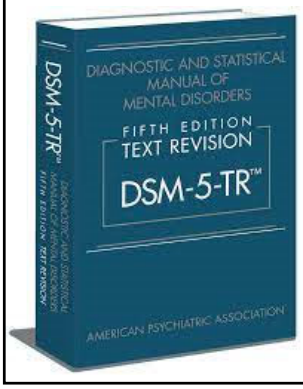

The DSM-5-TR:
Updates & Changes to Know

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Workshop Outline

- How did we get to the DSM-5-TR?
- What changes were made to already existing diagnoses?
- What new diagnostic categories have been added?

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A Brief History of Psychiatric Diagnosis

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Historical Background

- "For a long time confusion reigned. Every self-respecting alienist, and certainly every professor, had his own classification."
- The American Medico-Psychological Association (now the APA) issued the first nomenclature in 1918 - *Statistical Manual for Use of Institutions for the Insane* - but it failed to catch on with institutions or practitioners

Kendell (1975)

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Rise of the Nomenclatures

- APA introduced another edition in 1928, but it too was too narrowly focused to be useful to most practitioners
- By WWII, the military had already developed independent nomenclatures
- In 1948, WHO issued the ICD-6, which contained a section on mental disorders, but was seen needing modification for use in the US

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The DSM-I

- In 1952, APA published its nosology, based off of the ICD-6 and military system, called the *Diagnostic and Statistical Manual of Mental Disorders*
- Gained some acceptance, but many criticized its reliability, validity, and other inadequacies
- The ICD-6, meanwhile, failed miserably

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ICD-8 and DSM-II

- Newly revised ICD section on mental disorders was published in 1966, but the companion glossary didn't come out until 1972
- DSM was revised to be compatible with ICD-8, but still America-centered, with DSM-II published in 1968
- Still much criticism over reliability and validity issues for both systems

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ICD-9 and DSM-III

- Ninth revision of ICD still failed to provide explicit, precise descriptions of the disorders
- DSM-III, published in 1980, used a multiaxial diagnostic system, had specific and explicit criteria for disorders (including expanded information on each disorder) and moved towards being atheoretical
- These changes caused a major shift in mental health towards acceptance and use

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DSM-III-R

- Even with these innovations, "Criteria were not entirely clear, were inconsistent across categories, or were even contradictory."
- Revisions were made in many diagnostic criteria for many disorders, resulting in even more widespread adoption
- Coincided with the rise of managed care in mental health, with many insurance companies basically forcing use of DSM codes

APA (1987)

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DSM-IV

- DSM-IV (1994) was to be more compatible with ICD classification system
- Relied more heavily on research to guide criteria and diagnoses than other editions
- Included cultural and ethnic group, age, and gender variation, as well as laboratory and physical exam findings

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DSM-IV-TR

- Published in 2000, with very little changes to most disorders and categories
- The exceptions were Pervasive Developmental Disorder NOS and Asperger's Disorder, which were completely different from DSM-IV

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DSM-5

- Published in May 2013, it was the first major revision in almost two decades and the most significant since DSM-III
- Major changes to entire categories and specific diagnoses
  - Neurodevelopmental disorders (ID, ASD)
  - Schizophrenia spectrum (no more subtypes of SCZ)
  - Separating unipolar and bipolar disorders
  - Separating anxiety from trauma and OCRDs
- Many new diagnoses (Hoarding Dxo, Excoriation, DSED, DMDD)
- Removal of the multiaxial system

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DSM-5 Controversies

- 70% of the task force had financial relationships with Big Pharma
- Many new diagnoses were seen as non-scientific or highly problematic
- Field trials were seen as rushed and insufficient
- First printing of the DSM-5 had huge numbers of misspellings, typos, and errors

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DSM-5-TR

- Published March 2022, 9 years after DSM-5
- Involved over 200 subject matter experts, across many mental health disciplines
- Considered new diagnoses
- “The text revision scope did not include major changes to the criteria sets or to other DSM-5 constructs.”

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Overarching Changes

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Big Picture

- Includes updated descriptions of Prevalence, Risk, and Prognostic Factors for each disorder
- Culture-related and Sex- and Gender-related diagnostic issues were heavily updated
- Several notable changes to wording for existing diagnoses
- One completely new disorder and one “restored” disorder

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Coding & Organization

- DSM-5 had both ICD-9 and ICD-10 codes, but DSM-5-TR has *only* ICD-10-CM codes
- Same 20 disorder chapters as DSM-5

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Section III

- Several changes to assessment measures
  - Removal of "sex" checkboxes
  - Improving instructions
  - All updates posted online for free use - https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures
- Improvements to cultural formulation interview, with better definitions and less stigmatizing or generalizing language

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DSM-5-TR & Race

- DSM-5 had expanded sections on how culture, ethnicity, and race impact presentation of mental health problems, further changes seen in DSM-5-TR
- The term “racialized” is used instead of “race/racial” to highlight the socially constructed nature of race
- The term “ethnoracial” is used in the text to denote the U.S. Census categories, such as Hispanic, White, or African American, that combine ethnic and racialized identifiers
- The terms “minority” and “non-White” are avoided because they describe social groups in relation to a racialized “majority,” a practice that tends to perpetuate social hierarchies

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DSM-5-TR & Race

- The term “Latinx” is used in place of Latino/Latina to promote gender-inclusive terminology
- The term “Caucasian” is not used because it is based on obsolete and erroneous views about the geographic origin of a prototypical pan-European ethnicity
- Prevalence data on specific ethnoracial groups were included when existing research documented reliable estimates based on representative samples

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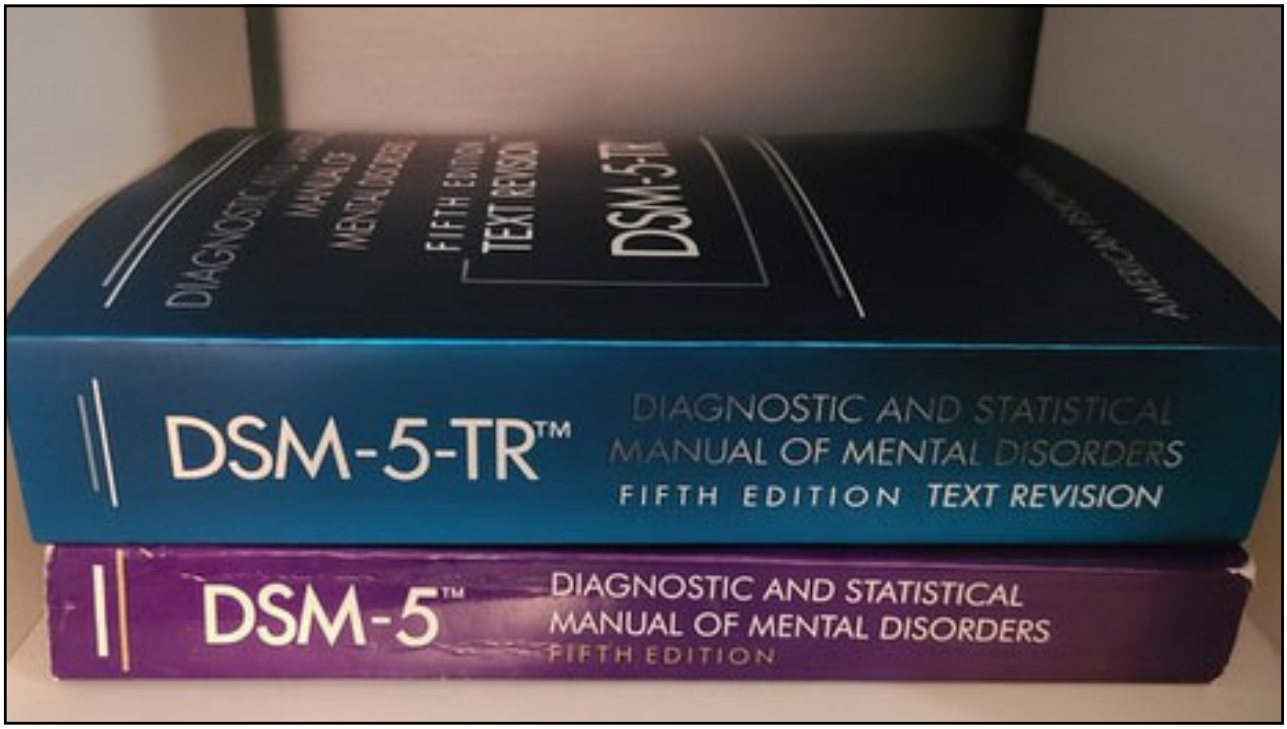

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Changes to Existing Diagnoses

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Autism Spectrum Disorder

- "A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by **all of** the following, currently or by history:
  - Deficits in social-emotional reciprocity….
  - Deficits in nonverbal communicative behaviors used for social interaction….
  - Deficits in developing, maintaining, and understanding relationships…."
- Changed to help maintain high diagnostic threshold

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Disruptive Mood Dysregulation Disorder

- Updated the age range for being diagnosed to 6-18 years of age
- Done to help restrict diagnoses for younger children, due to developmental inappropriateness of diagnostic criteria

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ID to IDD

- *Intellectual disability* has been renamed *intellectual developmental disorder*, with specified levels
  - Mild
  - Moderate
  - Severe
  - Profound

- In line with ICD-11 naming

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Avoidant/Restrictive Food Intake Disorder

A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) ~~as manifested by persistent failure to meet appropriate nutritional and/or energy needs~~ associated with one (or more) of the following:

1) Significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
2) Significant nutritional deficiency.
3) Dependence on enteral feeding or oral nutritional supplements.
4) Marked interference with psychosocial functioning.

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Gender Dysphoria

- Updated terminology
  - Birth-assigned gender (instead of “natal sex”)
  - Individual assigned male/female at birth (instead of “natal male/natal female”)
  - Gender affirming treatments (instead of “gender reassignment treatments”)
  - Experienced gender (instead of “desired gender”)
- Added definitions of *cisgender*

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Major Depressive & Bipolar Disorders

- Reverted to a modified version of the DSM-IV criteria, with respect to the relationship between the mood episode and psychotic disorders
- Better clarity regarding which mood episodes apply at what time
- Added mood episodes concurrent with a psychotic disorder as examples in “other specified bipolar and related disorder” and “other specified depressive disorder”

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Persistent Depressive Disorder

- Removed “dysthymia” from name
- Removed all specifiers except “anxious distress” and “with atypical features”

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Manic Episodes

- Added severity specifiers from DSM-IV back into criteria
- Mild (minimum criteria met)
- Moderate (significant increase in activity or impairment in judgment)
- Severe (almost continual supervision required)

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Adjustment Disorder

- Added duration of symptom specifiers
- Acute for less than 6 months
- Persistent for longer than six months

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Narcolepsy

- Changed to bring in line with International Classification of Sleep Disorders, 3rd edition (ICSD-3) and ICD-11
- Narcolepsy type 1 is distinguished by sleepiness plus cataplexy and a positive multiple sleep latency test (MSLT), or sleepiness plus hypocretin deficiency
- Narcolepsy type 2 requires sleepiness and a positive MSLT and the absence of type-1 markers

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FND / Conversion Disorder

- Reversed order of terms – now it's Functional Neurological Disorder (Conversion disorder)
- FND is preferred term for international clinicians and researchers
- "Conversion disorder" implies a specific etiology, which DSM tries to avoid for most areas

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Other Specified OCRD

- Added "Olfactory reference disorder" (traditionally known as jiko-kyofu in Japan) as a specific OCRD
- Believing that you are emitting an unpleasant body odor, often followed by repetitive cleaning/showering
- Has been added to ICD-11 as a new and separate disorder, prompting this inclusion

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Other Conditions That May Be a Focus of Clinical Attention

- Suicidal behavior
  - Suicidal ideation or attempt (T14.91A)
  - Subsequent encounters (T14.91D)
  - Sistory (but not current) suicidal behavior (Z91.51)
- Nonsuicidal self-injury
  - Current NSSI (R45.88)
  - History (not current) of NSSI (Z91.52)

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SB / NSSI

- Added and given codes because…
- Frequently encountered
- Helps draw attention to them outside of just being “part” of another disorder like MDD
- Allows for adding codes to disorders where this is present but not “typical” (e.g. OCD, SAD, etc.)

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Added Diagnoses

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Unspecified Mood Disorder

- Removed from DSM-5 due to the separation of the “Mood Disorders” category into bipolar and depressive disorder categories
- Reinstated and located in *both* the Depressive and Bipolar Disorders sections
- Also makes it more compatible with ICD-11

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Unspecified Mood Disorder

- Used when there are significant depressive symptoms that do not meet the full criteria for any disorder
- Must still show clinically significant distress or impairment in functioning
- Most typically used in triage or emergency settings where information is scare or early in treatment when there may be significant changes (e.g. later onset of manic symptoms)

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The Grief Controversy

- Research into grief and grieving dates back decades, with some arguing for a “prolonged grief” diagnosis since the early 1990s
- In the DSMs prior to DSM-5, there was a “bereavement exclusion” for depressive disorders
- DSM-5 removed that exclusion, effectively declaring that if you were experiencing depressive symptoms for more than two weeks after the loss of a loved one, you had a psychiatric disorder

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The Grief Controversy

- This was incredibly controversial and caused enormous negative blowback from professionals and the public
- Many argued this removal was essentially "medicalization" of a normal human experience – grieving in response to a loss
- "Prolonged grief disorder" was actually proposed as an addition for DSM-5, but it was dropped at the last minute

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Prolonged Grief Disorder

- Added to the "Trauma and Stressor-related Disorders" chapter of the DSM-5-TR
- "…intense yearning or longing for the deceased (often with intense sorrow and emotional pain), and preoccupation with thoughts or memories of the deceased (in children and adolescents, this preoccupation may focus on the circumstances of the death)."

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Prolonged Grief Disorder

- Diagnosed when bereavement lasts "longer than social norms" and causes both distress *and* functional impairment
- The loved one's death must have been at least 12 months ago for adults, or 6 months for children and adolescents
- Must display at least 3 of the following 8 symptoms

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Prolonged Grief Disorder

- Identity disruption (e.g., feeling as though part of one's self has died)
- Marked sense of disbelief about the death
- Avoidance of reminders that the person is dead
- Intense emotional pain (e.g., anger, bitterness, sorrow) related to the death
- Difficulty with reintegration (e.g., problems engaging with friends, pursuing interests, planning for the future)
- Emotional numbness
- Feeling that life is meaningless
- Intense loneliness (i.e., feeling alone or detached from others)

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Prolonged Grief Disorder

- Prior studies have shown anywhere from 7-20% of people would meet the criteria for PGD 12 months post-loss
- Higher rates found for those who have lost a child or when the death is sudden and violent

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PGD and Major Depressive Disorder

- Considerable overlap of population and symptoms
- 15% of widows/widowers can be diagnosed with MDD a year after losing their spouse
- Up to 25% of those who lose loved ones during a disaster meet MDD criteria after two years
- 50-70% of those who meet PGD criteria also meet MDD

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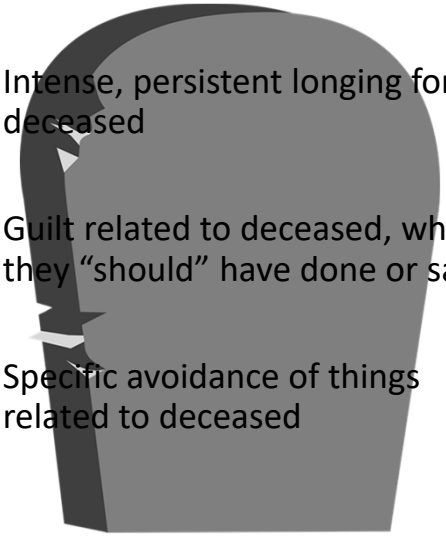
PGD vs. MDD



- Intense, persistent longing for deceased
- Guilt related to deceased, what they "should" have done or said
- Specific avoidance of things related to deceased

- Genera[illegible]g of interest in activiti[illegible]
- G[illegible]uilt or w[illegible]
- [illegible]nce an[illegible]ial
- More somatic symptom[illegible]

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WHY IS PGD IMPORTANT NOW?

"The circumstances in which we are living, with more than 660,000 deaths due to COVID, may make prolonged grief disorder more prevalent. Grief in these circumstances is normal, but not at certain levels and not most of the day, nearly every day for months. Help is available."

- American Psychiatric Association President, Vivian B. Pender, M.D.

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Controversies & Conflicts

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Same Song, Different Verse?

- As with any revision of the DSM, there has already been fair amount of criticism leveled
- Overwhelming number of task force members are still funded by pharmaceutical companies
- Lack of scientific evidence to support categories
- Published for profit to benefit the American Psychiatric Association

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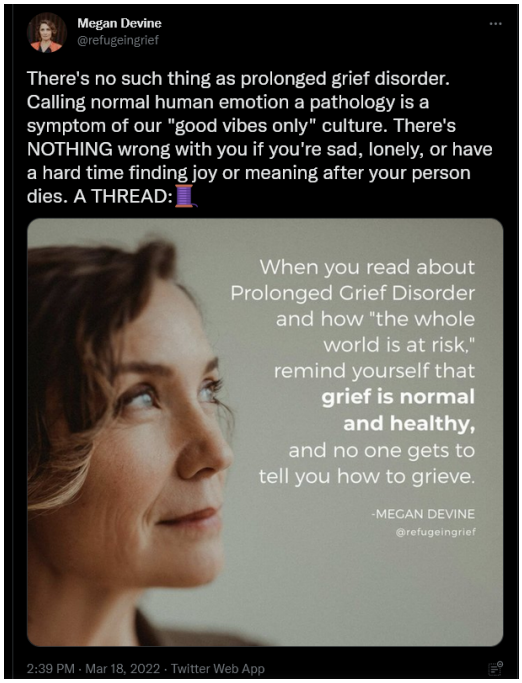

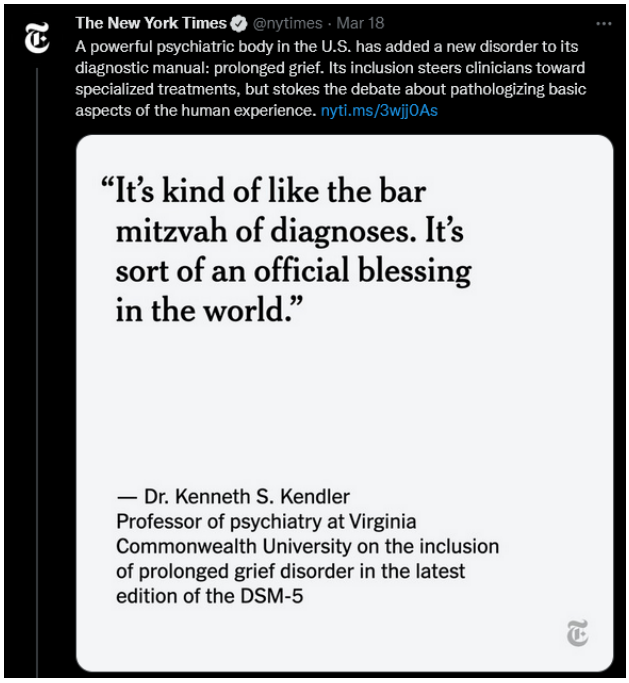

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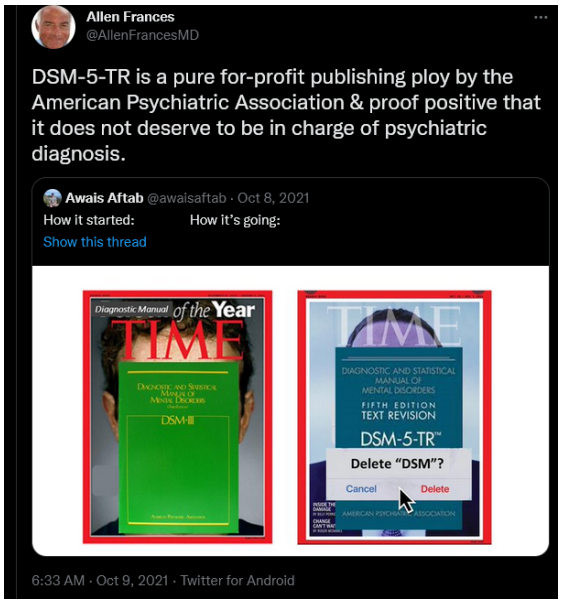

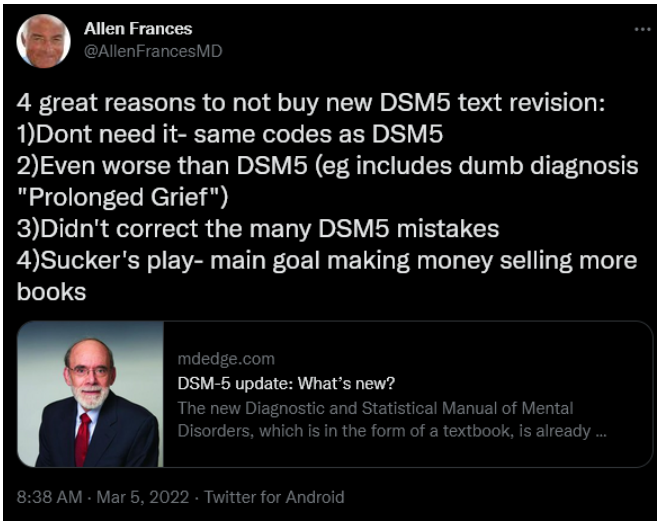

"The only purpose for publishing a DSM-5-TR is planned obsolescence, linked to financial gain: DSM-5-TR was published to sell more books and reap even greater publishing profits."

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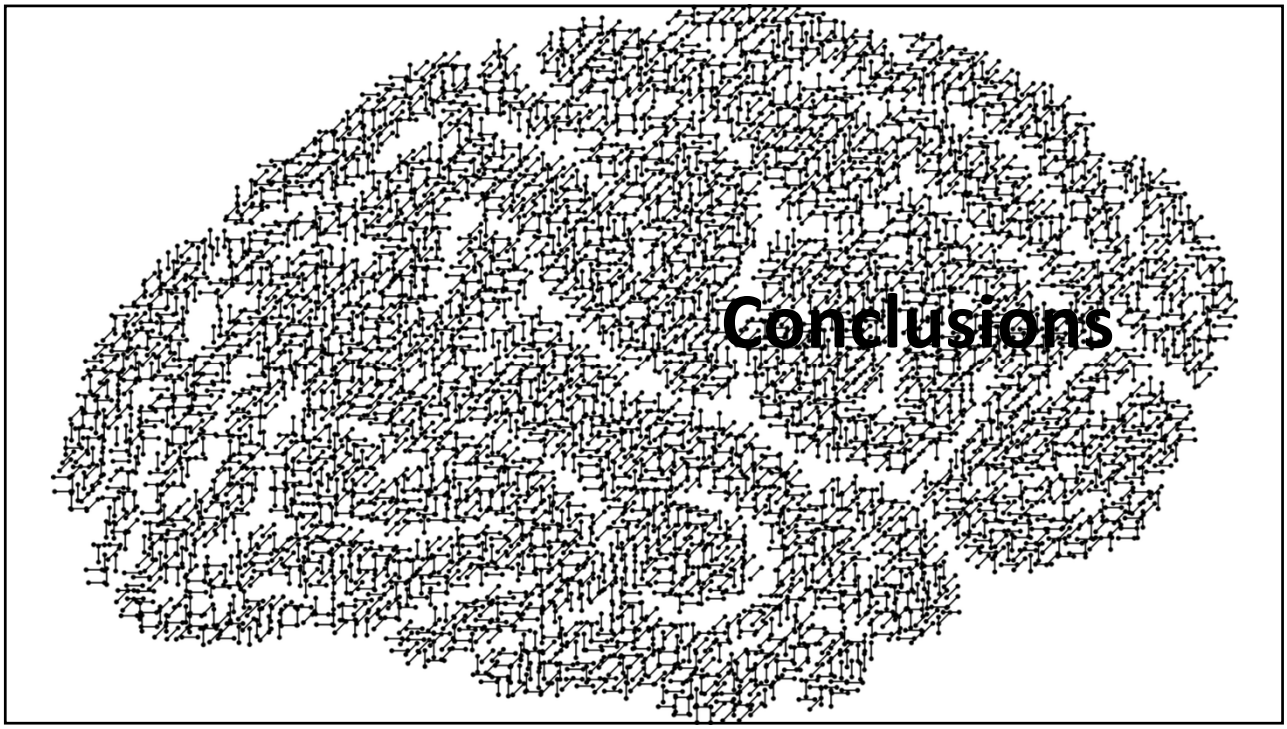

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- Majority of changes will have little to no impact on daily practice of most clinicians
- Added codes and disorders are most impactful change
- Updates to cultural/ethnic/racial aspects summarize most recent findings and are worth keeping in mind when working with diverse populations

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