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Seven Short Tutorials in Clinical Psychology

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CONTENTS

Page Number

1. PUBLIC-SPEAKING ANXIETY

There is general anxiety, but also specific anxieties like public speaking. Public-speaking anxiety (PSA) is the fear of speaking in public (ie: giving a talk in front of an audience). It can occur alone or as part of Social Anxiety Disorder (SAD). Together they include performance fears, social interaction fears, observation fears, and fears of showing visible signs of anxiety (Pull 2012). Individuals will be anxious before and during the speech, and concerned with the performance afterwards.

Bogels et al (2010), for example, suggested that individuals who experience PSA only are different to SAD sufferers in characteristics like age of fear developing (later with PSA), physiological anxiety reaction (stronger with PSA), and shyness (generally not among PSA sufferers) (Pull 2012).

The cognitive model of PSA focuses on thought processes as the cause, like negative self-statements and negative-biased perceptions of their performance (Pull 2012). This leads to a cognitive distortion in the perception of their behaviour. The cognitive model can be tested in three different ways:

i) Compare sufferers and non-sufferers of PSA on the amount of negative thoughts or self-statements.

ii) The use of cognitive therapy to help sufferers. The assumption being that if changing an individual's cognitions about public-speaking to be positive reduces the PSA, then the cause of the PSA was the negative cognitions. This is sometimes called "reverse engineering".

iii) An experimental manipulation of the self-thoughts of non-sufferers of PSA to see if they show behaviours similar to sufferers.

For example, Hirsch et al (2006) asked volunteers with low PSA to prepare a speech about themselves either focusing on the positive, negative, or neutral. The participants who had to produce the negative self-image speech were more anxious about the speech, reported more negative thoughts about their abilities, and rated their performance as poorer than the positive self-image group (Pull 2012).

Exposure therapy is reported as an effective treatment (Pull 2012). This involves giving a speech to a small audience (eg: two people) in real-life or virtual reality, and the size of the audience is increased and/or length of speech.

Tutorial Questions

1. What are the characteristics of PSA, and how might each be measured?

2. Is PSA a separate disorder or is a characteristic or sub-type of SAD?

3. What alternative models to the cognitive approach might there be, and how do they explain PSA?

4. Is the assumption of reverse engineering right?

5. How might PSA be treated with virtual reality techniques.

Research Topic

Is drug treatment effective in reducing PSA? Which drugs are used?

Methodological Issues

• How to establish if drug treatment is effective?
• How to measure PSA in objective/standardised way?

Philosophical Issues

How much is PSA a product of the modern Western world where presentations/speeches to an audience is common? Would PSA have existed in the past?

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Pull, C.B (2012) Current status of knowledge on public-speaking anxiety Current Opinion in Psychiatry 25, 1, 32-38

2. INTERPRETING OFFICIAL STATISTICS: HOMICIDE BY THE MENTALLY ILL

Official statistics are a welcomed source of data for researchers because the quantity collected is usually far more than individuals can get hold of. But researchers are dependent on the accuracy of collection and the definitions of categories used. This can lead to disputes over the interpretation of the figures, as in the relationship between homicides by individuals with mental illness (henceforth called "abnormal homicides") and homicides generally.

Are the two connected or not? Coid (1983) proposed that they are not. He argued that the rate of abnormal homicides was related to the rate of mental illness and nothing to do with the rate of homicides generally in a society [1].

Other studies have found a positive correlation between abnormal homicides and homicides generally (ie: both are high or low together). While Large et al (2008) found an inconsistent relationship in England and Wales since 1957. During the period 1957-80, abnormal homicides and homicides generally were positively correlated (r = 0.898), but for 1981-2004 abnormal homicides declined while homicides generally increased (negative correlation) (r = -0.920).

One problem is how to define "abnormal homicide". Large et al (2008) used the following categories:

- Diminished responsibility - "an abnormality of mind... as substantially impairing his mental responsibility for his acts".

- Infanticide - a woman who kills her child because her "balance of mind disturbed" after childbirth.

- Not guilty by reason of insanity - an individual "unable to appreciate the nature and quality of the wrongfulness of his acts" due to severe mental illness.

- Unfit to plead/stand trial - unable to understand charges and court proceedings.

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[1] The prevalence rate of mental disorders is higher in the prison population than the general population. For example, Fazel and Seeweld (2012) calculated rates of psychosis of 3.6% for male and 3.9% for female prisoners, and 10.2% and 14.1% respectively for major depression based on 109 samples (between 1966 and 2010) of 33 588 prisoners in 24 countries. The diagnoses were made by interviews using DSM or ICD criteria. The rates were higher for prisoners in low/middle- than high-income countries - 5.5% vs 3.5% (psychosis) and 22.5% vs 10.0% (major depression). Among the general population, in England, for example, psychosis is 0.4% in the past year, and a depressive episode, 2.3% (McManus et al 2009).

Tutorial Questions

1. Name two advantages and two disadvantages of using official statistics compared to collecting own data (primary statistics).

2. Is there a relationship between psychosis and homicide? How can this question be answered?

3. Is it possible to compare figures between different countries? Why?

4. How do the legal categories of "abnormal homicide" compared to those in classification systems like DSM-IV and ICD-10?

Methodological Issue

• How might primary statistics be collected on the relationship between mental illness and homicide?

Research Topic

How does the media report "abnormal homicide"? What are the social representations (appendix 2A?) Does this give the impression that it is more or less common than homicide by individuals who are not mentally ill?

Appendix 2A - Social Representations

    Social representations (SRs) "can be thought of as constellations of beliefs, social practices and shared knowledge that exist as much in individuals' minds as in the fabric of society" (Morant 2006 p817).
    SRs are "postulated to help laypersons symbolically cope with unfamiliar and potentially menacing scientific and technological innovations" (Bangerter and Heath 2004 p605). They are part of the social processes by which expert knowledge is transformed into common sense.
    Anchoring is a key process here. This is the linking of the new ideas with already-existing representations or concepts.

    Morant (2006) explored the SRs of "mental ill-health" among mental health practitioners in London and Paris. "A defining feature of professionals' representations of mental illness is uncertainty. The heterogeneity and lack of definitive knowledge that characterises mental health 'expertise' appear to give practitioners few fixed anchors to make sense of mental ill-health, such that their representations are

characterised by high levels of ambiguity, debate and uncertainty" (p825). Despite this, three core themes emerged around difference, disruption, and distress.

Mental ill-health was seen as an exaggeration of "normal" (difference), which disrupted an individual's life, and caused distress to them. These ideas were the "professional common sense" of the practitioners.

SRs exist for other areas of life like the history of a country. SRs of history are central to creating a national identity [2]. "SRs of history contain descriptive components... These include important events and people, woven into stories with temporal form referred to as narratives of origin. In general, there seems to be a broad consensus across ethnic and regional groups as to what events and figures are important in constituting their nation's history" (Liu and Hilton 2005 p539) [3].

SRs of history may be (Moscovici 1988):

i) Hegemonic - consensus throughout society.

ii) Emancipated - different interacting versions in different groups in society.

iii) Polemical - conflicting representation between different groups in society.

"SRs of history often reflect real conflicts between groups; indeed, real conflicts between groups are often commemorated purposefully..." (Liu and Hilton 2005 p544).

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[2] "SRs of history function as resources for managing the interplay of social identities" (Liu and Hilton 2005 p545).

[3] "SRs of history are capable of influencing groups' thinking about their futures" (Liu and Hilton 2005 p549).

Research

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3. DUAL DIAGNOSIS

"Dual diagnosis" refers to individuals with a mental disorder and another condition, originally a learning or intellectual disability (but more recently, alcohol or drug misuse) (or vice versa).

Morgan et al (2008) used official statistics in the state of Western Australia to calculate the prevalence of a learning disability and a mental disorder together. The Intellectual Disability Register, used as the basis of receipt of services, defines a learning disability as an IQ score of 70-74 or less. The Mental Health Information System records all contact with psychiatric services including hospitalisations. At the time of the study (February 2008), the former included 11 576 individuals and the latter 236 973 people.

Of the individuals with a learning disability, 31.7% also had a mental disorder.

But the data sources used are not complete. The Intellectual Disability Register is estimated to cover only 75% of cases, and underestimates borderline cases (Morgan et al 2008). The Mental health Information System does not include private consultations, for example.

Hogan (2009) was critical of "lumping together all ranges of intellectual disability". For example, Morgan et al's data showed that schizophrenia was more common among borderline learning disabled individuals, and pervasive developmental disorder among those severe/profound learning disabled.

Mental Disorders and Substance Use Disorders

In the case of the dual diagnosis of severe mental disorders and substance use disorders (SUDs), there are certain issues (Morojele et al 2012).

i) The assessment instruments for mental disorders and SUDs are not designed for dual diagnosis. Furthermore, it is difficult to establish the prevalence of dual diagnosis.

The desire to gain accurate figures has led to various methods and samples being studied including (Assanangkornchai and Edwards 2012):

a) Residents of Salvation Army alcohol and other drug treatment units in Australia (Mortlock et al 2011).

b) Attendees at a hospital emergency department (eg: Flint, Michigan, USA; Booth et al 2011).

c) Patients on a methadone maintenance treatment

programme (eg: Eindhoven, Netherlands; Carpentier et al 2011).

d) A specially adapted questionnaire to use with Indigenous Australian youngsters (Dingwall and Cairney 2011).

e) National population survey - eg: National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) in USA.

ii) How do the two conditions interact (figure 3.1)? "Dual diagnosis is commonly associated with symptom exacerbation of one or both disorders, increased illness severity, increased risk of suicide, higher relapse rates, and treatment non-compliance" (Morojele et al 2012 p182) [4]. For example, individuals with bipolar disorder and excessive substance use were more impaired and had poorer outcomes than bipolar disorder only sufferers in Norway, though there was no difference in the course of the bipolar disorder or the current symptom levels (Lagerberg et al 2010 [5]) [6].
In a SUD treatment unit in Egypt, in-patients with depression as well had significantly worse functioning (as scored by the Addiction Severity Index) (Erfan et al 2010). While over a fifteen-year period, individuals with schizophrenia and SUDs had more frequent and longer hospitalisations than the schizophrenia alone group (Schmidt et al 2011).

iii) There are debates as to whether the conditions are separate or part of the same clinical syndrome (Morojele et al 2012).

iv) With dual diagnosis, which condition comes first? It is more common for the mental disorder to develop before the SUD (Morojele et al 2012).

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[4] For example, the role of cannabis use as the cause of psychosis in mentally health individuals is debated, but cannabis use by individuals already diagnosed with a psychotic disorder has negative consequences.
Zammit et al (2008) collected the information from thirteen longitudinal studies on the subject, which included outcome measures like symptom severity, relapse, and adherence to medication. Use of cannabis was associated consistently with increased relapse or rehospitalisation and less treatment adherence (compared to non-use). The relationship between cannabis use and symptom severity was inconsistent between studies.
[5] 125 patients with bipolar disorder (part of the Thematically Organised Psychosis Research (TOP) study) compared to 327 individuals in Oslo. The bipolar disorder sufferers were three times more likely to have used an illicit substance in their lifetime than the general population sample.
[6] Rates of SUD among individuals with bipolar disorder vary between 35-60% depending on the study (Lagerberg et al 2010).

INDEPENDENT

SUD   MD

ONE CAUSES OTHER

SUD ———————→ MD

ONE CAUSES OTHER
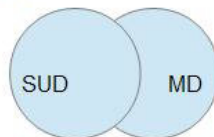
MD ———————→ SUD

INTERACTING

SUD MD
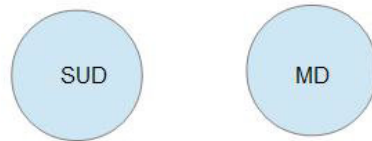
Figure 3.1 - Possible relationships between mental disorders and SUDs.

     v) Difficulties in treating both conditions, particularly as services are designed to deal with them singly.

Tutorial Issues

1. How accurate are figures on the number of dual diagnosis sufferers? How can this question be answered?

2. Morgan et al (2008) is a study in Australia, how do the findings compare to studies in other countries?

3. What is the relationship between the two disorders in dual diagnosis?

4. Are dual diagnosis sufferers different to sufferers of

the individual disorders?

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4. SOCIAL CONSEQUENCES OF MENTAL DISORDERS

Suffering from a mental disorder has social consequences like "out-of-role days". These are days where the sufferer cannot fulfil their role whether that is paid employment or childcare, for example. Another consequence is failure to complete education.

Lee et al (2009) highlighted this consequence using World Health Organisation Mental Health Survey Initiative data from 16 countries - nine high-income (eg: Germany) and seven low and middle-income (eg: Mexico). Substance use disorders and impulse control disorders were associated with non-completion of education in all countries, and anxiety disorders and mood disorders were additionally associated in high-income countries.

Individuals with a mental disorder may also receive poorer quality care for a physical condition (ie: inequality of care) (Mitchell et al 2009 - 19 of 27 studies reviewed).

Bruffaerts et al (2012) found that mental disorders led to partial disability (ie: partially unable to perform role) among 26 nationally representative samples in the World Mental Health Survey (n = 61 259) [7]. Partial disability was measured by three questions:

• How many days out of the past 30 were you able to work and carry out your normal activities, but had to cut down on what you did or not get as much done as usual because of problems with either your physical health, your mental health, or your use of alcohol or drugs?

• How many days out of the past 30 did you cut back on the quality of your work or how carefully you worked because of problems with either your physical health, your mental health, or your use of alcohol or drugs?

• How many days out of the past 30 did it take an extreme effort to perform up to your usual level at work or at your other normal daily activities because of problems with either your physical health, your mental health, or your use of alcohol or drugs?

Overall, the mean number of days with partial disability was 1.6 per month, but this was 3.3 for

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[7] Africa (Nigeria, South Africa); the Americas (Brazil, Colombia, Mexico, USA), Asia and the Pacific (Japan, New Zealand, in the People's Republic of China: Beijing, Shanghai and Shenzhen), Europe (Belgium, Bulgaria, France, Germany, Italy, The Netherlands, Northern Ireland, Portugal, Romania,Spain, Ukraine); and the Middle East (India, Israel, Lebanon, Iraq).

individuals with physical disorders [8], and 4.4 with mental disorders. Individuals who suffered from Post-Traumatic Stress Disorder (PTSD) had the highest mean number of days with partial disability at 5.8, followed by Generalised Anxiety Disorder (5.0) and depression (4.6).

Put another way, an individual with a physical or mental disorder had an average additional nineteen partial disability days per year (23 in high-income countries, and 14 in middle- and low-income ones) (figure 4.1).
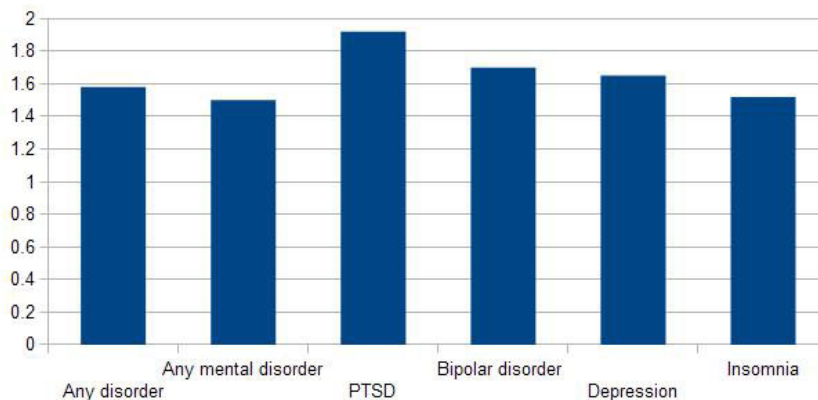
(Data from Bruffaerts et al 2012 table 2 p458)

Figure 4.1 - Mean additional partial disability days per month.

Key Methodological Issues

1. Sampling in each country used a stratified multi-stage clustered-area probability sampling method. This involves dividing a population into groups (eg: geographical area), and then randomly sampling from them. Within each area a random sample of households are taken, and then a random sample from within the household, for example.

2. The data were collected via face-to-face interviews with trained lay interviewers in each country.

3. The time period of 30 days prior to the interview was used. Was this period typical of the interviewee's life?

4. The response to the three questions was dependent on the "honesty" of the interviewees with the biggest issue being recall accuracy.

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[8] The most common were back/neck pain, cardiovascular disease, and respiratory disease.

5. Also the "honesty" of replies in relation to diagnosing the mental disorder and the stigma attached to such conditions in some countries.

6. Some mental disorders not included in the survey (eg: psychosis, dementia).

7. The collection of data from 24 countries allowed cross-national comparisons, and between level of income countries (eg: high vs middle).

8. Interviewees were asked about their inability to perform their role generally, not just in paid employment (which many other studies concentrate on).

9. The three questions offered a forced choice between able to perform normally/not able when counting how many days. A scale with a greater number of choices may have been better.

10. The median number of days of partial disability were calculated. This measure of central tendency is not distorted by outliers as with the mean. For example:

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1, 2, 10, 14, 38    mean = 13; median = 10; range = 37
12, 13, 14, 15, 16  mean = 14; median = 14; range = 4
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5. OESTROGEN AND SCHIZOPHRENIA

The "oestrogen protection hypothesis" for schizophrenia (Reichler-Rossler et al 1993) proposes that women are less likely to suffer from early-onset schizophrenia than men because of increased oestrogen, but prone to late-onset or relapse with the decline in oestrogen after the menopause (Kulkarni et al 2012).

Schizophrenia is now seen as a "sexually dimorphic disease" (ie: gender differences) with more male sufferers than female, and men presenting four years earlier on average than women. The severity of symptoms is also milder in younger women, but more severe in middle-aged/older women (post-menopause) (Kulkarni et al 2012).

Oestrogen is a hormone whose primary function is reproductive (ie: in relation to the menstrual cycle), but it does have receptors in certain areas of the brain like the limbic system, which suggest a role beyond just reproduction. Oestrogen interacts with dopamine and serotonin, for example, in animal studies (Kulkarni et al 2012).

If the observations about oestrogen protection are correct, then oestrogen could have potential as a treatment for schizophrenia. For example, Kulkarni et al (2008) reported benefits among 102 women with psychosis given oestradiol (ie: increased oestrogen) over 28 days as compared to anti-psychotic medication. Small-scale studies have also reported benefits for men with psychosis (eg: Kulkarni et al 2011).

There has also been interest in testosterone as a cause of psychosis with limited research at this stage (Kulkarni et al 2012).

Tutorial Issues

1. What are the main theories of schizophrenia? How does the "oestrogen protection hypothesis" compare in terms of evidence?

2. What other lesser known theories of schizophrenia are there? How much " good" evidence exists for each one? What is "good" evidence?

3. What other mental disorders are sexually dimorphic? How are gender differences established? Are they "true" differences or artefacts of the research method used?

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6. POST-TRAUMATIC STRESS DISORDER AND MEDICAL STAFF

Medical staff dealing with traumatic events in their work can suffer from Post-Traumatic Stress Disorder (PTSD). For example, Weiniger et al (2006) found that 15.6% [9] of 188 hospital doctors in two medical centres in Jerusalem, Israel, working in the aftermath of suicide-bombing attacks had PTSD symptoms. The respondents completed a number of validated questionnaires.

The PTSD sufferers were compared to the non-PTSD individuals. Both groups were similar in age, gender, number and age of children, number of years in clinical practice, and number of years living in Israel. The non-PTSD group contained more Jewish individuals, married doctors, higher incomes, and those who had done army service. The PTSD group had more symptoms of burnout, anxiety, depression, and other psychological problems. Few of these doctors sought help (Einav et al 2008).

Tutorial Issues

1. What are the symptoms of PTSD?

2. What other professions have higher risks for PTSD?

3. How accurate are self-reports of distress in environments where individuals are discouraged from showing weakness? How to improve accuracy?

4. PTSD did not appear as a named disorder until the late 20th century. Does that it mean that it did not exist before that time, or that it has always existed (but was called something different)? In other ways, how "real" is PTSD? What does "real" mean in this context?

5. Are too many events now associated with the risk of PTSD (eg: childbirth)?

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Weiniger, C.F et al (2006) Post-traumatic stress disorder among hospital surgical physicians exposed to victims of terror: A prospective, controlled questionnaire survey Journal of Clinical Psychiatry 67, 890-896

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[9] This is a similar level to the civilian population in Israel during that period, and to doctors working in trouble spots around the world (Einav et al 2008).

7. RESEARCH TOPIC: INVESTIGATING DSM-5

"The philosophical difficulties inherent in diagnosing mental illness are taken for granted by many psychiatrists. Yet it is important to remember that an entire branch of the modern medical profession relies on a diagnostic system in which imaging and laboratory methods can only exclude physical causes of presenting symptoms. The psychiatrist must rely on his or her judgment, and the wisdom of those predecessors and peers who constructed the psychiatric diagnostic manuals" (Boyce 2011 p1816) [10].

The main classification systems are the "Diagnostic and Statistical Manual of Mental Disorders" (DSM) produced by the American Psychiatric Association (APA), and the World Health Organisation's (WHO) "International Classification of Diseases" (ICD). These are updated periodically, with the current versions being DSM-IV-TR (4th edition, text revision) and ICD-10 (10th edition). At the time of writing, DSM-5 is in development [11].

Boyce (2011) listed some of the major changes proposed for DSM-5 at the time of his writing:

a) New mental disorders, like "disruptive mood dysregulation disorder" or "attenuated psychosis syndrome".

b) The movement of disorders to new categories - eg: "obsessive-compulsive disorder" to its own section instead of part of "anxiety disorders".

c) The removal of certain disorders, like "Aspergers syndrome".

Research Questions

1. What are the main differences between DSM-5 and DSM-IV-TR? What categories and disorders remain unchanged?

2. How does DSM-5 compare to earlier classification systems like DSM-II and DSM-III?

3. How similar are the DSM and ICD classification systems?

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[10] Boyce, N (2011) The first flight of DSM-5 Lancet 377, 1816-1817
[11] Details at http://www.dsm5.org.