

## Diagnostic and Statistical Manual(DSM-V): What's in it for Global Psychiatric Mental Health Nursing?

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### Introduction

The purpose of this paper is to inform the reader of the changes in the DSM-5 and generate discussion through this special issue on the opportunities and challenges for psychiatric mental health nurses. The changes are not major. The DSM-5 has an app available for iOS and Android devices. DSM-IV had a dedication page "To Melvin Sabshin, a man for all seasons" this "dedication" no longer appears in the DSM-5. In DSM-5 the long "DSM-5 Classification" list appears before the "Preface", while the DSM-IV has a long "Introduction".

The specific aim of the Diagnostic and Statistical Manual (DSM) is to provide the reader with the symptom checklists that allow for a mental disorder or problem assessment, diagnosis, and intervention to be made. The aim set for DSM-5 is to help clinicians, educators, and researchers design evidence-based assessment, plan of care, prevention and intervention, and evaluation strategies for all persons across the life span. Understanding DSM-5 could lead to better collaboration, consultation and communication strategies with clients, families, and psychiatric or mental health experts and reduce the use of general labels that tend to be inconsistently applied across diverse patients and users [1].

### Substantive Changes

The most significant changes from the DSM-IV to DSM-5 under the Neurodevelopmental Disorders chapter are: Intellectual Disability (Intellectual Developmental Disorder) and the need to assess both cognitive capacity (IQ) and adaptive functioning, 2) Communication Disorders now includes language disorder, speech sound disorder, childhood-fluency disorder, and social (pragmatic) communication disorder. Autism Spectrum Disorder is a new DSM-5 disorder. Several changes have been made to attention-deficit/hyperactivity disorder (ADHD). Specific Learning Disorder includes reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified.

Two changes were made to Criterion A for Schizophrenia: 1) the elimination of the special attribution of bizarre delusions and Schneideran first-rank auditory hallucinations. Schizoaffective disorder is re-conceptualized as a longitudinal instead of a cross-sectional diagnosis. Bipolar Disorders now include both changes in mood and changes in activity or energy. Because of concerns about potential over diagnosis and overtreatment of Bipolar Disorder in children, a new diagnosis of Disruptive Mood Dysregulation Disorder is included for children up to age 18 years. Premenstrual Dysphoric Disorder is now found in the main body of DSM-5 [2,3].

Anxiety Disorder no longer includes Obsessive-Compulsive Disorder or Posttraumatic Stress Disorder because OCD and Related Disorders include Hoarding Disorder, Excoriation Disorder, and Substance/Medication-Induced Disorder due to Another Medical Condition. PTSD is now included in Trauma- and Stressor-Related Disorders along with Adjustment Disorder, Reactive Attachment Disorder, and Disinhibited Social Engagement Disorder.

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New disorders are placed into a section called "Conditions for Further Study." Proposed criteria sets are presented for conditions needing further research to help clinicians, educators, and researchers communicate with one another.

The topic/chapter on "Other Conditions that may be a Focus of Clinical Attention" in Section II, page 715, attracted my attention because they are not "disorders" but "problems". Their inclusion in DSM-5 is meant to draw attention to the scope of additional issues that may be encountered in psychiatric mental health nursing clinical practice. This is intended "to provide a systematic listing that may be useful to clinicians in documenting these issues" (DSM-5, p715). These conditions may be the first and only signs we observe in a clinical practice because individuals who think, feel, and behave this way are walking functioning persons who are confronted with other issues in relationships and social support [4].

Included in the "Other conditions..." topic are: 1) Problems Related to Family Upbringing, 2) Other Problems Related to Primary Support Groups, 3) Child Maltreatment and Neglect Problems, 4) Adult Maltreatment and Neglect Problems, 5) Educational and Occupational Problems, 6) Housing and Economic Problems, 7) Problems Related to Crimes or Interaction with the Legal System, 8) Other Health Service Encounters for Counseling and Medical Advice, 9) Problems Related to Other Psychosocial, Personal, and Environmental Circumstances, and 10) Problems Related to Access to Medical and Other Healthcare including nonadherence to medical treatment.

These topics and their subtopics in "Other Conditions that may be a Focus of Clinical Attention" call for our understanding of others who are pleading "Do not label me as having a mental disorder but talk to me as one who needs to be listened, believed and cared for because we are alike, only our circumstances differ". The impact of these changes could matter in our clinical practice, but may not be realized immediately. DSM-5 is here to stay. We need to pay closer

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attention to the “Other Conditions” listed on the DSM-5 because they are not diagnostic categories or disorders but their consequences cuts through the intersection of health care and social justice. Most of those who injure or kill are not in psychiatric or mental health treatment but family members say s/he showed signs of violence, anger, or alienation; s/he was angry at someone; we never imagined s/he is capable of doing this or I didn't know where or who to ask for help because no one understands. Other conditions that may be a focus of clinical attention ask us to be accommodating and understanding. The impact of DSM-5 could matter in our clinical practice, but may not be realized immediately. DSM-5 is here to stay. I invite you to read and study it.

## References

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