Conflict of Interest

- The speakers have no conflicts of interest to disclose
- The speakers will not be discussing off-label uses

Objectives

- Describe the history/timeline of the Diagnostic and Statistical Manual (DSM)
- Compare the DSM-IV-TR organizational structure with the organizational structure of the DSM-5
- Describe major changes to specific diagnostic categories and specific disorders
- Identify the role of psychiatric nurses in the development of the DSM-5

Before the DSM

- 1840 US Census: insane and idiots
- 1880 US Census: mania, melancholia, monomania, dementia, dipsomania
- 1890 Kraepelin organized psychopathology including dementia praecox and manic-depression
- 1893 International Classification of Disease (ICD)
- 1918 American Medico-Psychological Association (former APA). Statistical Manual for the Use of Institutions for the Insane with 22 categories

DSM-I 1952

- Directed by William C. Menninger, a psychiatrist and brigadier general
- Focus on treatment of soldiers
- 70 terms used “Reaction” e.g., Schizophrenic Reaction
- Controversy about being psychoanalytic – used the term unconscious a few times vs. “codified Freudian ideas”
**DSM-II 1968**
- Based on psychoanalytic principles
- Goal of using terms that coincided with ICD-8
- Removed all “reactions”
- A 1974 revision replaced homosexuality with egodystonic homosexuality
- Gap between neurosis and psychosis

**DSM-5 2013**
- Arabic numbers to clarify online revisions (DSM-5.1, DSM-5.2, etc.)
- Goal to decrease number of disorders (297 DSM-IV-TR)
- About the same number of ways to say “You’re not okay”
- Psychobiological dysfunction replaces behavioral, psychological, biological dysfunction

**DSM-III 1980**
- 5 axis
- Terms made consistent with the ICD
- Listed symptoms rather than causes – banished neurosis
- Vast increase in background information
- PTSD added
- 1987 egodystonic homosexuality removed

**Timeline**
- 1999-2007: Development of DSM-5 Pre-Planning white papers,
- 2006-2008: Chairs, work group chairs, and members are appointed and announced
- April 2010 – February 2012: Field trial testing
- October 2011-April 2012: Data analysis of field trials
- Spring 2012: Revisions posted and open to a third public feedback for two months; further edits
- December 31, 2012: Published
- May 18-22, 2013: Released during the APA’s 2013 Annual Meeting in San Francisco, CA

**DSM-IV 1994
DSM-IV-TR 2000**
- Symptoms that caused “clinically significant distress” included
- Retained Freudian-based terms such as fetishism
- Greater international involvement and consultation with other disciplines
- Client centered – patient with schizophrenia
- Many NOS and co-morbidities

**Some of APA’s Selling Points**
- Evidence based (20 years)
- More in-line with International Classification of Disease (ICD)
- Categories ordered based on relatedness
- Neurodevelopmental approach within categories
- Recognizes the influence of gender and culture on the presentation of psychiatric illness
- Dimensional assessments
- Severity rating for symptoms specific to diagnosis
- Severity of symptoms that are present across multiple disorders (e.g., suicide risk, anxiety)
- Biomarkers for some diagnoses (e.g., narcolepsy/hypocretin deficiency)
**Axis I, II, III, IV, V**

“No Scientific Basis”

**DSM-IV-TR**

- **Axis I**: Major mental disorders
- **Axis II**: Personality disorders and intellectual disabilities
- **Axis III**: Acute medical conditions
- **Axis IV**: Environmental factors contributing to the disorder
- **Axis V**: Global Assessment of Functioning Scale

**DSM-5**

- **Simpler**: Collapse I, II, and III and put together to align with ICD codes
- **More complex**: Change IV to match ICD codes – 15 p. checklist
- **Functioning**: World Health Organization’s Disability Assessment Scale (WHODAS)

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**Neurodevelopmental Disorders**

Formerly known as Disorders Usually First Evident in Infancy, Childhood, and Adolescence

- Intellectual Developmental Disorder (formerly mental retardation)
- Communication Disorders
- Autism Spectrum Disorder
- Attention Deficit/Hyperactivity Disorder
- Learning Disorders
- Motor Disorders

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**Changes to Specific Diagnostic Categories within the DSM-5**

**Autism Spectrum Disorders**

Autistic Disorder, Asperger’s Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder NOS

**Specifiers**: Rett Syndrome, Fragile X, Asperger’s

**Levels of Support**:

1. Requires support
2. Requires substantial support
3. Requires very substantial support

**Symptom Onset (previously age 3)**:

Begin in early childhood, but may not be manifest until social demands exceed capacity (e.g. adolescence).

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**Categories of Disorders**

1. Neurodevelopmental
2. Schizophrenia Spectrum
3. Bipolar and Related
4. Depressive
5. Anxiety
6. Obsessive-Compulsive
7. Trauma and Stressor
8. Dissociative
9. Somatic Symptom
10. Feeding and Eating
11. Elimination
12. Sleep-Wake
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse Control, and Conduct
16. Substance Use and Addictive
17. Neurocognitive
18. Personality
19. Paraphilias
20. Other Disorders

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**Attention Deficit/Hyperactivity Disorder**

**DSM-IV-TR**

Hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7

**DSM-5**

- Raising the age of onset before age 12:
  - “...trigger a fad of Adult Attention Deficit Disorder leading to widespread misuse of stimulant drugs.”

~ Allen Frances

Professor Emeritus, Duke University
Chair of DSM-IV Task Force

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Schizophrenia Spectrum Disorders

- Schizotypal Personality Disorder
- Schizophrenia
- Schizoaffective Disorder
- Schizophreniform Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Psychotic Disorder Due to Another Medical Condition
- Substance Induced Psychotic Disorder
- Catatonic Features Specifier
- Catatonia Disorder Due to Another Medical Condition

Bipolar and Related Disorders

Mixed Episodes

**DSM-IV**

- Bipolar I Mixed Episode
  - Simultaneous presence of:
    1. fully manic syndrome
    2. fully depressive syndrome for at least 4 days

**DSM-5**

- Mixed specifier for major depression, hypomania, or mania
  - Simultaneous presence of:
    1. 2 to 3 manic or hypomanic symptoms
    2. fully depressive syndrome for at least 2-3 days

Schizophrenia Spectrum Attenuated Psychosis Syndrome Controversy

**Pro:** People with early psychotic-like symptoms are often diagnosed as depressed or anxious. Early detection of symptoms and treatment can reduce severity and disability

**Con:** Ambiguous diagnosis results in unnecessary alarm and stigmatization; early antipsychotic treatment not helpful in the long-term and exposes people to unnecessary antipsychotic therapy

Moved to Section III for further study

Depressive Disorders

- Disruptive Mood Dysregulation Disorder
  - (old childhood bipolar, onset before age 10)
- Major Depressive Disorder
  - (single and recurrent)
- Dysthymic Disorder
- Premenstrual Dysphoric Disorder (new)

- Substance Induced Depressive Disorder

Bipolar and Related Disorders

Formerly listed under Mood Disorders

- Increased energy/activity has been added as a core symptom of manic and hypomanic episodes

- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder
- Substance Induced Bipolar Disorder
- Bipolar Disorder Associated with Another Medical Condition

Disruptive Mood Dysregulation Disorder

**For**

- Children are being wrongly diagnosed with bipolar disorder
- Accurate treatment is withheld
- Powerful and unnecessary medication is being used

**Against**

- Pathologizing temper tantrums
- Increases the unnecessary use of medication
- Oppositional defiant disorder already covers this problem
- "Fighting a fire with kerosene."

Severe recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation.
Medicalizing Grief
Removing the Bereavement Exclusion

**For**
- Losing a loved one is similar to other losses/stressors in life.
- Treatment delay for severe grief increases the risk of suffering and impairment.
- Criteria for grief could be tightened to reduce false positives.

**Against**
- Losing a loved one is essentially different than other stressors.
- A diagnosis impairs the normal, dignified process of grief and the usual reliance on cultural rituals.
- A variation of normal grief would result in a mental disorder label and unnecessary treatment.

Anxiety Disorders

Changes:
- Agoraphobia a category separate from Panic Disorder
- Obsessive-Compulsive Disorder was moved into its own chapter (next)
- Posttraumatic Stress Disorder added to Trauma and Stressor-Related Disorders
- Separation Anxiety Disorder (not just for kids anymore!)
- Generalized Anxiety Disorder (physical sx lowered from 6-2)
- Panic
- Specific Phobia
- Social Anxiety Disorder

Dissociative Disorders

- Depersonalization-Derealization Disorder
- Dissociative Amnesia
- Dissociative Identity Disorder

Obsessive Compulsive Disorders

- Obsessive-Compulsive Disorder
- Formerly listed with anxiety disorders
- Body Dysmorphic Disorder
- Formerly listed with somatoform disorders
- Hoarding Disorder (new)
- Hair Pulling Disorder (trichotillomania)
- Skin Picking (excoriation) Disorder (new)

Somatic Symptom Disorders

- Formerly known as Somatoform Disorders – all disorders in this group have physical symptoms and/or psychosocial distress.
- Somatic Symptom Disorder - replaces Somatization Disorder, Undifferentiated Somatoform Disorder, and Pain Disorder
- Illness Anxiety Disorder (Hypochondriasis)
- Functional Neurological Symptom Disorder (Conversion Disorder)
- Psychological Factors Affecting Medical Condition
- Factitious Disorder
Feeding and Eating Disorders
- Pica
- Ruminating Disorder
- Avoidant/Restrictive Food Intake Disorder (formerly a childhood disorder)
- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder (new - moved from appendix) - one eating binge per week for three months

Elimination Disorders
- Enuresis
- Encopresis

Sleep-Wake Disorders (formerly Sleep Disorders)
- Insomnia Disorder (Primary insomnia)
- Hypersomnia Disorder (Primary Hypersomnia)
- Narcolepsy/Hypopnea Deficiency
- Obstructive Sleep Apnea
- Hypopnea Syndrome (new)
- Central Sleep Apnea (new)
- Sleep Related Hypoventilation (Sleep-Wake Schedule Disorder)
- Circadian Rhythm Sleep Wake Disorder
- Disorder of Arousal (Sleep Terror)
- Nightmare Disorder (Dream Anxiety)
- Rapid Eye Movement Sleep Behavior Disorder (new)
- Restless Legs Syndrome (new)
- Substance Induced Sleep Disorder

Substance Use and Addictive Disorders
- Alcohol-Related Disorders
- Caffeine-Related Disorders
- Cannabis-Related Disorders
- Hallucinogen-Related Disorders
- Inhalant-Related Disorders
- Opioid-Related Disorders
- Sedative-hypnotic-Related Disorders
- Tobacco-Related Disorders
- Gambling Disorder

Sexual Dysfunction
- Erectile Disorder
- Delayed Ejaculation
- Early Ejaculation
- Male Hypoactive Sexual Desire Disorder
- Genito-Pelvic Pain/Penetration Disorder
- Female Orgasmic Disorder
- Female Sexual Interest/Arousal Disorder
- Female Orgasmic Disorder

Gender Dysphoria (not 'Disorder')
- Gender Dysphoria in Children
- Gender Dysphoria in Adolescents and Older Adults

Disruptive, Impulse Control, and Conduct Disorders
- Oppositional Defiant Disorder
- Intermittent Explosive Disorder (6+ years)
- Conduct Disorder
- Callous and Unemotional Specifier
- Limited Prosocial Emotions Specifier
- Dysocial Personality Disorder (Antisocial Personality Disorder)

Binge-Drinking = Alcoholism

For
- Earlier interventions could nip problem in the bud
- Stop physical problems from occurring
- Save money in the long-run by reducing disability

Against
- 31% of all college students could be labeled alcoholic
- One study suggests that there will be 60% more alcoholic diagnoses with the new criteria
- Scarce resources could be taxed further
- Stigmatizing
- Obliterates distinction between "problem drinkers" and alcoholics
Neurocognitive Disorders

- Delirium
- Mild Neurocognitive Disorders – Modest cognitive decline, functions with effort.
- Major Neurocognitive Disorders – Substantial cognitive decline, independence not possible

Mild and Major types:
- Alzheimer’s, Vascular, Frontotemporal, Traumatic Brain Injury, Lewy Body, Parkinson’s, HIV, Substance Induced, Huntington’s, Prion

Paraphilias

- Exhibitionistic Disorder
- Fetishistic Disorder
- Pedophilic Disorder (formerly pedophilia)
- Sexual Masochism Disorder
- Sexual Sadism Disorder
- Transvestic Disorder
- Voyeuristic Disorder

Previously in the Sexual and Gender Identity chapter
Adds risk-assessing specifiers:
- In a Controlled Environment
- In Remission (no distress, impairment, or recurring behavior for five years in an uncontrolled environment)

Other Disorders

- Non-Suicidal Self Injury Disorder – 5x in one year intentional self-inflicted damage to the surface of the body (new)
- Suicidal Behavior Disorder – within the last two years initiated a behavior in the expectation that it would lead to the individual’s own death (new)

Suicidal Behavior Disorder

For the diagnosis
- Creates a way to track suicide risk
- Distinguishes a disorder from a “symptom”
- Distinguishes between self-injury and suicidal actions (DSM-IV-TR did not)

Against the diagnosis
- We don’t need it.
- Gives another stigma to label a patient with
- Are people suicidal without other symptoms?

Personality Disorders

**DSM-IV-TR**
- Pervasive pattern of thinking/emotionality/behaving
- Ten personality types: antisocial, avoidant, borderline, obsessive-compulsive, schizotypal, paranoid, schizoid, narcissistic, histrionic, dependent, and a not otherwise specified category

**DSM-5**
- Impaired sense of self-identity or failure to develop effective interpersonal functioning
- Six personality types: antisocial/psychopathic, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal types

Transitioning to the DSM-5

- Clinicians began using the diagnostic codes in May 2013
- Insurance companies will make the transition by December 31, 2013
- Insurers can decide to cover or not cover diagnoses
Normal Behavior as a Diagnosis?

- Grief is now Major Depressive Disorder
- Medical illness is now Somatic Symptom Disorder
- Everyday worries are now Generalized Anxiety Disorder
- Forgetting of old age is Mild Neurocognitive Disorder
- Being geeky-smart makes you Autistic
- Gorging is Binge-Eating Disorder
- Behavioral addictions open the door for shopping addiction, sun tanning, etc.

Removing the Axes: Reduced Stigma?

- Personality disorders (Axis II) no longer a separate axis
- Psychiatric disorders (Axis I) and "physical" disorders (Axis III) blended
- Attention deficit hyperactivity disorder
- Bipolar mixed
- Bereavement exclusion
- Generalized anxiety disorder
- Somatic symptom disorder
- First time substance abusers

Easier to Gain Diagnoses

- Attention deficit hyperactivity disorder
- Binge-drinking
- Binge-eating

Could inflation of diagnoses result in decreased stigma?

No Funding for DSM Based Research

April 29, 2013

- "While DSM has been described as a 'Bible'... it is, at best, a dictionary."
- DSM is fairly reliable (clinicians use the same terms in the same way), but lacks validity (not based on well-founded evidence)
- Symptoms dictate diagnoses in the absence of evidence of disease
- Research Domain Criteria (RDoC): A decade-long project to develop a new classification system

Psychiatric Nurses in the Development of the DSM-5

- Compiled comments from the American Psychiatric Nurses Association’s (APNA) membership
- APNA sought and gained member inclusion in clinical field trials
- "Recruitment of a volunteer sample of clinicians, consisting of psychiatrists, psychologists, licensed clinical social workers, licensed counselors, licensed marriage and family therapists, and advanced practice psychiatric-mental health nurses."

A rose by any other name...
Psychiatric Nurses and the Implementation of the DSM

San Francisco - Train-the-Trainer, May 20, 2013

Selected Assessment Measures

- Clinician-Rated Scales:
  - Severity of Autism & Communication Disorders
  - Dimensions of Psychosis Severity Symptoms
  - Severity of Somatic Symptoms
  - Severity of Conduct & Oppositional Defiant Disorders
  - Severity of Nonsuicidal Self-Injury

Selected Assessment Measures

- Cultural Formulation Interviews
- WHO Disability Assessment Schedule 2.0
  - May be used as outcome measure for treatment planning
  - Coordinate with the Recovery Model
  - Periodic reassessment
- Disorder-Specific Severity Measures: Adult, Child 11-17 years

Selected Assessment Measures

- Level 1 Cross-Cutting Symptom Measures
  - Self-Rated Adult & Child 6-17 years
  - Parent/Guardian-Rated Child 6-17 years
- Level 2 Cross-Cutting Symptom Measures

Selected Assessment Measures

- Level of Personality Functioning Scale
- Personality Trait Rating Form
- Personality Inventory for DSM 5

Selected Assessment Measures

- Level 1 Cross-Cutting Symptom Measures
  - Self-Rated Adult & Child 6-17 years
  - Parent/Guardian-Rated Child 6-17 years
- Level 2 Cross-Cutting Symptom Measures

Selected Assessment Measures

- Depression
- Anger
- Mania
- Anxiety
- Irritability (Child)

- Somatic Symptoms
- Sleep Disturbance
- Repetitive Thoughts & Behaviors
- Substance Use
- Inattention (Child)

Alternative Model for Personality Disorders

- Criteria A: Level of Personality Functioning
  - Identity
  - Self-direction

- Criteria B: Pathological Traits
  - Empathy
  - Intimacy

- Criteria C & D: Pervasiveness & Stability

- Criteria E, F, & G: Alternative Explanations for pathology


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