Introduction to DSM-5

Paul O’Leary, M.D.
Mark Haygood, D.O., M.S.
DSM-5: Classification, Criteria, and Use
Purpose

This course is for clinicians who are already familiar with DSM-IV-TR, its content, and its use. This presentation is solely to facilitate transition from DSM-IV-TR to DSM-5 and is not intended to be a basic course on DSM-5.
DSM-5 Revisions: Brief History and Conceptual Approaches
ICD-8-9 and DSM-II

1. 1967-1972 US-UK study: demonstrated need for common definitions (incorporated in semi-structured PSE interview) for clinicians to eliminate wide national variations in diagnosis. DSM-II had glossary in 1968
In contrast to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-II), in which the diagnostic classification is based upon the “best clinical judgement and experience” of a committee and its consultants, this communication will present a diagnostic classification validated primarily by follow-up and family studies. The following criteria for establishing diagnostic validity in psychiatric illness have been described elsewhere and may be divided into five phases.8

Diagnostic Criteria

Primary Affective Disorders.6-16
—Depression.—For a diagnosis of depression, A through C are required.

A. Dysphoric mood characterized by symptoms such as the following: depressed, sad, blue, despondent, hopeless, “down in the dumps,” irritable, fearful, worried, or discouraged.

B. At least five of the following criteria are required for “definite” depression; four are required for “probable” depression. (1) Poor appetite or weight loss (positive if 2 lb a week or 10 lb or more a year when not dieting). (2) Sleep difficulty (include insomnia or hypersomnia). (3) Loss of energy, eg,
ICD-9 and DSM-III

• 1977 ICD-9: Glossary of symptom definitions

• 1978 Spitzer et al. modified and expanded Feighner to create the Research Diagnostic Criteria (RDC) and SADS Interview

• 1980 DSM-III—went beyond glossary of symptoms to explicit criteria sets based on RDC
DSM-III and ICD-9 Impact on Diagnostic Instrument Development

• 1979 Robins et al. developed NIMH Diagnostic Interview Schedule (DIS) incorporated DSM-III criteria for use in ECA

• 1982 Spitzer et al. developed the Structured Clinical Interview for DSM (SCID)
  – Emerged as a standardized instrument for clinical research in U.S. and abroad
Impact of DSM-III on International Collaboration

• ADAMHA-WHO Collaboration (1980-94)
  • 14 international Task Forces examined approaches of national “schools” of psychiatry
  • Copenhagen Conference, April 1982: 150 participants from 47 countries
    • Resulted in joint WHO/ADAMHA/APA effort to develop DSM-IV and ICD-10; CIDI, SCAN, and IPDE. ICF was next phase
Conceptual Development of DSM

DSM-I
Presumed etiology

DSM-II
Glossary definitions

DSM-III
Reconceptualization
Explicit criteria
(emphasis on reliability rather than validity)

DSM-III-R
Criteria broadened
Most hierarchies dropped

DSM-IV
Requires clinically significant distress or impairment

DSM-5
New approaches considered
(dimensional, spectra, developmental, culture, impairment thresholds, living document)

DSM-III Hierarchy

• DSM-III showed that greater reliance on explicit criteria drastically improved diagnoses’ dependability and consistency.

• However, it introduced a system in which a “higher-order” disorder subsumed all “lower-order” disorders in the following hierarchy:
  – traumatic/infections brain diseases,
  – schizophrenia,
  – manic-depressive disorder,
  – major depression,
  – anxiety disorders,
  – somatization disorder (multiple unexplained physical symptoms),
  – substance use and personality disorders.
The Conceptual Development of DSM-V

Am J Psychiatry 166:6, June 2009

- **DSM-III-R**: Hierarchical arrangement partially abandoned, but...

- **DSM-IV**: Strict separation between disorders continues

- **DSM-5**: Dimensional Metrics
Perceived Shortcomings in DSM-IV

♦ High rates of comorbidity
♦ High use of –NOS category
♦ Treatment non-specificity
♦ Inability to find a laboratory markers/tests
♦ DSM is starting to hinder research progress
New Developments

Pressures to improve “validity”

Move toward an “etiologically based” classification

Are there data in these areas that can be helpful in developing/changing/refining diagnoses?

- Cognitive or behavioral science
- Family studies and molecular genetics
- Neuroscience—NIMH RDoC Program
- Functional and structural imaging

Requires a Shift
Neo-Kraepelinian to ??
Strategies for Improving DSM

• Incorporate research into the revision and evolution of the classification

• Move beyond a process of clinical consensus and build diagnoses on a foundation of empirical findings from scientific disciplines

• Seek multidisciplinary, international scientific participation in the task of planning the DSM-5 revision
APA/WHO/NIH Diagnosis Research Planning Conferences: Participant Distribution

- 397 Participants
- 39 Countries
- 16 Developing Nations
- 51% Non-US Participants
- 10% Developing Nation Participants
DSM-5 Conference Output

- 13 Conferences (2003-08)
- 10 monographs published
  - Dimensional Models of Personality Disorders
  - Diagnostic Issues in Substance Use Disorders
  - Diagnostic Issues in Dementia
  - Dimensional Approaches in Diagnostic Classification
  - Stress-Induced and Fear Circuitry Disorders
  - Somatic Presentations of Mental Disorders
  - Deconstructing Psychosis
  - Depression and GAD
  - Obsessive-Compulsive Behavior Spectrum Disorders
  - Public Health Aspects of Psychiatric Diagnosis

- More than 200 journal articles published

DSM-5 Development

DSM-5 Task Force
(appointed 2006-2007)

Work group chairs
Health professionals from stakeholder groups

DSM-5 Work Groups
(appointed 2007-2008)
Members work in specific diagnostic areas (e.g., Mood Disorders, Anxiety Disorder, etc.)
Advisors for work groups

For more information, visit www.dsm5.org
DSM-5 Work Groups and Chairs

- ADHD & Disruptive Behavior Disorders (David Shaffer, M.D.)
- Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders (Katharine Phillips, M.D.)
- Disorders in Childhood and Adolescence (Daniel Pine, M.D.)
- Eating Disorders (Timothy Walsh, M.D.)
- Mood Disorders (Jan Fawcett, M.D.)
- Neurocognitive Disorders (Dan Blazer, M.D.; Ron Petersen, M.D. [Co-Chair]; Dilip Jeste, M.D. [Chair Emeritus])
- Neurodevelopmental Disorders (Susan Swedo, M.D.)
- Personality and Personality Disorders (Andrew Skodol, M.D.)
- Psychotic Disorders (William Carpenter, M.D.)
- Sexual and Gender Identity Disorders (Kenneth Zucker, Ph.D.)
- Sleep-Wake Disorders (Charles Reynolds, M.D.)
- Somatic Distress Disorders (Joel Dimsdale, M.D.)
- Substance-Related Disorders (Charles O’Brien, M.D., Ph.D.)

Cross-Cutting Study Groups and Chairs

- Diagnostic Spectra (Steven Hyman, M.D.)
- Life Span Developmental Approach Study Group (Susan K. Schultz, M.D.)
- Gender and Cross-Cultural Study Group (Kimberly Yonkers, M.D.)
- Psychiatric/General Medical Interface Study Group (Lawson Wulsin, M.D.)
- Impairment and Disability Assessment (Jane S. Paulsen, Ph.D.)
- Diagnostic Assessment Instruments (Jack D. Burke, Jr., M.D., M.P.H.)
DSM-5 Classification Structure
DSM-5 Structure

- Section I: DSM-5 Basics
- Section II: Essential Elements: Diagnostic Criteria and Codes
- Section III: Emerging Measures and Models
- Appendix
- Index

Section I

♦ Brief DSM-5 developmental history
♦ Guidance on use of the manual
♦ Definition of a mental disorder
♦ Cautionary forensic statement
♦ Brief DSM-5 classification summary
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

Section III: Purpose

• Section III serves as a designated location, separate from diagnostic criteria, text, and clinical codes, for items that appear to have initial support in terms of clinical use but require further research before being officially recommended as part of the main body of the manual.

  – This separation clearly conveys to readers that the content may be clinically useful and warrants review, but is not a part of an official diagnosis of a mental disorder and cannot be used as such.
Section III: Content

Section III: Emerging Measures and Models

- Assessment Measures
- Cultural Formulation
- Alternative DSM-5 Model for Personality Disorders
- Conditions for Further Study
Section III: Content

Section III, Conditions for Further Study

– Attenuated Psychosis Syndrome
– Depressive Episodes With Short Duration Hypomania
– Persistent Complex Bereavement Disorder
– Caffeine Use Disorder
– Internet Gaming Disorder
– Neurobehavioral Disorder Due to Prenatal Alcohol Exposure
– Suicidal Behavior Disorder
– Non-suicidal Self-Injury
Appendix: Content

♦ Separate from Section III will be an Appendix, which will include

  - Highlights of Changes From DSM-IV to DSM-5
  - Glossary of Technical Terms
  - Glossary of Cultural Concepts of Distress
  - Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)
  - Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)
  - Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM)
  - DSM-5 Advisors and Other Contributors

Changes in Specific DSM Disorder Numbers; Combination of New, Eliminated, and Combined Disorders (net difference = -15)

<table>
<thead>
<tr>
<th></th>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Mental Disorders*</td>
<td>172</td>
<td>157</td>
</tr>
</tbody>
</table>

* NOS (DSM-IV) and Other Specified/Unspecified (DSM-5) conditions are counted separately.

New and Eliminated Disorders in DSM-5
(net difference = +13)

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
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—PDD-NOS is in the NOS count)

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, & Pain Disorder)

8. **Insomnia Disorder** (Primary Insomnia & Insomnia Related to Another Mental Disorder)

9. **Hypersomnolence Disorder** (Primary Hypersomnbia & Hypersomnbia 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 and Alcohol Dependence)
13. Cannabis Use Disorder (Cannabis Abuse and Cannabis Dependence)
14. Phencyclidine Use Disorder (Phencyclidine Abuse and Phencyclidine Dependence)
15. Other Hallucinogen Use Disorder (Hallucinogen Abuse and Hallucinogen Dependence)
16. Inhalant Use Disorder (Inhalant Abuse and Inhalant Dependence)
17. Opioid Use Disorder (Opioid Abuse and Opioid Dependence)
18. Sedative, Hypnotic, or Anxiolytic Use Disorder (Sedative, Hypnotic, or Anxiolytic Abuse and Sedative, Hypnotic, or Anxiolytic Dependence)
19. Stimulant Use Disorder (Amphetamine Abuse; Amphetamine Dependence; Cocaine Abuse; Cocaine Dependence)
20. Stimulant Intoxication (Amphetamine Intoxication and Cocaine Intoxication)
22. Substance/Medication-Induced Disorders (aggregate of Mood (+1), Anxiety (+1), and Neurocognitive (-3))
Changes from NOS to Other Specified/Unspecified

(net difference = +24)

<table>
<thead>
<tr>
<th></th>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOS (DSM-IV) and Other Specified/Unspecified (DSM-5)</td>
<td>41</td>
<td>65</td>
</tr>
</tbody>
</table>

Other Specified and Unspecified Disorders in DSM-5 replaced the Not Otherwise Specified (NOS) conditions in DSM-IV to maintain greater concordance with the official International Classification of Diseases (ICD) coding system. This statistical accounting change does not signify any new specific mental disorders.