Changes to DSM-5 are not as drastic as they may seem

SM-5 is out. Apart from the writings of a cranky few, the manual mostly has been greeted with a collective yawn. Critics implied that the sky would fall, but nothing of the sort happened.

I have co-authored the *DSM-5 Guidebook* (with *Annals* Editorial Board member Jon E. Grant, MD, JD, MPH). Let me briefly summarize what I consider the most important changes:

- The manual’s organization has changed (i.e., “meta-structure) so that diagnostic chapters follow the developmental lifespan; thus the childhood disorders chapter (“Neurodevelopmental disorders”) appears first.
- The multiaxial system has been scrapped. Although it was included in DSM-III to elevate developmental issues and personality disorders, over time it had the opposite—and detrimental—effect. I doubt it will be missed.
- New chapters: Obsessive-compulsive and related disorders and Trauma- and stressor-related disorders are examples
- New disorders or consolidated disorders: disruptive mood dysregulation disorder (for irritable kids who might have been called “bipolar”); premenstrual dysphoric disorder; somatic symptom disorder (which consolidates 5 former somatoform disorders); hoarding disorder; and mild neurocognitive disorder are a few examples.
- Substance abuse and dependence have been merged into a single “use disorder” diagnosis.

The changes are too numerous to describe here, and I urge readers to thumb through a copy of DSM-5, and to gradually incorporate it into your practice. Note that coding is still based on ICD-9-CM and will convert to ICD-10-CM in October 2014. For that reason, each disorder is dually coded in DSM-5 with both ICD-9-CM and ICD-10-CM codes presented.

The most frequent question I get about DSM-5 has to do with the demise of the multiaxial system. My response is: Don’t sweat it. Simply rank the diagnoses from the most to least important (or relevant) conditions; if you were used to using Axis IV (stressors), simply record an appropriate V-code diagnosis (or under ICD-10-CM, Z-code); instead of Axis V (GAF score), you may use the World Health Organization Disability Assessment Schedule, version 2, or WHODAS 2.0 (found in Section III of DSM-5).

Moving to this issue, I will focus on “A prospective study of the onset of PTSD symptoms in the first month after trauma exposure,” written by Jeannie B. Whitman, PhD, and colleagues (including *Annals* Editorial Board member Carol S. North, MD, MPE). In this article, the authors show that the early appearance of the “avoidance/numbing” (cluster C) symptoms after a traumatic event is predictive of developing posttraumatic stress disorder (PTSD). The 47 patients had suffered a medically serious injury and were re-interviewed weekly for a month. The authors showed that group C symptoms in the first days and weeks after trauma exposure successfully identified PTSD well before 1 month. These symptoms had high sensitivity and specificity from the second week onward at levels comparable to those for diagnosis of medical disorders (my italics) such as dipstick tests for malaria. Impressive!

We are already planning the next AACP/Current Psychiatry meeting. It will take place at the Hilton Hotel on the Magnificent Mile in Chicago, March 27-29, 2014. We have lined up terrific speakers, including some of your favorites. Reserve the date.

Donald W. Black, MD
Editor-in-Chief