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

182 diagnoses, 134 pages

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

265 diagnoses, 494 pages

DSM-IV 1994
- 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

297 diagnoses, 934 pages

Timeline
- 1999-2007: Development of DSM-5 Pre-Planning white papers
- 2004-2007: APA/NIMH/WHO global research planning conferences
- 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-TR 2000
- 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)

Some of APA's Selling Points
- Evidence based (20 years)
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**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 Schedule (WHODAS)

**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

**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**:
  - I. Requires support
  - II. Requires substantial support
  - III. 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).

**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

**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
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.

Trauma and Stressor-Related Disorders (new)
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder (new)
- Acute Stress Disorder
- Post Traumatic Stress Disorder
  - Ages six and up
  - Subtype for pre-six year olds
- Adjustment Disorder (may be related to bereavement)

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!)
- Specific Phobia
- Generalized Anxiety Disorder (physical sx lowered from 6-2)
- Panic
- Agoraphobia
- Social Anxiety Disorder

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

Obsessive Compulsive Disorders
- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- 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
- 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
- Rumination 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

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)

Sleep-Wake Disorders (formerly Sleep Disorders)
- Insomnia Disorder (Primary insomnia)
- Hypersomnia Disorder (Primary Hypersomnia)
- Narcolepsy/Hypopetin 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
- Big change: Substances AND non-substances
- Abuse vs. Dependence: categories arbitrary
- Mild, Moderate, and Severe
- Reduced number of symptoms for dx
- 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

Binge-Drinking = Alcoholism
- Earlier interventions could nip problem in the bud
- Stop physical problems from occurring
- Save money in the long-run by reducing disability
- Substance Use Disorder Severity Scale
- 0-1 criterion: No diagnosis
- 2-3 criteria: Mild
- 4-5 criteria: Moderate
- 6+ criteria: Severe
- 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, Fronto-temporal, Traumatic Brain Injury, Lewy Body, Parkinson’s, HIV, Substance Induced, Huntington’s, Prion

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)

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)

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

Easier to Gain Diagnoses
- Attention deficit hyperactivity disorder
- Bipolar mixed
- Bereavement exclusion
- Generalized anxiety disorder
- Somatic symptom disorder
- First time substance abusers

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."

Does Changing the Label Reduce Stigma?
- Mental Retardation... Intellectual Developmental Disorder
- Gender Identity Disorder...Gender Dysphoria
- Dementia ... Mild and Major Neurocognitive Disorders

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

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

<table>
<thead>
<tr>
<th>Symptom Category</th>
<th>Measures</th>
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<tbody>
<tr>
<td>Depression</td>
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<td>Irritability (Child)</td>
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<td>Somatic Symptoms</td>
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<td>Repetitive Thoughts &amp; Behaviors</td>
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<td>Substance Use</td>
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<td>Inattention (Child)</td>
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Selected Assessment Measures

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

Selected Assessment Measures

- Criteria A: Level of Personality Functioning
  - Identity
  - Self-direction
- Criteria B: Pathological Traits
- Criteria C & D: Pervasiveness & Stability
- Criteria E, F, & G: Alternative Explanations for pathology

Alternative Model for Personality Disorders
References


References (4 of 5)

References (5 of 5)