Experts Discuss Changes, Updates in DSM-5

By Heidi Anne Duerr, MPH | May 22, 2013

The much awaited and debated Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, made its debut at the American Psychiatric Association Annual meeting, and with it came excitement and concerns over the changes found within. To address these concerns, a panel of experts shared insights and highlights as well as how these changes may affect clinical practice.

The eating disorders section underwent some organizational changes, reported Evelyn Attia, MD, Clinical Professor of Psychiatry at Columbia University, Director of the Eating Disorders Research Program at the New York State Psychiatric Institute, and Director of the Columbia Center for Eating Disorders at Columbia University Medical Center. Specifically, the section, which is now titled “Feeding and Eating Disorders,” no longer segregates early childhood from the remainder of eating diagnoses; all eating disorders have been gathered under a single umbrella. In doing so, DSM-5 creators have listed disorders in order of age/development: disorders of early childhood appear first. So, Attia explained, pica is toward the top of the list since it is associated with and starts in childhood. Also, the designers of the DSM-5 decided to reduce the number of not otherwise specified (NOS) disorders, she said, because they felt these were less helpful when grouped in this manner. Additionally, she noted research since the publication of DSM-IV has provided additional insights to make some disorders their own entity.

For childhood eating disorders of pica and rumination, very little has changed from DSM-IV to DSM-5. The “feeding disorder” was changed, however, and is now called “Avoidant/Restrictive Food Intake Disorder” or “ARFID.” The NOS section is now divided into “other specified feeding and eating disorders,” which includes purge eating and night eating, and “unspecified feeding and eating disorders.” It is expected that this latter group of diagnoses will be small, she remarked.

All together, the diagnoses are: pica, rumination, ARFID, anorexia nervosa, bulimia, binge eating, other specified feeding and eating disorders, and unspecified feeding and eating disorders.

Since ARFID is new, Attia discussed its definition and criteria. Essentially, ARFID is the apparent lack of interest in eating or food or the avoidance of food based on sensory characteristics. The avoidance of food may not be the result of cultural influences or lack of access to food. As a result of the avoidance behavior, the patient must also fail to meet nutritional and/or energy needs (as can be seen by diminished weight, height, or growth). The patient may be dependent on external feeding means. The disorder usually interferes with psychosocial functioning, she added. Attia hypothesized that this diagnosis may be used as a placeholder for certain cases until further information about the patient comes to light. For instance, she spoke of a patient who claimed he wanted to gain weight and met all the criteria of ARFID, but, at a later date, hospital staff noted he was not eating all of his food, refusing continued treatment, and vomiting in the bathroom (though he denied such). The diagnosis was then changed from ARFID to anorexia.

The substance abuse section also received an organizational facelift, said Raymond Raad, MD, MPH, of Weill Cornell. In DSM-5, the disorders are organized by particular substance, and there is no distinction
between abuse and dependence, he said. Other big changes included the addition of intoxication and withdrawal syndromes, the elimination of “polysubstance dependence,” and the inclusion of gambling disorder. By removing polysubstance dependence, Raad noted the manual encourages clinicians to better investigate and document each individual substance of abuse.

Substances included in DSM-5 are: alcohol, caffeine, cannabis, hallucinogens, opioids, sedatives/analgesics, stimulants, inhalants, tobacco, and other. Inhalants and tobacco are new to DSM-5, Raad noted. Gambling disorder is organized similar to the substance use disorders, with issues such as concealing, attempts to quit, affecting job/family, and need to increase frequency/amount wagered included in the criteria. The manual also allows for disorders to be classified as mild (meets 2 to 3 criteria), moderate (meets 4 to 5 criteria), or severe (meets 6 to 11 criteria). New in DSM-5, the criteria do not consider legal problems/issues associated with substance use.

Another section to receive an organizational facelift is the somatoform disorders, which is now known as “Somatic Symptom and Related Disorders,” explained Anna Lopatin Dickerman, MD, of Weill Cornell. The authors of DSM-5 sought to uncomplicate the section by reducing the number of disorders and subcategories, Dickerman said. The focus, she explained was shifted from diagnosing based on the lack of medical evidence/disease to the presence of psychiatric symptoms associated with the physical complaints. The creators of DSM-5 also sought to eliminate the pejorative term hypochondriasis.

Besides the name and emphasis change, this section saw the addition of “psychological factors affecting other medical conditions,” which previously resided in the appendix. The creators of DSM-5 felt there was enough evidence that warranted such a move. The other disorders in the section are: somatic symptom disorder (SSD), illness anxiety disorder (IAD), conversion disorder (functional neurological symptom disorder), factitious disorder, other specified somatic symptom and related disorder, and unspecified somatic symptom and related disorder.

New in DSM-5, the IAD diagnosis replaced hypochondriasis, Dickerman explained. Patients with this disorder exhibit a preoccupation with a serious medical or health condition with either no or mild somatic symptoms, she added. These behaviors should persist 6 months. In exploring previous diagnostic criteria and modifying the IAD and SSD, the DSM-5 creators hypothesized that 75% of previous hypochondriasis diagnoses would be classified with SSD while 25% will meet the IAD criteria.

While IAD focuses on health anxiety without somatic symptoms, Dickerman noted SSD consists of one or more distressing somatic symptom along with health anxiety or maladaptive thoughts/feelings/behaviors. As in IAD, SSD symptoms must be persistent for 6 months. Specifiers for this diagnosis include severity, chronicity, and predominant pain.

One thing that has not completely changed is the inherent ambiguity in these diagnoses, she said. It will be up to each clinician to determine what “excessive” or “disproportionate” means in terms of pathological response.

Finally, she noted there was a slight terminology modification in the factitious disorder section; “by proxy” has been changed to “imposed on another.”

All the presenters agreed that the DSM-5 presented some useful changes to the diagnostic dialogue, but also emphasized the importance of clinical expertise and judgment. As George S. Alexopoulos, MD, Director of the Weill-Cornell Institute of Geriatric Psychiatry at Weill Cornell, noted during a case discussion, “DSM-5 gives us a language to discuss diagnoses,” but only clinicians can diagnose.