DSM-5 Draft Criteria Shift Diagnostic Emphasis

The fifth edition of the diagnostic manual is likely to include many changes for specific disorders.

BY MARY ELLEN SCHNEIDER

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders could significantly change the way in which physicians diagnose psychiatric illness by placing a greater emphasis on the severity of patients' symptoms as well as those symptoms that crosscut different disorders.

The current edition of the DSM does not have a good way to account for symptoms that do not fit discretely into a single diagnosis, so the American Psychiatric Association is proposing to add "dimensional assessments" to the standard diagnostic evaluations of mental disorders. This dimensional approach is aimed at helping clinicians take into account symptoms that exist across several diagnoses, such as insomnia or anxiety. APA officials also are hopeful that it could help assess whether a patient is improving with treatment or even provide effective treatment earlier when symptoms are not yet severe.

"One of the challenges we have in accurately diagnosing mental disorders is having an ability to evaluate the full range of symptoms that a given patient presents with," Dr. Darrel A. Regier, vice chair of the DSM-5 Task Force and director of the division of research at the APA, said during a press briefing to announce the proposed changes.

"A person with schizophrenia may also present with insomnia or symptoms of depression and anxiety, and these aren't a part of the diagnostic criteria for this diagnosis. But they still can affect the patients' lives and affect the treatment planning."

The APA, which publishes the DSM, released the draft diagnostic criteria on Feb. 10. The proposed revisions were also posted online at www.DSM5.org, and the APA will be accepting comments until April 20. Once the comments are in, the APA plans to continue to refine the diagnostic criteria in the DSM and field test the changes in clinical settings. The final DSM-5 is scheduled for publication in May 2013.

This is the first time the DSM has been revised since 1994.

The fifth edition of the DSM also is likely to include numerous changes to specific diagnoses. For the first time, "autism spectrum disorders" will be grouped together into a single diagnostic category. The new category will include the current diagnoses of autistic disorder, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder (not otherwise specified).

"This was done because the work group recognized that the symptoms of these disorders represent a continuum from mild to severe, rather than being distinct disorders," said Dr. Edwin Cook, a member of the DSM-5 Neurodevelopmental Disorders Work Group and professor of psychiatry and director of Autism and Genetics at the University of Illinois at Chicago.

The proposed criteria for autism spectrum disorders also include a new assessment of symptom severity that is related to the person's degree of impairment. In addition, rather than having the three domains of social impairment, communication impairment, restrictive and repetitive behavior, the draft criteria calls for only two domains: social interaction and communication, and the presence of repetitive behaviors and fixated interests and behaviors. The change was necessary, Dr. Cook said, because the issues of social and communication impairment are so closely related.

Under the proposal, the DSM-5 would remove the term "mental retardation" and instead use the term "intellectual disability," which is used in other disciplines and by the Department of Education. The proposed DSM also would include only one diagnosis of intellectual disabilities, with severity defined by both IQ and impairments in adaptive functioning.

The DSM-5, as currently proposed, also would eliminate the separate diagnostic categories for substance abuse and dependence, and replace them with a new category called "Addiction and Related Disorders." Removing the dependence category should help clinicians better differentiate between compulsive drug-seeking behavior, and the normal responses of tolerance and withdrawal when using prescribed medications, according to members of the DSM-5 Task Force.

'Dimensional assessments' will help clinicians take into account symptoms that exist across several diagnoses, such as insomnia or anxiety.

The DSM-5 proposal also includes a new category for "behavioral addictions." Currently, gambling is the only disorder included in the category. The work group on Substance-Related Disorders had considered adding "Internet Addiction" to the category but decided that research data were insufficient. Instead, Internet Addiction will be included in the appendix.

Another new category being proposed for the DSM-5 is temper dysregulation with dysphoria (TDD). This would be included in the Mood Disorders section of the DSM. The proposed diagnosis of TDD would include severe, recurrent outbursts of temper that occur three or more times a week, and are grossly out of proportion to the situation and interfere with functioning. The criteria also would include extreme verbal and physical displays of aggression when facing minor demands or stress. Between outbursts, the individual's mood is persistently negative, according to the proposed criteria. Only children over age 6 can be assigned the diagnosis, and symptoms must have begun before age 10.

By adding this new category, clinicians might be able to better differentiate children with TDD symptoms from those with bipolar disorder or oppositional defiant disorder, task force members said.

The DSM-5 Task Force also is considering creating a new category called "Risk Syndromes" aimed at helping clinicians identify people who are higher risk for later developing a serious mental disorder. If the risk syndromes category is included in the final DSM-5, it initially would include two new diagnoses: psychosis risk syndrome (a precursor to psychosis) and minor neurocognitive disorder (a precursor to major neurocognitive disorder or dementia).

The DSM-5 also includes greater recognition for binge-eating disorder. The current proposal would take the disorder out of the appendix, as it is in the current edition, and include it as a specific disorder in the new manual. Since the last edition of the DSM, hundreds of studies have been published on binge-eating disorder, and it's now clear that compared with other individuals with weight problems, those with binge-eating disorder are more distressed and have a lower quality of life, said Dr. B. Timothy Walsh, chair of the Eating Disorders Work Group and a professor of pediatric psychopharmacology at the New York State Psychiatric Institute.

There are also two new suicide scales in the proposed DSM-5, one for adults and one for adolescents.

These scales are designed to be used when evaluating anyone for a mental disorder, regardless of whether thoughts of suicide are one of the symptoms of their condition. ■

Physicians Are Reticent About Taking On Bipolar Depression

BY KATE JOHNSON

MONTREAL — Primary care physicians are not confident when it comes to diagnosing and managing patients with bipolar depression, according to a cross-sectional survey of providers participating in a national electronic health record database.

Among 85 primary care providers in GE Healthcare's Medical Quality Improvement Consortium, self-rated confidence in managing bipolar disorder averaged 1.7 on a scale of 1 to 5, with 5 being "very confident," said Dr. Dana King, who presented the findings as a poster at the annual meeting of the North American Primary Care Research Group.

"For other more common disorders such as reflux disease, heart disease, or diabetes, these physicians have more confidence in their ability to sort out complex problems and deal with them. But bipolar disorder is less common and people have less exposure to it during their training," explained Dr. King, a professor at the Medical University of South Carolina, Charleston.

Of the respondents, 86% had been using electronic health records for 3 or more years, and 94% had access to the Internet from their clinical workstations. At the same time, only 8% had recommended Web site information on bipolar disorder to their patients in the last 3 months.

Although 72% of the respondents said they screened depressed patients for bipolar disorder, 38% reported frequently using a standard screening tool, the most common being the Mood Disorder Questionnaire.

Informal screening was more common than was the use of standardized tools and consisted of "a few questions about manic activity in patients with depression," Dr. King said. Such information screening may involve questions such as, "Do you go on spending sprees? Do you stay up all night? Do you find yourself having ups and downs, including periods of high irritability, anger, or stress?"

As the use of electronic medical records becomes more widespread, they may help prompt physicians to screen patients for bipolar disorder by offering pop-up information, he said. This represents an opportunity for quality improvement.

"Physicians seem to like the idea that we could offer them quick medical information via the electronic medical record that will give them some quick answers," he said.

The survey did not include formal interviews, but discussions with the participants have revealed that they prefer referring patients with suspected bipolar disorder to mental health specialists if screening comes up positive, Dr. King said. "Many are willing to comanage the patient, but they first want the diagnosis to be confirmed, typed according to bipolar I or II, with an identification of the phase and recommended medications."

The study was funded by Delaware Valley Outcomes Research and GE Healthcare as part of a quality improvement project dealing with several medical disorders. ■