Some Highlights of DSM-5

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Conflicts of Interest: More Enjoyment Than DSM-5
Overview of the DSM-5 Process

• Every 7-14 yrs (DSM III-IIIIR-IV) to 12-19 years (DSM IV, IV TR, DSM-5) the APA commissions an update of the DSM for the purpose of reflecting new knowledge in the field and correcting aspects that need improvement for utility.

• About 6 conferences were held since 2004-2006 on various aspects (is GAD separate from MDD)

• Recruitment of Workgroup chairs started 2006

• Recruitment of Workgroups by chairs - 2007
Overview of DSM-5 Process II

• 13 Diagnostic Workgroups started meeting in 2007 – Weekly-biweekly phone conferences- face to face meetings q 6 months

• Task Force – Decision making group made up of Workgroup Chairs and psychiatric illuminati met q 6 mos.

• Assignment – Starting with DSM-IV – leave what works, change what doesn’t – must have evidence for major changes* (much of DSM-IV not based on evidence) – but evidence required for a change.
Overview of DSM-5 Process III

• Workgroup members provide financial evidence of money from pharma – must pledge under $10,000/yr. Advisors must disclose conflicts to WG, but had no vote.

• Initially very bottom-up process.

• SRC – Scientific Review Comm. Had to approve level of evidence for major changes.

• CPHC – Clinical and Public Health Comm. Must approve changes that are controversial or where scientific evidence is not relevant.
Overview of DSM-5 Process IV

• Summit Committee – APA President, select members of BOT must approve changes
• Writing of DSM-5 sections by WG, and appointed WG Editor
• Simultaneous editing going on for Harmony by Emily Kuhl, PhD and Michael First, MD (from DSM-IV)
• Process gets more top down as time gets shorter to finish.
• BOT approval – Dec 2013, Release at APA May 2013
What About Unintended Consequences?

• Effort was made to anticipate them and weigh versus no change.
• Will they change caseness?
• Will they help target treatment or more effective treatment development?
• Will DSM-5 focus clinicians attention on areas deserving more consideration? e.g. comorbid anxiety, suicide assessment, covert bipolar disorder, chronic depression.
Why DSM-5 instead of DSM-V?

• Planned that DSM-5 would be a living, evolving document. Instead of revision every 12-19 years, it would evolve as important findings emerge relevant to diagnosis and treatment. These changes can be posted on internet, with revisions being distributed.

• Therefore at times dictated by new information, DSM-5.1, 5.2 etc. could emerge.
Overall Changes in DSM-5 – General Changes

- No separate child section - developmental committee oversees child changes – eg DMDD. In Mood Section. (Liaisons from Dev Comm.)
- Every diagnosis on Axis I
- No GAF – Disability determined by a 12 item WHODAS II.
- Level 1 and level 2 cross-cutting self-rated dimensions, clinician rated dimensions and a Suicide Assessment.
- Listing of Disorders eg Depressive Disorders separate from Bipolar and related disorders.
- Listing of disorders – based on presumed evolving causative factors – e.g. Bipolar chapter next to schizophrenia chapter, Depressive Disorders next to Anxiety Disorders.
- NOS (not otherwise specified) – studies of large insurance data bases show that NOS diagnoses are represented from 35-45% of diagnoses – they transmit little clinical information. E.g. - Change to Depression Specified (1. too few symptoms, 2. Too short duration) vs. Unspecified – Too little time to get data – e.g. Emergency Room. Different specified criteria for different diagnoses.
Selected Examples of Change- If Approved- in DSM-5

• Personality Disorders – Attempt to go dimensional to avoid overlap – problems with perceived complexity. 9 to 6 PD, with 25 features – areas of impairment/at least two present. – Because of difficulties with complexity has reverted to same as DSM-5 with new proposal in section !!! (Appendix in DSM-IV)

• Cognitive Disorders – Mild Neuro Cognitive – may be in Section III

• Asbergers as PDD dropped – all Autism Spectrum.
Personality Disorders- a Problem

• Wanted to be more dimensional to avoid overlap – problem with complexity
• Compromise – 6 categories: Schizotypical, Antisocial, Borderline, Narcissistic, Avoidant, Obsessive- Compulsive
• Criteria A – impairment: Identity, Self-Direction, Empathy, Intimacy ( must have impairment in at least two)
• Pool of 25 traits ( one or more to characterize sub-type)
• Final decision – left similar to DSM-IV with new dimensional approach placed in Section III ( was Appendix in DSM-IV)
Examples of Change in DSM-5 II

- Substance – Induced (dropping exemption for ADM for mania if lasting beyond physiologic effects of ADM)
- Anxiety Disorders – Adjustment Disorders – Grief added. PTSD – tighten criteria (eg electronic stress excluded) Obsessive Compulsive Disorder – separate chapter – Hoarding Disorder added.
- Somatoform – simplified
- Substance Addiction – no separation between abuse and dependence – Substance Use Disorder – add gambling addiction (first non-substance)
- Eating Disorders – reduce use of EDNOS - ARFID
- Avoidant-restrictive food intake disorder
- Mental Retardation changed to intellectual disabilities – Less emphasis on IQ 70 – Coping scale more important.
Mood Disorders Workgroup

Jan Fawcett, MD – chair
Sir David Goldberg MD
Michael Phillips, MD, MPH
Mario Maj, MD - moved to ICD-11
Ken Kendler, MD – moved to SRC
William Coryell, MD
Trish Suppes, MD, PhD
Ellen Frank, PhD
RayDePaulo, MD
Lori Davis, MD
Carlos Zarate, MD
James Jackson, PhD
Liaisons to Mood Workgroup

• Kimberly Yonkers, MD – Gender/Cross Culture
• David Schaffer, MD – Child Adolescent
• Ellen Leibenluft, MD
• Rachel Klein, PhD
• Daniel Pine, MD
• Renato Alercon, MD – Personality
• Juan Bustillo, MD – Psychotic Disorders
• Hans – Ulrich Witchen, Ph D – Anxiety Disorders
Advisors

• Jules Angst, MD
• Sidney Zisook, MD
• Elizabeth Ford, MD
Mood Disorder Changes in DSM-5

• Drop Bereavement Exclusion for MDE
• Add mixed-specifier across all bipolar and MDD – drop Bipolar I, Mixed State
• Drop substance exclusion for ADM for BP Disorder
• BP disorder- add increased activity to A criteria
• Add DMDD – Disruptive Mood Dysregulation Disorder – under 10 – To try to deal with frequency of child BP dx.
• Add PMDD, change post-partum to peri-partum specifier.
• Change Dysthymia to Persistent Depression- duration conveys severity more than number of symptoms.
• Add Anxiety Dimension from section III
What Effects Will Changes Have?

- Possible reduction in increased frequency of child bipolar Dx and Rx? Maybe-----
- Possible earlier detection and treatment if covert Bipolar Disorder in MDD patients? Maybe
- Ability to Dx and Rx BP II with mixed features-earlier dx of bipolar depression..
- Increased focus on chronicity.
- Possible more clinical attention to Anxiety severity
- Possible more clinical attention to Suicide Assessment.
- Focus more attention on areas that require therapeutic research. e.g. current risk factors for suicide, risk factors for bipolar disorder, better treatment for bipolar depression, improved treatment of comorbid anxiety, for chronic depression.
Limitations in DSM-5 Process

• The policy governing our procedure was that any major changes (new diagnoses, dropping diagnoses, change in criteria) required review.
• The SRC (Scientific Review Committee) headed by Robert Freedman, Kenneth Kendler – must give the submission a passing grade (1-3) in order for it to go forward.
• For major changes (adding or deleting categories, criteria changes) – submission – reason for change, validators, literature review, unintended consequences if accepted or not.
• For issues not supportable by data – CPHC (Clinical and Public Health Committee) review.(both if controversial)
• Re-submissions considered
• Effect: Changes proposed (even if not supported by data) had to be supported by published data.(example: Demoralization)
Thoughts About the Limitations of Categorical Diagnoses

• Not very helpful for research – move towards RDOC- Dimensions (endophenotypres) vs domains. (e.g. genetics, circuitry, temperament)

• Overly heterogeneous – symptom components respond to medications – not diagnoses (depression, schizophrenia) even though treatments are approved for categories in current form. (e.g. slowed movement-depression, anxiety-agitation (Katz M 2011), anhedonia-inability to initiate in TRD.

• Depression: may be several or more subtypes (ICAD- inflammatory cytokine associated depression related to IL 6, IL 1, TNF alpha)

• Symptom components may be indicative of different causation chains and different treatments.

• Major symptoms e.g. Anxiety, Depression, Impulsiveness, Anger, Psychosis occur across diagnostic categories – reason for adding Anxiety Severity dimension in Mood Disorder – Anxiety not a diagnostic criterion, but studies show that severity t predicts poor out come and increased risk of suicide.