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What's new with DSM-5? (formerly known as DSM-V)

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After reading this article participants will be able to list proposed changes to the DSM-5 and describe where to find more information on DSM-5. This article offers an overview of new directions which may be taken with the DSM-5.

Course Outline:

Introduction- "working out the bugs"

Learning Disabilities and Intellectual Disability (i.e. goodbye Mental Retardation)

Changes to the Pervasive Developmental Disorders (i.e. "Goodbye" Aspergers Disorder)

ADHD, ODD, Pediatric Bipolar Disorder and Temper Dysregulation Disorder with

Dysphoria

Conduct Disorder- "psychopathy's minor leagues"

Non-suicidal Self Injury

Neurocognitive Disorders

Substance Use

Sexual and Gender Identity Disorders

Attenuated Psychotic Symptoms Syndrome and changes to Schizophrenia

Chronic Depressive Disorder

Mixed Anxiety Depression

Premenstrual Dysphoric Disorder

Hoarding Disorder

Posttraumatic Stress Disorder in Preschool Children

Other Proposed Changes to Mood and Anxiety Disorders

Agoraphobia and/or Panic

Complex Somatic Symptoms

Dissociative Disorders

Eating Disorders

Sleep Disorders

Personality Disorders- traits in a state of flux

Conditions proposed by outside sources

Cross-Cutting Issues

Conclusions

Introduction- “working out the bugs”

Nothing has been set in stone yet, however in February, 2010 the American Psychiatric Association released draft proposals for the next edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The DSM lists the criteria for recognized diagnoses in American psychiatry. Just prior to releasing the proposals, the official publication date of the next edition was delayed one year and is now scheduled for May, 2013. The DSM-5 field trials also got a much later start than had been previously anticipated. There has not been a substantial update of the actual diagnostic criteria since DSM-IV was published in 1994. There will still be additional research and committee meetings to determine the exact appearance of DSM-5, however some things have been made fairly clear via the website at DSM5.org, public discussions and published articles. Some proposals, new disorders and criteria changes continue to be debated. In addition, even after the initial publication of DSM-5, the American Psychiatric Association has indicated a desire to make more frequent updates when needed to specific portions of the DSM without needing to wait for a whole scale revision of the manual.

The naming of DSM-V has officially been changed to DSM-5 by the American Psychiatric Association. Much like how numerical versions of computer software work, one may wish to view DSM-5 as DSM-“5.0” given that it may continue to be updated piece by piece even after its 5/2013 official publication.

Learning Disabilities and Intellectual Disability (i.e. goodbye Mental Retardation)

Even well before the signing of Rosa’s Law by President Obama in late 2010 changed the federal government’s use of Mental Retardation (MR) to Intellectual Disability, there has been a movement to end the use of “retard” and the MR term which is seen as stigmatizing. In keeping with current trends, the DSM-5 work group has also proposed to change the term from MR to Intellectual Disability. The proposal also includes wording recommending the use of standardized measures of adaptive behaviors in the diagnosis (in addition to IQ).

The workgroup has also proposed changes to Learning Disorders. For one, the naming may be changed to “learning disabilities.” In addition, the DSM-5 work group proposals note that *“the diagnostic criteria do not depend upon comparisons with overall IQ and are consistent with the change in the USA’s reauthorized IDEA regulations (2004) which state that: “the criteria adopted by the State must not require the use of a severe discrepancy between intellectual ability and achievement for determining whether a child has a specific learning disability, as defined in 34 CFR 300.8(c)(10).”*

The work group has also proposed the use of terms like “Dyslexia” and “Dyscalculia” over the current DSM-IV Reading Disorder and Mathematics Disorder. These and other potential name changes may be impacted by international use and a movement to be more similar to the ICD terminology.

Changes to the Pervasive Developmental Disorders (i.e. “Goodbye” Aspergers Disorder?)

Would Aspergers disorder by any other name smell as sweet? Perhaps not if that name is “Autism.” Many families and patients who sometimes refer to themselves as “Aspies” may prefer to see the differences in what they typically view as Autism, however the DSM-5 is focusing on the dimensional similarities and may cluster these disorders together. Aspergers Disorder, which was first introduced in to the DSM in 1994, will likely be shown the door in

DSM-5. However, it may also become a coded sub-type of Autistic Spectrum Disorder. So too will many of the other pervasive developmental disorder categories such as pervasive developmental disorder NOS and Childhood Disintegrative Disorder be lumped in to the “spectrum.” They will likely be folded together with Autism in to a broader “Autistic Spectrum Disorder” dimension. Rett’s disorder has simply been proposed to be removed primarily because it has a generally known etiology and can not be lumped in as easily with other Autistic Spectrum Disorders. The fact that we know more about Retts than other “autistic” presentations may be the main reason for the proposal to eliminate it from the DSM-5. This should not be confused with limited support for the diagnosis, though the APA’s actions could do more harm than good in this respect. For example, Rett’s syndrome is actually one of the few disorders in the DSM-IV which participates in the compassionate allowance initiative for social security disability benefits. If awareness of the disorder is reduced it may take longer for patients to receive the assistance that they need. However, no one will argue that every known syndrome should be included in the DSM-5. For example, Down Syndrome is not included in the DSM though MR/Intellectual Disability is.

ADHD, ODD, Pediatric Bipolar Disorder and Temper Dysregulation Disorder with Dysphoria

In order to resolve confusion in making differential diagnoses in children between pediatric bipolar disorder, oppositional defiant disorder (ODD), Attention Deficit/Hyperactivity Disorder (ADHD), and disruptive behavior disorder NOS, why not add one more diagnosis to the mix? Given the plethora of kids being diagnosed with Bipolar Disorder NOS with the prominent symptoms noted in the proposed Temper Dysregulation Disorder with Dysphoria, it may not be as crazy as it sounds. If you’ve ever met them you would know, however, that these are a group of children with severe problems, and it should in no way be comically reduced to kids who “just have a temper.” In addition, there are age specifiers proposed for onset to attempt to weed out behaviors which may be closer to typical development. The “terrible twos” can not be diagnosed in a 6 year old, for example, which is the earliest age at which the proposed diagnosis can be made. The Temper Dysregulation Disorder with Dysphoria proposal is anchored on research in to severe mood dysregulation in children.

Conduct Disorder- *“psychopathy’s minor leagues”*

A “callous and unemotional” specifier has also been proposed for conduct disorder, so that it may be easier to point out the children with a tendency toward psychopathy.

Non-suicidal Self Injury

You've probably heard all about "cutting" behavior, and it along with other self-injurious acts will likely be given their very own diagnosis: Non-suicidal Self Injury. While self-mutilation may often be associated with Borderline Personality Disorder, it also can co-occur with many other difficulties.

Reactive Attachment Disorder

It has been proposed that Reactive Attachment Disorder be split in to two separate diagnoses (as opposed to the 2 types it previously had). There would be "RAD" as well as the newly proposed Disinhibited Social Engagement Disorder. These disorders are impairments in attachment behaviors which by their criteria result from "pathogenic care." In RAD children do not typically seek out the comfort of others whereas in DSED they will approach and interact with strangers.

Neurocognitive Disorders

Cognitive Disorder NOS, Amnesic Disorder and Dementia have been proposed to simply become Minor Neurocognitive Disorder and Major Neurocognitive Disorder. An alzheimers subtype of the neurocognitive disorders is also proposed. These disorders represent declines from previously higher cognitive functioning.

Substance Use

Under DSM-IV, there is a distinction made between abuse and dependence and these are noted to be separate diagnostic categories. The abuse and dependence diagnoses will simply be coded together as a substance "use" disorder. For example, instead of Alcohol Dependence and Alcohol Abuse, (or Alcoholism), the proposal is for an Alcohol-Use Disorder.

In addition, behavioral addictions will be added such as pathological gambling (once an impulse control disorder). You may also look for internet addiction to possibly appear in the appendix

for further research. However, the concept of “sexual addiction” will likely appear not as an “addiction” but under the proposed Hypersexual disorder.

Sexual and Gender Identity Disorders

While a sexual addiction was proposed, the DSM-5 task force has added instead a proposed “Hypersexual Disorder” which reflects repeated, intense fantasies, urges and behaviors.

Paraphilic Coercive Disorder is another new, proposed diagnosis which involves fantasies of sexual coercion, forcing sex on others.

It is possible that “Pedophilia” may be renamed Pedohebephilic Disorder. This will have additional specifiers:

Pedophilic Type—Sexually Attracted to Prepubescent Children (Generally Younger than 11)

Hebephilic Type—Sexually Attracted to Pubescent Children (Generally Age 11 through 14)

Pedohebephilic Type—Sexually Attracted to Both

You would also code whether there was attraction to males, females or both.

The work group has also proposed other minor name changes in this area (learn more at DSM5.org).

Attenuated Psychotic Symptoms Syndrome and changes to Schizophrenia

A “psychosis risk syndrome,” or prodromal schizophrenia, may be included for further research and is designed to identify young people at risk for the development of schizophrenia or other psychotic disorders.

Catatonia may also be added as a specifier for many disorders.

The subtypes of Schizophrenia (Catatonic, Residual, Undifferentiated, Disorganized and Paranoid type) may be removed from the DSM, leaving us with simply “Schizophrenia.” This will

make all of those people who still remember the “CRUD-P” mnemonic wish they could stop remembering it. We also may lose the term “paranoid schizophrenia,” though in all likelihood such uses would not end.

Chronic Depressive Disorder

Ever hear of Chronic Depressive Disorder? That’s right chronic depression under the DSM-5 may become more simple and with fewer arbitrary exclusion criteria. The proposal is to rename Dysthymic Disorder to Chronic Depressive Disorder while also dropping some exclusion criteria such as not having a major depressive episode in the first two years. In addition, the chronic specifier for major depressive disorder will also be dropped in favor of Chronic Depressive Disorder. Given that there are two distinctly different criteria sets for the former dysthymia and chronic major depressive disorder, it’s not fully clear how this will be resolved dimensionally at this point. However, what is clear is that chronic depression tends to be similar across these diagnoses and attempting to include them together simply makes sense.

Individuals with chronic depression (whether dysthymia or a major depression that is chronic) tend to have more functional problems in their daily life and require a longer course of treatment than those with depression that has not become chronic. There may be similar underlying processes and the extent that stable tendencies such as those reflected by Neuroticism/Negative Emotionality is at work in this and other disorders should be considered.

Mixed Anxiety Depression

The DSM-IV included “Mixed Anxiety-Depressive Disorder” in the appendix for further research. The current taskforce has proposed an amended “Mixed Anxiety Depression.” The proposals suggests that the patient has three or four of the symptoms of major depression (which must include depressed mood and/or anhedonia), and they are accompanied by anxious distress. The symptoms must have lasted at least 2 weeks, and no other DSM diagnosis of anxiety or depression must be present, and they are both occurring at the same time. Anxious distress is defined as having two or more of the following symptoms: irrational worry, preoccupation with unpleasant worries, having trouble relaxing, motor tension, fear that something awful may happen.” This criteria reflects revisions from the MADD proposal in DSM-IV.

Given the popularity of adjustment disorder with Mixed Anxiety and Depressed Mood and comorbid anxiety disorder nos and depressive disorder nos, this diagnosis may be welcomed by practitioners. It is certainly not an unwelcome proposal given the high number of patients with both anxious and depressive symptoms.

Premenstrual Dysphoric Disorder

It was only a matter of time. PMDD has been proposed for inclusion in to DSM-5. The criteria for PMDD includes *“In most menstrual cycles during the past year, five(or more) of the following symptoms occurred during the final week before the onset of menses, started to improve within a few days after the onset of menses, and were minimal or absent in the week postmenses, with”* at least one of the criteria noted to be one of the first 4 mood/anxiety related criteria they list (see DSM5.org for the full criteria).

Agoraphobia and/or Panic

The with and without agoraphobia specifiers for panic disorder may be dropped, and agoraphobia included as a separate diagnosis regardless of panic disorder. In addition, anxiety disorders including hoarding disorder, skin picking disorder, and *“olfactory reference syndrome”* have been proposed. Body Dysmorphic Disorder and Trichotillomania (Hair-pulling disorder) may be reclassified as an Anxiety and Obsessive Compulsive Spectrum Disorder.

Hoarding Disorder

Individuals with hoarding behaviors may not only have their own TV show, they may soon get a new diagnosis. Patients with *“difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions”* with *“strong urges to save items and/or distress associated with discarding”* may qualify for the diagnosis. This may also result in *“The symptoms result in the accumulation of a large number of possessions that fill up and clutter active living areas of the home or workplace to the extent that their intended use is no longer possible. If all living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).”*

Other Proposed Changes to Mood and Anxiety Disorders

The specifier of “mixed episode” for mood disorders is being looked at and may be replaced with a “mixed features” approach. Similarly, Bipolar disorder with most recent episode mixed may be dropped.

Depressive Disorder NOS (Not otherwise specified) may be renamed to “Depressive Conditions Not Elsewhere Classified” or Depressive CNEC. This may depend on the overall structure of the DSM and decisions related to making it more consistent with the ICD. There are separate categories of Depressive CNEC suggested such as “Depressive CNEC with insufficient information to make a diagnosis,” “Subsyndromal Depressive CNEC,” and “other Depressive CNEC.” This can assist in clarifying why a depressive disorder NOS / depressive disorder NEC diagnosis was made. The subsyndromal or subthreshold depression specifier includes examples of prodromal depression in individuals with a past history of major depressive episodes and depression which does not quite meet the criteria for another diagnosis. Similarly, Anxiety Disorder NOS may become Anxiety Disorder “NEC” (which is more consistent with the ICD terminology). There are additional recommendations that will “be forthcoming” to the dsm5.org website as noted under the Anxiety Disorder NOS section. With the exception of Depressive Disorder NOS, it would appear most NOS categories have been proposed to be changed to NEC similar to the ICD.

Developmental manifestations, or separate age-specific expressions of diagnostic criteria, may be included in DSM-5 for some disorders such as PTSD. There may be separate criteria for a preschool PTSD and “developmental trauma disorder” may also receive consideration. In these instances it is suggested that disorders may look differently in young children. As an example of this, the work group has proposed separate criteria for Posttraumatic Stress Disorder in Preschool Children.

Adjustment disorders may also cease to be its own category and join Trauma and Stress Related Disorders.

Complex Somatic Symptoms

Factitious Disorder and Somatoform disorders like Somatization Disorder, Undifferentiated Somatoform Disorder, Pain Disorder and Hypochondriasis have been proposed to be lumped together as Complex Somatic Symptom Disorder. There will be optional specifiers to help resolve the different presentations.

The work group noted on the DSM-5 website that they intend to “de-emphasize” medically unexplained symptoms due to the unreliability of making these distinctions. This “*de-emphasis of medically unexplained symptoms would pertain to somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder. We now focus on the extent to which such symptoms result in subjective distress, disturbance, diminished quality of life, and impaired role functioning.*”

Dissociative Disorders

Some minor changes to the dissociative disorder criteria have been proposed, including moving dissociative fugue in to a subtype of dissociative amnesia and revising some of the criteria of dissociative identity disorder (formerly multiple personality disorder).

Eating Disorders

A Binge eating disorder has been proposed with recurrent episodes of binge eating.

Sleep Disorders

A number of sleep disorders have been proposed for inclusion in to the DSM-5, including a Disorder of Arousal (includes the former sleepwalking and sleep terror disorders) and Restless Leg Syndrome.

Personality Disorders- *traits in a state of flux*

Are personality disorders dying? It’s possible that many of the specific personality disorders from DSM-IV will. Perhaps one of the biggest proposed changes and signaling a trend in moving

towards a more dimensional view of disorders (as opposed to disorders as separate and distinct categories that are not related), is the the DSM-5 personality disorder system including the use of specific personality traits proposed. All DSM-IV personality disorders have been “recommended for reformulation.” The proposed “personality disorders” section under DSM-5 may be seen as a test case in moving other diagnoses to more dimensional criteria. The current proposals may also be seen as a temporary compromise between researchers who feel the personality disorders (and in particular the “clusters” noted in DSM-IV) lack scientific merit and are removed from more “normal” personality disorder research and theory. Some suggest that the concept of a personality disorder may need to be removed entirely and replaced with a representation of different degrees of personality traits which may impact an individual’s presentation. How these will be specifically coded remains to be seen.

The current proposal includes (at this time) 5 personality disorder “types.” These are the “Antisocial/Psychopathic type,” the “Avoidant type,” the “Borderline type,” the “Obsessive-Compulsive type,” and “Schizotypal type.” The work group did not propose using specific types representing other personality disorders from DSM-IV but did note potential personality traits associated with each. There will be “type ratings” in which the clinician proposes the extent to which a person fits the type, however at this time there appears to be few guidelines or specific anchors that would allow this to be done in a standardized fashion. There appears to be disagreement on the work group between those who wish to maintain “types” and those who want to move to only coding specific personality traits and facets.

Do you like to diagnose Personality Disorder NOS? While Personality Disorder NOS as we know it will be removed, all Personality Disorders may become Personality Disorder NOS, and from DSM-5 on no personality disorder will likely be diagnosed “Personality Disorder NOS” (or even NEC). Instead of Personality Disorder NOS, the specific personality traits and facets (much like a specific “sub-trait” or component of a trait) may be described on a single personality disorder diagnosed on Axis I. Every patient with a personality disorder may receive a “specific trait profile,” recognizing that there can be many variations and combinations of personality traits and facets under the sun. The 5 suggested personality disorder “types” that include some of the old names of former personality disorders can be viewed as simply one suggested profile of a personality disorder. There could be and are many others. For example, under the depressive personality disorder category the task force recommends a profile of the prominent traits/facets of “Pessimism, Anxiousness, Depressivity, Low Self-esteem, Guilt/Shame, Anhedonia.” The extent to which future “personality types” (ex: “depressive type,” “histrionic type,” “Negativistic type,” etc.) will be developed, standardized and included to be coded as

short-hand remains to be seen. There is a number of research studies comparing personality disorders with their results on the NEO-PI-R, however it's not entirely clear at this point the full relevance of the traits and facets of the NEO-PI-R to the traits and facets proposed for DSM-5. There are also other psychological tests authored by work group members such as the SNAP-2 and DAPP-BQ which are similar to the proposed trait/facet structure proposed for DSM-5.

The structure of the personality "disorder" section has been modified from the Five-Factor Model of Personality. The 6 proposed broad personality traits are similar to 4 out of the 5 domains of the Five-Factor model (FFM), however these traits have different names and facets than the FFM and may reflect more of a maladaptive expression of the FFM domains rather than a full range of normal personality (ex: one trait is Negative Emotionality which may be somewhat similar to the FFM's Neuroticism, though the noted facets or component/sub-traits also have different names. The trait Introversion is similar to the FFM's Extraversion but also includes more maladaptively phrased facets. Openness to Experience was not included as it is not viewed as strongly related to personality disorder. As the FFM traits did not cover obsessive compulsive personality disorder (OCPD) or schizotypal personality disorder well, the compulsivity and schizotypy trait domains were added (though the specific names may change prior to publication).

The 6 personality traits proposed, each with multiple components or "facets," are Negative Emotionality, Introversion (technically shyness could be "diagnosed" now), Antagonism, Disinhibition, Compulsivity, Schizotypy. The wording of the traits and facets, including Schizotypy in particular, are still very much subject to change. While the Five Factor Model is often called "the Big Five," the hybrid system for DSM-5 may come to be called the "Pathological Five."

The Personality Disorders may be one area where continued research and debate could have a significant impact on the outcome now and even after the initial publication of DSM-5.

Conditions proposed by outside sources

What do Apathy Syndrome, Body Integrity Identity Disorder, Complicated Grief Disorder, Developmental Trauma Disorder, Disorders of Extreme Stress Not Otherwise Specified, Fetal Alcohol Syndrome, Internet Addiction, Male-to-Eunuch Gender Identity Disorder, Melancholia,

Parental Alienation Disorder, Seasonal Affective Disorder and Sensory Processing Disorder have in common? They didn't make the initial list of proposals anointed by the DSM-5 work groups. However, they are listed as on the radar screen of the framers of DSM-5.

Cross-Cutting Issues

In 1980 the DSM introduced the multiaxial system including Axis II. Axis II is where personality disorders as well as mental retardation (start thinking intellectual disability) are coded. However, to be more consistent with the ICD DSM-5 will likely do away with coding diagnoses on Axis II and III. The DSM-5.org website notes that there is a proposal that *"DSM-5 collapse Axes I, II, and III into one axis that contains all psychiatric and general medical diagnoses. This change would bring DSM-5 into greater harmony with the single-axis approach used by the international community in the World Health Organization's (WHO) International Classification of Diseases (ICD)."*

In addition, the Global Assessment of Functioning Scale (GAF) is seen as problematic and tends to mix both symptom severity and functional severity. Those involved in DSM-5 are considering alternatives to the use of the GAF. DSM-5 may attempt to *"operationalize disability in a way that is more consistent with the World Health Organization's approach in the International Classification of Functioning, Disability and Health (ICF)."*

The DSM-5 will likely continue to move toward a dimensional rather than categorical view of mental disorders. In conjunction with this, we are likely to see an increase in the use of various rating scales. Some of these rating scales may be consistent with screeners and brief psychological measures, while others may simply be subjective assessments of a position on a scale made by the clinician. The extent to which these are implemented remains to be seen.

There is no escaping the fact that there will be many changes in store with DSM-5. PsychContinuingEd.com will continue to develop new courses based on new disorders and other changes with the DSM-5.

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If you are a fast reader and have not yet spent one hour reading this article please finish the hour by reviewing the current state of the proposals in more detail by going to <http://www.DSM5.org>

Quiz Questions

Enter your answers online at <http://www.PsychContinuingEd.com>

You will be asked to answer whether the following statements are True or False (T/F):

- (1) I have reviewed the course materials (must answer T)
- (2) The DSM-5 will likely include “learning disabilities” and “intellectual disability”
- (3) Aspergers and Autistic Disorder may be combined in to “Autistic Spectrum Disorder”
- (4) The APA has proposed to “do away” with Bipolar Disorder entirely.
- (5) A “hypersexual disorder” has been proposed for DSM-5.
- (6) The proposal suggests keeping the subtypes of Schizophrenia.
- (7) Dysthymic Disorder and the chronic specifier of Major Depressive Disorder may be combined in to Chronic Depressive Disorder.
- (8) Substance Abuse and Dependence may be combined in to “Substance Use.”
- (9) Agoraphobia has not been proposed to be split away from panic disorder.
- (10) Personality Disorders will likely see few changes under DSM-5.