DSM-5: research informed changes?

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The history that led to the Diagnostic and Statistical Manual of Mental Disorders -5
History of DSMs

• The initial impetus for developing a classification of mental disorders in the US was the need to collect statistical information.

• The first official attempt was the 1840 census which used a single category, "idiocy/insanity".

• The 1880 census distinguished among seven categories:
  1. Mania
  2. Melancholia
  3. Monomania
  4. Paresis
  5. Dementia
  6. Dipsomania
  7. Epilepsy
History of DSMs

• **1917**: Statistical Manual for the Use of Institution for the Insane
  - Developed by the Committee on Statistics (what is now known as the APA) and the National Commission on Mental Hygiene.
  - Included 22 diagnoses

• **1933**: Standard Classified Nomenclature of Disease
  - APA and the New York Academy of Medicine, provided the psychiatric nomenclature subsection of this US medical guide. Commonly referred to as the ‘Standard’.

• **1943**: Medical 203
  - Issued as a ‘Was Department Technical Bulletin’ under the auspices of the Office of the Surgeon General.

• **1949**: International Classification of Diseases 6 (ICD-6)
History of DSMs

• First Diagnostic and Statistical Manual of Mental Disorders was published in 1952.

• DSM-I was 130 pages long and listed 106 mental disorders.

• DSM-II was published 1968, listed 182 disorders/134 pages long.

• Symptoms were not specified in detail for specific disorders. Many disorders were seen as reflections of maladaptive reactions to life problems, rooted still in the distinction between neurosis and psychosis.
History of DSMs

On Being Sane in Insane Places

D. L. Rosenhan

If sanity and insanity exist, how shall we know them?

SCIENCE, VOL. 179
19 JANUARY 1973
The Rosenhan experiment

• An experiment into the validity of psychiatric diagnosis conducted by David Rosenhan in 1972. The study consisted of two parts.
  1. using healthy associates or "pseudopatients," who briefly simulated auditory hallucinations in an attempt to gain admission to 12 different psychiatric hospitals in five different states in various locations in the United States.
  2. asking staff at a psychiatric hospital to detect non-existent "fake" patients.

• In the first case hospital staff failed to detect a single pseudopatient.

• In the second the staff falsely identified large numbers of genuine patients as impostors.
History of DSMs

• *DSM-III* was published in 1980. It is 494 pages and 265 diagnostic categories.

• Rapidly came into widespread international use by multiple stakeholders and has been termed a revolution or transformation in psychiatry.


- Categories were renamed, reorganized, and significant changes in criteria were made.

- Removed “Egodystonic Homosexuality”
History of DSMs


- Modifications of some criteria sets:
  - Removed ‘organic’ as a concept and replaced with condition related to ‘General Medical Conditions’
  - Removed Self-defeating and Sadistic Personality Disorder from Disorders to be studied.

- A major change from previous versions was the inclusion of a clinical significance criterion to almost half of all the categories, which required symptoms cause "**clinically significant distress or impairment in social, occupational, or other important areas of functioning**".
History of DSMs

• A "Text Revision" published in 2000. *DSM-IV-TR*

• The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged.

• Text improved considerably.

• The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes in order to maintain consistency with the ICD.
Era of Neuroscience

Black and Andreasen (1995) in their seminal ‘Introductory Textbook of Psychiatry state:

The dream of understanding mental phenomena in terms of neural mechanisms now lies within our reach.

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The image above illustrates various neural structures, including neurons and brain scans, which are relevant to the discussion of neuroscience.
Perceived Shortcomings in DSM-IV (1)

- Categorical diagnostic system
- Reliability ≠ Validity
- Measureable criteria tell little about severity and disability
- Multiaxial system did not capture the quantitative components of a categorical diagnostic system

Perceived Shortcomings in DSM-IV (2)

- High rates of comorbidity
- High use of NOS category
- Treatment non-specificity
- Inability to find laboratory markers/tests
- DSM is starting to hinder research progress

Momentous advances in genetics and brain imaging since publication of DSM-IV in 1994 have generated optimism that an improved understanding of the neurobiologic underpinnings of psychiatric disorders might lead to a paradigm shift from the current descriptive classification system to a more scientific etiopathophysiologial system similar to that used by other medical specialties.
Revision Principles (1)

- The highest priority in modifying DSM-5 should be optimizing clinical utility
- Recommendations should be guided by research evidence
- Continuity with previous editions should be maintained
- Unlike in DSM-IV, there will be no *a priori* constraints on the degree of change between DSM-IV and DSM-V

Revision Principles (2)

• Development- across the life span

• Dimensional concepts- measurement of Distress, disability, and severity

• Incorporation of new knowledge- risk factors, prodromes, prevention

• Living document

Strategies for Improving DSM

• Incorporate **research** into the revision and evolution of the classification

• Move beyond a process of clinical consensus and build diagnoses on a foundation of empirical findings from scientific disciplines

• Seek multidisciplinary, international scientific participation in the task of planning the DSM-5 revision
Questions???

Comments???
Overall changes to DSM-5
The traditional Roman numeral is gone. *DSM-IV to DSM-5.*

- Research advances will continue to require text revisions to DSM, and a TR designation, as was done with DSM-IV-TR, can only be appended once.

- Future changes prior to the manual’s next complete revision will be signified as DSM-5.1, DSM-5.2, and so on.
DSM-5 Structure

Section I: DSM-5 Basics

Section II: Essential Elements: Diagnostic Criteria and Codes

Section III: Emerging Measures and Models

Appendix

Index
Section I

Brief DSM-5 developmental history

Guidance on use of the manual

Definition of a mental disorder

Cautionary forensic statement

Brief DSM-5 classification summary
Section II

DSM-5 Chapter order

• DSM-5’s 20 chapters are restructured based on disorders’ apparent relatedness to one another, as reflected by:
  – similarities in disorders’ underlying vulnerabilities
  – symptom characteristics

• These changes also align DSM-5 with ICD-11.
Section II

DSM-5 Organization

• Organized in a sequence with the developmental lifespan, with disorders typically in childhood detailed first, followed by those in adolescence, adulthood and later life.

• Disorders previously addressed in a single “infancy, childhood, and adolescence” chapter are now integrated throughout the manual.
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Section II

Removal of Multiaxial System

DSM-5 has moved to a non-axial documentation of diagnosis, combining the former Axes I, II, and III, with separate notations for psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V).

Terminology

The phrase “general medical condition” is replaced in DSM-5 with “another medical condition” where relevant across all disorders.
Section II

Structure of Disorder Chapters

• Criteria

• Subtypes and/or specifiers

• Severity
  – Codes and recording procedures

• Explanatory text (new or expanded)
  – Diagnostic and associated features; prevalence; development and course; risk and prognosis; culture- and gender-related factors; diagnostic markers; functional consequences; differential diagnosis; comorbidity
Section III

Content

• Section III: Emerging Measures and Models
  – Assessment Measures
  – Cultural Formulation
  – Alternative DSM-5 Model for Personality Disorders
  – Conditions for Further Study
Section III

Purpose

• Section III includes a designated location for items that appear to have initial support in terms of clinical use but require further research before being officially recommended as part of the main body of the manual.

– This separation clearly conveys to readers that the content may be clinically useful and warrants review, but is not a part of an official diagnosis of a mental disorder and cannot be used as such.
Section III

Content

• 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
Appendix

Content

• Separate from Section III, that includes:
  – Highlights of Changes From DSM-IV to DSM-5
  – Glossary of Technical Terms
  – Glossary of Cultural Concepts of Distress
  – Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)
  – Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)
  – Numerical Listing of DSM-5 Diagnoses and Codes (ICD 10-CM)
  – DSM-5 Advisors and Other Contributors
Changes in Specific DSM Disorder Numbers
Combination of New, Eliminated, and Combined Disorders
(net difference = -15)

<table>
<thead>
<tr>
<th>Specific Mental Disorders*</th>
<th>DSM-IV</th>
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<td>172</td>
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*NOS (DSM-IV) and Other Specified/Unspecified (DSM-5) conditions are counted separately.

# New and Eliminated Disorders in DSM-5

**New Disorders**

- Social (Pragmatic) Communication Disorder
- Disruptive Mood Dysregulation Disorder
- Premenstrual Dysphoric Disorder (DSM-IV appendix)
- Hoarding Disorder
- Excoriation (Skin-Picking) Disorder
- Disinhibited Social Engagement Disorder (split from Reactive Attachment Disorder)
- Binge Eating Disorder (DSM-IV appendix)
- Central Sleep Apnea (split from Breathing-Related Sleep Disorder)
- Sleep-Related Hypoventilation (split from Breathing-Related Sleep Disorder)
- Rapid Eye Movement Sleep Behavior Disorder (Parasomnia NOS)
- Restless Legs Syndrome (Dyssomnia NOS)
- Caffeine Withdrawal (DSM-IV Appendix)
- Cannabis Withdrawal
- Major Neurocognitive Disorder with Lewy Body Disease (Dementia Due to Other Medical Conditions)
- Mild Neurocognitive Disorder (DSM-IV Appendix)

**Eliminated Disorders**

- Sexual Aversion Disorder
- Polysubstance-Related Disorder
Combined Specific Disorders in DSM-5 (1)  
(net difference = -28)

1. Language Disorder (Expressive Language Disorder & Mixed Receptive Expressive Language Disorder)
2. Autism Spectrum Disorder (Autistic Disorder, Asperger’s Disorder, Childhood Disintegrative Disorder, & Rett’s disorder — PDD-NOS is in the NOS count)
3. Specific Learning Disorder (Reading Disorder, Math Disorder, & Disorder of Written Expression)
4. Delusional Disorder (Shared Psychotic Disorder & Delusional Disorder)
5. Panic Disorder (Panic Disorder Without Agoraphobia & Panic Disorder With Agoraphobia)
6. Dissociative Amnesia (Dissociative Fugue & Dissociative Amnesia)
7. Somatic Symptom Disorder (Somatization Disorder, Undifferentiated Somatoform Disorder, & Pain Disorder)
8. Insomnia Disorder (Primary Insomnia & Insomnia Related to Another Mental Disorder)
9. Hypersomnia Disorder (Primary Hypersomnia & Hypersomnia Related to Another Mental Disorder)
10. Non-Rapid Eye Movement Sleep Arousal Disorders (Sleepwalking Disorder & Sleep Terror Disorder)
Combined Specific Disorders in DSM-5 (2)

(net difference = -28)

11. Genito-Pelvic Pain/Penetration Disorder (Vaginismus & Dyspareunia)
12. Alcohol Use Disorder (Alcohol Abuse and Alcohol Dependence)
13. Cannabis Use Disorder (Cannabis Abuse and Cannabis Dependence)
14. Phencyclidine Use Disorder (Phencyclidine Abuse and Phencyclidine Dependence)
15. Other Hallucinogen Use Disorder (Hallucinogen Abuse and Hallucinogen Dependence)
16. Inhalant Use Disorder (Inhalant Abuse and Inhalant Dependence)
17. Opioid Use Disorder (Opioid Abuse and Opioid Dependence)
18. Sedative, Hypnotic, or Anxiolytic Use Disorder (Sedative, hypnotic, or anxiolytic Abuse and Sedative, hypnotic, or anxiolytic Dependence)
19. Stimulant Use Disorder (Amphetamine Abuse; Amphetamine Dependence; Cocaine Abuse; Cocaine Dependence)
20. Stimulant Intoxication (Amphetamine Intoxication and Cocaine Intoxication)
22. Substance/Medication-Induced Disorders (aggregate of Mood (+1), Anxiety (+1), and Neurocognitive (-3))
Other Specified and Unspecified Disorders in DSM-5 replaced the Not Otherwise Specified (NOS) conditions in DSM-IV to maintain greater concordance with the official International Classification of Diseases (ICD) coding system. This statistical accounting change does not signify any new specific mental disorders.
Questions???

Comments???
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Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Other Conditions That May Be a Focus of Clinical Attention
Specific Changes in Diagnostic Criteria:

Neurodevelopmental Disorders
**Intellectual Disabilities**
- Intellectual Disability (IDD)
- Global Developmental Delay
- Unspecified Intellectual Disability

**Communication Disorders**
- Language Disorder
- Speech Sound Disorder (previously Phonological Disorder)
- Childhood Onset Fluency Disorder (Stuttering)
- Social (Pragmatic) Communication Disorder
- Unspecified Communication Disorder

**Autism Spectrum Disorder**
- Autism Spectrum Disorder

**Attention-Deficit/Hyperactivity Disorder**
- Attention-Deficit/Hyperactivity Disorder
- Other Specified ADHD
- Unspecified ADHD

**Specific Learning Disorder**
- Specific Learning Disorder

**Motor Disorders**
- Developmental Coordination Disorder
- Stereotypic Movement Disorder
- Tourette’s Disorder
- Persistent (Chronic) Motor or Vocal Tic Disorder
- Provisional Tic Disorder
- Other Specified Tic Disorder
- Unspecified Tic Disorder

**Other Neurodevelopmental Disorders**
- Other Specified Neurodevelopmental Disorder
- Unspecified Neurodevelopmental Disorder

**Shared features**
- Onset during the “developmental period”
- Negatively impact developmental trajectory
ND – Intellectual Disability

• Mental retardation is 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.
• ASD replaces DSM-IV’s autistic disorder, Asperger’s disorder, childhood disintegration disorder, Rett disorder and pervasive developmental disorder NOS

– Rationale: Clinicians had been applying the DSM-IV criteria for these disorders inconsistently and incorrectly; subsequently, reliability data to support their continued separation was very poor.

• Scientific validity
  – Lack of specificity and sensitivity in separating the diagnoses
  – Lack of accurate historical information about very early language development put emphasis on current speech (trainable)
  – Overlap in samples when VIQ controlled
ND – Autism Spectrum Disorder (ASD) (2)

ASD is characterized by:

1) Deficits in social communication and social interaction
2) Restricted repetitive behaviors (RRBs), interests, and activities

Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRBs are present.

– 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).
ASD Severity Specifiers (1)

• Current severity based on social communication impairments and restricted repetitive patterns of behavior

  – Level 1: Requiring support (mild)

  – Level 2: Requiring substantial support (moderate)

  – Level 3: Requiring very substantial support (Severe, very little to no language)

  – Support is recorded for both of the domains and may be different for each domain
ND – Autism Spectrum Disorder (ASD) (4)

ASD Severity Specifiers (2)

- With or without intellectual impairment
- With or without language impairment
- Associated with a known medical, genetic, or environmental factor
- Associated with another neurodevelopmental, mental, or behavioral disorder
ND – Autism Spectrum Disorder (ASD) (5)

Concerns about ASD in DSM-5

• Sensitivity has been “sacrificed” in order to improve specificity

• Merging Asperger disorder (and PDD-NOS) into Autism Spectrum Disorder results in loss of identity and ignores uniqueness of Asperger’s

• Pre-/post DSM-5 research studies won’t be comparable

Examples:

• For subcriterion A.3,
  – DSM-IV checklist item is “failure to develop peer relationships and abnormal social play.”
  – DSM-5 recommendations include higher-order impairments of “difficulties adjusting behavior to suit different social contexts.”

• For criterion C,
  – DSM-IV requires that symptoms begin prior to the age of 3 years.
  – DSM-5 requires that symptoms begin in early childhood, with the caveat that “symptoms may not be fully manifest until social demands exceed capacity” (during middle-school years, later adolescence, or young adulthood).
ND – Autism Spectrum Disorder (ASD) (5)

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Examples:

**DSM-5 may be MORE sensitive that DSM-IV, not less.**

adjusting behavior to suit different social contexts.

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ND – 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.

• Changed to facilitate application across the lifespan

• Diagnosis now allowed together with ASD
• Specific learning disorder consolidates four DSM-IV learning disorders, but includes specifiers related to deficits in reading, written expression, and mathematics.

• Three communication disorders - language disorder, childhood onset fluency disorder (stuttering), and speech sound disorder - replace DSM-IV diagnoses of expressive language disorder, stuttering, and phonological disorder, respectively.

• DSM-5 criteria for Tourette’s syndrome and chronic motor or vocal tic disorder state that tics may “wax and wane in frequency but have persisted for more than a year.” DSM-IV criteria had stated that tics occur many times a day nearly every day.”
Questions???

Comments???
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Medication-Induced Movement Disorders and Other Adverse Effects of Medication
Other Conditions That May Be a Focus of Clinical Attention
Specific Changes in Diagnostic Criteria:

Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenia Spectrum and Other Psychotic Disorders

1. Schizotypal Personality Disorder
2. Delusional Disorder
3. Brief Psychotic Disorder
4. Schizophreniform Disorder
5. Schizophrenia
6. Schizoaffective Disorder
7. Substance/Medication-Induced Psychotic Disorder
8. Psychotic Disorder Due to Another Medical Condition
9. Catatonia Associated with Another Mental Disorder (Catatonia Specifier)
10. Catatonic Disorder Due to Another Medical Condition
11. Unspecified Catatonia
12. Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
13. Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
Two changes to DSM-IV Criterion A:

1. Elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing).
   – In DSM-IV, only one such symptom was needed to meet the diagnostic requirement for Criterion A, instead of two of the other listed symptoms. This special attribution was removed and, in DSM-5, two Criterion A symptoms are required for any diagnosis of schizophrenia.

2. Addition of a requirement in Criterion A that the individual must have at least one of these three symptoms: delusions, hallucinations, and disorganized speech.
   – At least one of these core “positive symptoms” is necessary for a reliable diagnosis of schizophrenia.
Schizophrenia subtypes eliminated

Rationale: The DSM-IV subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) are eliminated due to their limited diagnostic stability, low reliability, and poor validity
The primary change to schizoaffective disorder is the requirement that a major mood episode must be present for a majority of the time the disorder has been present in the person.

Rationale: This change was made on both conceptual and psychometric grounds. It makes schizoaffective disorder a longitudinal instead of a cross-sectional diagnosis.
Delusional disorder (1)

- Criterion A for delusional disorder no longer has the requirement that the delusions must be non-bizarre.

- The separation of delusional disorder from psychotic variants of obsessive-compulsive disorder and body dysmorphic disorder is explicitly noted.

- A new exclusion criterion - the symptoms must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs.
Delusional disorder (2)

- DSM-5 no longer separates delusional disorder from shared delusional disorder.

- If criteria are met for delusional disorder then that diagnosis is made.

- If the diagnosis cannot be made but shared beliefs are present, then the diagnosis “other specified schizophrenia spectrum and other psychotic disorder” is used.
Catatonia

Now exists as a specifier for neurodevelopmental, psychotic, mood and other mental disorders; as well as for other medical disorders (catatonia due to another medical condition)

• Rationale: As represented in DSM-IV, catatonia was under recognized, particularly in psychiatric disorders other than schizophrenia and psychotic mood disorders and in other medical disorders. It was also apparent that inclusion of catatonia as a specific condition that can apply more broadly across the manual may help address gaps in the treatment of catatonia.
Area for Further Study

• **Attenuated psychosis syndrome** is included in Section III of the new manual; conditions listed there require further research before their consideration as formal disorders.

  - This potential category would identify a person who does not have a full-blown psychotic disorder but exhibits minor versions of relevant symptoms.

Rationale: Identifying individuals with an increased risk for developing a psychotic disorder is significant for effective early intervention, but more study is needed to ensure that attenuated psychosis syndrome can be reliably diagnosed.
Questions???

Comments???
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**Medication-Induced Movement Disorders and Other Adverse Effects of Medication**

**Other Conditions That May Be a Focus of Clinical Attention**
Specific Changes in Diagnostic Criteria:

Mood Disorders

to

Bipolar and Related Disorders
Bipolar and Related Disorders

1. Bipolar I Disorder
2. Bipolar II Disorder
3. Cyclothymic Disorder
4. Substance/Medication-Induced Bipolar and Related Disorder
5. Bipolar and Related Disorder Due to Another Medical Condition
6. Other Specified Bipolar and Related Disorder
7. Unspecified Bipolar and Related Disorder
**Bipolar (1)**

**Mania and Hypomania**

- Inclusion of increased energy/activity as a Criterion A symptom of mania and hypomania

  **Rationale:** Many individuals with bipolar disorder present for the first time in an episode of depression. Collateral informants can only infer mood, not observe it. Changes in activity can be observed objectively and will improve the specificity of the diagnosis and make it faster.

- “**Mixed episode**” is replaced with a “with mixed features” specifier for manic, hypomanic, and major depressive episodes

  **Rationale:** DSM-IV criteria excluded from diagnosis the sizeable population of individuals with subthreshold mixed states who did not meet full criteria for major depression and mania, and thus were less likely to receive treatment.
“With anxious distress” also added as a specifier for bipolar (and depressive) disorders

Rationale: The co-occurrence of anxiety with depression is one of the most commonly seen co-morbidities in clinical populations. Addition of this specifier will allow clinicians to indicate the presence of anxiety symptoms that are not reflected in the core criteria for depression and mania but nonetheless may be meaningful for treatment planning.

PROBLEM: FREQUENT AND OFTEN INACCURATE DIAGNOSIS OF BIPOLAR DISORDER IN PRE-PUBERTAL CHILDREN
Questions???

Comments???
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*Medication-Induced Movement Disorders and Other Adverse Effects of Medication*
*Other Conditions That May Be a Focus of Clinical Attention*
Specific Changes in Diagnostic Criteria:

Mood Disorders

to

Depressive Disorders
Depressive Disorders

1. Disruptive Mood Dysregulation Disorder
2. Major Depressive Disorder, Single and Recurrent Episodes
3. Persistent Depressive Disorder (Dysthymia)
4. Premenstrual Dysphoric Disorder
5. Substance/Medication-Induced Depressive Disorder
6. Depressive Disorder due to Another Medical Condition
7. Other Specified Depressive Disorder
8. Unspecified Depressive Disorder
Disruptive Mood Dysregulation Disorder (1)

Rationale:
• Effort to define a condition that may share some characteristics with pediatric bipolar disorder, but on prospective follow-up does not evolve into a bipolar disorder.

• Children meeting these criteria typically develop unipolar depression and/or anxiety disorders in adolescence or adulthood.

*Essential feature:* Severe recurrent temper outbursts in response to common stressors. Outbursts can be verbal and/or behavioral, are out of proportion to the provocation, and inconsistent with the child’s developmental level

*Frequency:* On average, ≥ 3 times per week.
Disruptive Mood Dysregulation Disorder (2)

*Mood between temper outbursts*: persistently angry irritable and/or sad and observable by others

*Duration*: At least 12 months with no more than 3 consecutive months without symptoms

*Ubiquity*: Temper outbursts and/or negative mood are present in at least two settings (at home, at school, or with peers) and must be severe in at least in one setting

*Minimum age*: > 6 years (or equivalent developmental level)

*Age at onset*: < 10 years
Disruptive Mood Dysregulation Disorder (3)

• 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). Children who meet criteria for DMDD and ODD would be diagnosed with DMDD only.
New in Depressive Disorders

• **Premenstrual dysphoric disorder** has been moved from DSM-IV Appendix B to the main body of DSM-5.

• **Persistent Depressive Disorder** combines dysthymic disorder and chronic major depressive disorder.

  Rationale: An inability to find scientifically meaningful differences between these two conditions led to their combination with specifiers included to identify different pathways to the diagnosis and to provide continuity with DSM-IV.
PROBLEM: THE Bereavement exclusion and consequent under-diagnosis of major depressive episode in the context of bereavement

Elimination of the bereavement exclusion

Rationale:
• Bereavement is a severe psychosocial stressor that can precipitate an MDE in vulnerable individuals.

• The probability of an MDE and the nature of the symptoms do not differ in the aftermath of bereavement vs. other equally severe psychosocial stressors for which no such exclusion exists.
Bereavement Exclusion (2)

Rationale:
• The DSM-IV bereavement exclusion implied that bereavement typically lasts only 2 months when the duration is commonly 1 to 2 years

• Presence of MDE adds additional risks for suffering, sense of worthlessness, suicidal ideation, poorer medical health, and poorer interpersonal and work functioning

Notes:
– Criteria note that the presence of an MDE can be considered in addition to the normal response to a significant loss

– Footnote that offers explanatory information about the difference between bereavement and MDE
Change to severity specifiers

• Mild
• Moderate
• Severe
• With psychotic features
• In partial remission
• In full remission
• Unspecified

Rationale:
• Not all severe mood episodes are psychotic
• Not all psychotic mood episodes are severe
• In DSM-IV there was no way to indicate psychosis in the absence of high severity
Depression and pregnancy

PROBLEM: MISPERCEPTION THAT PREGNANCY IS A PROTECTED PERIOD FOR MOOD DISORDERS, MEANING THAT MANY ONSETS DURING PREGNANCY ARE MISSED

Change postpartum specifier from with postpartum onset to with peripartum onset:
When mood episode onset is during pregnancy or within 4 weeks of parturition (childbirth)

Rationale: Reflects the fact that mood episodes, particularly major depressive episodes, can occur during pregnancy as well as after parturition.
Questions???

Comments???
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Specific Changes in Diagnostic Criteria:

Feeding and Eating Disorders
Feeding and Eating Disorders

1. Pica
2. Rumination Disorder
3. Avoidant/Restrictive Food Intake Disorder
4. Anorexia Nervosa
5. Bulimia Nervosa
6. Binge Eating Disorder
7. Other Specified Feeding and Eating Disorder
8. Unspecified Feeding and Eating Disorder

Elimination Disorders

1. Enuresis
2. Encopresis
3. Other Specified Elimination Disorder
4. Unspecified Elimination Disorder
Feeding and Eating Disorders

Change:
• This chapter in DSM-5 includes several disorders included in DSM-IV as feeding and eating disorders of infancy or early childhood in the chapter “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.”

Pica and Rumination Disorder
• The DSM-IV criteria have been revised for clarity
• The diagnoses can be made for individuals of any age.

Avoidant/Restrictive Food Intake Disorder
• DSM-IV feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder, and the criteria have been significantly expanded.
Feeding and Eating Disorders

Avoidant/restrictive food intake disorder was renamed from feeding disorder of infancy or early childhood

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).
Anorexia Nervosa
• The core diagnostic criteria are conceptually unchanged from DSM-IV with one exception: the requirement for amenorrhea has been eliminated.

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.
Anorexia Nervosa

- The wording of the criterion A has been changed for clarity, and guidance regarding how to judge whether an individual is at or below a significantly low weight is now provided in the text. ‘Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected.’

- Criterion B is expanded to include not only overtly expressed fear of weight gain but also persistent behavior that interferes with weight gain.
Feeding and Eating Disorders

Bulimia Nervosa
• The only change to the DSM-IV criteria for bulimia nervosa is a reduction in the required minimum average frequency of binge eating and inappropriate compensatory behavior frequency from twice to once weekly.
Feeding and Eating Disorders

Binge Eating Disorder
• Elevated to the main body of the DSM-5 manual from DSM-IV’s Appendix

Rationale: Binge Eating Disorder is highly recognized in the clinical literature as a valid and clinically useful diagnosis. Further, a significant proportion of cases of DSM-IV’s eating disorder Non Otherwise Specified would meet criteria for BED; therefore, this should reduce use of the unspecified eating and feeding disorder designation in DSM-5.

• The only significant difference from the preliminary DSM-IV criteria is that the minimum average frequency of binge eating required for diagnosis has been changed from at least twice weekly for 6 months to at least once weekly over the last 3 months.
Obesity

What could have been…
Questions???

Comments???
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20. Other Disorders

Medication-Induced Movement Disorders and Other Adverse Effects of Medication
Other Conditions That May Be a Focus of Clinical Attention
Specific Changes in Diagnostic Criteria:

Trauma and Stressor-Related Disorders
Trauma- and Stressor-Related Disorders

1. Reactive Attachment Disorder
2. Disinhibited Social Engagement Disorder
3. Posttraumatic Stress Disorder
4. Acute Stress Disorder
5. Adjustment Disorders
6. Other Specified Trauma- and Stressor-Related Disorder
7. Unspecified Trauma- and Stressor-Related Disorder
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.

- DSED is more similar to ADHD and disruptive behavior disorders and reflects poorly formed or absent attachments to others.

- RAD is more similar to depression and other internalizing disorders but occurs in children with both insecure and more secure attachments.
Posttraumatic Stress Disorder (1)

• 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.
Posttraumatic Stress Disorder (2)

Expansion to four symptom clusters:
1. intrusion symptoms
2. avoidance symptoms
3. negative alterations in mood and cognition
4. alterations in arousal and reactivity

Rationale: Confirmatory factor analyses suggest PTSD is best conceptualized by four factors rather than three. Further, active avoidance and emotional numbing have been shown to be distinct; thus they have been separated here (with numbing expanded to include negative mood and cognitive symptoms).
Posttraumatic Stress Disorder (3)

- Separate criteria are now available for PTSD occurring in preschool-age children (i.e., 6 years and younger)

Rationale: DSM-IV criteria for PTSD were not developmentally sensitive to very young children. For instance, young children are limited in their capacity to describe cognitions and internal experiences. Numerous studies indicate that children exposed to trauma can exhibit significant anxiety and other forms of distress that warrant treatment but, due to the inadequacy of the adult criteria, do not meet threshold for PTSD in DSM-IV.

- The adult criteria are used in children older than age 6

- Exposure is to actual or threatened death, serious injury, or sexual violence- (Witnessing does not include by electronic media)

- Can include learning that trauma occurred to a caregiver
Questions???

Comments???
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Medication-Induced Movement Disorders and Other Adverse Effects of Medication
Other Conditions That May Be a Focus of Clinical Attention
Specific Changes in Diagnostic Criteria:

Gender Dysphoria
Gender Dysphoria

1. Gender Dysphoria
2. Other Specified Gender Dysphoria
3. Unspecified Gender Dysphoria
Gender Dysphoria (1)

• **A new category + and separate chapter** - for gender dysphoria emphasizes the phenomenon of “gender incongruence” rather than cross-gender identification.

• Gender dysphoria is now separate from the chapters on sexual dysfunctions and on paraphillic disorders.

• The category is re-conceptualized as one overarching diagnosis with separate developmentally appropriate criteria sets for children and for adolescents and adults.

• In DSM-5, people whose gender at birth is contrary to the one they identify with will be diagnosed with gender dysphoria.

• This diagnosis is a revision of DSM-IV’s criteria for gender identity disorder and is intended to better characterize the experiences of affected children, adolescents, and adults.
Gender Dysphoria (2)

Newly added as a **separate diagnostic** class in DSM-5

Rationale: 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.

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.
Questions???

Comments???
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Other Conditions That May Be a Focus of Clinical Attention
Specific Changes in Diagnostic Criteria:

Neurocognitive Disorders
Neurocognitive Disorders

1. Delirium
2. Other Specified Delirium
3. Unspecified Delirium
4. Major & Mild Neurocognitive Disorders
5. Major or Mild Neurocognitive Disorder Due to Alzheimer’s Disease
6. Major or Mild Frontotemporal Neurocognitive Disorder
7. Major or Mild Neurocognitive Disorder with Lewy Bodies
8. Major or Mild Vascular Neurocognitive Disorder
9. Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury
10. Substance/Medication-Induced Neurocognitive Disorder
11. Major or Mild Neurocognitive Disorder Due to HIV Infection
12. Major or Mild Neurocognitive Disorder Due to Prion Disease
13. Major or Mild Neurocognitive Disorder Due to Parkinson’s Disease
14. Major or Mild Neurocognitive Disorder Due to Huntington’s Disease
15. Neurocognitive Disorder Due to Another Medical Condition
16. Major or Mild Neurocognitive Disorder Due to Multiple Etiologies
17. Unspecified Neurocognitive Disorder
Neurocognitive Disorders (1)

• Neurocognitive Disorders replace the DSM-IV Category of *Delirium, Dementia, Amnestic, and Other Geriatric Cognitive Disorders*.

• The defining characteristics of these disorders are that their **core or primary deficits are in cognition** and that these deficits **represent a decline** from a previously attained level of cognitive functioning – distinguishing them from the neurodevelopmental disorders in which a neurocognitive deficit is present at birth or interferes with development.

• This section includes three broadly defined syndromes.
  (1) Delirium
  (2) Major Neurocognitive Disorder
  (3) Minor Neurocognitive Disorder
Neurocognitive Disorders (2)

• Use of the term *major neurocognitive disorder* rather than *dementia*

Rationale: The term *dementia* is usually associated with neurodegenerative conditions occurring in older populations, as in Alzheimer’s disease and Lewy Body dementia. However, DSM-5’s major neurocognitive disorders refers to a broad range of possible etiologies that can occur even in young adults, such as major neurocognitive disorder due to traumatic brain injury or HIV infection.
Neurocognitive Disorders (3)

• Addition of mild neurocognitive disorder as a new disorder

Rationale: Patients with mild neurocognitive disorder are frequently seen in clinics and in research settings, and there is widespread consensus throughout the field that these populations can benefit from diagnosis and treatment. The clinical utility of such a diagnosis also is highly supported in the literature.
Neurocognitive Disorders (4)

• Elevation of DSM-IV etiological subtypes (e.g., frontotemporal dementia, dementia with Lewy Bodies) to separate, independent disorders

Rationale: Separate criteria for 10 etiologies were developed based on clinical need and to reflect the best clinical practices endorsed by neurologists, neuropsychiatrists, and others who routinely work with these patients. Etiological criteria provide clarity for clinicians, more accurate diagnoses for patients, and support for researchers in uncovering potential biomarkers that may inform diagnosis in the future.
Neurocognitive Disorders (5)

Subclassification by Etiology

1. Alzheimer’s disease
2. Lewy body Disease
3. Frontotemporal neurocognitive impairment
4. Vascular neurocognitive impairment
5. Traumatic brain injury
6. HIV
7. Huntington’s disease
8. Prion Disease
9. Substance use disorders
10. Parkinson’s Disease
Neurocognitive Disorders (6)

• The distinction between Major and Minor disorders is primarily one of severity, with the threshold for Major Neurocognitive Disorder encompassing a greater degree of cognitive impairment and hence a loss of independence in instrumental activities of daily living.

• In most progressive disorders such as the neurodegenerative disorders and some forms of vascular cognitive impairment, Minor and Major may be earlier and later stages of the same disorder.

- In these settings, the differences may involve impairment in additional cognitive domains as well as more severe impairment within the domains as the patient crosses from the Minor to Major level of impairment.
Questions???

Comments???
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Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Other Conditions That May Be a Focus of Clinical Attention
Specific Changes in Diagnostic Criteria:

Medication-Induced Movement Disorders and Other Adverse Effects of Medication
Medication-Induced Movement Disorders

1. Neuroleptic-Induced Parkinsonism
2. Other Medication-Induced Parkinsonism*
3. Neuroleptic Malignant Syndrome (expanded text)
4. Medication-Induced Acute Dystonia
5. Medication-Induced Acute Akathisia
6. Tardive Dyskinesia
7. Tardive Dystonia*
8. Tardive Akathisia*
9. Medication-Induced Postural Tremor
10. Other Medication-Induced Movement Disorder

*New to DSM

Other Adverse Effects of Medication

1. Antidepressant discontinuation syndrome (expanded text)*
2. Other Adverse Effect of Medication (e.g., severe hypotension, cardiac arrhythmias, priapism)
Medication-Induced Movement Disorders and Other Adverse Effects of Medication

These are NOT Mental Disorders

Included because of their frequent importance in:

• the management by medication of mental disorders or general medical conditions

• the differential diagnosis with Axis I disorders, e.g.:
  - Anxiety disorder versus neuroleptic-induced akathisia
  - Catatonia versus neuroleptic malignant syndrome.
Questions???

Comments???
Specific Changes in:

Section III
Section III

Section III: Emerging Measures and Models

– Assessment Measures

– Cultural Formulation

– Alternative DSM-5 Model for Personality Disorders

– Conditions for Further Study
Conditions for Further Study

1. Attenuated Psychosis Syndrome
2. Depressive Episodes With Short Duration Hypomania
3. Persistent Complex Bereavement Disorder
4. Caffeine Use Disorder
5. Internet Gaming Disorder
6. Neurobehavioral Disorder Due to Prenatal Alcohol Exposure
7. Suicidal Behavior Disorder
8. Non-suicidal Self-Injury
Section III: Conditions for Further Study (1)

- **Attenuated Psychosis Syndrome** is seen in a person who does not have a full-blown psychotic disorder but exhibits minor versions of relevant symptoms. Identification could be key for effective early intervention.

- **Depressive Episodes With Short-Duration Hypomania** exhibit bipolar behavior characterized by a hypomanic episode that lasts less than four days.

- **Persistent Complex Bereavement Disorder** represents a prolonged and excessively debilitating grief that keeps an individual from recovering from a loss. It is a condition likely requiring a different treatment approach.
Section III: Conditions for Further Study (2)

• **Caffeine Use Disorder** relates to the potential addictive behavior caused by excessive, sustained consumption of caffeine.

• **Internet Gaming Disorder** deals with the compulsive preoccupation some people develop in playing online games, often to the exclusion of other needs and interests.

• **Neurobehavioral Disorder Due to Prenatal Alcohol Exposure** appears to be highly dependent on gestational age and the related stage of brain development.
Section III: Conditions for Further Study (3)

- **Suicidal Behavior Disorder** describes someone who has attempted suicide within the last 24 months. This new category may help identify the risk factors associated with suicide attempts including depression, substance abuse or a lack of impulse control.

- **Nonsuicidal Self-Injury** is self-harm, without the intention of suicide. This condition is regarded as a major problem on college campuses and a public health issue that needs to be better understood.
Section III: Conditions for Further Study (4)

How can this information be used in clinical practice?

• While conditions included in Section III are not intended for routine clinical use, clinicians can note the possible presence by using the “other specified” designation.

-For example, “Other Specified Bipolar and Related Disorder,” would be the official diagnosis but a clinician could refer to Section III for depressive episodes with short-duration hypomania by indicating this condition is present parenthetically when recording the diagnosis. This will allow clinicians to provide richer diagnoses for patients whose symptoms do not fit strictly within current disorders.
General Observations
Changes to the Multiaxial System

• DSM-5 combines all diagnoses onto a single axis (previously Axes I-III).

• Contributing psychosocial and environmental factors (previously Axis IV) or other reasons for visits are now represented through an expanded selected set of ICD-9-CM v codes and, from the forthcoming ICD-10-CM, z and t codes.

• With Axis V eliminated, clinicians are no longer required to use the Global Assessment of Functioning (GAF) Scale.
  -GAF confounds symptom severity, risk of harm to self or others, disability, and functioning and combines into a single score.

• Rather than use the single GAF score to reflect multiple areas of concern, we have unpacked the GAF such that these items can be documented separately.
New Assessment

• An optional measure of disability is provided in Section III of the manual called the **World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)**.

This is one of the most widely used disability scales in medicine and is considered superior to the GAF. Clinicians are highly encouraged, though not required, to use the WHODAS 2.0 rather than the GAF.
How are DSM-5 and ICD related?

- **DSM-5** and the *ICD* should be thought of as companion publications.

- **DSM-5** contains the most up-to-date criteria for diagnosing mental disorders, along with extensive descriptive text, providing a common language for clinicians to communicate about their parents.

- The *ICD* contains the code numbers used in DSM-5 and all of medicine, needed for insurance reimbursement and for monitoring of morbidity and mortality statistics by national and international health agencies.

- The APA works closely with staff from the WHO, CMS, and CDC-NCHS to ensure that the two systems are maximally compatible.
DSM-5 and ICD Codes (1)

- DSM-5 and its ICD-9-CM codes became effective in May 2013 and can be used immediately.

- ICD-10-CM codes do not go into effect until October 1, 2014.

- ICD-9-CM codes are numerical and listed first. ICD-10-CM codes are alphanumerical and listed second, in parenthesis.

- Codes accompany each criteria set, but **some codes are used for multiple disorders.**
  - For example, hoarding disorder and obsessive-compulsive disorder share the same codes (ICD-9-CM 300.3 and ICD-10-CM F42).
  - Because of this, the **DSM-5 diagnosis should be always be recorded by name** in the medical record in addition to listing the code.
**DSM-5 and ICD Codes (2)**

- For some disorders, unique codes are given for subtypes, specifiers, and severity (e.g., major depressive disorder).

- For neurocognitive and substance/medication-induced disorders, coding depends on further specification.

- New ICD codes could not be given to new DSM-5 disorders; instead, these new disorders were assigned the best available ICD codes. The names connected with these ICD codes sometimes do not match the DSM-5 names.

  - For example, disruptive mood dysregulation disorder is not listed in the ICD. The best ICD-9- CM code available for DSM-5 use was 296.99 (other specified episodic mood disorder). For ICD-10-CM the code will be F34.8 (other persistent mood [affective] disorders).
Questions???

Comments???
Thank you for your attendance!