Understanding the DSM-5: Problems and Prospects in the Diagnostic Revision.

GREG J. NEIMEYER, PHD
UNIVERSITY OF FLORIDA

Which edition did you train in?

DSM-IV-TR (2000)
DSM-IV (1994)
DSM-III-R (1987)
DSM-III (1980)
DSM-II (1968)
DSM-I (1952)

When it comes to my level of familiarity with the changes in the DSM-5, I would characterize myself as….

When it comes to my level of familiarity with the changes in the DSM-5, I would characterize myself as….

A. HIGHLY INFORMED. I KNOW MOST, IF NOT ALL OF THE MOST SIGNIFICANT CHANGES AND COULD EASILY TEACH THIS COURSE MYSELF- BUT I DON'T WANT TO.

When it comes to my level of familiarity with the changes in the DSM-5, I would characterize myself as….

B. MODERATELY WELL-INFORMED. I'VE HEARD ABOUT SOME, IF NOT MOST, OF THE CHANGES, AND PROBABLY KNOW MOST OF THE MAJOR ONES AT LEAST

When it comes to my level of familiarity with the changes in the DSM-5, I would characterize myself as….

C. SOMEWHAT WELL-INFORMED. I'VE HEARD BITS AND PIECES HERE AND THERE BUT I'M NOT SURE HOW MANY OF THEM I COULD RECALL OFF HAND.

When it comes to my level of familiarity with the changes in the DSM-5, I would characterize myself as….

D. I AM GENUINELY CLUELESS. IF I'VE HEARD ANYTHING AT ALL ABOUT THE CHANGES I HONESTLY CAN'T RECALL A SINGLE ONE OF THEM AT THE MOMENT.

Purpose

This course is for clinicians who are already familiar with DSM-IV-TR, its content, and its use. This presentation is solely to facilitate transition from DSM-IV-TR to DSM-5 and is not intended to be a basic course on DSM-5.

Copyright © 2013. American Psychiatric Association.

Disclaimers

- Not representing APA
- Not representing the *other* APA
- No proprietary or commercial interests
- All materials that are used are either open source or used with express permission, so you can feel free to use everything that we provide
- We all bring perspectives. I will share mine but there is nothing sacrosanct about it.

Overview of the Workshop

- *More heat than light?:*
  The Top 15 most significant changes in the DSM-5
- *Back to the future?*
  Historical backdrop of DSM and ICD
- *The devil is in the details*
  Disorder-Specific revisions
- *To infinity and beyond*
  Articulation with ICD and Future Developments

Top 15 Most Significant Changes in the DSM-5

1. Overall "Mission Creep" through relaxed criteria (ADHD, PTSD)
2. Discontinuation of the Multi-axial Diagnosis
3. Greater (bio)medical orientation (and presumed etiology)
4. Inclusion of Section III: Emerging Measures & Models
5. Dimensionalizing Disorders (e.g. ASD, Schiz)
6. Reclassification & Re-combination of Disorders (GDD, BDD, STPD)
7. Addition of Disorders NOT from the Appendix (e.g., DMDD)
8. Removal of Bereavement Exclusion in Major Depression
9. Addition of Non-Substance Addictive Disorders
10. Addition of Mild Neurocognitive Disorder (risk diagnosis)
11. Movement towards "Clinical Utility" vs. "Validity"
12. Personality Disorders (most significant for its lack of change)
13. NOS replaced with "Other Specified" and "Unspecified"
14. Movement from Roman to Arabic Numerals
15. Transparency vs. Opacity in Decision Making

DSM-5 and ICD-10-CM: Conceptual Evolution

ICD-10-CM Sample Chapters and Codes

Chapter	Range of Codes
I. Certain infectious and parasitic diseases	A00-B99
II. Neoplasms	C00-D48
III. Disease of the blood	D50-D89
IV. Endocrine, nutritional and metabolic diseases	E00-E90
V. Mental and behavioral disorders	**F00-F99**
VI. Diseases of the nervous system	G00-G99
VII. Diseases of the eye and adnexa	H00-H59
VIII. Diseases of the ear and mastoid process	H60-H95
IX. Diseases of the circulatory system	I00-I99
X. Diseases of the respiratory system	J00-J99
…continues through XXI. Factors influencing health status and contact with health services (Z00-Z98)	

Introduction: Diagnostic & Statistical Manual of Mental Disorders

1952: DSM-I
1968: DSM-II
1980: DSM-III
1987: DSM-III-R
1994: DSM-IV
2000: DSM-IV-TR
2013: DSM-5

Introduction: Diagnostic & Statistical Manual of Mental Disorders

1952: DSM-I
1968: DSM-II
1980: DSM-III
1987: DSM-III-R
1994: DSM-IV
2000: DSM-IV-TR
2013: DSM-5

Introduction: Diagnostic & Statistical Manual of Mental Disorders

1952: DSM-I
1968: DSM-II
1980: DSM-III
1987: DSM-III-R
1994: DSM-IV
2000: DSM-IV-TR
2013: DSM-5

Introduction: Diagnostic & Statistical Manual of Mental Disorders

1952: DSM-I
1968: DSM-II
1980: DSM-III
1987: DSM-III-R
1994: DSM-IV
2000: DSM-IV-TR
2013: DSM-5

Introduction: Diagnostic & Statistical Manual of Mental Disorders

1952: DSM-I
1968: DSM-II
1980: DSM-III
1987: DSM-III-R
1994: DSM-IV
2000: DSM-IV-TR
2013: DSM-5

Introduction: Diagnostic & Statistical Manual of Mental Disorders

1952: DSM-I
1968: DSM-II
1980: DSM-III
1987: DSM-III-R
1994: DSM-IV
2000: DSM-IV-TR
2013: DSM-5

Introduction: Diagnostic & Statistical Manual of Mental Disorders

1952: DSM-I
1968: DSM-II
1980: DSM-III
1987: DSM-III-R
1994: DSM-IV
2000: DSM-IV-TR
2013: DSM-5

Introduction: Diagnostic & Statistical Manual of Mental Disorders

1952: DSM-I
1968: DSM-II
1980: DSM-III
1987: DSM-III-R
1994: DSM-IV
2000: DSM-IV-TR
2013: DSM-5

Reliability, Validity and Clinical Utility

Copyright © 2013. American Psychiatric Association.

Reliability, Validity and Clinical Utility

- *"Until incontrovertible etiological or pathophysiological mechanisms are identified to fully validate specific disorders or disorder spectra, the most important standard for the DSM-5 disorder criteria will be their clinical utility."*
  -DSM-5

Copyright © 2013. American Psychiatric Association.

DSM-5 Structure

- Section I: DSM-5 Basics
- Section II: Essential Elements: Diagnostic Criteria and Codes
- Section III: Emerging Measures and Models
- Appendix
- Index

Copyright © 2013. American Psychiatric Association.

Section III: Conditions for Further Study

- Attenuated Psychosis Syndrome
- Depressive Episodes With Short Duration Hypomania
- Persistent Complex Bereavement Disorder
- Caffeine Use Disorder
- Internet Gaming Disorder
- Neurobehavioral Disorder Due to Prenatal Alcohol Exposure
- Suicidal Behavior Disorder
- Non-suicidal Self-Injury

Copyright © 2013. American Psychiatric Association.

Section II Diagnostic Codes and Criteria

Section II: Chapter Structure

A. Neurodevelopmental Disorders
B. Schizophrenia Spectrum and Other Psychotic Disorders
C. Bipolar and Related Disorders
D. Depressive Disorders
E. Anxiety Disorders
F. Obsessive-Compulsive and Related Disorders
G. Trauma- and Stressor-Related Disorders
H. Dissociative Disorders
J. Somatic Symptom and Related Disorders
K. Feeding and Eating Disorders
L. Elimination Disorders

Copyright © 2013. American Psychiatric Association.

Section II: Chapter Structure

M. Sleep-Wake Disorders
N. Sexual Dysfunctions
P. Gender Dysphoria
Q. Disruptive, Impulse-Control and Conduct Disorders
R. Substance-Related and Addictive Disorders
S. Neurocognitive Disorders
U. Personality Disorders
V. Paraphilic Disorders
W. Other Mental Disorders
X. Medication-Induced Disorders
Y. V and Z codes

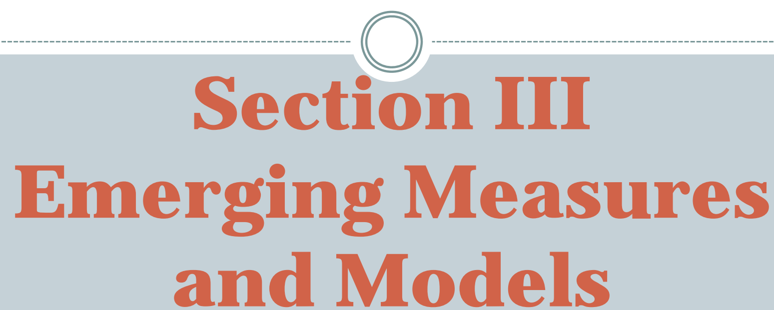
Copyright © 2013. American Psychiatric Association.

Section II:
Chapter Structure

Chapters organized to preserve

1. Developmental integrity
2. Conceptual integrity
3. Inter-system integrity (DSM and ICD)

Copyright © 2013. American Psychiatric Association.



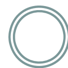
Section III
Emerging Measures and Models

Optional Measurements in DSM-5

- Level 1 and Level 2 Cross-Cutting Symptom assessments
- Diagnosis-specific Severity ratings
- Disability assessment (WHODAS 2.0)

- May be patient, informant, or clinician completed, depending on the measure
- Cultural Formulation Interview (CFI)
- Alternative DSM-5 Model for Personality Disorders
- Conditions for Further Study

Copyright © 2013. American Psychiatric Association.



Highlights of Specific Disorder Revisions and Rationales

Neurodevelopmental Disorders

AUTISM SPECTRUM DISORDER
SOCIAL (PRAGMATIC) COMMUNICATION DISORDER
SPECIFIC LEARNING DISORDER
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER
INTELLECTUAL DISABILITY (INTELLECTUAL DEVELOPMENTAL DISORDER)

Autism Spectrum Disorder

- Encompasses autistic disorder, Asperger's disorder, childhood disintegrative disorder, & pervasive developmental disorder NOS.
- Symptoms in two core areas:

A. deficits in social communication & social interaction

B. restricted repetitive behaviors, interests, & activities

Autism Spectrum Disorder (ASD) (Neurodevelopmental Disorders)

- *Rationale*: Clinicians had been applying the DSM-IV criteria for these disorders inconsistently and incorrectly; consequently, reliability data to support their continued separation was very poor.
  - Specifiers can be used to describe variants of ASD (e.g., the former diagnosis of Asperger's can now be diagnosed as autism spectrum disorder, without intellectual impairment and without structural language impairment).

Copyright © 2013. American Psychiatric Association.

Autism Spectrum Disorder

Severity specifiers:

- Based on social communication impairments and restricted, repetitive behavior patterns.
- Assessed using new dimensional assessment

- Severity Levels:
  1. Requiring Support
  2. Requiring Substantial Support
  3. Requiring Very Substantial Support

Social (Pragmatic) Learning Disorder

-Difficulty in the social use of language, e.g., meet and greet, volume regulation, social norms of speaking, etc.

-Absence of repetitive behaviors.

Specific Learning Disorder

- Now presented as a single disorder with coded specifiers for specific deficits in reading, writing, and mathematics
  - *Rationale:* There was widespread concern among clinicians and researchers that clinical reality did not support DSM-IV's three independent learning disorders. This is particularly important given that most children with specific learning disorder manifest deficits in more than one area.
  - By reclassifying these as a single disorder, separate specifiers can be used to code the level of deficits present in each of the three areas for any person.

Copyright © 2013. American Psychiatric Association.

Attention-Deficit/Hyperactivity Disorder

- Two symptom domains:
  1. inattention
  2. hyperactivity/impulsivity
- At least 6 symptoms in one domain required (adults: 5 symptoms)
- Onset prior to age 12
- Subtypes replaced by specifiers

Attention-Deficit/Hyperactivity Disorder

- Age of onset was raised from 7 years to 12 years
  - *Rationale*: Numerous large-scale studies indicate that, in many cases, onset is not identified until after age 7 years, when challenged by school requirements. Recall of onset is more accurate at 12 years
- The symptom threshold for adults age 17 years and older was reduced to five
  - *Rationale:* The reduction in symptom threshold was for adults only and was made based on longitudinal studies showing that patients tend to have fewer symptoms in adulthood than in childhood. This should result in a minimal increase in the prevalence of adult ADHD.

Copyright © 2013. American Psychiatric Association.

Intellectual Disability (Intellectual Developmental Disorder)

- Name change
- Severity specifiers:
- determined by adaptive functioning rather than IQ score
- Adaptive functioning includes
  1. Conceptual domain
  2. Social domain
  3. Practical domain
- Assessed using new dimensional assessment
- Severity Levels: Mild, Moderate, Severe, Profound

Intellectual Disability (Intellectual Developmental Disorder)

- Mental retardation was renamed intellectual disability (intellectual developmental disorder)
  - *Rationale*: The term *intellectual disability* reflects the wording adopted into U.S. law in 2010 (Rosa's Law), in use in professional journals, and endorsed by certain patient advocacy groups. The term *intellectual developmental disorder* is consistent with language proposed for ICD-11.
- Greater emphasis on adaptive functioning deficits rather than IQ scores alone
  - *Rationale*: Standardized IQ test scores were over-emphasized as the determining factor of abilities in DSM-IV. Consideration of functioning provides a more comprehensive assessment of the individual.

Copyright © 2013. American Psychiatric Association.

Schizophrenia Spectrum & Other Psychotic Disorders

DELUSIONAL DISORDER
BRIEF PSYCHOTIC DISORDER
SCHIZOPHRENIFORM DISORDER
SCHIZOPHRENIA
SCHIZOAFFECTIVE DISORDER
SCHIZOTYPAL PERSONALITY DISORDER

Schizophrenia

- Two Criterion A symptoms (one must include 1-3)
    1. Delusions
    2. Hallucinations
    3. Disorganized speech
    4. Grossly abnormal psychomotor behavior
    5. Negative symptoms

- Eliminated schizophrenia subtypes.

Schizophrenia (cont’d)

- Deletion of specific subtypes
  - *Rationale:* DSM-IV’s subtypes were shown to have very poor reliability and validity. They also failed to differentiate from one another based on treatment response and course

Copyright © 2013. American Psychiatric Association.

Schizophrenia

- Eliminated DSM-IV’s exception of only 1 Criterion A symptom if the individual has bizarre delusions or first rank auditory hallucinations.

Schizophrenia

- Severity
  - Proposed dimensional assessment
  - Video Illustration

Schizophrenia Spectrum & Other Psychotic Disorders

Schizotypal

Schizoaffective Disorder

- Criterion A requires that a major mood episode be present for the majority of the disorder's duration.

Delusional Disorder

- Criterion A no longer requires that delusions be "non-bizarre."

Catatonia

- A specifier that can be added to psychotic, bipolar, depressive, or other medical disorder, or an unidentified medical condition.

Bipolar and Related Disorders

Bipolar I disorder
Bipolar II disorder
Cyclothymic disorder
Substance/medication induced bipolar & related disorder
Other specified bipolar and related disorder
Unspecified bipolar and related disorder

Bipolar I Disorder

- At least one manic episode, which may be preceded by or followed by a hypomanic or major depressive episode.
- Changes:
  - Criterion A for Manic Episode and Hypomanic Episode emphasizes changes in *activity* and *energy*, as well as mood
  - Dropped "mixed episode"
  - Added "mixed specifier"
  - Added "with anxious distress" specifier

Bipolar I Disorder

DSM-5 Current or Most Recent Episodes: Manic, Hypomanic, Depressed

DSM-IV Bipolar I disorders:

1. Bipolar I Disorder, Single Manic Episode
2. Bipolar I Disorder, Most Recent Episode Hypomanic
3. Bipolar I Disorder, Most Recent Episode Manic
4. Bipolar I Disorder, Most Recent Episode Mixed
5. Bipolar I Disorder, Most Recent Episode Depressed
6. Bipolar I Disorder, Most Recent Episode Unspecified

DSM-5 Bipolar I Disorders:

1. Bipolar I Disorder, Current or Most Recent Episode Manic
2. Bipolar I Disorder, Current or Most Recent Episode Hypomanic
3. Bipolar I Disorder, Current or Most Recent Episode Depressed

Bipolar I Disorder

Specify if (clinical status/features):

- With anxious distress
- With mixed features
- With rapid cycling
- With melancholic features
- With atypical features
- With psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

Severity/course specifiers:

- Mild
- Moderate
- Severe
- In partial remission
- In full remission

Bipolar I Disorder

- Coding based on:
  - Current or most recent episode, and
  - Specifiers: mild, moderate, severe, with psychotic features, in partial remission, in full remission, unspecified

Example:

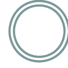
296.43 [F31.13] Bipolar I Disorder, Most Recent Episode Manic, Severe

Bipolar II Disorder

- At least one hypomanic episode and at least one major depressive episode.
- Specify current or most recent episode: hypomanic, depressed
- Specify "with anxious distress" or "with mixed features"
- Code number is 296.89 [F31.81] (don't code current or most recent episode or specifiers)
- Example:

  296.89 [F31.81] bipolar II disorder, current episode depressed, moderate severity, with anxious distress

Cyclothymic Disorder



- Both hypomanic and depressive periods without ever fulfilling the criteria for an episode of mania, hypomania or major depression.
- Duration: at least 2 years

Depressive Disorders

DISRUPTIVE MOOD DYSREGULATION DISORDER
MAJOR DEPRESSIVE DISORDER
PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA)
PREMENSTRUAL DYSPHORIC DISORDER

Disruptive Mood Dysregulation Disorder (DMDD)

- Temper outbursts involving yelling, rages or physical aggression
- Overreacting to common stressors
- Temper outbursts occurring on average 3 or more times a week for at least 12 months (not symptom-free for more than 3 months at a time)
- Children age 6 to 18 years
- Introduced by Brotman (2006) as Severe Mood Disregulation Disorder; DSM-5 considered "Temper Disregulation Disorder"

Disruptive Mood Dysregulation Disorder (DMDD)

- Newly added to DSM-5
  - *Rationale:* This addresses the disturbing increase in pediatric bipolar diagnoses over the past two decades, which is due in large part to the incorrect characterization of non-episodic irritability as a hallmark symptom of mania. DMDD provides a diagnosis for children with extreme behavioral dyscontrol but persistent, rather than episodic, irritability and reduces the likelihood of such children being inappropriately prescribed antipsychotic medication. These criteria do not allow a dual diagnosis with oppositional-defiant disorder (ODD) or intermittent explosive disorder (IED), but it can be diagnosed with conduct disorder (CD)

Copyright © 2013. American Psychiatric Association.

Disruptive Mood Dysregulation Disorder (DMDD)

- Geller et al (2008) observed strong co-morbidity with other disruptive behavior disorders (CD, ODD, ADHD, none of which are pre-cursors to BPD. Why categorize as Depressive Disorder rather than Conduct or Impulse Control Disorder?

  1. want to move it *minimally* from BPD category
  2. want to emphasize its mood dysregulation rather than behavioral acting-out dimensions

Copyright © 2013. American Psychiatric Association.

Major Depressive Disorder

- Added “anxious distress” specifier
- Added “with mixed features”
- “Postpartum” changed to “peripartum”
- Removed Bereavement exclusion

What is the Bereavement Exclusion?

IN THE DSM-IV THERE WAS AN EXCLUSION FOR A MAJOR DEPRESSIVE EPISODE THAT WAS APPLIED TO DEPRESSIVE SYMPTOMS LASTING LESS THAN 2 MONTHS FOLLOWING THE DEATH OF A LOVED ONE (I.E. THE BEREAVEMENT EXCLUSION)

Why the Bereavement Exclusion was not Maintained in DSM-5

DSM-5 DROPS THIS EXCLUSION BECAUSE:

1. BEREAVEMENT CAN PRECIPITATE A MDE
2. IMPORTANT TO REMOVE IMPLICATION THAT BEREAVEMENT LASTS ONLY 2 MONTHS

Bereavement Exclusion
Depressive Disorders

- Eliminated from major depressive episode (MDE)
  - *Rationale:* In some individuals, major loss – including but not limited to loss of a loved one – can lead to MDE or exacerbate pre-existing depression. Individuals experiencing both conditions can benefit from treatment but are excluded from diagnosis under DSM-IV. Further, the 2-month timeframe required by DSM-IV suggests an arbitrary time course to bereavement that is inaccurate. Lifting the exclusion alleviates both of these problems.

Copyright © 2013. American Psychiatric Association.

DSM-5: Diagnostic Criteria for Major Depressive Disorders (Footnote, Pg. 161)

	Grief	Major Depression
Predominant affect	Emptiness and loss	Persistent depressed mood and the inability to anticipate happiness or pleasure
Dysphoria	Decreases in intensity over days to weeks and occurs in waves, the so-called pangs of grief; waves associated with thoughts or reminders of the deceased	Persistent and not tied to specific thoughts or preoccupations
Pain	Accompanied by positive emotions and humor	Pervasive unhappiness and misery

Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (Copyright © 2013). American Psychiatric Association. All rights reserved.

DSM-5: Diagnostic Criteria for Major Depressive Disorders

	Grief	Major Depression
Thought content	Preoccupation with thoughts and memories of the deceased	Self-critical or pessimistic ruminations
Self-esteem	Preserved; If self-derogatory ideation is present, it typically involves perceived failing vis-à-vis the deceased (e.g. not visiting frequently enough, not telling the deceased how much he or she was loved)	Feelings of worthlessness and self-loathing are common
Suicidal thoughts	Focused on the deceased and possibly about "joining" the deceased	Focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (Copyright © 2013). American Psychiatric Association. All rights reserved

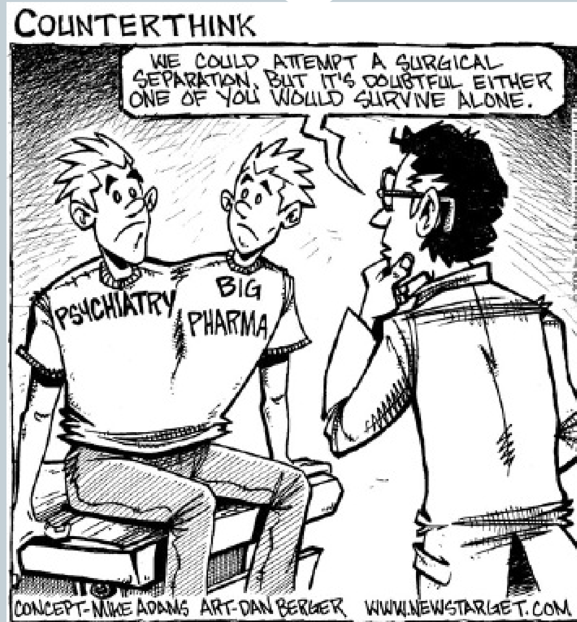
Continued Objections to Removing the Bereavement Exclusion

"*The saddest moment in my 45 year career of studying, practicing, and teaching psychiatry.*" said Allen Frances, MD, Chair of the DSM-IV Task Force, upon hearing the APA Board of Trustees' final approval of the DSM-5 (http://www.huffingtonpost.com/allen-frances/dsm-5_b_2227626.html)

- Depression is an "expectable" and culturally sanctioned response to the death of a loved one
- Bereavement-excluded depression is different than MDE in that it is not likely to recur
- Even with the Bereavement Exclusion, the diagnosis of severe cases are still possible
- Medicalizes sadness and grief
- Provides the pharmaceutical industry a bonanza

Maj M. World Psychiatry. 2012;11(1):1-2 Paksarian D. Mojtabai R. Psychiatric Annals, In Press
Wakefield JC. Schmitz MF. World Psychiatry, 2013;12(1):44-52 First MB. Current Opinion in Psychiatry, 2011, 24:1–9 Frances A. New York Times, August 15, 2010

Medical Model



Persistent Depressive Disorder (Dysthymia)

- Incorporates both Dysthymia and Major Depressive Disorder, Chronic
- Depressed mood that occurs for most of the day for at least 2 years (1 year for children)
- Not considered “milder” form of depression

Premenstrual Dysphoric Disorder

- Moved from DSM-IV Appendix (for further study) to DSM-5 Section II
- Mood, irritability, dysphoria and anxiety symptoms that occur during the majority of menstrual cycles.

Anxiety Disorders

Generalized anxiety disorder
Specific phobia
Panic disorder
Agoraphobia
Social anxiety disorder (social phobia)
Separation anxiety disorder
Selective mutism

Anxiety Disorders

- Separation of DSM-IV Anxiety Disorders chapter into four distinct chapters
  - *Rationale:* Data from neuroscience, neuroimaging, and genetic studies suggest differences in the heritability, risk, course, and treatment response among fear-based anxiety disorders (e.g., phobias); disorders of obsessions or compulsions (e.g., OCD); trauma-related anxiety disorders (e.g., PTSD); and dissociative disorders. Thus, four anxiety-related classifications are present in DSM-5.

Copyright © 2013. American Psychiatric Association.

Generalized Anxiety Disorder

- Excessive anxiety and *worry (apprehensive expectation)* occurring for at least 6 months (had considered 3 months)
- Difficulty controlling the *worrying*
- *GAD vs. GAWD*
- 3 or more of the following (1 or more for children):
  1. Restlessness
  2. Fatigue
  3. Difficulty concentrating
  4. Irritability
  5. Muscle tension
  6. Sleep problems

Anxiety Disorders

Specific Phobia, & Social Anxiety Disorder (Social Phobia)

- Eliminated requirement that individuals over age 18 recognize that their anxiety is excessive or unreasonable.
- Instead, the anxiety must be out of proportion to the actual danger or threat in the situation.
- The 6-month duration requirement, which was limited to individuals under age 18 in DSM-IV, is now extended to all ages.

Anxiety Disorders

Panic Disorder: Combined Panic Disorder with and without Agoraphobia

Agoraphobia: Codable diagnosis

Separation Anxiety Disorder: revised to be more applicable to adults. Fearful or anxious about separation from attachment figures (duration: 4 weeks in children; 6 months in adults).

Panic Attacks Specifier

- Now a specifier for any mental disorder
  - *Rationale:* Panic attacks can predict the onset severity and course of mental disorders, including anxiety disorders, bipolar disorder, depression, psychosis, substance use disorders, and personality disorders.

Copyright © 2013. American Psychiatric Association.

Selective Mutism

- Failure to speak in specific social situations (e.g., school, with playmates) where speaking is expected.
- Duration: at least 1 month
- The failure to speak is not due to a lack of knowledge with the spoken language required

Obsessive-Compulsive & Related Disorders

OBSESSIVE-COMPULSIVE DISORDER
BODY DYSMORPHIC DISORDER
HOARDING DISORDER
TRICHOTILLOMANIA (HAIR-PULLING DISORDER)
EXCORIATION (SKIN-PICKING) DISORDER

Obsessive Compulsive Disorder (OCD)

- Replaced "impulse" with "urge" because OCD is not in the impulse and conduct disorder category
- Removed criterion that individual recognizes that obsessions and/or compulsions are excessive or unreasonable
- New specifiers:
  - good or fair insight
  - poor insight
  - absent insight/delusional

Body Dysmorphic Disorder

- Repetitive behaviors or mental acts in response to preoccupations with perceived defects or flaws in physical appearance.
- Added “with muscle dysmorphia” specifier

Hoarding Disorder

- Persistent difficulty discarding or parting with possessions due to a perceived need to save the items and distress associated with discarding them
- Newly added to DSM-5
  - *Rationale:* Clinically significant hoarding is prevalent and can have direct and indirect consequences on the health and safety of patients as well as that of others (e.g., dependents, neighbors). Inclusion will increase the chances of these individuals receiving treatment.

Copyright © 2013. American Psychiatric Association.

Trichotillomania (Hair-Pulling Disorder)

- Repeated pulling of one's own hair
- Deleted DSM-IV's Criterion B & C (tension and gratification).
- Added: Repeated attempts to decrease hair

Excoriation (Skin-Picking) Disorder

- Repeated skin picking that results in skin lesions
- Most common areas: face, arms, hands

Trauma- & Stress-Related Disorders

REACTIVE ATTACHMENT DISORDER
DISINHIBITED SOCIAL ENGAGEMENT DISORDER
POSTTRAUMATIC STRESS DISORDER
ACUTE STRESS DISORDER
ADJUSTMENT DISORDERS

RAD and DSED

- DSM-IV's reactive attachment disorder (RAD) subtypes are now two distinct disorders: RAD and disinhibited social engagement disorder (DSED)
  - *Rationale:* These appear to be two distinct conditions that are characterized by different attachment behaviors. RAD is more similar to ADHD and disruptive behavior disorders and reflects poorly formed or absent attachments to others. DSED is more similar to depression and other internalizing disorders but occurs in children with both insecure and more secure attachments.

Copyright © 2013. American Psychiatric Association.

Posttraumatic Stress Disorder

- Criterion A is more explicit with regard to how an individual experienced "traumatic" events.
  1. directly experiences the traumatic event
  2. witnesses the traumatic event in person
  3. learns that the traumatic event occurred to a close family member or close friend or
  4. experiences first-hand repeated or extreme exposure to aversive details of the traumatic event

Posttraumatic Stress Disorder

- The stressor criterion (Criterion A) is more explicit (e.g., elimination of "non-violent death of a loved one" as a trigger) and subjective reaction (Criterion A2) is eliminated
  - *Rationale*: Direct and indirect exposure to trauma are still reflected in the criteria, but a review of the literature indicated more restrictive wording was needed. Criterion A2 is not well-supported by the data and rarely endorsed by military and other professionals who otherwise would meet full criteria for PTSD.

Copyright © 2013. American Psychiatric Association.

Posttraumatic Stress Disorder

- Separate criteria set for “PTSD for Children 6 Years and Under”
- Directly under the PTSD criteria box
- Same code number

Specify:

- With dissociative symptoms
- With delayed expression

Acute Stress Disorder

- The development of characteristic anxiety, dissociative, and other symptoms that occurs from 3 days to 1 month after exposure to a trauma.

Adjustment Disorders

- The development of emotional/behavioral symptoms in response to an identifiable stressor (within 3 months of the stressor)
- These symptoms/behaviors are clinically significant as evidenced by **either**:
  1. Distress that is more excessive than what is normally expected from such a stressor.
  2. Impaired social, occupational, or academic functioning.

Adjustment Disorders

Specify:

- With Depressed Mood
- With Anxiety
- With Mixed Anxiety & Depressed Mood
- With Disturbance of Conduct
- With Mixed Disturbance of Emotions & Conduct
- Unspecified

Dissociative Identity Disorder (Dissociative Disorders)

- Additional text to support Criterion D (exclusion based on cultural or religious practices)
  - *Rationale:* This acknowledges that possession states are commonly recognized in cultures around the world and do not necessarily indicate presence of DID or any other mental disorder. In contrast, possession-form DID is recurrent and unwanted, leads to distress or impairment, and is not part of a broadly accepted cultural or religious practice.

Copyright © 2013. American Psychiatric Association.

Dissociative Amnesia

- Now includes a dissociative fugue specifier, which was previously an independent disorder
  - *Rationale:* This revision was implemented due to a lack of clinical and epidemiological data supporting dissociative fugue as an independent disorder and due to the low validity of DSM-IV dissociative fugue criteria.

Copyright © 2013. American Psychiatric Association.

Somatic Symptom Disorder (SSD)

- Replaces somatoform disorder, undifferentiated somatoform disorder, hypochondriasis, and the pain disorders
  - *Rationale:* DSM-IV's somatoform disorders have been shown to be rarely used in most clinics and across numerous countries, due in part to criteria and terminology that are confusing, unreliable, and not valid.

No longer includes the difficult to prove statement that psychological conflict lies behind these disorders-

Copyright © 2013. American Psychiatric Association.

Somatic Symptom and Related Disorders

- The central focus of medically unexplained symptoms has been de-emphasized throughout the chapter, and instead emphasis is placed on disproportionate thoughts, feelings, and behaviors that accompany symptoms. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed. Previous hypochondriasis (w/out physical symptoms) is *illness anxiety disorder,* and *Psychological factors affecting other medical conditions is* reserved for SSRDs with physical symptoms. *Other Specified SSRD* include pseudocysis.
  - *Rationale:* The reliability of medically unexplained symptoms is low. Further, presence of medically explained symptoms *does not* rule out the possibility of a somatic symptom or related disorder being present.

Copyright © 2013. American Psychiatric Association.

Somatic Symptom and Related Disorders

- Somatic Symptom Disorder
  -Specify if *with predominant pain (*replaces pain disorder*)*
  -Specify if *Persistent (6 months+)*
  -Specify *Severity (Mild, Moderate, Severe)*
- Illness Anxiety Disorder
- Conversion Disorder (Functional Neurological Symptom Disorder)
- Psychological Factors Affecting Other Medical Conditions
- Factitious Disorder

Combined Feeding Disorders of Infancy and Early Childhood with Eating Disorders

- Feeding and Eating Disorders
- Feeding disorders: pica, rumination disorder and avoidant/restrictive food intake disorder
- The Eating disorders:
  - Anorexia Nervosa
  - Bulimia Nervosa
  - New Binge Eating Disorder
    - binge eating *on average* once weekly over the last 3 months

Copyright © 2013. American Psychiatric Association.

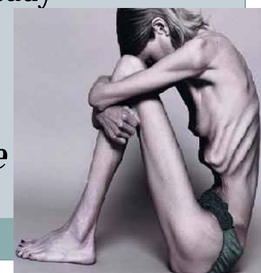
Avoidant/Restrictive Food Intake Disorder (ARFID)

- Feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder
  - *Rationale:* The new name will facilitate more accurate diagnosis in children presenting to pediatric clinics with significantly restricted eating patterns or nutritional problems, thus also likely reducing the use of the unspecified eating or feeding disorder diagnosis in DSM-5 (formerly EDNOS in DSM-IV).

Copyright © 2013. American Psychiatric Association.

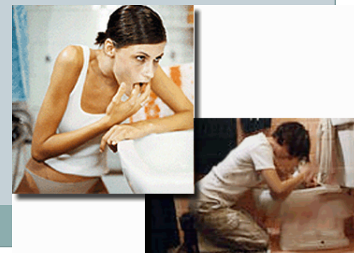
Disorders: Anorexia Nervosa

1. Refusal to maintain body weight at or above minimally normal weight for age and height (e.g., less than 85% of body weight)
2. Intense fear of gaining weight or becoming fat or persistent behavior that interferes with weight gain
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of low body weight
1. Amenorrhea (absence of at least three consecutive menstrual cycles)- *Rationale:* This requirement was already excluded for males, premenarcheal and postmenopausal females, and women using birth control pills. Data indicate females who menstruate but otherwise meet criteria for AN are clinically similar to non-menstruating females with AN.
4. *Restricting* and *Binge-Eating or Purging Type* (twice the mortality rate of restricting type)



Disorders: Bulimia Nervosa

1. Feel incapable of controlling the urge to binge and consumes more food than a person normally would at one sitting
2. Purging or other compensatory behavior (vomiting, laxatives, diuretics, exercising)
3. Engages in such behavior at least once per week for three months
4. Self-evaluation is unduly influenced by body shape and weight
5. Does not meet criteria for anorexia



Disorders: Binge Eating Disorder

1. Loss of control and distress about binge eating
2. At least one binge per week for an extended period of time (3 months or longer)
3. Differentials from Bulimia include

- no compensatory behavior
- more likely to be obese
- only slightly more common in females than in males
- bingeing *precedes* dieting
- prevalence: probably about 2% of adults in U.S.

Sexual Dysfunctions

Sexual Dysfunctions

- Vaginismus and dyspareunia are merged into genito-pelvic pain/penetration disorder
  - *Rationale*: These two DSM-IV disorders were highly comorbid and difficult to differentiate, resulting in poor clinical utility and reliability. Data suggest they likely represent overlapping features of a single condition.

Copyright © 2013. American Psychiatric Association.

Sexual Dysfunctions

- Lifetime vs. Acquired
- Generalized vs. Situational
- Level of Severity (patient distress)
  Mild
  Moderate
  Severe

Copyright © 2013. American Psychiatric Association.

Gender Dysphoria

Gender Dysphoria

- Newly added as a separate diagnostic class in DSM-5
  - *Rationale:* This new diagnostic class reflects a change in the conceptualization of gender identity disorder's (GID) defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification, as in DSM-IV.
  - The name change responds to concerns from consumers and advocates that the term *gender identity disorder* was stigmatizing. The revised term is already familiar to clinicians working with these populations and better reflects the emotional component of the diagnostic criteria

Copyright © 2013. American Psychiatric Association.

Gender Dysphoria

- Criteria now include two separate sets for children and for adults/adolescents
  - *Rationale:* Slight changes in the wording of criteria for children were necessary given developmental considerations. For example, some children might not verbalize the desire to be of another gender due to fear of social reprimand or if living in a household where such verbalizations lead to punishment.
  - LGBT community strongly endorses inclusion
  - Paul McHugh closed sexual re-assignment clinical at Johns Hopkins arguing that no doctor should honor a patient's request to remove a fully intact and functional organ for other than medically necessarily conditions

Copyright © 2013. American Psychiatric Association.

Substance-Related & Addictive Disorders

Substance Use Disorders
Substance-Induced Disorders
 intoxication
 withdrawal
Gambling disorder

Substance-Related & Addictive Disorders

1. Alcohol
2. Caffeine
3. Cannabis
4. Opioid
5. Hallucinogen (PCP)
6. Inhalant
7. Sedative, Hypnotic or Anxiolytic
8. Stimulant
9. Tobacco
10. Other (or unknown)

Substance-Related Disorders

Substance	Use Disorders	Intoxication	Withdrawal
Alcohol	X	X	X
Caffeine		x	x
Cannabis	x	x	x
Hallucinogens	x	x	
Inhalants	x	x	
Opioids	x	x	x
Sedatives	x	x	x
Stimulants	x	x	x
Tobacco	x		x

Substance Use Disorders

DSM-IV Diagnoses

Substance Dependence	Substance Abuse
At least 3 of 7: 1.Tolerance 2.Withdrawal 3.Using larger amounts than intended 4.Unsuccessful attempts to stop or control substance use 5.Spending a great deal of time obtaining, using, or recovering from the effects of the substance 6.Important activities given up or reduced because of substance use 7.Continued use despite substance-related physical or psychological problems	At least 1 of 4: 1.Failure to fulfill major role obligations at work, home, or school 2.Use in physically hazardous situations (e.g., drunk driving) 3.Substance-related legal problems 4.Continued use despite recurrent substance-related social or interpersonal problems * Add craving

Substance Use Disorder

Problematic pattern of use with at least 2 of the following occurring within a 12 month period:

1. Using larger amounts than intended
2. Unsuccessful attempts to stop or control substance use
3. Spending a great deal of time obtaining, using, or recovering from the effects of the substance
4. Craving or strong urge to use substance
5. Failure to fulfill obligations at work, home, or school
6. Continued use despite recurrent substance-related social or interpersonal problems
7. Important activities given up or reduced because of use
8. Use in physically hazardous situations (e.g., drunk driving)
9. Continued use despite substance-related physical or psychological problems
10. Tolerance
11. Withdrawal

Substance Use Disorder

Problematic pattern of use with at least 2 of the following occurring within a 12 month period:

Impaired control

1. Using larger amounts than intended
2. Unsuccessful attempts to stop or control substance use
3. Spending a great deal of time obtaining, using, or recovering from the effects of the substance
4. Craving or strong urge to use substance
5. Failure to fulfill obligations at work, home, or school
6. Continued use despite recurrent substance-related social or interpersonal problems
7. Important activities given up or reduced because of substance use
8. Use in physically hazardous situations (e.g., drunk driving)
9. Continued use despite substance-related physical or psychological problems
10. Tolerance
11. Withdrawal

Substance Use Disorder

Problematic pattern of use with at least 2 of the following occurring within a 12 month period:

Social impairment

1. Using larger amounts than intended
2. Unsuccessful attempts to stop or control substance use
3. Spending a great deal of time obtaining, using, or recovering from the effects of the substance
4. Craving or strong urge to use substance
5. Failure to fulfill obligations at work, home, or school
6. Continued use despite recurrent substance-related social or interpersonal problems
7. Important activities given up or reduced because of substance use
8. Use in physically hazardous situations (e.g., drunk driving)
9. Continued use despite substance-related physical or psychological problems
10. Tolerance
11. Withdrawal

Substance Use Disorder

Problematic pattern of use with at least 2 of the following occurring within a 12 month period:

1. Using larger amounts than intended
2. Unsuccessful attempts to stop or control substance use
3. Spending a great deal of time obtaining, using, or recovering from the effects of the substance
4. Craving or strong urge to use substance
5. Failure to fulfill obligations at work, home, or school
6. Continued use despite recurrent substance-related social or interpersonal problems
7. Important activities given up or reduced because of substance use
8. Use in physically hazardous situations (e.g., drunk driving)
9. Continued use despite substance-related physical or psychological problems
10. Tolerance
11. Withdrawal

Risky use

Substance Use Disorder

Problematic pattern of use with at least 2 of the following occurring within a 12 month period:

1. Using larger amounts than intended
2. Unsuccessful attempts to stop or control substance use
3. Spending a great deal of time obtaining, using, or recovering from the effects of the substance
4. Craving or strong urge to use substance
5. Failure to fulfill obligations at work, home, or school
6. Continued use despite recurrent substance-related social or interpersonal problems
7. Important activities given up or reduced because of substance use
8. Use in physically hazardous situations (e.g., drunk driving)
9. Continued use despite substance-related physical or psychological problems
10. Tolerance
11. Withdrawal

pharmacological

Substance Use Disorder Coding Protocol

1. Use code that applies to the class of substances but record the *specific substance*
   e.g. 305.70 (F15.10) mild methamphetamine use disorder (rather than mild stimulant use disorder)
2. Coding for Severity
   -*Mild* (2-3 symptoms)
   -*Moderate* (4-5 symptoms)
   -*Severe* (6 or more symptoms)
3. Specify remission
   -in early remission (no criteria for 3-12 months)
   -in sustained remission (no criteria for 12 months or more)
   -In a controlled environment (if individual in an environment where substance access is limited)

Substance-Induced Disorders

INTOXICATION
WITHDRAWAL
(SUBSTANCE-INDUCED MENTAL DISORDERS)

DiagnoSTIC SPECIFIERS Associated with Substance Class

	PSY	BP	De p	Anx	OC D	Sleep	Sex	Deler	Neur o
Alcoh	I/W	I/W	I/W	I/W		I/W	I/W	I/W	I/W/P
Caff				I		I/W			
Cann	I					I/W		I	
Hall	I	I	I	I				I	
Inhal	I		I	I				I	I/P
Opioid			I/W	W		I/W	I/W	I/W	
Seda	I/W	I/W	I/W	W		I/W	I/W	I/W	I/W/P
Stim	I	I/W	I/W	I/W	I/W	I/W	I	I	
Tobac						W			

I= specifier "with onset during intoxication" may be used for the category
W=specifier "with onset during withdrawal may be used for the category
P=the disorder is persisting

Coding Example: Depression

	ICD-9	ICD-10-CM	ICD-10-CM	ICD-10-CM
		With Use, Mild	With Use, Moderate	Without Use Disorder
Alcohol	291.89	F10.14	F10.24	F10.94
Hallucinogen	292.84	F16.14	F16.24	F16.94
Inhalant	292.84	F18.14	F18.24	F18.94
Opioid	292.84	F11.14	F11.24	F11.94
Sedative	292.84	F13.14	F13.24	F13.94
Amphetamine	292.84	F15.14	F15.24	F15.94
Cocaine	292.84	F14.14	F14.24	F14.94
Other	292.84	F19.14	F19.24	F19.94

Coding Convetnions

A. **When recordnig the name of the disorder, the comorbid SUD (if any) is listed first, followed by the word "with," followed by the name of the substance-induced disorder, followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal).**

E.g., in the case of depressive symptoms occurring during withdrawal in a man with severe cocaine use disorder, the diagnosis is:

F14.24, severe cocaine use disorder with cocaine-induced depressive disorder, with onset during withdrawal **(a separate dx of the comorbid severe cocaine use disorder is not given).**

Gambling Disorder

Gambling Disorder

- "Pathological Gambling" to Gambling Disorder
- Removed "*has committed illegal acts such as forgery, fraud,theft or embezzlement to finance gambling*."
- Changed, "*Gambles as a way to escape from problems*" to, "*gambles when feeling distressed*."
- Changed number of required symptoms from 5 to 4.
- Must occur within a 12-month period.

Gambling Disorder

- Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by 4 or more of the following within a 12-month period:

1. Needs to gamble with increasing amounts of money
2. Restless or irritable with attempting to cut down or stop
3. Has made repeated unsuccessful efforts to control or stop
4. Often preoccupied with gambling
5. Often gambles when feeling distressed
6. After losing money gambling, returns to re-coup losses
7. Lies to conceal the extend of involvement with gambling
8. Jeopardized or lost significant relationship, job or educational or career opportunity because of gambling
9. Relies on other to provide money to relieve desperate financial situations caused by gambling

Gambling Disorder

- Specify if

  1. Episodic (gambling-free for several months) or Persistent (continuous symptoms)

  2. In early remission (symptom-free for 3-12 months) or sustained remission (symptom-free > 12 months).

  3. Severity:
  Mild: 4-5 criteria met
  Moderate: 6-7 criteria met
  Severe: 8-9 criteria met

Internet Gaming

- Added Internet Gaming Disorder to Section 3

Types of Problematic Internet Use

- Online Gaming
- Cybersex
- Online Relationships
- Online Social Networking
- Online Shopping and Auction Houses
- Others

Personality Disorders

PARANOID, SCHIZOID, AND SCHIZOTYPAL

ANTISOCIAL, BORDERLINE, HISTRIONIC, NARCISSISTIC

AVOIDANT, DEPENDENT AND OBSESSIVE-COMPULSIVE

DSM-IV (and DSM-5…)

Cluster A	Cluster B	Cluster C	Appendix
Paranoid	Borderline	Avoidant	Passive-Aggressive
Schizoid	Antisocial	Dependent	Sadistic
Schizotypal	Histrionic	Obsessive-Compulsive	Depressive
	Narcissistic		

Exercise

- You are on the DSM-5 committee and have been mandated to trim the number of PDs down to 6 or less. What do you cut?
  - Schizotypal
  - Schizoid
  - Paranoid
  - Antisocial
  - Borderline
  - Narcissistic
  - Histrionic
  - Dependent
  - Avoidant
  - Obsessive-Compulsive

Exercise

- You are on the DSM-5 committee and have been mandated to trim the number of PDs down to 6 or less. What do you cut?
  - Schizotypal
  - Schizoid
  - Paranoid
  - Antisocial
  - Borderline
  - Narcissistic
  - Histrionic
  - Dependent
  - Avoidant
  - Obsessive-Compulsive

Exercise

- How similar is your list to the DSM-5 proposal?
  - Antisocial
  - Avoidant
  - Borderline
  - Narcissistic
  - Obsessive-Compulsive
  - Schizotypal

Personality Disorders : PID-5

- Negative Affect
- Detachment
- Antagonism
- Disinhibition
- Pyschoticism

Personality Disorders : PID-5

- Negative Affect (Emotional Lability, Anxiousness, Separation Anxiety)
- Detachment (Withdrawal, anhedonia, intimacy avoidance)
- Antagonism (manipulativeness, deceiptfulness, grandiosity)
- Disinhibition (irresponsibility, impulsivity, distractability)
- Pyschoticism (unusual beliefs and experiences, eccentricity, perceptual dysregulattion)

Neurocognitive Disorders

DELIRIUM
MAJOR NEUROCOGNITIVE DISORDER
MILD NEUROCOGNITIVE DISORDER

Delirium

- Disturbance of attention, awareness, cognition
- Occurs over short time period
- Caused by medical condition, substance use or withdrawal

Major Neurocognitive Disorder
Mild Neurocognitive Disorder

Cognitive decline from previous level of functioning in at least 1 of 6 domains:

1. Complex attention
2. Executive function
3. Learning and memory
4. Language
5. Perceptual motor
6. Social cognition

Major Neurocognitive Disorder
Mild Neurocognitive Disorder

Major:

- Decline in at least 1 of 6 neurocognitive domains
- Interferes with independence
- Specify etiology

Mild:

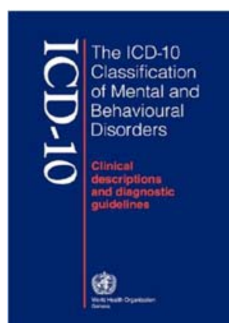
- Decline in at least 1 of 6 neurocognitive domains
- No interference with independence
- Specify etiology

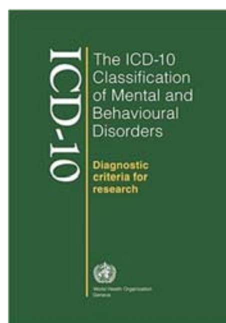
  Really a "risk diagnosis" and no way to determine whether mild neurocognitive disorder is normal aging or precursor to major neurocognitive disorder

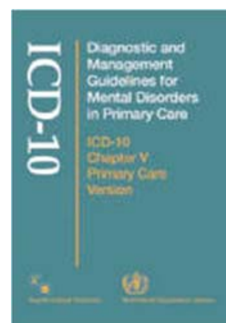
ICD and the DSM

International Classification of Diseases (ICD) (1)

- Classification system used to track morbidity and mortality of *all* diseases.
- Developed by the World Health Organization







ICD-10-CM Sample Chapters and Codes

Chapter	Range of Codes
I. Certain infectious and parasitic diseases	A00-B99
II. Neoplasms	C00-D48
III. Disease of the blood	D50-D89
IV. Endocrine, nutritional and metabolic diseases	E00-E90
V. Mental and behavioural disorders	**F00-F99**
VI. Diseases of the nervous system	G00-G99
VII. Diseases of the eye and adnexa	H00-H59
VIII. Diseases of the ear and mastoid process	H60-H95
IX. Diseases of the circulatory system	I00-I99
X. Diseases of the respiratory system	J00-J99
…continues through XXI. Factors influencing health status and contact with health services (Z00-Z98)	

ICD

- **ICD-9-CM** (Clinical Modification) – current version
  - Based on WHO's ICD-9 (1975)
  - National Center for Health Statistics developed "clinical modification" (CM) version for U.S.
  - Codes are numerical from 001 to 999.

ICD

- **ICD-10-CM**
  - Based on WHO's ICD-10 (1989)
  - Implementation in U.S. scheduled for **October 2014**
  - Codes are alphanumerical (A00-Z99)
  - Chapter V Mental & Behavioral Disorders are "F codes"
  - Codes available free online at http://www.cdc.gov/nchs/icd/icd10cm.htm

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
FIFTH EDITION
DSM-5
AMERICAN PSYCHIATRIC ASSOCIATION