The DSM-5: The Changes Ahead (Part 2)

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Part I of this series described the process underway to reconstruct the American Psychiatric Association's "Bible," the Diagnostic and Statistical Manual of Mental Disorders (DSM), creating a 5th edition after more than 20 years of DSM-IV. Time for a new model.

The DSM is a hefty tome that specifies 283 mental illnesses, categorized by disorders, including mood, anxiety, eating, sleep, personality, impulse control, adjustment, substance-related, schizophrenia and other psychoses, delirium and dementia, developmental impairments and other diverse conditions.

In Part I of this series, I described how the APA is trying to ensure public transparency, continuous input and ongoing improvements into the drafting of the DSM-5. In this second part, I will cover some of the actual changes in how diagnoses will be made for the DSM-5. In theory, the DSM-5's new and revised diagnostic conditions will reflect the additional scientific information gathered since the last edition, as well as efforts to better cluster and recognize the varied levels of severity of conditions. It will also provide measures for patients, families and doctors to determine if treatment is working. Let's look at some examples.

I will start with substance abuse and addictive disorders, since they are ubiquitous throughout the world -- and as controversial as they are universal. The current draft of DSM-5 proposes that "substance use disorder" replace what we now think of as abuse (seen by behaviors) and dependence (evidenced by withdrawal when the body is denied its drug). Each intoxicant would have its own section, such as alcohol use or inhalant use disorder.

The website identifies the primary reason for this revision as the view that the term "dependence" is misleading: We are urged to not confuse the fact that tolerance and withdrawal are normal responses to some prescribed (read: medically necessary) medications that affect the central nervous system, and thus these physical states should not be seen as an illness. A substance disorder, instead, is a distinct syndrome that includes compulsive drug-seeking behavior, loss of control, craving and marked decrements in social and occupational functioning. Maybe we can reduce stigma with this revision? A good question that time will answer.

But the addiction soup gets thicker when it comes to wondering what, indeed, is an addiction? Is gambling (yes, probably)? Is sex? How about the Internet (without porn)? The votes are not in.

Another critical -- and very controversial -- diagnostic grouping is autism spectrum disorders. Is there an epidemic going on? You would think so, if you listen to the news. The workgroup's recommendation for a new category of autism spectrum disorders reflects its view that autism and Asperger's syndrome (think Dustin Hoffman and "The Rain Man") are a continuum from mild to severe. Many families and advocacy groups are a bit agitated about ending the distinction, which would have effects (likely good and bad) on policy, clinical programs and funding.

In the world of developmental disabilities, the DSM revisionists want to do some wordsmithing on intellectual developmental disorders. "Mental retardation," the experts urge, should be changed to "intellectual developmental disorders" (which would bring the DSM in line with the International Classification of Diseases proposal for its 11th edition -- see Part I for insight into the international scene). But importantly, and realistically, severity of an intellectual disability would not be based only on IQ but by impairment in adaptive functioning as well. That is really overdue.

Another critical cluster of disorders is called "Schizophrenia Spectrum and Other Psychotic Disorders." These are serious and often persistent mental illnesses where a person has profound impairments in being able to appreciate the reality about him or her and diminished functioning in education, work and social relations. The revisions for these conditions, which affect about 1 percent of the population but are among the most costly in terms of loss of quality of life and social cost, are less controversial but allow for an extensive assessment of severity that includes hallucinations, delusions, disorganized thinking and behavior, loss of mental capacity (cognitive impairment) and diminution of feelings, expression and even the ability to act (called avolition, or loss of the ability to start an action). This detailed assessment is a very good idea but is raising questions about the paperwork burden of completing severity measurement scales.

Premenstrual dysphoric disorder (PDD) is a serious mood problem in women that occurs during the premenstrual period. It will appear in the appendix to the main body of the DSM-5 text. The evidence is that this is distinct from premenstrual syndrome (PMS). The addition of this condition could help promote its recognition and promote more research (and better treatment) on this common and disturbing condition. Is this pathologizing monthly lunar-menstrual mood swings, some wonder?

Another debated condition is what is called mild neurocognitive disorder. The aim of this brand new disorder is to identify people at risk for developing dementia, including both Alzheimer's disease and vascular dementia (caused by loss of blood supply to a region of the brain). Symptoms include memory and language loss as well as attentional and reasoning impairments. Do you want to know if you have dementia?

There is a lot more -- including eating disorders, personality disorders (a huge and evocative topic since we all have personalities), and traumatic stress disorders (all the more critical in light of our soldiers, domestic violence, sexual abuse and disaster victims). You can see all of this, and more, on the DSM-5 website. The design of each section on a disorder is very well done, since there are tabs for the proposed revision, the rationale for the revision, severity scales and the current DSM-IV to compare to.

Perhaps one of the most important changes in the DSM is called dimensional assessments (noted above in the discussion of schizophrenic disorders). DSM-IV has had the problem of fitting neatly into the complexity of human symptoms: People with schizophrenia have problems with depression, anxiety even insomnia. There has been, to date, no means to account for these problems, their severity -- and, perhaps most importantly -- to determine if a person is improving in treatment. Dimensional assessments will enable clinicians to record the presence of a variety of problems as well as their severity (very severe, severe, moderate and mild) and thereby be able to track how a person is doing over time and in response to different treatments. This is as needed as it is complicated and demanding.

No wonder the APA constructed 13 work groups, more than 160 people, to revise the DSM -- even before it has to go through the gauntlet of its internal committees, councils and the APA Board of Trustees. Some will say, have said, a fool's errand. After all, how many angels can dance on the head of a pin? I say, however, medicine is a science. Psychiatry is a branch of medicine, a huge limb, in fact, in need of continuous pruning, watering and shaping. Science is not perfect. But the quest for the perfect, in progressive approximations, is what separates science from fiction, opinion from evidence and guesswork from clinical medicine.

For more information see the DSM-5 website.

**Disclosure: I am an APA member. I have held numerous elected state and national positions at the APA, worked there from 2000-2002.*

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The opinions expressed here are solely my own as a psychiatrist and public health advocate. I receive no support from any pharmaceutical or device company.

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