptoms has been de-emphasized throughout the chapter, and instead emphasis is placed on disproportionate thoughts, feelings, and behaviors that accompany symptoms

  Rationale: The reliability of medically unexplained symptoms is low. Further, presence of medically explained symptoms does not rule out the possibility of a somatic symptom or related disorder being present.

Somatic Symptom and Related Disorders

Replaced Somatoform Disorders with this category

- Eliminated the following: Somatization Disorder; Pain Disorder; and Hypochondriasis
- Added Complex Somatic Symptom Disorder
- Added Simple Somatic Symptom Disorder
- Added Illness Anxiety Disorder
- Conversion Disorder renamed Functional Neurological Symptom Disorder
**Substance Use Disorder (SUD)**
(Substance-Related and Addictive Disorders)

- Consolidate substance abuse with substance dependence into a single disorder called substance use disorder
  - Studies from clinical and general populations indicate DSM-IV substance abuse and dependence criteria represent a singular phenomenon which encompass different levels of severity.

  Added Gambling to category

**Substance Use Disorder (cont’d)**

- Removal of one of the DSM-IV abuse criteria (legal consequences), and addition of a new criterion for SUD diagnosis (craving or strong desire or urge to use the substance)
  - Rationales: The legal criterion had poor clinical utility and its relevance to patients varied based on local laws and enforcement of those laws. Addition of craving as a symptom is highly validated, based on clinical trials and brain imaging data, and may hold potential as a future biomarker for the diagnosis of SUD.

**Neurocognitive Disorders**

- Category replaces Delirium, Dementia, and Amnestic and Other Cognitive Disorders Category
- Now distinguishes between Minor and Major Disorders
- Replace wording of Dementia due to … with Major Neurocognitive Disorder Associated with for all conditions listed
- Added Fronto-Temporal Lobar Degeneration; Traumatic Brain Injury; Lewy Body Disease
- Renamed Head Trauma as Traumatic Brain Injury
- Renamed Creutzfeldt-Jakob Disease as Prion Disease

**Neurocognitive Disorders (NCD)**

- Use of the term *major neurocognitive disorder* rather than *dementia*
  - Rationale: The term *dementia* is usually associated with neurodegenerative conditions occurring in older populations, as in Alzheimer’s disease and Lewy Body dementia. However, DSM-5’s major NCD refers to a broad range of possible etiologies that can occur even in young adults, such as major NCD due to traumatic brain injury or HIV infection.
Mild NCD

- Newly added to DSM-5
  - Rationale: Patients with mild NCD are frequently seen in clinics and in research settings, and there is widespread consensus throughout the field that these populations can benefit from diagnosis and treatment. The clinical utility of such a diagnosis also is highly supported in the literature.

Personality Disorders

- Ten Personality Disorders from DSM-IV remain in this category: Borderline; Obsessive-Compulsive; Avoidant; Schizotypal; Antisocial; Narcissistic; Histrionic; Schizoid, Paranoid, and Dependent
  - This category no longer stands alone as another AXIS II but rather as a diagnosed category with dimensions
  - Relationship of specific personality disorders to other conditions clarified
    - Schizotypal Personality Disorder also under Schizophrenia and Other Psychotic Disorders
    - Antisocial Personality Disorder also under Disruptive Impulse Control & Conduct Disorders as Dyssocial Personality Disorder
  - New Trait-specific based typology in Section 3

Conceptual Development of DSM-5. From Aspiration to Reality

INITIAL ASPIRATION
  - Paradigm Shift
  - Etiopathological basis
  - Multiple validators with biological markers
  - Dimensional Spectra
  - Developmental Simplification
  - Living document
  - Validity

CURRENT REALITY
  - More Modest Scope
  - Iterative criteria changes
  - Some simplification
  - Addition of Dimensions
  - Significant text revisions to incorporate advances in neurobiology of disorders
  - Improve Clinical Utility + Establish better foundation for desired etiopathological nosology in future

THANK YOU

Questions?