DSM-V Updated Guidelines

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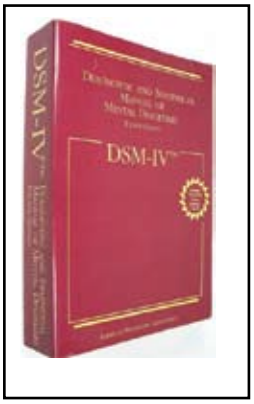

The fifth edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-V) is currently underway, and publication of the updated guidelines is pending. This is a long-awaited event, and a vast array of experts have been involved in the DSM-V task forces and working groups in order to develop a comprehensive resource upon which clinicians can consistently rely. Preliminary updates, related to several areas of mental health, are already available for public review. New DSM-V disorders are considered, based on clinical need, distinct manifestations, potential harm, and potential for treatment. Though the list of revised criteria is quite extensive, particular areas of interest include psychosis and schizophrenia, post-traumatic stress disorder (PTSD), addiction, and substance abuse.

William T. Carpenter, MD, University of Maryland School of Medicine, Baltimore, MD, discussed potential changes concerning psychosis and schizophrenia. Current criteria for schizoaffective disorder are lacking a few key points. First, there is a discrepancy between DSM and International Classification of Diseases (ICD) definitions, which may confuse diagnostic measures and result in inconsistencies across practices. Another issue that may pose difficulties for clinicians relates to schizoaffective disorder Criterion C: Symptoms that meet criteria for a mood disorder are present for a substantial portion of the total duration of the active and residual period of the illness. According to Dr. Carpenter, this criterion should be more well defined, as it is unreliable in its current state. However, the diagnosis is commonly used and important to clinicians. New criteria to be field-tested shift from the DSM-IV episode to an overall illness period and, more specifically, define the overlap with mood disorder. This will be more similar to the ICD and may be fully harmonized with the next edition of ICD.

DSM-V A criteria for schizophrenia include having two or more of the following symptoms—delusions, hallucinations, disorganized speech, grossly abnormal psychomotor behavior (eg, catatonia), and negative symptoms (eg, restricted affect or avolition and apathy)—for a significant portion of time during a 1-month period with at least one of the symptoms being delusions, hallucinations, or disorganized speech. Unlike DSM-IV, a single bizarre delusion will not be sufficient for a diagnosis of schizophrenia but will become compatible with a delusional disorder diagnosis.

The issue of catatonia, as it applies to schizophrenia, is in need of refining, as there is some debate regarding how it should be defined and how it should be positioned within the DSM-V. Catatonia may be better suited as a single diagnostic entity, because optimal treatment for catatonia does not coincide with standard schizophrenia therapy. Additionally, catatonia is not uniformly accepted by clinicians. Therefore, catatonia may be best positioned as a specifier for psychoses, mood disorders, and general medical disorders. It may also have a place as catatonia not otherwise specified. Proposed criteria that correspond with Fink and Taylor's measures may be the most adequate representation

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of catatonia: A) Immobility, mutism, or stupor of at least one hour in duration, associated with at least one of the following: catalepsy, automatic obedience, or posturing, observed or elicited on two or more occasions; and B) In the absence of immobility, mutism, or stupor, at least two of the following, which can be observed or elicited on two or more occasions: stereotypy, echophenomena, catalepsy, automatic obedience, posturing, negativism, gegenhalten, and ambitendency [Fink & Taylor. *AJP* 2003].

Advances have been made concerning the prodromal risk syndrome of psychosis, which may allow for early detection and proactive treatment. The proposed criteria address characteristic symptoms in an attenuated form (unusual thought content, suspiciousness/persecutory ideas, grandiose ideas, hallucinations/perceptual abnormalities, and disorganized communication), as well as frequency, progression, and the level of distress that is imposed on the patients or others, particularly pertaining to functionality. This opens up a new diagnostic class in the area of psychosis. However, there are some concerns about the development of a psychotic risk syndrome. There is often a stigma that is attached to psychosis, so there is question as to whether or not this would present a problem for those who are diagnosed at such a premature level. It is also important to note that the prodromal syndrome is not limited to psychosis as an outcome. Therefore, false positives and unwarranted drug therapies may occur. These problems may be addressed by naming the class Attenuated Positive Symptom Syndrome, recognizing that these help-seeking individuals who experience distress and dysfunction can be identified for clinical care for the current symptoms, perhaps preventing further exacerbation of psychotic symptoms.

PTSD is another diagnostic element that requires modification. Matthew J. Friedman, MD, PhD, VA National Center for PTSD, Washington, DC, discussed potential DSM-V changes that are related to PTSD. While the symptoms were categorized into three clusters (re-experiencing, avoidance/numbing, and hyperarousal) in the DSM-IV, it has since been recognized that symptoms manifest in four clusters, which include re-experiencing, avoidance of trauma-associated stimuli, negative alterations in cognitions and mood that are associated with the traumatic event, and hyperarousal. Proposed changes include breaking out the avoidance/numbing cluster into two separate categories and providing more detailed conditions. Additionally, responding to the event with fear, hopelessness, or horror has been removed from the guidelines, as they do not appear to be clinically relevant.

Hyperarousal was previously defined as two or more persistent symptoms, including difficulty sleeping, irritability or outburst of anger, difficulty concentrating, hypervigilance, and exaggerated startle response. Suggested modifications require the addition of reckless or self-destructive behavior and incorporating aggression into the irritability category rather than outburst of anger. Three of the qualifying symptoms are now needed to meet PTSD criteria, except for in the case of children, who require only two.

There has been some contention regarding the inclusion of second-hand traumatic events in PTSD criteria—in other words, treating "learning about" a friend or loved one's traumatic exposure as a qualifying PTSD criterion. Though there is evidence that qualifies

these circumstances as PTSD, the criticism has been that this criterion is too broad and may lead to forensic inaccuracies. In response to these issues, proposed DSM-V criteria add the caveat that such cases should involve actual or threatened death that were violent or accidental in nature.

Secondary data analyses, internet surveys, and field trials are currently underway to establish the utility of the new PTSD criteria and DSM-V qualifications.

Nancy M. Petry, PhD, University of Connecticut Heath Center, Farmington, CT, discussed guideline issues that are related to nonsubstance-related addictions, specifically internet/gaming addictions and gambling. To date, there is some dispute as to whether pathological gambling is best classified with substance use disorders or impulse control disorders.

According to a study by Petry and colleagues, pathological gambling is often accompanied by substance-related comorbidities [Petry NM et al. *J Clin Psychiatry* 2005]. Additionally, patients with pathological gambling disorders share analogous physiological components with those with substance use disorders. These similarities include frontal lobe dysfunction, impulse dysregulation, and genetic variants. Psychosocial and pharmacological treatments for both are also quite comparable. Based on these factors, moving pathological gambling to the substance use and related disorders section of the DSM-V and renaming the disorder to ensure that it is more accurately represented (eg, disordered gambling) has been proposed. The deletion of the legal criterion from this area of the DSM-V to allow for this diagnostic transition has also been recommended.

Technological advances have brought about a new form of addiction, the internet/gaming addiction. There is currently no definite category within the DSM-IV for this putative disorder. While it does meet some of the criteria that are needed to categorize it as a mental disorder, it is still lacking some key components, and there is not sufficient data to include it as a disorder as yet. Therefore, the research appendix within DSM-V will likely recommend further study in order to better understand internet/gaming addiction and appropriate diagnostic indicators.

The DSM nosology is also being reconsidered during this revision phase. Wilson M. Compton, MD, National Institute on Drug Abuse, Bethesda, MD, discussed the idea of new terminology concerning substance disorders. There is a stigma that is associated with the word "abuse" that has been shown to impact clinical perception and treatment [Kelly JF & Westerhoff CM. *International J Drug Policy* 2009]. With this in mind, it may be more appropriate to use the term "use disorder" when referring to substance-related conditions. The DSM-V working group has proposed renaming the chapter in its entirety and calling it Addiction and Related Conditions. Recommendations for the disorder itself include removing the term "abuse" and terming the disorder "Substance Use Disorder." This new nomenclature will allow for the incorporation of more physiologically related conditions and will lessen the stigmatic burden of such a diagnosis. Thus far, external input regarding the proposed nosology modification has been quite favorable.

Final decisions for DSM-V have not yet been made. The revision of DSM-IV has proven to be quite an endeavor. Expert panels, field trials, and careful literature reviews will continue to contribute to the development of a comprehensive manual that may be relied upon to provide consistent clinical diagnoses. The DSM-V is expected to be released in May 2013.