What Clinicians Need to Know about DSM-5

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The fifth version of the Diagnostic and Statistical Manual has been available since May 2013 and is now the guide for making psychiatric diagnoses. This article presents an overview of key changes in this version, debates on various topics leading to the revisions and reasons for the changes.

In late 2012, the American Psychiatric Association (APA) Assembly approved the fifth version of the Diagnostic and Statistical Manual, better known as DSM-5. The manual became available in May of 2013. DSM-5 was a massive undertaking, done over a 12-year period. It reflects progress in neuroscience, brain imaging, genetics and epidemiology. It also reflects the APA’s desire to be in harmony with the World Health Organization’s International Classification of Diseases (ICD), the official coding system used in the United States and other countries. According to the APA, DSM-5 provides clinicians, patients, families and researchers with “a clear and concise description of each mental disorder organized by explicit diagnostic criteria, supplemented, when appropriate, by dimensional measures that cross diagnostic boundaries, and a brief digest of information about the diagnosis, risk factors, associated features, research advances and various expressions of the disorder.”

The process of revising the DSM was fraught with robust debate and commentary. Some of those discussions focused on the disorders themselves, which ones to retain, which ones to eliminate, whether there was a scientific basis for newly proposed disorders and whether the research on some disorders was reliable. Others focused on the process—whether it lacked transparency, whether decisions were being made based on scientific evidence, the effects of not having an independent scientific review, and the fact that many task force and work group members had conflicts of interest.

Although there are many opinions about DSM-5, it is the diagnostic manual currently used by the mental health profession. Therefore, clinicians should at least be aware of the changes that may have an impact on their clinical practice. This article highlights some of those changes.

Approach and Organization
A key distinction between DSM-5 and previous versions is that it takes into account the severity of disease. Although dimensional views of disease were present in DSM-IV, earlier versions of the DSM have given users the impression that a psychiatric diagnosis is either present or absent—ie, that one either meets or does not meet the criteria for a particular disorder. To correct that simple dichotomized approach, DSM-5 includes an expanded approach to the dimensional aspects of diagnoses. For example, a clinician diagnosing stimulant-use disorder can now specify whether it is mild, moderate or severe. This was not an option in DSM-IV-TR, the revision of the DSM-IV published in 2000. With specifiers, subtypes, severity ratings and new tools for assessing symptoms, DSM-5 enables clinicians to better capture gradients of a disorder. A new section in the DSM (Section III) includes a measure for assessing symptoms in 13 domains (including depression, anger and sleep problems) and encourages clinicians to be aware that symptoms may not fit neatly into diagnostic categories. Scores on the symptom measure may be tracked at each follow-up visit, and these can serve as a guide for additional inquiry and to assess response to treatment.

A second major change is the elimination of the multiaxial system. The multiaxial system was first included in DSM-III and was a means of facilitating a comprehensive and systematic evaluation
with attention to medical conditions, psychosocial and environmental problems, and level of functioning. In the multiaxial system, personality disorders and mental retardation (now referred to as intellectual disability) were listed as Axis II-level issues. In DSM-5, personality disorders and intellectual disability are no longer relegated to second-level importance. Also, in DSM-5, psychosocial stressors are considered "other conditions that may be a focus of clinical attention" and are coded using V-codes, which allow for more specificity. For example, instead of listing housing as a problem on Axis IV, the clinician would specify V60.0 homelessness, V60.1 inadequate housing or V60.6 problems related to living in a residential institution. Additionally, ability to function, previously conveyed as a score on the Global Assessment of Functioning in Axis V, is now indicated as a WHODAS 2.0 (World Health Organization Disability Assessment Schedule, version 2) score. WHODAS 2.0 assesses disability across six domains (eg, self-care, getting along with people). The score reflects degrees of dysfunction in very specific domains (eg, whether a patient has mild or severe problems maintaining a friendship and making new friends).

A third major change is that the section on the cultural factors affecting mental health has been greatly expanded. Additions include the Outline for Cultural Formulation and Cultural Formulation Interview. The Outline for Cultural Formulation is for assessing the patient’s cultural identity, cultural conceptualization of distress, cultural features of vulnerability and resilience, and cultural features affecting the patient-clinician relationship. The Cultural Formulation Interview consists of 16 questions about the impact of culture on the patient’s clinical presentation.

The manual’s overall organization has changed as well. Chapters about specific diagnoses now follow those about development across the lifespan. DSM-5 also includes chapters on new disorders and new groups of disorders. Among the new chapters are ones on obsessive-compulsive and related disorders, trauma- and stressor-related disorders, elimination disorders, and disruptive impulse-control and conduct disorders.

**Diagnoses**

In addition to the changes in approach and organization, DSM-5 includes new diagnoses and revisions to several others to better reflect what is known about them. One important change is that autism disorder, Asperger’s disorder, the pervasive developmental disorder not otherwise specified (NOS) have been combined into a single diagnosis—autism spectrum disorder. DSM-5, however, includes specifiers to help reflect heterogeneity within the autism spectrum disorder diagnosis. For example, a person previously diagnosed with Asperger’s disorder now would be diagnosed with autism spectrum disorder “without accompanying intellectual impairment” or “without accompanying language impairment.”

The decision to combine these disorders was met with considerable debate. Some argued that high-functioning individuals would not meet the diagnostic criteria for autism spectrum disorder and thereby become ineligible for services and treatment. They called the removal of Asperger syndrome extreme. On the other side, some argued that the changes would make diagnosing patients easier and thereby enable clinicians to better identify those needing services. In the past, they said, clinicians often had difficulty differentiating between the disorders.

Another change is that DSM-5 has eliminated the diagnoses “substance abuse” and “substance dependence” and combined them into “substance use disorder” with the specifiers of “mild to severe” based on the number of symptoms. There were several reasons for this change. First, studies showed clinicians had trouble distinguishing between abuse and dependence. Many had assumed that abuse was often a prodromal phase of dependence, but several prospective studies showed that this was not the case. In addition, the division between abuse and dependence led to “diagnostic orphans,” whereby persons with two criteria for dependence but none for abuse could go undiagnosed, although they may have as severe a problem as someone else with a diagnosis.

Furthermore, the chapter on addiction has been retitled “Substance-Related and Addictive Disorders” to allow for the inclusion of gambling disorder as a diagnosis. Based on research showing that gambling and substance-use disorders stem from common underlying genetic vulnerabilities and are associated with similar biological markers and cognitive deficits, the APA determined that gambling should be moved from the section on impulse disorders to the chapter on substance addiction.

DSM-5 also has eliminated subtypes of schizophrenia (paranoid, disorganized, catatonic, undifferentiated and residual). There was little evidence to support either their clinical utility or predictive value. Because the course of schizophrenia is highly variable, it is not unusual for a person to meet criteria for several different subtypes. For that reason, DSM-5 uses course specifiers (eg, “first episode, currently in acute episode”) and severity specifiers (eg, delusions “present and moderate”) to reflect the heterogeneity of the disorder in a manner that is more clinically useful.

In addition, DSM-5 reconceptualized schizoaffective disorder as a longitudinal, rather than cross-sectional, diagnosis. The most significant aspect of this change is that a major mood episode must be present for most of the duration of the illness in order to make a diagnosis of schizoaffective disorder (in contrast to diagnosing schizophrenia with mood symptoms).

Finally, “major neurocognitive disorder” replaces “dementia” as a diagnosis in DSM-5. Neurocognitive problems that are not severe enough to cause significant impairment would meet the criteria for a new disorder: mild neurocognitive disorder. In addition to the core criteria for major and mild neurocognitive disorders, 10 specific etiological subtypes with separate diagnostic criteria are now included.

One of the most public debates during the development of DSM-5 involved proposed changes to the category of per-
personality disorders. Over the years, various changes were proposed, including eliminating five of the 10 personality disorders and taking a dimensional approach to personality pathology. Although DSM-5 includes a new model for personality disorders that emphasizes pathological personality traits, the personality disorders in the text are the same as those in DSM-IV.

Conclusion
The changes to DSM-5 are too numerous to describe in a single article. In addition to those described here, the new version includes changes related to coding, new assessment measures, new disorders (eg, hoarding disorder and excoriation disorder) and new conditions included for further study (eg, attenuated psychosis syndrome and caffeine use disorder). Years of debate and controversy have not resolved all differences of opinion. Still, clinicians need to accept that DSM-5, for better or worse, is our new diagnostic manual, and they would be well-advised to become familiar with it.

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Dr. Grant has received research grants from NIMH, the National Center for Responsible Gaming, and Roche and Forest Pharmaceuticals. He also receives compensation from Springer as the editor-in-chief of the Journal of Gambling Studies and has received royalties from McGraw-Hill, Oxford University Press, Norton and the APPI.

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