

The Impact of the *DSM-5*'s Dimensional Classification System on
Social Security Disability Insurance and Supplement Security Income Rolls

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The research reported herein was performed pursuant to a grant from Policy Research, Inc. as part of the U.S. Social Security Administration's (SSA's) Improving Disability Determination Process Small Grant Program. The opinions and conclusions expressed are solely those of the author(s) and do not represent the opinions or policy of Policy Research, Inc., SSA or any other agency of the Federal Government.

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Abstract

The publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* is expected in May 2013. Preliminary information from *DSM* work groups indicates that there will be substantial changes in the criteria for some diagnoses, reorganization of old and introduction of new diagnoses, and inclusion of dimensional severity ratings for most diagnoses. These changes may represent a critical challenge to disability evaluation for several reasons. First, some argue that base rates of mental disorders will concomitantly increase because individuals with less severe disorders can receive a diagnosis. Second, the reorganization of disorders, such as the neurocognitive disorders, will change the meaning and perception of functioning that we might attach to a diagnosis. Third, the proposed addition of dimensional severity ratings will provide information that was not included before and how that information is used can impact the disability determination process. The current study examines various mental disorders representative of nine broad categories based on the Social Security Administration's "Disability Evaluation Under Social Security". In order to address the question of the impact of *DSM-5* on SSA's disability determination, a systematic literature review was performed. The specific changes in diagnostic criteria reveals that some disorders will have limited impact on base rates whereas others may significantly impact prevalence rates as well as conceptualizations of some disorders. Furthermore, dimensional severity ratings can provide important information regarding the extent of an individual's functional impairment and, in some cases, can significantly predict morbidity score better than the categorical diagnosis alone.

Introduction

Approximately three million Americans (one-third of disabled individuals) reported that a mental condition contributes to their disability (Druss et al., 2000). Moreover, individuals who reported a disability due to a mental condition were five times more likely than those with a disability due to a general medical condition to indicate experiencing difficulties in cognitive and social role functioning. General medical disability was most commonly associated with difficulties in only one area of functioning whereas mental disability was more commonly associated with multiple deficits. In addition, comorbidity increased the odds of receiving disability benefits by two-thirds compared with having a single physical or mental condition (Druss et al., 2000). Research in primary care settings has revealed that general medical conditions appear to primarily affect physical functioning whereas mental conditions lead to deficits in higher-order social and cognitive skills (Ormel et al., 1994). The implication is that these higher-order functions may be particularly important for successful functioning in the workplace. Shiels, Gabbay, and Ford (2004) investigated sickness certification in U.K. general practice and found that mild mental disorders were significantly associated with claimants developing long-term work incapacity.

Bilder and Mechanic (2003) investigated the prevalence and correlates of disability in the U.S. civilian population and found that 48.1% of individuals with any mental disorder were employed, with 37.4% of those with any mental disorder reporting an inability to work. For example, among individuals with schizophrenia, 23% were employed and 65.3% reported an inability to work. Furthermore, the effect of severity of mental illness on disability was examined. In this study, serious mental illness was defined as the presence of schizophrenia, paranoid states, mood disorders, other nonorganic psychoses, or psychoses with origins to childhood. The results revealed that 52% of individuals with a non-serious mental disorder were employed compared to 37% of individuals with a serious mental illness. These rates are significantly lower than the 75% employment rate for the entire sample, which includes individuals with and without a mental disorder. Additionally, they found that 25.8% of individuals diagnosed with any mental disorder applied for and received Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI). Specifically, 40% of those with a serious mental illness and 20.8% of those with a non-serious mental illness applied for and received SSDI and/or SSI.

Although the Social Security Administration (SSA) determines disability decisions according to their definition of disability, a diagnosis based on the *DSM* can provide information on the severity of the disorder and functioning of an individual. The *DSM-IV* is based on categorically defined diagnostic criteria of mental disorders. There is substantial evidence that both the cross-sectional co-occurrence of symptoms and the presence of prior and concurrent threshold categorical mental disorders have a substantial impact on course, outcome, and treatment decisions (Wittchen, Höfler, Gloster, Craske, & Beesdo, 2011). However, substantial changes will be made with the publication of *DSM-5*, which will allow greater concordance with the mental disorders section of the World Health Organization's *International Classification of Diseases (ICD), 10th Edition – Clinical Modifications* (Bedrossian, 2010). Changes include introducing dimensional assessments that measure severity of symptoms, which will be particularly useful for those symptoms that appear in multiple diagnostic categories. This will

undoubtedly provide more transparency and additional guidance for disability service providers in determining the appropriate accommodations.

However, the chair of the *DSM-IV* Task Force believes that several of the proposed new diagnoses (i.e., binge eating, mixed anxiety depression, minor neurocognitive disorder, risk of psychosis, and temper dysregulation), as well as changes to existing diagnoses (i.e., attention deficit hyperactivity disorder, bipolar disorder, and major depressive disorder) could potentially create at least eight new false positive epidemics of psychiatric disorders (Frances & Widiger, 2012). Because of these changes, it is imperative to examine the potential impact on the SSA's determination of disability. In line with the above, the study addresses the following questions:

1. How will the *DSM-5* diagnostic criteria impact SSA's disability determination process?
2. To what extent should the dimensional components of *DSM-5* diagnoses be considered in the SSA's disability determination process?
3. What considerations should the SSA make in response to the changes in *DSM-5*?

Methods

A literature search was conducted using keywords: *DSM-5*, *DSM-V*, prevalence rates, and base rates in EBSCO Host, Science Direct, and PsycINFO databases. There was no time limit for published articles. The databases were referred on, at least, a quarterly basis between March 2012 and October 2012 to ensure that new literature that might be relevant would not be missed. After removal of duplicates, 36 citations remained.

The SSA's "Disability Evaluation Under Social Security" organizes mental disorders into nine broad categories: 1) organic mental disorders, 2) schizophrenic, paranoid and other psychotic disorders, 3) affective disorders, 4) intellectual disability, 5) anxiety-related disorders, 6) somatoform disorders, 7) personality disorders, 8) substance addiction disorders, and 9) autistic disorder and other pervasive developmental disorders. The current study investigates one or more germane disorders from the *DSM* for each category based on "Disability Evaluation Under Social Security". For each disorder, a brief description of the significant changes from *DSM-IV* to *DSM-5* is provided. Then, the implications of these changes are discussed.

Organic Mental Disorders

Neurocognitive Disorders

Introduction

Important changes from the *DSM-IV* dementia criteria include a name change to neurocognitive disorder and not necessarily requiring memory to be one of the impaired domains, thereby allowing cognitive deficit not limited to one domain (American Psychiatric Association [APA], 2010). The term "dementia" will be replaced by major neurocognitive disorder due to its stigmatizing connotation. There were notable issues regarding the diagnostic criteria of dementia in *DSM-IV*; therefore, proposed changes in this category are aimed to address these issues. First, the revision of the language in the diagnostic criteria focuses on decline (from a previous level of performance) as opposed to deficit, which is consistent with the

requirement in the definition of an acquired disorder. Second, the previous criteria for dementia used Alzheimer's disease as the prototype and, therefore, required memory impairment as a universal criterion for all dementias (APA, 2010). There is growing evidence that in other neurocognitive disorders (e.g., HIV-related cognitive decline, cerebrovascular disease, Pick's-related dementia, traumatic brain injury), other cognitive domains such as language or executive functioning may be impaired first, or exclusively, depending on the part of the brain affected as well as the natural course of the disease (APA, 2010).

Mild/major neurocognitive disorder is a disorder with cognitive deficits in at least one cognitive domain. The primary distinction between mild and major neurocognitive disorder is that mild neurocognitive disorder requires a decline in neurocognitive performance, typically between 1 and 2 standard deviations, whereas major neurocognitive disorder requires a decline in neurocognitive performance, typically 2 or more standard deviations below appropriate norms on formal testing (APA, 2012). In mild/major neurocognitive disorder, the cognitive deficits must be substantial enough to interfere with functional independence. However, in mild neurocognitive disorder, the cognitive deficits may not necessarily interfere with independence, but greater effort, compensatory strategies, and assistance may be needed to achieve independence.

Finally, the new definition focuses on performance more than it does on disability (APA, 2010). This encourages the use of objective measures, including formal neuropsychological evaluation when possible, and less exclusive reliance on clinical judgment. Moreover, the requirement of the presence of symptoms through both observations and objective assessment is included to ensure specificity. To this end, the proposed rewording preserves the traditional function-based threshold for dementia while attempting to operationalize it more clearly as a loss of independence.

Implications

As mentioned above, mild/major neurocognitive disorder does not require memory to be one of the impaired cognitive domains. The implication is that it is possible that a large number of individuals who did not meet criteria for dementia (or other cognitive disorders) under *DSM-IV* may meet criteria for mild/major neurocognitive disorder under *DSM-5*. For example, individuals who have experienced cognitive decline due to cerebrovascular disease would not meet the threshold for cognitive disorder not otherwise specified (NOS) under *DSM-IV* unless they experienced a significant impairment in memory. However, there are some neurocognitive disorders that affect other cognitive domains first, before affecting memory, if memory is affected at all. As a result, this may increase the prevalence rates of neurocognitive disorders. Nevertheless, diagnosing neurocognitive decline as early as possible rather than waiting until memory gets affected will likely provide better treatment outcomes. That is, if a diagnosis is made when any cognitive domain appears substantially impaired, intervention can begin as soon as possible. If, on the other hand, memory is the last domain to be affected by a neurocognitive disorder, it will likely be the case that, under *DSM-IV*, a diagnosis will not be made until the advanced stages of the disease.

The SSA does not require memory to be one of the impaired domains in order to be considered disabled due to an organic mental disorder; therefore, the *DSM-5*'s neurocognitive disorders may be more consistent with the SSA's conceptualization of organic mental disorders

based on the “Disability Evaluation Under Social Security”. As a result, this change may not significantly impact the rates for those individuals who qualify for disability due to an organic mental impairment. Nonetheless, the change in the *DSM-5*’s neurocognitive disorders will likely affect the type of information the SSA will look for when they receive an application in which the individual has a diagnosis of neurocognitive disorder. First, it is anticipated that there will be more individuals that will meet criteria for neurocognitive disorder who did not meet criteria under *DSM-IV*. To reiterate, this is largely related to the fact that memory impairment is currently a requirement for diagnosis under *DSM-IV*.

Secondly, the dichotomous diagnosis of mild and major neurocognitive disorder has an implicit indicator of functional impairment. For example, major neurocognitive disorder requires a decline in neurocognitive performance, typically 2 or more standard deviations below appropriate norms on formal assessment. The SSA may be able to use the distinction between mild and major neurocognitive disorder as a screening tool for severity even before gathering formal evidence to determine functional impairment, which may streamline the disability determination process for some individuals. Lastly, many individuals who received a diagnosis of cognitive disorder NOS under *DSM-IV* will likely meet criteria for neurocognitive disorder. As a result, those that meet criteria for neurocognitive disorder will be a more heterogeneous group since not all of them will exhibit symptoms of memory impairment.

Schizophrenic, Paranoid, and Other Psychotic Disorders

Schizophrenia

Introduction

The *DSM-IV* definition of schizophrenia has been found to be clinically useful, have high reliability, and fair validity (Haahr et al., 2008). *DSM-IV*’s schizophrenia has high diagnostic stability, with approximately 90% of individuals who received an initial diagnosis of schizophrenia retained that diagnosis after 1 to 10 years. Therefore, the core of the *DSM-IV* diagnostic criteria for schizophrenia will be retained, with modest changes proposed mainly for the purpose of clarity (APA, 2012). The proposed changes in the diagnostic criteria are also aimed to improve alignment with the *ICD-10*.

Proposed changes to the diagnostic category of schizophrenia include removing the schizophrenia subtypes (i.e., paranoid, disorganized, catatonic, undifferentiated, residual) on the basis that they lack validity and clinical usefulness (Rey, 2010). Secondly, diagnostic criteria for schizophrenia are simplified slightly. Also, all patients diagnosed with schizophrenia will be cross-sectionally rated from 0 (not present) to 4 (present and severe) according to 9 dimensions: hallucinations, delusions, disorganization, abnormal psychomotor behavior, restricted emotional expression, avolition, impaired cognition, depression, and mania (APA, 2012).

Implications

Bilder and Mechanic (2003) investigated how the profile of a mental disorder affected application and receipt of SSI/SSDI. For example, while 6% of the national sample and 37% of the sample with any mental disorder applied for benefits, 78% of individuals with schizophrenia

applied. Similarly, individuals with schizophrenia who applied for benefits were more likely to receive them (83%) than were those applicants with any mental disorder (70%). Given the relatively high disability application and receipt rate of individuals with schizophrenia, it is consequential to examine the implications of a change in diagnostic criteria.

The most significant proposed change to the diagnostic criteria of schizophrenia is the elimination of the schizophrenia subtypes. This is the result of the growing acceptance that the heterogeneity of schizophrenia may be better conceptualized in terms of dimensions rather than the traditional subtypes (Peralta & Cuesta, 2003). In fact, these subtypes do not adequately capture the heterogeneity of this disorder, have low diagnostic stability, and with the exception of the paranoid and undifferentiated subtypes, the remaining subtypes are rarely diagnosed (APA, 2012). Because the catatonic, disorganized, and residual subtypes are rarely used, this change is expected to have minimal impact on routine clinical practice.

Another change in the diagnostic criteria of schizophrenia is the deletion of the note regarding delusions and hallucinations in criterion A. Criterion A requires at least 2 (out of 5) characteristic symptoms to be present for a significant portion of time during a 1-month period (APA, 1994). *DSM-IV* currently specifies that only one criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other (APA, 1994). Bizarre delusions and first-rank symptoms have not demonstrated diagnostic specificity. Specifically, research has shown that first-rank symptoms in a heterogeneous group of psychotic disorders do not have prognostic relevance with a family history of schizophrenia (Nordgaard, Arnfred, Handest, & Parnas, 2008). Therefore, in *DSM-5*, two criteria A symptoms must be present for a diagnosis of schizophrenia. This proposed change is anticipated to have little impact on base rates, with about 2% of individuals diagnosed with schizophrenia under *DSM-IV* no longer meeting criteria for schizophrenia under *DSM-5* (Tanenberg-Karant et al., 1995).

Lastly, another proposed criteria for schizophrenia is the requirement that at least one of two required symptoms that meet criterion A be delusions, hallucinations, or disorganized speech (APA, 2012). These are core "positive symptoms" diagnosed with high reliability and might reasonably be considered necessary for an accurate diagnosis of schizophrenia. It is anticipated that this proposed change will not affect prevalence rates as one of these symptoms is present in all cases of *DSM-IV* schizophrenia across various datasets (APA, 2012).

Affective Disorders

Major Depressive Disorders

Introduction

The proposed *DSM-5* changes to the category of major depressive episode are not significantly different from *DSM-IV* in terms of symptomatology and duration. However, one notable difference in the proposed diagnostic criteria for the major depressive disorders (MDDs) is the elimination of the "bereavement exclusion." That is, an individual who has experienced the loss of a loved one and meets the criteria for a major depressive episode will no longer be excluded from receiving an MDD diagnosis under *DSM-5*. This would, therefore, be more consonant with the *ICD* classification of mood disorders, which has never endorsed a formal

bereavement exclusion in the diagnosis of major depression. Moreover, because the SSA also does not endorse a bereavement exclusion, the *DSM-5* would be more congruent with the SSA's conceptualization of affective disorders.

Implications

An accurate diagnosis of depression has far-reaching implications for facilitating judgments regarding disability decisions. Given that 23.5% of individuals with depressive symptoms apply for and receive SSDI and/or SSI benefits, it is important to look at factors that might predict disability receipt among these individuals (Bilder & Mechanic, 2003). Studies that have compared functional impairment between patients with mental disorders and patients with general medical conditions within medical populations have found that major depression is associated with comparable overall impairment and uniquely high levels of social and role impairment (Wells et al., 1989). These researchers concluded that the functioning of depressed patients is comparable to, or worse than, that of patients with major chronic medical conditions. Wells and colleagues (1989) also found that depressive symptoms and medical conditions have additive effects on functioning. For instance, the co-occurrence of advanced coronary artery disease and depressive symptoms was associated with approximately twice the reduction in social functioning associated with either condition alone.

A likely result of the proposed removal of the bereavement exclusion will be an increase in the number of diagnoses for major depression by health professionals. However, given that the proposed criteria for MDD is more congruent with the SSA's conceptualization of affective disorders, a formal *DSM-5* diagnosis of depression may expedite decisions regarding disability. It has been recognized that while grief is not the same as depression, bereavement is a major stressor that has the potential to trigger an episode of major depression in some individuals (Shear, 2011). Research indicates that approximately 30% of bereaved individuals meet diagnostic criteria for depression (Zisook et al., 2010). If *DSM-5* ultimately removes the bereavement exclusion, it is important to recognize the implication of the recurrence of depressive episodes in bereavement-related depression and "standard" major depression. Mojtabai (2011) conducted a longitudinal study, using a community sample from the National Epidemiologic Survey on Alcohol and Related Conditions, to address this issue. His research compared individuals with bereavement-related depression versus standard major depression at baseline and recurrence at a 3-year follow-up. He found that individuals who had experienced a single lifetime bereavement-excluded depression ($N = 162$) were no more likely to have an MDD diagnosis during the follow-up period than were those in the general population who had no lifetime history of MDD at baseline (4.3% and 7.5%, respectively). Therefore, this study revealed that an individual experiencing bereavement-related depression was at less risk of developing future depressive episodes as compared to individuals suffering from standard major depression.

Another study examined the degree to which categorical *DSM-IV* diagnoses of depressive disorders predicted long-term course and outcome (Wittchen et al., 2011). They found that having any threshold depressive diagnosis (i.e., major depression, dysthymia, or anxiety and depression), as compared with "no diagnosis" at baseline, was associated with higher proportions of malignant psychopathological outcomes after 10 years. Specifically, only 16.9% of all

participants with a baseline depressive disorder had no threshold mental disorder in the 10-year follow-up period; in contrast, 34.9% had at least three mental disorders.

Wittchen and colleagues (2011) also evaluated the extent to which various additional dimensional measures improved prediction beyond the contribution of the categorical baseline diagnosis. Most dimensional measures examined were associated with improved prediction for most outcome measures beyond the value of the categorical diagnosis, as expressed by significant odds ratios. Specifically, the numbers of panic (odds ratio = 6.0) and generalized anxiety disorder (GAD; odds ratio = 6.9) symptoms were found to have a somewhat stronger correlation with malignant outcomes among baseline depression cases. Some differences between outcome measures should be noted. For instance, suicide attempts appeared to be better predicted by prior depression duration and number of depressive symptoms than anxiety measures. The number of depressive symptoms, dysthymic symptoms, and depression duration were best in predicting hospitalization days. The number of GAD symptoms was the only significant anxiety outcome measure. Finally, ad hoc measures of anxiety, depression, and depression duration were best in predicting number of disability days.

Wittchen et al. (2011) also examined associations for diagnostic subtypes of depression. Specifically, they found that the categorical baseline diagnosis of dysthymia was highly predictive of morbidity score (odds ratio = 11.1). Moreover, the dimensional measures did not significantly add further predictive power. A significant prediction based on the categorical baseline diagnosis of MDD was not found (odds ratio = 2.9). However, for MDD, it was found that the dimensional measures yielded higher odds ratios than the categorical diagnosis. Given these findings, it would seem to suggest that a diagnosis of MDD alone may not be useful in predicting long-term disability; however, information regarding dimensional ratings may be more helpful in facilitating disability determination decisions. Conversely, dimensional ratings may be less important for individuals with dysthymic disorder in predicting disability than the diagnosis of the disorder itself.

Bipolar Disorder

Introduction

It is estimated that approximately 31% of patients with major depression are misdiagnosed as having MDD rather than bipolar disorder (Hirschfeld et al., 2003), with an average of a 7 to 10 year delay of receiving a correct diagnosis (Kupfer et al., 2002; Hirschfeld, Lewis, & Vornik, 2003). The proposed changes in diagnostic criteria for manic episode attempts to address this issue by improving diagnostic specificity. The *DSM-5* work groups hope to achieve this by including a period of increased activity or energy to the criteria for manic episode. The crux of the problem is likely related to the fact that oftentimes the patient seeks help when they are in a depressed state and, therefore, the clinician attempts to assess hypomania/mania retrospectively. In these common situations, the patient is more likely to remember a period of increased energy rather than changes in mood that may be more subtle (Benazzi, 2003).

A substantial number of individuals who seek treatment for symptoms that meet criteria for a major depressive episode also report an admixture of manic symptoms that do not meet the *DSM-IV* criteria for a mixed episode (Kupfer et al., 2011). The presence of sub-threshold manic

symptoms has been associated with earlier onset (Akiskal & Benazzi, 2003; Zimmermann et al., 2009), a greater number of episodes (Akiskal & Benazzi, 2003; Zimmermann et al., 2009), and a greater likelihood of a lifetime diagnosis of bipolar disorder (Angst et al., 2011). There is garnering evidence that the significant prevalence of subthreshold mixed states among individuals who have experienced major depressive episodes increase the likelihood that the presenting disorder reflects a bipolar trajectory.

Implications

Currently, it is possible for an individual to receive a diagnosis of bipolar I/II disorder without indicating a change in activity or energy. The proposed criteria for a manic episode to include a period of increased activity or energy to criterion A means this symptom is required for a diagnosis of bipolar disorder (APA, 2012). It should be clarified that this inclusion of increased energy or activity should not be confused with the criterion B symptom of an “increase in goal-directed activity.” The criterion A proposed revision is intended to be a broad inquiry about overall changes in activity or energy whereas criterion B is intended to be a detailed inquiry of goal-directed activity. Overall, it is expected that the increased precision will have a net null effect on base rates (APA, 2012). More specifically, it is anticipated that these changes will result in an increase in correct diagnoses and a decrease in incorrect diagnoses of bipolar disorders.

The *DSM-IV* only recognizes the coexistence of full manic and major depressive syndromes as having mixed states and thus fails to capture the important information conveyed by subthreshold admixtures of manic and depressive symptoms. Both the proposed changes to major depressive episode and manic episodes include a specifier for mixed features. Consequently, if an individual presents with major depressive disorder with mixed features, this may be a harbinger of a bipolar trajectory. Therefore, this specifier may be helpful to the SSA in determining thresholds for disability.

Intellectual Disability

Intellectual Developmental Disorder

Introduction

The most apparent change to the diagnostic category of mental retardation is the name change to intellectual disability (APA, 2012). Additionally, in *DSM-IV*, mental retardation was an Axis II diagnosis. However, with the proposed elimination of the multi-axial structure, intellectual developmental disorder (IDD) in *DSM-5* will be an Axis I diagnosis (APA, 2012). The *DSM-5* proposal includes the elimination of IQ test score requirements in the formal diagnostic criteria, which is consonant with the proposed *ICD-10*. Nonetheless, *DSM-5* continues to emphasize that standardized psychological testing must be included in the clinical assessment. Finally, *DSM-5* proposes the removal of IQ-based subtypes (i.e., mild, moderate, severe, and profound). *DSM-5* will have mild, moderate, and severe severity levels; however, the severity levels are intended to focus on adaptive functioning rather than IQ test performance (APA, 2012).

Implications

First, because the SSA relies, at least in part, on IQ ranges for determining intellectual disability, the SSA will need to take into consideration that a *DSM-5* diagnosis of IDD will not have an implicit indicator of IQ level due to the elimination of the IQ-based subtypes. Second, test score requirements will no longer be in the formal diagnostic criteria. Consequently, the SSA may need to find IQ test scores within clinicians' reports, which may not always be available. Another implication is the possibility that, in practice, clinicians may not administer tests that produce a full-scale IQ. For example, the proposed *DSM-5* conceptualizes IDD as a disorder "characterized by deficits in general mental abilities such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning and learning from experience" (APA, 2012). Based on this definition, clinicians might administer memory and executive functioning tests, which do not yield a full-scale IQ score, yet may still satisfy the definition of *DSM-5*'s IDD. Therefore, it may be appropriate for the SSA to revise their criteria to eliminate any reference to a full-scale IQ for determining intellectual disability.

Anxiety-Related Disorders

Generalized Anxiety Disorder

Introduction

The changes that the *DSM-5* Anxiety Work Group proposes for GAD have the potential to exponentially increase the number of individuals who meet criteria for a GAD diagnosis (Horwitz, 2012). The concern is whether this change represents greater precision in capturing the pathology associated with GAD or if this change will lead to an increase in misdiagnoses (false positives). The proposed criteria for GAD runs the risk of pathologizing what may be considered to be "normal" worry or anxiety. First, the duration for GAD will be lowered from 6 to 3 months and the severity thresholds will be changed from 3 out of 6 to 1 out of 2 symptoms. Because the types of worries the *DSM-5* criteria specify (i.e., family, health, finances, and school/work difficulties) are the most common concerns in the population, lower thresholds have the potential to dramatically increase the number of people who meet criteria for GAD.

Implications

Wittchen et al. (2011) found that having any threshold baseline anxiety diagnosis (i.e., panic attack, panic disorder, agoraphobia, GAD, social phobia, specific phobia), as compared with "no diagnosis" at baseline, was associated with higher proportions of malignant psychopathological outcomes 10 years later. Only 17.5% (panic attack) to 18.6% (GAD) of all participants with a baseline anxiety disorder had no subsequent threshold mental disorders in the 10-year follow-up period. In contrast, 40.3% (panic attack) to 73.1% (panic disorder) had at least three mental disorders at follow up. Number of diagnoses at baseline was associated with an increasing proportion of severe/multimorbid-severe outcome – that is, no baseline diagnosis (11.1%), one (24.5%), two (43.1%), or three or more (66.7%).

Most of the dimensional measures that Wittchen et al. (2011) examined were associated with improved prediction of most outcomes measures beyond the value of the categorical anxiety disorder diagnosis, as revealed by significant odds ratios. The highest odds ratios were found for numbers of dysthymia (7.7) and depressive symptoms (6.2), depression duration in months (5.5), and numbers of GAD and panic symptoms (4.9). It is noteworthy that two of the lengthy psychometric scale measures that were used in this study did not demonstrate superiority over the simpler, ad hoc scales.

Given the heterogeneity of anxiety disorders, Wittchen and colleagues (2011) also examined the predictive value of diagnostic subtypes. They found that the categorical baseline diagnoses for panic attack, panic disorder, and GAD were highly predictive of the morbidity score (odds ratios = 28.8, 18.6, 12.2, respectively). For these disorders, the dimensional measures did not significantly add further predictive power. However, for agoraphobia, social phobia, and specific phobia, the dimensional ratings yielded higher odds ratios than the categorical diagnosis alone.

Because of the high comorbidity between depression and anxiety, it is important to consider the impact of comorbidity on disability. Research has demonstrated that anxiety and depression at baseline were significantly associated with subsequent disability pension awards, an effect only partially explained by adjusting for comorbid somatic symptoms and diagnoses (Mykletun et al., 2006). Moreover, the effect of comorbid anxiety/depression was stronger than that of either anxiety or depression alone. In addition, Kessler, DuPont, Berglund, and Wittchen (1999) found that a substantial amount of GAD occurs independently of major depression and that the role impairment of GAD is similar to that of major depression.

A study investigated the effect of the proposed *DSM-5* criteria for GAD on prevalence and severity using data from the 2007 Australian National Survey of Mental Health and Well Being (Andrews & Hobbs, 2010). The results revealed that reducing the duration from 6 to 3 months and removing the clinical significance criterion raised the prevalence of GAD by 22% (AUC = 0.97, Kappa = 0.84); however, revising the associated symptoms and adding behavioral symptoms reduced the prevalence (Andrews & Hobbs, 2010). Although the overall prevalence rates increased by 9%, it was associated with comparable levels of distress and impairment as *DSM-IV* cases. In summary, this study provides preliminary evidence that the proposed criteria may increase the prevalence of GAD without influencing the severity of cases.

Posttraumatic Stress Disorder

Introduction

The proposed revisions to *DSM-IV*'s posttraumatic stress disorder (PTSD) primarily involve changing the types of events satisfying the traumatic stressor criterion (Criterion A1 in *DSM-IV*); deleting the requirement for initial subjective reactions of intense fear, helplessness, or horror to the stressor event (Criterion A2); and broadening the scope of symptoms beyond re-experiencing, avoidance, and numbing and arousal symptoms in order to include dysphoria (Criterion C; APA 2012).

The proposed changes to *DSM-5*'s PTSD criteria involve several changes to Criterion A1 (APA, 2012). First, the proposed change requires that indirect exposure through witnessing a stressor event must occur in person. Second, the proposal suggests that for indirect exposure to

occur through learning about a loved one's traumatic experience, it must involve violent or accidental death (versus death from natural causes or old age). Third, it is proposed that indirect exposure may also involve persistent or prolonged exposure to aversive details of a traumatic event, with the condition that such aversive exposure can be through electronic media only if it occurs as part of one's occupation (Elhai et al., 2012).

Implications

Elhai et al. (2012) examined the impact of the proposed PTSD diagnostic criteria on the prevalence rates of trauma exposure and PTSD, along with symptom structure differences, among non-clinical college students. As a result of applying the proposed *DSM-5* changes, estimated trauma exposure prevalence decreased significantly, while the prevalence of PTSD increased (but not significantly). The results revealed prevalence estimates of trauma exposure of 67% and 59% when applying *DSM-IV* and *DSM-5* criteria, respectively. Additionally, they found that among students who reported being witness to a traumatic event that met *DSM-IV*'s traumatic stressor criterion, only 43% of those individuals indicated witnessing the trauma in person and would thus count as qualifying trauma according to the proposed *DSM-5* stressor criterion. Consequently, the remaining 57% of subjects who reported witnessing a trauma would not qualify for the *DSM-5* stressor criterion because they were not exposed to the events in person. More than half of this subgroup could be diagnosed with PTSD by *DSM-IV* criteria but not by *DSM-5* criteria because they did not report any other traumatic events. Thus, based on these results, the *DSM-5*'s restriction to include only in-person experiences of witnessed trauma should lead to slightly decreased trauma exposure prevalence rates.

The proposed PTSD criteria include the deletion of the requirement for initial subjective reactions of intense fear, helplessness, or horror to the stressor event (Criterion A2). Elhai et al. (2012) investigated whether Criterion A2's deletion would substantially impact PTSD diagnostic stability. Using the proposed *DSM-5* criteria, they found the difference to be small in absolute terms, with an increase of approximately one-half of a percentage point in estimated prevalence from *DSM-IV* criteria with A2 (4.3%) to *DSM-5* criteria without A2 (4.8%). Overall, findings suggest that the proposed criteria may slightly increase the prevalence of PTSD, although not significantly.

Somatoform Disorders

Somatic Symptom Disorder

Introduction

Somatic symptom disorder was not listed in *DSM-IV*; however, this proposed disorder subsumes *DSM-IV* diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriasis, and the pain disorders (APA, 2012). The proposed classification for somatic symptom disorder places less emphasis on the role of medically unexplained symptoms. Moreover, the conceptualization of this syndrome of disorders is based on positive psychological symptoms. Depending on the number of psychological criteria endorsed, a severity specifier will

be assigned (i.e., mild = 1 criterion; moderate = 2 or more criteria; severe = 2 or more criteria with the presence of somatic symptoms).

Implications

Voigt and colleagues (2012) examined the diagnostic stability as well as predictive validity in functional impairment of *DSM-5*'s somatic symptom disorder compared to *DSM-IV*'s somatoform disorders. Participants included 456 psychosomatic inpatients who were diagnosed with somatoform, depressive, and anxiety disorders based on *DSM-IV* criteria. Measures assessing somatic symptom severity, severity of depression and anxiety, relevant psychological symptoms, and health-related quality of life were administered at admission and discharge. Scores on these measures were used to apply the proposed diagnostic criteria of *DSM-5*'s somatic symptom disorder. Overall, they found that there was only a fair degree of agreement between *DSM-IV*'s somatoform disorders and the proposed *DSM-5* somatic symptom disorder (Cohen's $\kappa = 0.235$). The proposed criteria identified patients who were generally younger and reported more somatic, depressive, and anxiety symptoms. However, these individuals did not differ in physical disability from patients who met the criteria for somatoform disorders and not the criteria for somatic symptom disorder.

Voigt et al. (2012) also found that when only one psychological symptom was met, somatic symptom disorder had a higher prevalence rate (67.9%) than somatoform disorders (56.5%). A threshold of two psychological symptoms (moderate severity level) resulted in 55% of the sample meeting criteria for somatic symptom disorder, which is more congruent with the prevalence rate for somatoform disorder. Patients' physical level of functioning at discharge was similar to that at admission, regardless of whether they were diagnosed with somatoform disorder or with somatic symptom disorder. However, *DSM-5*'s somatic symptom disorder was significantly associated with mental functioning at discharge. In all, these data suggest that *DSM-5*'s somatic symptom disorder identifies individuals who are more psychologically impaired. Finally, the threshold of 1 out of 3 psychological symptoms of somatic symptom disorder may increase the prevalence of the disorder whereas a threshold of 2 or 3 symptoms may not substantially change prevalence rates.

Personality Disorders

Introduction

Arguably, the proposed changes to the personality disorders category are not only significant, but the most controversial. Debates surrounding the appropriateness of a dimensional classification of the personality disorders have been ongoing for several years. Additionally, a high rate of comorbidity among the personality disorders has been identified as a prominent problem (Trull & Durrett, 2005; Westen & Shedler, 1999). Because of the high comorbidity rates among the personality disorders, some researchers have interpreted this finding as an indication that the personality disorders do not accurately represent unique clinical phenomena (Trull & Durrett, 2005; Westen & Shedler, 1999). The *DSM-5* Personality Disorders Work Group have addressed the problem of comorbidity by recommending the reduction of the number of personality disorders from 10 to 6, thereby eliminating paranoid, schizoid, histrionic, and

dependent personality disorders (APA, 2012). The *DSM-5* proposes that individuals with a retained personality disorder (i.e., narcissistic, borderline, antisocial, obsessive-compulsive, avoidant, and schizotypal) be assessed on personality functioning (i.e., self-functioning and interpersonal functioning) and on personality traits (i.e., negative affectivity, disinhibition, and antagonism).

Implications

Zimmerman, Chelminski, Young, Dalrymple, and Martinez (2012) were the first researchers to investigate the impact of the proposed *DSM-5* personality disorders on prevalence rates in a large sample of psychiatric outpatients. It should be noted that at the time of their study, the *DSM-5* proposal of personality disorders included the elimination of narcissistic personality disorder, in addition to the four that are currently being recommended for exclusion.

The results of Zimmerman and colleagues' study (2012) revealed that more than one-fourth of the patients were diagnosed with one of the 10 *DSM-IV* personality disorders (28.6%, $n = 614$). However, when schizoid, paranoid, histrionic, narcissistic, and dependent personality disorders were removed from consideration, 25.8% ($n = 555$) of the patients were diagnosed with at least one of the retained personality disorders. Overall, 7.8% ($n = 168$) of the patients were diagnosed with at least one of the removed personality disorders. Specifically, 59 individuals were diagnosed solely with an excluded personality disorder and the remaining individuals ($n = 109$) were also diagnosed with a retained personality disorder.

The researchers also examined whether comorbidity rates would decrease as a result of reducing the number of personality disorder diagnoses (Zimmerman et al., 2012). Of the individuals ($n = 614$) who were diagnosed with any of the 10 *DSM-IV* personality disorders, 29.8% ($n = 183$) were diagnosed with at least one other personality disorder. On the other hand, of the 555 individuals with a retained personality disorder, 21.3% ($n = 118$) were diagnosed with another retained personality disorder. Finally, Zimmerman et al. (2012) found no difference between the retained and excluded personality disorder categories on any indicators of severe illness or psychosocial morbidity. However, they found that patients with a retained personality disorder exhibited more Axis I diagnoses than those with an excluded personality disorder. Moreover, patients with an excluded personality disorder exhibited significantly more Axis I disorders, had poorer social functioning, had lower Global Assessment of Functioning ratings, and missed more time from work compared to individuals without any personality disorder.

Based on the only study examining the overall impact of the deletion of 5 personality disorders, approximately 10% of individuals with a personality disorder would no longer have a diagnosis of personality disorder because they were diagnosed with at least one of the disorders that was recommended for exclusion (Zimmerman et al., 2012). Therefore, the goal of reducing comorbidity would be achieved by the deletion of 5 personality disorders; however, it would not completely resolve the problem. Moreover, there appeared to be little difference in morbidity between individuals with a retained and excluded diagnosis. Also, psychosocial morbidity was greater in individuals with an excluded diagnosis compared to patients without a personality disorder diagnosis. Based on these findings, it may be possible that the reduction of comorbidity may come with a concomitant cost of false-negative diagnoses (Zimmerman et al., 2012). However, it may be that false-negatives will be obviated because the *DSM-5* will allow such pathology to be captured in the trait ratings. As a result, the SSA may need to consider whether

the excluded personality disorders warrant a change in their conceptualization of disability. If not, the SSA may need to consider how individuals who have an excluded personality disorder can provide medical evidence to satisfy the severity requirements for disability.

Substance Addiction Disorders

Substance Use Disorder

Introduction

Changes to the diagnostic criteria for substance use disorders (SUDs) in *DSM-5* include eliminating the “recurrent legal problems” criterion and introducing a “craving” criterion (APA, 2012). Additionally, results from factor and latent class analyses suggest that substance-related problems may be better conceptualized along a single dimension rather than as separate abuse and dependence factors (Krueger et al., 2004). Therefore, the proposed SUD category will include four levels of severity based on the total number of positive criteria: No diagnosis (0 criteria or 1 criterion), Mild (2-3 criteria), Moderate (4-5 criteria), and Severe (6 or more criteria). Given that substance-dependent individuals tend to experience poorer prognosis and treatment outcomes relative to individuals with a substance abuse diagnosis (Hasin, Van Rossem, McCloud, & Endicott, 1997; Schuckit et al., 2008, 2001), the question is to what extent the severe SUD designation of the proposed *DSM-5* will effectively classify those with a more severe clinical profile and also identify those with a more chronic course.

Additionally, many authors argue that “diagnostic orphans” may manifest severe substance-related problems similar in severity level to those with a qualified substance dependence diagnosis (Peer et al., 2012; Proctor, Kopak, & Hoffman, 2012). Diagnostic orphans are individuals who meet one or two of the diagnostic criteria for substance dependence yet fail to report indications of substance abuse, thereby receiving no diagnosis. Considering the negative clinical and prognostic implications of diagnostic orphans failing to receive a formal *DSM-IV* substance abuse/dependence diagnosis, it seems appropriate to consider to what extent these cases will be identified by the proposed *DSM-5* revisions.

Implications

Research that has investigated the prevalence of *DSM-IV*'s substance abuse/dependence and *DSM-5*'s SUDs has generally found that the proposed changes in *DSM-5* will have minimal impact on prevalence rates (Peer et al., 2012). Peer and colleagues (2012) investigated the prevalence of *DSM-IV* and *DSM-5* alcohol, cocaine, opioid, and cannabis use disorders among individuals with one or more SUD. The Semi-Structured Assessment for Drug Dependence and Alcoholism was used to determine lifetime *DSM-IV* diagnoses of SUDs. For each substance, questions regarding craving were included, which allowed an assessment for prevalence estimates based on *DSM-5* criteria. The results revealed that the prevalence rates for *DSM-5* consistently exceeded those for *DSM-IV*; however, the differences were modest. The overall agreement between the diagnoses under *DSM-IV* and *DSM-5* was very high, ranging from 92.9% to 99.0%. The majority of “diagnostic switching” from no *DSM-IV* diagnosis to a *DSM-5* diagnosis was due to the lower threshold, specifically, 99% for alcohol, 90% for cocaine, 93%

for opioids, and 85% for cannabis. Proctor and colleagues (2012) investigated the diagnostic utility of the proposed criteria for cocaine use disorders (CUD) in accounting for *DSM-IV* diagnostic orphans among state prison inmates. They found that when *DSM-5* criteria were applied, 11.8% of the diagnostic orphans received a mild CUD diagnosis and none received a severe CUD diagnosis.

Peer et al. (2012) also found a clear concordance between a substance dependence diagnosis under *DSM-IV* and a severe SUD diagnosis under *DSM-5*. Moreover, there was high concordance between *DSM-IV* and *DSM-5* on the absence of a diagnosis. However, there was greater variability among individuals with a *DSM-IV* abuse diagnosis. The majority of individuals who received a *DSM-IV* substance abuse diagnosis received a *DSM-5* mild SUD diagnosis, with the remaining receiving either no diagnosis or a moderate SUD. Therefore, *DSM-IV* abuse did not consistently correspond onto a single severity level in *DSM-5*. These findings are generally consistent with research examining the compatibility of the diagnostic criteria between *DSM-IV*'s cocaine abuse/dependence and *DSM-5*'s CUD among state prison inmates (Proctor et al., 2012). Taken together, these studies suggest that the application of *DSM-5* criteria will have a negligible impact on the prevalence of SUD diagnoses. However, it appears that the adoption of the proposed *DSM-5* SUD criteria may provide at least a partial solution in identifying *DSM-IV* diagnostic orphans.

Autistic Disorder and Other Pervasive Developmental Disorders

Autism Spectrum Disorder

Introduction

DSM-IV's autistic disorder will be renamed to autism spectrum disorder (ASD) in *DSM-5* (APA, 2012). The proposed criteria for ASD are more stringent than *DSM-IV*, in which more ASD symptomatology is needed in order to meet criteria for a diagnosis. Specifically, the *DSM-5* proposal includes requiring three deficits in social interaction: social-emotional reciprocity, nonverbal communicative behaviors, and developing and maintaining age-appropriate relationships (APA, 2012). However, *DSM-IV* requires only 2 out of 4 deficits in social interaction. A recent study investigated the potential impact of the proposed changes in criteria for ASD among adults with intellectual disability from two developmental centers (Matson, Belva, Horovitz, Kozlowski, & Bamburg, 2012). Matson and colleagues (2012) found that individuals who met the criteria for ASD based on *DSM-5* exhibited significantly greater ASD symptoms than those who met criteria based on *DSM-IV* as well as a control group. Moreover, they found that the *DSM-IV* group exhibited significantly more ASD symptoms than the control group. These results suggest that there will be a subgroup of adults who exhibit a significant amount of ASD symptoms as compared to non-ASD individuals; however, these individuals will no longer meet criteria under *DSM-5*.

Frazier et al. (2012) evaluated specific changes in the proposed *DSM-5* algorithm that was examined in phase I field trials. *DSM-5* criteria had superior specificity compared to *DSM-IV* criteria (0.97 versus 0.86, respectively); however, sensitivity was lower compared to *DSM-IV* criteria (0.81 versus 0.95, respectively). The increase in specificity is notable in that it could

reduce false positives by more than four times the estimated *DSM-IV* rate (*DSM-5* = 3% versus *DSM-IV* = 14%).

Implications

A major concern of the above-mentioned findings is the impact on prevalence rates of ASD once *DSM-5* is published (Matson et al., 2012). Because *DSM-5* will utilize a higher diagnostic threshold in order to obtain an ASD diagnosis, the prevalence rates of ASD will likely decrease as a result. This decrease may result in many individuals who would have previously received necessary interventions, but may no longer qualify for such services, despite exhibiting significant impairments.

The SSA does not base their disability decisions on a formal *DSM* diagnosis; nevertheless, it is important to raise possible issues in this diagnostic category when *DSM-5* is released. Specifically, because the SSA may accept a *DSM* diagnosis from a health professional as an acceptable medical source from an applicant, the change in *DSM-5* will likely affect judgments involved in the disability determination process. For example, if an individual with *DSM-IV* autistic disorder is currently receiving SSI/SSDI and is required to get an updated disability evaluation, they may or may not receive an ASD diagnosis based on *DSM-5* criteria. This means that the SSA will likely need to rely on other sources of information (i.e., documentation, observations, etc.) in order to ascertain whether the individual meets the severity requirements based on their definition of disability.

Discussion

A review of some of the most prevalent mental disorders reveals that some of the proposed changes in *DSM-5* may range from limited impact to substantial changes with respect to base rates and conceptualizations of certain mental disorders (see Appendix B for summary). Moreover, it appears that the proposed changes in *DSM-5* may provide the SSA with an indicator of severity through the dimensional ratings that will be available for many disorders. For example, the SSA might consider utilizing the severity ratings in order to make informed decisions regarding a person's functional capacity and to establish a cutoff that is consistent with their definition of disability. This might allow the disability determination process for mental disorders to be less arbitrary and more transparent.

The ability to objectively quantify symptom severity in a manner that is relatively consistent across time, patients, and clinicians would have significant advantages over the current intuitive approach (Helzer, 2011). The dimensional measures are meant to be sensitive to differences between patients and to changes within patients (Kraemer et al., 2010), which the SSA can utilize in disability determination decisions. For instance, under *DSM-5*, a person diagnosed with bipolar disorder with a "severe" severity rating may be deemed disabled by the SSA. If the person receives a significantly lower rating at his/her next disability evaluation, it may be determined that he/she does not meet the severity requirements for disability. Furthermore, the SSA might consider the frequency of disability evaluations to be contingent on *DSM-5* severity ratings.

One of the limitations of this study is that the proposed diagnostic criteria for many disorders were revised at least once during the time of this study. Furthermore, for many

disorders, decisions regarding the appropriate dimensional severity ratings were still being explored at the time of this writing. Therefore, the final version of *DSM-5* may differ from the changes discussed in the present study. In a related vein, some of the research that investigated the proposed changes to *DSM-5* examined the changes at the time of their study. Therefore, the criteria that were investigated may have changed from the most recent proposal as well as from the final version of *DSM-5*. Another limitation of this study is that the research on *DSM-5* has been more widely investigated for certain disorders than others. For example, at the time of this writing, there was a paucity of research on somatic symptom disorder. Finally, each study used different methodological approaches in applying the *DSM-5* criteria, thereby limiting generalizability across studies.

Future research should investigate the diagnostic stability in various clinical settings between *DSM-IV* and *DSM-5* after *DSM-5* is published. Also, future research should investigate the clinical utility of severity ratings. This can be achieved by empirically relating neuroimaging, sophisticated diagnostic tools, and measures of everyday functioning to severity ratings. Finally, future research should compare the base rates for *DSM-IV* and *DSM-5* disorders as it relates to rates of disability as defined by the Social Security Administration.

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Appendix A
Acronyms

APA	American Psychiatric Association
ASD	Autism spectrum disorder
AUC	Area under curve
CUD	Cocaine use disorder
<i>DSM</i>	<i>Diagnostic and Statistical Manual of Mental Disorders</i>
GAD	Generalized anxiety disorder
<i>ICD</i>	<i>International Classification of Diseases</i>
ID	Intellectual disability
IDD	Intellectual developmental disorder
MDD	Major depressive disorder
NOS	Not otherwise specified
PTSD	Posttraumatic stress disorder
SSA	Social Security administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SUD	Substance use disorder

Appendix B
Summary Table

SSA's Listing of Mental Impairments	DSM-5 Disorders Examined
1. Organic Mental Disorders	Neurocognitive Disorders
2. Schizophrenic, Paranoid and Other Psychotic Disorders	Schizophrenia
3. Affective Disorders	Major Depressive Disorders; Bipolar Disorder
4. Intellectual Disability	Intellectual Developmental Disorder
5. Anxiety-Related Disorders	Generalized Anxiety Disorder; Posttraumatic Stress Disorder
6. Somatoform Disorders	Somatic Symptom Disorder
7. Personality Disorders	Personality Disorders
8. Substance Addiction Disorders	Substance Use Disorders
9. Autistic Disorder and Other Pervasive Developmental Disorders	Autism spectrum disorder

1. Organic Mental Disorders

Proposed <i>DSM-5</i> Changes*	Implications
<p><i>Neurocognitive Disorders</i></p> <ul style="list-style-type: none"> • “Neurocognitive disorder” will replace the term “dementia” • “Mild” and “major” severity level distinctions • Focus on a decline from a previous level of neurocognitive performance (as opposed to “deficit”) <ul style="list-style-type: none"> ➔ Mild = between 1 and 2 standard deviations ➔ Major = 2 or more standard deviations • Not requiring memory to be one of the impaired cognitive domains 	<ul style="list-style-type: none"> • Individuals who did not meet <i>DSM-IV</i> criteria because of the memory impairment requirement may meet <i>DSM-5</i> criteria for neurocognitive disorders <ul style="list-style-type: none"> ➔ Will likely increase prevalence rates • Dichotomous severity distinctions may serve as a screening tool for the SSA in assessing functional impairment • Proposed changes may be more congruent with the SSA’s conceptualization of organic mental disorder • Possibility of better treatment outcomes; early intervention

2. Schizophrenic, Paranoid and Other Psychotic Disorders

Proposed <i>DSM-5</i> Changes*	Implications
<p><i>Schizophrenia</i></p> <ul style="list-style-type: none"> • Removal of the schizophrenia subtypes (i.e., paranoid, disorganized, catatonic, undifferentiated, residual) • Deletion of the note that only one criterion A symptom is required if 1) delusions are bizarre or 2) hallucinations consist of (a) a voice keeping up a running commentary on the person’s behavior or thoughts, or (b) two or more voices conversing with each other • Two criteria A symptoms will be required for diagnosis <ul style="list-style-type: none"> • At least 1 of the 2 required symptoms for criterion A must be a core positive symptom (i.e., delusions, hallucinations, 	<ul style="list-style-type: none"> • Removal of the schizophrenia subtypes is expected to have little impact on routine clinical practice • Deletion of the note regarding delusions and hallucinations is anticipated to have little impact on base rates • Requirement of one core “positive symptom” is expected to not affect prevalence rates

<p>or disorganized speech)</p> <ul style="list-style-type: none"> Severity ratings will be made according to 9 dimensions: hallucinations, delusions, disorganization, abnormal psychomotor behavior, restricted emotional expression, avolition, impaired cognition, depression, and mania 	
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3. Affective Disorders

Proposed DSM-5 Changes*	Implications
<p><i>Major Depressive Disorders</i></p> <ul style="list-style-type: none"> Elimination of the “bereavement exclusion” Inclusion of a specifier for mixed features 	<ul style="list-style-type: none"> Elimination of the “bereavement exclusion” will likely lead to an increase in prevalence rates for major depressive disorders <ul style="list-style-type: none"> ➔ Proposed change will be more congruent with SSA’s conceptualization of affective disorder Research suggests that bereavement-related depression and “standard” major depression may differentially predict an individual’s risk of developing future depressive episodes Research has shown that a categorical diagnosis of dysthymia may be significantly predictive of morbidity score; however, dimensional ratings do not add to predictive power Research has shown that a categorical diagnosis of major depressive disorder was not found to be significantly predictive of morbidity score; however, dimensional ratings demonstrated predictive power Inclusion of a specifier for mixed features will capture individuals who exhibit subthreshold admixtures of manic and depressive symptoms (may be harbinger of a bipolar trajectory)

<p><i>Bipolar Disorder</i></p> <ul style="list-style-type: none"> • Inclusion of a period of increased activity or energy • Inclusion of a specifier for mixed features 	<ul style="list-style-type: none"> • Inclusion of a period of increased activity or energy may improve diagnostic specificity • Expected to have a net null effect on prevalence rates • Inclusion of a specifier for mixed features will capture individuals who exhibit subthreshold admixtures of manic and depressive symptoms (may be harbinger of a bipolar trajectory)
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4. Intellectual Disability

<p>Proposed DSM-5 Changes*</p>	<p>Implications</p>
<p><i>Intellectual Developmental Disorder</i></p> <ul style="list-style-type: none"> • “Mental retardation” will be renamed to “intellectual disability” • Axis I diagnosis (no longer an Axis II diagnosis) • Elimination of IQ test score requirements • Removal of IQ-based subtypes (i.e., mild, moderate, severe, and profound) • Severity levels (i.e., mild, moderate, and severe) will focus on adaptive functioning as opposed to IQ test performance • Proposed definition does not require standardized testing that yields a full-scale IQ 	<ul style="list-style-type: none"> • SSA may need to consider how removal of IQ test score requirements will affect their definition of intellectual disability • SSA may need to consider how removal of IQ-based subtypes will affect how an individual will meet criteria for disability • Clinicians may administer tests that are proxies to intellectual functioning; therefore, the SSA may need to consider elimination of any reference to a full-scale IQ in their definition

5. Anxiety-Related Disorders

Proposed <i>DSM-5</i> Changes*	Implications
<p><i>Generalized Anxiety Disorder</i></p> <ul style="list-style-type: none"> • Duration of symptoms will be lowered from 6 to 3 months • Severity thresholds will be changed from 3 out of 6 to 1 out of 2 symptoms 	<ul style="list-style-type: none"> • Proposed changes may increase prevalence rates without influencing the severity of cases • Research has shown that a categorical diagnosis of GAD may be highly predictive of morbidity score; however, dimensional ratings may not significantly add further predictive power
<p><i>Posttraumatic Stress Disorder</i></p> <ul style="list-style-type: none"> • Revision of events satisfying the traumatic stressor criterion <ul style="list-style-type: none"> ➔ Indirect exposure through witnessing a stressor event must occur in person ➔ Indirect exposure through learning about a loved one’s traumatic experience must involve violent or accidental death ➔ Indirect exposure may involve persistent or prolonged exposure to aversive details of a traumatic event, with the condition that such aversive exposure can be through electronic media only if it occurs as part of one’s occupation • Deletion of the requirement for the initial subjective reactions of intense fear, helplessness, or horror to the stressor event • Broadening the scope of symptoms beyond re-experiencing, avoidance, and numbing and arousal symptoms to include dysphoria 	<ul style="list-style-type: none"> • Trauma exposure prevalence may decrease significantly • Overall prevalence of PTSD may increase (but not significantly)

6. Somatoform Disorders

Proposed <i>DSM-5</i> Changes*	Implications
<p><i>Somatic Symptom Disorder</i></p> <ul style="list-style-type: none"> • “Somatic symptom disorder” will subsume <i>DSM-IV</i> diagnoses of somatization disorder, undifferentiated somatoform disorder, hypochondriasis, and pain disorders • Proposed category will place less emphasis on the role of medically unexplained symptoms • Conceptualization will be based on positive psychological symptoms • Severity specifier will be assigned based on the number of psychological criteria endorsed <ul style="list-style-type: none"> ➔ Mild = 1 criterion ➔ Moderate = 2 or more criteria ➔ Severe = 2 or more criteria plus the presence of somatic symptoms 	<ul style="list-style-type: none"> • Proposed diagnostic category may identify individuals who are more psychologically impaired • Prevalence rates will likely be impacted depending on the number of psychological symptoms endorsed <ul style="list-style-type: none"> ➔ 1 out of 3 psychological symptoms may increase prevalence rates ➔ 2 out of 3 psychological symptoms may not change prevalence rates appreciably

7. Personality Disorders

Proposed <i>DSM-5</i> Changes*	Implications
<p><i>Personality Disorders</i></p> <ul style="list-style-type: none"> • Reduction in the number of personality disorders (PDs) from 10 to 6 (eliminating paranoid, schizoid, histrionic, and dependent) • Retained PDs (i.e., narcissistic, borderline, antisocial, obsessive-compulsive, avoidant, and schizotypal) will be assessed on: <ul style="list-style-type: none"> ➔ Personality functioning (i.e., self-functioning and 	<ul style="list-style-type: none"> • Research has shown that the proposed elimination of 4 PDs may reduce the problem of high comorbidity rates among the PDs <ul style="list-style-type: none"> ➔ However, may also increase the number of false-negative diagnoses • Research suggests that there may be little difference in

<p>interpersonal functioning)</p> <p>➔ Personality traits (i.e., negative affectivity, disinhibition, and antagonism)</p>	<p>morbidity between individuals with a retained and excluded diagnosis</p> <ul style="list-style-type: none"> • SSA may need to consider whether excluded PDs warrant a change in their conceptualization
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8. Substance Addiction Disorders

Proposed DSM-5 Changes*	Implications
<p><i>Substance Use Disorder</i></p> <ul style="list-style-type: none"> • Will no longer have “abuse/dependence” distinctions; will be renamed as “substance use disorder” (SUD) • Severity will be based on total number of positive criteria: <ul style="list-style-type: none"> ➔ No diagnosis (0 criteria or 1 criterion) ➔ Mild (2 – 3 criteria) ➔ Moderate (4 – 5 criteria) ➔ Severe (6 or more criteria) • Elimination of the “recurrent legal problems” criterion • Addition of a “craving” criterion 	<ul style="list-style-type: none"> • Proposed changes are expected to have minimal impact (modest increase) on prevalence rates • Severe SUD may effectively classify individuals with a more severe clinical profile and identify those with a more chronic course • May provide a partial solution in identifying “diagnostic orphans”

9. Autistic Disorder and Other Pervasive Developmental Disorders

Proposed DSM-5 Changes*	Implications
<p><i>Autism Spectrum Disorder</i></p> <ul style="list-style-type: none"> • Autistic disorder will be renamed to autism spectrum disorder (ASD) • Instead of requiring 2 out of 4 deficits in social interaction, the 	<ul style="list-style-type: none"> • Shift to a more stringent criteria will likely decrease prevalence rates • Research suggests that the proposed criteria may have greater

<p>presence of 3 deficits in social interaction will be required:</p> <ul style="list-style-type: none">➔ Social-emotional reciprocity➔ Nonverbal communicative behaviors➔ Developing and maintaining age-appropriate relationships	<p>specificity, which may reduce false positives; however, may have less sensitivity compared to <i>DSM-IV</i></p> <ul style="list-style-type: none">• Proposed changes appear to identify individuals who exhibit significantly more ASD symptoms than those who met criteria based on <i>DSM-IV</i>• SSA will need to consider how to evaluate the subgroup of individuals who exhibit significant ASD symptoms compared to non-ASD individuals, but not enough to receive an ASD diagnosis
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* Proposed changes are as of 8/14/12 (APA, 2012). The final *DSM-5* version may differ from the proposed criteria at the writing of this project.