DSM-5: CONCEPTS, CHANGES, AND CRITIQUE

DSM-5, The Diagnostic and Statistical Manual of Mental Disorders, was released at the American Psychiatric Association’s (APA) meeting in May 2013. There are several versions available: hardback book (947 pp.), smaller Desk Reference of the criteria, and an electronic version (an app.) This is the fifth major revision, starting in 1952. By international treaty, DSM has to live within the International Statistical Classification of Diseases and Related Health Problems (ICD), with which it is synchronized. However, each country is permitted to add clinical modifications and descriptions—e.g. in the U.S., it is ICD 10-CM, in Canada, ICD 10-CA.

Work is now beginning internationally for ICD-11, due in 2015, by the World Health Organization. Currently, insurance companies in the U.S. are still using ICD-9 codes. Unless delayed again by Congress, there will be a transition to ICD-10 CM in October 2014. There is actually no significant difference between these two versions of ICD other than the code numbers; ICD-10 codes start with a letter, F for mental health. To be prepared, both sets of codes are listed in DSM-5. (Don’t go to the needless expense of taking an ICD-10 CM course.)

Many people worked on and contributed to DSM-5. The initial work was done in Work Groups, which struggled with sifting information and then consensus, as any group of professionals will do. DSM 5.org, a website, generated over 30,000 comments, each of which was reviewed by a Work Group member. Many DSM planning conferences included over 50% international participants. The final recommendations were then reviewed by both clinical and research Task Forces before a vote was taken in the APA Assembly.

The guiding principles for the development of DSM-5 were that revisions must be feasible for routine clinical practice and guided by research evidence. Although there were no constraints on changes, an effort was made for continuity with previous versions of DSM. It is important to always think of DSM as a work-in-progress, and in fact, the next revision in a few years will be 5.1, then 5.2, etc. Additionally, no diagnostic manual is a perfect document; it always reflects a process of working through experts’ differing opinions and the integration of advancements made in the field.

DSM-5 is in effect now. The numeric codes used in the U.S. (ICD-9) are the same as in DSM-IV, so there is no need to change computer programs. However, one always has the option of using an ICD-9 code where DSM-5 may have combined the disorder into a group—for example, Asperger’s is now subsumed under the Autistic Spectrum Disorders—but one may still use the separate ICD-9 code.
The full version of DSM-5 consists of three sections and an appendix. Section One is an introduction and information on how to use DSM-5. Section Two has the Disorders ready for clinical use, and Section Three has conditions that require further research, as well as cultural formulations and glossary. Overall, there is a wealth of information!

Comments on general changes of note:

- There is no longer a multiaxial system, which was not supported by research data. Thus, Personality Disorders are no longer Axis II diagnoses, but simply a diagnosis. Axes III, IV, and V have been eliminated.
- An effort was made to have fewer disorders, thus many are combined in one diagnosis.
- There are 15 new diagnoses, including Binge Eating Disorder and Hoarding Disorder. The corresponding ICD codes are included.
- Each clinical chapter covers the lifespan, e.g. in the trauma section, there are criteria for Posttraumatic Stress Disorder (PTSD) in children 6 years of age and younger, as well as cultural issues. Thus, there is not a separate child section.
- All of the clinical chapters (Section Two) replace NOS (Not Otherwise Specified) with Other or Unclassified.
- Substance “abuse” and “dependence” are combined into Substance Use with mild, moderate, severe modifiers. (Addictionologists are not necessarily comfortable with this.)
- Bereavement is no longer an exclusion for Major Depression, to recognize that it may well be a precipitant for or exacerbate a Major Depression. This is not meant to imply that normal grief is a disorder. (There is an interesting proposed diagnosis for further research: Persistent Complex Bereavement Disorder.)
- There are a number of V codes (ICD 10 uses similar Z codes), which cover problems affecting mental disorders. These include family upbringing, child and adult maltreatment and neglect, and educational, occupational, and housing problems. Important to use. (Similar to Axis IV in DSM-IV.)
- With regard to overall function, DSM-5 suggests the World Health Organization Disability Assessment Scale (WHODAS 2.0). It is a series of questions on difficulties due to health/mental health conditions and is included in the Assessment Measures section. (Similar to Axis V in DSM-IV.) There is concern that insurance companies will ask for this information, although it is only suggested, not required.
Highlights of changes of particular interest to us in working with complex trauma and dissociation:

- PTSD is no longer included in Anxiety Disorders, following review of data from neuroscience, neuroimaging, and differences in risk, course, and treatment response.

- Specific attention to these three consecutive chapters:
  - Trauma-and-Stressor Related Disorders
  - Dissociative Disorders
  - Somatic Symptom Disorder (this includes psychological factors affecting medical conditions and pain syndromes)

- The chapter on Trauma-and-Stressor Related Disorders starts with Reactive Attachment Disorder and Disinhibited Social Engagement Disorder, both child diagnoses. They are followed by PTSD criteria for adults, adolescents and children older than 6 years. The next diagnosis is that of Acute Stress Disorder and then Adjustment Disorders (recognizing that an Adjustment Disorder follows an identifiable stressor.) At the end of the chapter, there are explanations of “other” and “unspecified.”

- PTSD uses a definition of trauma as “exposure to actual or threatened death, serious injury, or sexual violence.” (Sexual violence is a term now being used by the Center for Disease Control in the U.S.) One can be the actual victim or witness. There is an exclusion for exposure through electronic media, television, movies, and pictures, unless work-related. (See DSM-5 for the lengthy definition.)

- The expanded criteria for PTSD now include symptoms, which are a much better fit for our clinical diagnosis of Complex Trauma. They are much closer to the criteria for Complex Trauma Disorder (based on DESNOS, Disorders of Extreme Stress, Not Otherwise Specified, study done in the 1980’s.)

- There are four PTSD symptom clusters (rather than three)
  - Intrusion symptoms which now include dissociative reactions, e.g. flashbacks
  - Avoidance symptoms
  - Negative alterations in mood and cognitions (a bow to the research in PTSD showing that the dysphoric type is common)
  - Marked alterations in arousal and reactivity

- PTSD in children includes trauma-specific reenactment in play and marked physiological symptoms.

- Acute Stress Disorder has a list of 14 symptoms, which did not cluster neatly in clinical studies. So, one may choose any 9 symptoms to make the diagnosis.

- The Dissociative Disorders include Dissociative Identity Disorder (DID), Dissociative Amnesia (fugue included), Depersonalization/Derealization
Disorder (combined). Also “other” and “unspecified” not expected to be used frequently.

- **Dissociative Identity Disorder**
  - “Disruption of identity characterized by two or more distinct personality states, involving marked discontinuity in sense of self and sense of agency”
  - Signs and symptoms may be observed by others or self-report
  - Not a normal part of a cultural or religious practice, although described as possession in some cultures
  - In children, not explained by imaginary playmates or fantasy play, usually don’t present with identity changes, but more interference in mental states
  - Excellent description of the diagnostic features!
  - Prevalence of childhood abuse/neglect in 90%
  - Over 70% attempt suicide, also other self-injurious behaviors

- **Somatic Symptom and Related Disorders**
  - Radical change in de-emphasizing medically unexplained symptoms and emphasis on disproportionate thoughts, feelings, and behaviors that accompany symptoms
  - Somatic Symptom Disorder includes somatization and pain
  - Hypochondriasis now called Illness Anxiety Disorder
  - Conversion Disorder included in this section
  - Psychological Factors Affecting Other Medical Conditions—increasing risk for increased suffering, delayed recovery and/or exacerbation of the illness
  - Also includes Factitious Disorder

- **Note:** The Sleep-Wake Disorders section has been updated, reflecting ample data in clinical studies, supported by sleep studies, and treatment responses. More and more studies of PTSD now suggest that sleep disorders may be the hallmark of PTSD and should be the first symptom to be treated.

**Reflections:**
In reviewing the full version, it is obvious how much work has gone into its development. The cost of the entire process was in the millions, even with so many experts volunteering professional time. It is a textbook in mental health and deserves time and study.

Not surprisingly, there have been many criticisms of DSM-5, ranging from accusations that it pathologizes normal human experience (the bereavement inclusion) to questions why certain diagnoses (e.g. Dissociative Disorders, “a fad”) are included. The National Institute of Mental Health (NIMH), in the U.S.,
raised the most cogent criticism when it decided not to use DSM-5 as a guide in its research.

“The diagnostic categories represented in DSM and ICD remain the contemporary consensus standard for how mental disorders are diagnosed and treated. Yet, what may be realistically feasible today for practitioners is no longer sufficient for researchers...It is increasingly evident that mental illness will be best understood as disorders of brain structure and function...This is the focus of NIMH’s Research Domain Criteria (RDoc) project.”

There is a middle ground. We are all interested in cause-and-effect, particularly in the field of traumatology. Research in genetics, neuroscience, and behavioral science is important to lay the groundwork for more sophisticated diagnosis, treatment and prevention. In the years ahead, undoubtedly there will emerge exciting advances, yet clinical research is important as well. Many of the changes in DSM-5 have come about as an integration of clinical studies and neuroscience.

With regard to PTSD, it is gratifying to see that the clinical research, which resulted in the expanded criteria, validates what we have seen in our work for years. Many of us have struggled with the narrow definition of PTSD in DSM-IV and have been driven to make multiple diagnoses in one individual with a human response to trauma. Dissociative reactions are included in the criteria, including flashbacks, Derealization, Depersonalization. Clearly, the intent is to include a dissociative subtype of PTSD.

Dissociative Disorders continue to have their own section with fewer diagnoses than in DSM-IV, as some diagnoses are combined. (This seems to be a wise move.) The criteria for DID are not as strict as in DSM-IV, with self-report accepted as a criterion. If I were faced with such an intake or consultation, I would want to do assessment measures (e.g. Trauma Symptom Inventory, Multidimensional Inventory of Dissociation, Structured Clinical Interview for Dissociation) to rule out Factitious Disorder or malingering.

I encourage all of us to include the appropriate V codes for trauma. DSM-5 has trauma-related codes for both children and adults. Since trauma is a factor in so many DSM diagnoses in addition to PTSD and Dissociative Disorders, we will be contributing to the trauma-informed literature and data collection.

Overall, DSM-5 is a step forward, and with the more frequent revisions ahead to keep up with advances, even more so.

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