DSM-5: A Summary of Proposed Changes

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Introduction

The new edition of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) will be released during the American Psychiatric Association (APA) Annual Meeting in San Francisco on May 18-22, 2013. No specific event or time for the release of the DSM-5 is mentioned in the APA conference program highlights. The release of the DSM-5 will have significant impact for social workers who use mental health diagnoses in their work. The update of the DSM system has been through several stages of review since it was initiated in 1999. The recommended changes were summarized at a website (www.dsm5.org) sponsored by the APA throughout the review process, but the proposed changes were removed from the website after the APA Board of Trustees approved the DSM changes on December 1, 2012.

DSM users must now await the actual release of the DSM-5 to know the exact details of the changes. The APA issued a letter that contains an overview of the changes and the changes are summarized later in this article. Any comments in this article about the DSM-5 changes are based on information that has been made available by the APA and reliable published commentaries. None of the descriptions in this article should be interpreted as what will actually appear in the DSM-5.

Controversies and Commentaries

The DSM-5 proposed changes generated much controversy in a number of areas regarding concern about the scientific rigor of the review process and content of changes in specific disorders. The American Psychological Association, American Counseling Association, the American Mental Health Counselors Association, and the British Psychological Society and others submitted responses to the APA’s call for commentary on the changes. Although clinical social workers deliver the majority of the mental health services in the United States, the social work profession did not have much input to the review process. Belatedly, one social work member was appointed to a DSM-5 work group. A number of psychiatrists who contributed to past revisions of the DSM such as Dr. Robert Spitzer, who chaired the DSM-III revisions, and Dr. Allen Frances, who chaired the DSM-IV revisions, submitted comments about the process and content of disorder changes. For more information about specific scientific rigor issues and impact of the DSM-5 on mental health clients, see an article by Rosie Mestel (2012), Health and Science Editor at the Los Angeles Times. She provides commentary and cites a number of Internet resources that are very helpful. For details of the vast array of the responses to the DSM-5, visit the website www.DxRevisionWatch.com, which is an extensive Internet resource that is monitoring the DSM-5, ICD-10, and ICD-11 revisions.

During the later stages of the DSM-5 review and update, a number of mental health professionals conducted continuing education training seminars that were promoted as containing information
about what are precisely the changes in the *DSM*. These claims of insider information will most likely continue until the *DSM-5* is released. Social workers who attend seminars prior to the release of the *DSM-5* should be cautious about relying on or implementing any actions based on the claims made in *DSM-5* training seminars. Only when the *DSM-5* is released will we know the exact diagnostic criteria for specific disorders.

When the *DSM-5* planning began in 1999, there was much written and speculated about the magnitude of the changes through use of words like “revolutionary change.” A sweeping change based on using a manual-wide dimensional model of diagnosis versus the historic traditional categorical model was frequently mentioned. It appears that the categorical model has primarily survived. Two books published by the APA, *Relational Processes and DSM-V* (Beach, Wamboldt, Kaslow, Heyman, First, Underwood, and Reiss, 2006) and *The Conceptual Evolution of the DSM-5* (Regier, Narrow, Kuhl, and Kupfer, 2011) convey many of the ideas and conceptual models that played a role in the evolution of the *DSM-5*. The books may help practitioners in understanding the forthcoming diagnosis-specific disorder criteria changes, global manual changes, areas of the manual where dimensional assessments are applied, and the application of neuroscience and developmental concepts in the manual. Serious students of the *DSM* conceptualization should review these books to understand how the change process played out and what was cast aside to perhaps be considered in the next era of DSM changes.

**Major Changes**

The major *DSM-5* changes publicly announced to date are the following:

*Organization of the Manual:* According to the APA release, the manual will have approximately the same number of disorders as the *DSM-IV*. The manual is composed of three sections: Section 1 contains an introduction to the *DSM-5* and information on how to use the updated manual. Section 2 lists categorical diagnoses using a significantly revised chapter organization with an increase from 16 to 20 categories of disorders. Section 3 includes conditions that require further research before they can be considered as formal disorders, as well as cultural concepts of distress and the names of individuals involved in *DSM-5*’s development.

*Coding of Disorders:* The coding system reportedly will change to be consistent with the *ICD-10-CM* changes that are to be released in October 2013. Indications are this change will result in the use of a seven-digit code that replaces the current five-digit coding system. This may result in alteration of the codes again in 2015 when the *ICD-11* is scheduled to be released. There are rumors that an e-version of the *DSM-5* may be developed so the manual can be updated as new information becomes available. In other words, *DSM* revisions may become an ongoing process rather than a periodic event. An open-revision process will most likely present new opportunities and challenges for users of the *DSM*. Also, the American Medical Association Clinical Procedure Codes changed on January 1, 2013 (See AMA, 2013). Any social workers reimbursed by insurance companies for mental health services will need to become familiar with the new codes. Websites are available to assist in making this transition. Some of the websites limit access to psychiatrists only.

*Diagnostic Recording Procedures:* APA reports that the multiaxial system will be replaced by “nonaxial” documentation of diagnosis in *DSM-5*. The former Axes I, II, and III will be combined and there will be separate notations for psychosocial and contextual factors (formerly
Axis IV) and disability (formerly Axis V). The change in the psychosocial factors will be of particular interest for social workers. The Axis IV “Psychosocial/Environmental Problems” (PEPs) have been part of the DSM system since the release of the DSM III. For 30 years, the PEPs provided a way to record as part of diagnosis the impact of psychosocial problems that are paramount in the interventions made by social workers. Interestingly, the DSM-III-R conceptualized Axis IV as “Severity of Psychosocial Stressors” that were measured on a six-point scale in seven areas. This scale was a concise empirical, evidence-based measure. With the emphasis placed on severity measures in the DSM-5 field trials, it is hoped the DSM-5 will introduce precise measures that go beyond the system used in the DSM-III-R that eroded in the DSM-IV and DSM-IV-TR.

**Minor Changes**

The following is a very brief summary of the other publicly announced changes to the DSM system. For more details see the APA News Release (American Psychiatric Association, 2012).

**Title Change:** The Roman numeral use in the DSM title has been discontinued. The official title is “DSM-5.” The APA reports at that after DSM-5 is published changes prior to the manual’s next complete revision will be signified as DSM-5.1, DSM-5.2 and so on.

**Autism Spectrum Disorder:** The new autism criteria will combine several diagnoses from the DSM-IV-TR into the diagnosis of autism spectrum disorder.

**Binge Eating Disorder:** This disorder will be moved from the DSM-IV-TR Appendix B to DSM-5 Section 2.

**Disruptive Mood Disregulation Disorder:** This disorder will be added to DSM-5 to diagnose children who exhibit persistent irritability and frequent episodes of behavior outbursts three or more times a week for more than a year.

**Excoriation (skin-picking) Disorder:** This new disorder will be in the Obsessive-Compulsive and Related Disorders chapter.

**Hoarding Disorder:** This disorder is new to DSM-5. The disorder focuses on people with persistent difficulty discarding or parting with possessions, regardless of their actual value.

**Pedophilic Disorder:** The criteria for this disorder will be unchanged, but the disorder name will be revised from pedophilia to pedophilic disorder.

**Personality Disorders:** The categorical model and criteria for the 10 personality disorders included in DSM-IV will remain. New trait-specific methodology will be added in section 3 to encourage study of how the methodology could be used to clinically diagnose personality disorders.

**Posttraumatic Stress Disorder (PTSD):** This disorder will be moved to a new chapter on Trauma- and Stressor-Related Disorders. There will be increased focus on behavioral symptoms that accompany PTSD. DSM-5 will have four diagnostic clusters instead of current three clusters.
The PTSD diagnostic criteria will be more developmentally sensitive for children and adolescents.

**Removal of Bereavement Exclusion:** The DSM-IV-TR exclusion criterion applied to people experiencing depressive symptoms lasting less than two months following the death of a loved one has been removed and replaced by several notes within the text delineating differences between grief and depression.

**Specific Learning Disorder:** This disorder broadens DSM-IV-TR criteria to represent distinct disorders that interfere with acquisition and use of one or more academic skills (oral language, reading, written language, or mathematics).

**Substance Use Disorder:** This disorder will combine the DSM-IV-TR categories of substance abuse and substance dependence. In this singular disorder format, the criteria have been combined and strengthened. Previous substance abuse criteria required one symptom. The DSM-5 mild substance use disorder will require two to three symptoms.

**Culture and DSM-5**

The DSM-IV had the first official recognition of the role of culture in diagnosing mental illness in its Appendix I, which contained a Glossary of Cultural Bound Syndromes and an Outline of Cultural Formulation. The appendix provided a method of categorizing and narratively defining culturally bound disorders that parallel, but did not precisely fit, DSM defined disorders. The Appendix I needed updating, but appears to have been eliminated from the DSM-5. There are reports that the DSM-IV cultural formulation is being replaced with the Cultural Formulation Interview (CFI), which is a 14-item, structured clinical interview to be administered during a patient’s initial assessment. The CFI is reportedly designed to make cultural formulation quicker and easier. Sample questions from the CFI are:

- **Question 1:** What problems or concerns bring you to the clinic?
- **Question 3:** People often understand their problems in their own way, which may be similar or different from how doctors explain the problem. How would you describe your problem to someone else?
- **Question 7:** Is there anything about your background, for example your culture, race, ethnicity, religion or geographical origin that is causing problems for you in your current life situation? (Lewis-Fernández, 2009)

Some have questioned the use of the CFI without collateral information from family members and associates of the patient. Also, concern has been expressed about whether the CFI differentiates content for specific cultures. The CFI was tested as part of the DSM-5 field trials. If the CFI is used in the DSM-5, social workers will need to carefully assess their utilization of the CFI because of our extensive service to clients from various cultures.

**Implementation of the DSM-5**

There are likely many changes in the DSM-5 organization and structure that we will not be able to anticipate in advance of the manual’s publication. Many questions remain about the details of the alterations that will require adjustments of performing diagnosis in the daily practice of mental health treatment and psychotherapy. The APA has not released any information on the implementation of the DSM-5. Most likely, as with past editions of the DSM, there will not be a
mandate requiring use of the DSM system. In the past, new editions of the DSM have had varying degrees of initial acceptance and utilization. Given the increased learning curve for mental health practitioners and the computer processing adjustments that will have to be made by payers, the DSM-5 utilization transition period may be longer than in the past.

Dr. Munson is Professor of Social Work at the University of Maryland School of Social Work. He is author of the Mental Health Diagnostic Desk Reference that is a guide to using the DSM-IV-TR and he participated in the American Psychiatric Association field trials for the DSM-5. Dr. Munson is currently working on a new edition of his book for use with the DSM-5.

References


