



## The DSM-V Sleep-Wake Disorders Nosology: An Update and an Invitation to the Sleep Community

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During the period of January 18–March 18, 2010 (approximately), the American Psychiatric Association is planning to post on its website updates of the DSM-V sleep-wake disorders nosology. The updates will include draft diagnostic criteria, research and clinically based rationales for changes, and proposed dimensional measures of severity. We would like to invite the readers of the *Journal of Clinical Sleep Medicine* to comment, to offer a rationale and supporting evidence to argue for or against the changes proposed by the DSM-V sleep-wake disorders workgroup, and to propose additional revisions to the criteria. The workgroup's recommended changes were posted on the website (DSM5.org) on or about January 20, 2010.

The overriding goal of the revision has been to enhance the clinical utility, reliability, and validity of the DSM sleep-wake disorders nosology. The primary users of DSM are mental health and general medical clinicians, not sleep disorder specialists. Mindful of these users, the workgroup has sought to simplify the classification of sleep-wake disorders in clinically meaningful ways, to facilitate identification of sleep disorders, and to offer useful dimensional measures of severity. In refining the diagnostic criteria and expanding the accompanying text, the DSM-V workgroup has also strived to incorporate information that reflects major advances in the basic physiology and genetics of sleep conditions, information about lifespan issues, and evidence-based research in treatment outcomes that have occurred in the years since DSM-IV. In this context, we have an abundance of biomarker data (polysomnographic and neurobiologic) generally lacking in other areas of psychiatric diagnosis. Thus, we have an opportunity to model for other areas of psychiatric classification the incorporation of quantitative, physiologic measures into the diagnostic classification system, dimensional measures of severity, and the accompanying text.

An important goal of DSM-V sleep nosology will be to improve recognition of sleep disorders by mental health and general medical clinicians, to improve appropriate referrals to a sleep specialist, and to improve the approach to treatment of sleep disorders that are comorbid with other health conditions. The major changes under consideration include: (1) eliminating the diagnosis of “primary insomnia” in favor of “insomnia disorder,” with concurrent specification of clinically comorbid conditions (both medical and psychiatric). Making this change will allow us also to (2) eliminate “sleep disorder related to another mental disorder” and “sleep disorder due to a general medical condition,” in favor of “insomnia disorder” (or “hypersomnia

disorder”) with concurrent specification of clinically comorbid conditions. These changes move away from the causal attribution inherent in DSM-IV and simply specify clinically relevant comorbidities. As such they are consistent with the data and recommendations of the 2005 NIH State of the Science position on classification of insomnia disorders. The criteria underscore that the patient has a sleep disorder (either insomnia or hypersomnia) that warrants independent clinical attention, in addition to mental/psychiatric or medical disorders also present.

The workgroup will also propose (3) aggregating hypersomnia disorder and narcolepsy *without* cataplexy, which will be distinguished from narcolepsy/cataplexy/hypocretin-1 deficiency disorder. We will also propose (4) breaking up the unitary DSM-IV “breathing-related sleep disorder” into distinct syndromes of obstructive versus central forms of sleep apnea in order to better inform treatment planning.

Similar to other workgroups in DSM-V, we will (5) decrease the use of “not otherwise specified” (NOS) as a diagnostic category. This change will encompass elevation of REM sleep behavior disorder and restless legs syndrome to full-fledged diagnostic status (from their current classification in DSM-IV as “not otherwise specified”). We will argue for (6) aggregation of NREM parasomnias under “confusional arousal disorders” (to include confusional arousal disorder, sleep walking, and sleep terrors). Finally, we will propose (7) further elaboration of a greater number of distinct types of circadian rhythm disorders, such as advanced sleep phase syndrome, which were not in DSM-IV.

The secondary analyses performed by the workgroup and our reviews of the literature published since DSM-IV are leading to greater and more specific quantification of some criteria, as well as elaboration of epidemiologic, genetic, neurobiological, and treatment response data in the accompanying text. These data serve as concurrent and prognostic validators of the proposed diagnostic categories. We will continue to provide linkages to ICSD nosology in the text, while recognizing that DSM-V diagnoses are often broader in scope than those in ICSD. “Insomnia disorder” is a good example of this. Finally, we anticipate engaging in field trials to assess the clinical utility and reliability of some of the diagnostic changes proposed, especially related to insomnia disorder. We are working with other DSM-V groups to incorporate simple dimensional measures of sleep quality into their field trials. We believe that the use of dimensional severity measures is also likely to reveal subthreshold or

subdiagnostic conditions in some patients at risk for developing full-fledged, syndromal sleep disorders. Such patients may be candidates for preventive interventions.

Many of these recommendations resulted from long hours of careful deliberation. Compromise was sometimes needed to strike the appropriate balance between scientific precision and clinical utility. At other times, the evidence base was relatively weak and required expert opinion. For these reasons, the workgroup recognizes that some stakeholders will have different, valid perspectives about the proposed changes. The process of revision of the DSM-V has been intended to be transparent and inclusive. For these reasons the sleep community's input is sincerely sought and will be considered before finalizing the recommendations.

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