Introduction to the DSM-5
(published May 2013)

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September 23, 2013
Goodbye DSM-IV-TR!

http://www.youtube.com/watch?v=h3nxGb-aM5g

How many have the DSM-5?
How many using DSM-5 in your clinical practice?
What have you heard about the DSM-5? The good? The bad? The ugly?
http://www.youtube.com/watch?v=-AMvrcBvYWk
Overview of DSM-5

DSM-5 (May, 2013):
• 3 sections in DSM-5:
  I. Introduction and Use of the Manual
    • Review of development
    • Goals
    • Changes
    • Nonaxial diagnostic format
  II. Categorical diagnoses and revised chapter organization
    • New chapter organization and new criteria
  III. Emerging Measures and Models
    • Conditions requiring further research
    • Dimensional measures
    • Cultural formulation
    • Glossary, other information
Development of the DSM-5

- **DSM-V Task Force formed late 1990s**
- 1999: joint effort of APA and NIMH to develop agenda for scientific basis of DSM-V
- DSM-V Research Planning Conference
- “A Research Agenda for DSM-5" published 2002
- **Changed from DSM-V to DSM-5**
  - According to the APA website, tradition of using Roman numbers changed to Arabic numbers because are less limiting: plan to have revisions before complete revisions numbered 5.1, 5.2, etc.
- Series of conferences from 2004-2008; number of monographs and pubs
- Kraemer et al. (2007): results of Launch and Methodology Conference for statistical issues in the DSM-5 and ICD
- Coordination with the World Health Organization (WHO) for revision of ICD; support through US agencies (e.g., NIDA)
- **2006: David Kupfer appointed chair, Darrell A. Regier vice-chair** DSM-5 Task Force
  - (University of Pittsburgh)
  - (Director, division of research, APA)
Development of the DSM-5

• 6 study groups: to address conceptual issues and guide overall development:
  – diagnostic spectra (spectrum disorders) -- developmental issues
  – gender and culture -- interface with medicine
  – functional impairment and disability assessment
  – diagnostic assessment instruments

• 13 work groups for disorders: members nominated and reviewed for conflict of interest, members announced in 2008
  – conducted literature reviews, developed proposals for criteria

• Draft published online Feb 2010; comment period Feb-April 2010

• Field trials to test proposed criteria: Oct 2010-Feb 2012
  – started with university medical centers: 279 clinicians, 11 academic centers US and Canada
  – Results published 3 articles in the *American Journal of Psychiatry* (2013)
    • Clarke et al. (2013); Regier et al. (2013); Narrow et al. (2013)
  – also planned to test in other clinical settings – Routine Clinical Practice (RCP)
Development of the DSM-5

• Based on comments, revised version published online May 2011; comment period May-June 2011
• Another comment period in spring 2012; closed in the fall
• Scheduled release in 2012; revised to May 2013
• December 2012: APA News Release: DSM-5 approved by APA Board of Trustees; publication date of May 2013
  – took down web pages with draft proposals “to avoid confusion”
  – very little information; an appendix with very brief overview of the changes
  – kept about the same number of dx, but made changes to improve validity and reliability
  – some radical changes in organization; however, many of proposals in the DSM-5 drafts not made
  – some feel changes in the final DSM-5 too radical, others disappointed that changes were so conservative (e.g., PD virtually unchanged from DSM-IV)
Goals and Objectives of DSM-5

• Tried to consider the diverse needs of different groups – clinical, research and administrative/statistical
  – input from experts, across related disciplines, and public comment periods
  – MDs, psychologists, SWs, RNs, counselors, neuroscientists, neuropsychologists, other constituents: patients, families, consumer groups, advocacy groups

• Integration of scientific findings in research on genetics, neuroimaging, and cognitive science
  – Kupfer & Regier (2011): goal of a biologically based classification based on advances in neuroscience, brain imaging and genetics, with lab tests, values to assign diagnoses
  – can see increased biological basis (medical model) of the DSM-5:
    • in renaming of disorders (Neurodevelopmental Disorders; Neurocognitive Disorders)
    • DSM-5 Introduction: the DSM-5 is a “medical classification of disorders” (p.10)
  – Reorganization of diagnoses to reflect the symptoms domains and common underlying vulnerabilities of disorders
    • based on diagnoses purported relatedness to each other, and alignment with ICD-11 (Kupfer & Regier, 2011)
    • Diagnostic Spectra Study Group: to look at how DSM-5 could be organized, especially with regard to advances in neuroscience, brain imaging, and genetics
Goals and Objectives of DSM-5

• Revised chapter order and organization is also consistent with NIMH Research Domain Criteria (RDoC) Project: (2010)
  – goal to transform diagnostic classification to one based on a biology as well as symptoms
  – not limited by current categories but broad domains of cognition, emotion, behavior

• The new organization also corresponds with new organization structure of upcoming ICD-11 (expected in 2015) – to help with replication of research, consistency of definitions
  – Goal to increase harmonization with ICD-11 – worked closely with WHO and ICD Task Force
  – DSM-5 uses ICD-9 codes followed by ICD-10-CM codes in parentheses
  – Use ICD-9 codes through Sept 30, 2014 – still the official coding system of the United States – not effect billing codes
  – The U.S. adopts the ICD-10-CM codes on Oct 1, 2014 – so these codes listed in parentheses
  – For example: 309.81 (F43.10) Posttraumatic Stress Disorder
    • after Oct 1, 2014, use F43.10
Goals and Objectives of DSM-5

• Recognition of limitations of categories:
  – unclear and fluid boundaries between disorders; comorbidity, overlap
  – Categories not describe full range of mental disorders
  – Problems widely recognized by clinicians and researchers
  – however, dimensions supported by researchers, but not always accepted by clinicians (e.g., PDs)

• Designed DSM-5 to provide clear concise descriptions of each mental disorder with explicit diagnostic criteria
  – DSM-5 is a categorical classification
  – Supplemented with dimensional measures in the appendices and dimensional measures that cross diagnostic boundaries (e.g., dimensional assessment of symptoms and severity for Schizophrenia)
  – Increased specification of levels of severity (e.g., autism spectrum, major and minor neurocognitive disorders)
Goals and Objectives of DSM-5

• Recognition of spectrum of closely related disorders with shared symptoms, genetic and environmental risk factors
  – Reorganization of chapters of disorders: e.g., Trauma- and Stressor-Related Disorders: PTSD, Acute Stress Disorder, Adjustment Disorder, others
  – Spectrums: autism spectrum disorder; Schizophrenia Spectrum and Other Psychotic Disorders chapter
  – Cross-listing of schizotypal PD in Schizophrenia Spectrum and Other Psychotic Disorders and antisocial PD in Disruptive, Impulse control and Conduct Disorders - full criteria in Personality Disorder chapter
  – Moved a number of the “Disorders Usually First Evident in Infancy, Childhood or Adolescence” into other chapters based on similarity

• Disorders from same chapter separated when evidence not similar
  – Bipolar disorders separated from Depressive disorders (i.e., biological evidence suggests bipolar more similar to psychotic spectrum than depressive disorders; Goldberg et al., 2009)

• Subtypes dropped for several disorders in favor of specifiers or dimensions
  – e.g., Schizophrenia; Specific Learning Disorder – specifiers instead of separate diagnoses; mixed specifier instead of mixed episode for mood disorders
Goals and Objectives of DSM-5

• **Gender:**
  – uses “gender” rather than “sex” to recognize differences based on psychological, behavioral, social factors as well as biological “sex”
  – “Gender-Related Diagnostic Issues” section in text expanded: addresses differences in risk, prevalence, symptom endorsement and manifestations

• **Culture:** increased attention to cultural issues:
  – “Culture-Related Diagnostic Issues” section in text for each diagnosis
  – Cultural concepts of distress added as examples of “Other specified...” disorders
  – expanded information on cultural diagnoses in section III
  • Cultural Formulation: culture-bound syndrome replaced with 3 constructs: cultural syndrome (group of sx within cultural group), cultural idiom of distress (linguistic terms used to discuss the distress), and cultural explanation or perceived cause
  • Cultural Formulation Interview (CFI) and informant version
  • Cultural Glossary
Goals and Objectives of DSM-5

**Age:** Increased developmental perspective:
- chapters organized from those most likely diagnosed in childhood (Neurodevelopmental disorders) to those most likely diagnosed in the elderly (Neurocognitive disorders)
  - However, not entirely consistent in this framework:
    - some childhood onset disorders (e.g., ODD and conduct disorder) moved into chapters with disorders usually diagnosed in adults based on shared symptoms and over-arching dimensions
    - Substance Use Disorders chapter and Personality Disorders chapter near end of manual yet often see onset in adolescence, early adult
  - Diagnoses within chapters organized by age: childhood onset diagnoses listed first
- Increased information on presentation of disorders in children
- changes in some criteria to better fit presentation in adults (e.g., ADHD)
DSM-5: A Work in Progress

• **Kupfer & Regier (2011):** goal of a biologically-based classification was unrealistic, premature
  
  – “We realized from our Research Agenda conference series that we would not be able to accomplish by DSM-5’s deadline all of the things we set out to do...**DSM-5 is a work in progress.**” (p. 673)
  
  – **Carroll (2013):** aspiration to include biomarkers in DSM-5 based on a misunderstanding: lab tests are not definitive; few have high sensitivity and specificity; predictive value also depends on the prevalence rates of the diagnosis; can assist in diagnosis

• **A work in Progress:**
  
  – Kept DSM-IV PD: shift to dimensional model in the DSM-5 drafts, widely criticized; no consensus; but included dimensional model in section III - transitional
  
  – Kept categories but supplemented with dimensions
  
  – Dimensions for schizophrenia: provided rating scale for dimensions of psychosis and mood in section III, not sure will be widely used – surprised did not use proposed dimensions in DSM-IV appendix
  
  – ICD-10 codes in parentheses – US adopts in Oct 2014
  
  – **DSM-5: a dynamic document, expect to make minor revisions (DSM-5.1, DSM-5.2, etc.) based on research findings - not have to wait 20+ years for next revision to be published!**
DSM-5 Controversies

- Lack of openness of the DSM-5 development process:
    - Task force members signed confidentiality agreement
    - Did not invite previous members of task force (DSM-III, DSM-IV)
  - APA website: was a “member acceptance form” to protect intellectual property; work group members published some of their work
  - according to APA website, DSM-V planning committees did not invite developers of DSM-III and IV “to encourage new ideas”
  - Blashfield & Reynolds (2012): members of PD work group all part of the Collaborative Longitudinal Personality Disorder Study (CLPDS) – “invisible college”- group that works together, share ideas; represent one perspective
DSM-5 Controversies

• **DSM-5 Criteria had Poor Reliability in the Field Trials:**
  
  • **Allen Frances (2012):** chair of DSM-IV, IV-TR: DSM-5 draft criteria had poor reliability for many disorders
    – minimized on APA website and in results of field trials published in the *Am J of Psychiatry*: “most diagnoses...had good to very good reliability”
    – Not usual standards for what is considered “good”
      » **Regier et al. (2013):** kappa values for inter-clinician agreement (same patient interviewed separate times by different clinicians) for 23 dxs:
        • Claimed 5 diagnoses had “very good” reliability ($\kappa = .60-.79$)
        • 9 diagnoses in the “good” range ($\kappa = .40-.59$)
        • 6 diagnoses “questionable” ($\kappa = .20-.39$); included MDD and GAD – because attention on revised and new diagnoses;
        • only 3 “unacceptable” ($\kappa < .2$) : were revised or not included
          – also, the Field Trial Testing in Routine Clinical Practices (RCPs) planned for Oct 2010-Feb 2012 was not conducted because they were behind schedule
  
  • **Spitzer et al. (2012):** argued $\kappa$ values were weak ($\kappa < .40$ is poor)
DSM-5 Controversies

• Increased boundaries of mental disorders
  – Frances (2013): *Saving normal: an insider’s revolt against out-of-control psychiatric diagnosis*
  • Claims normal life experiences like grief being labeled as a mental disorder in DSM-5
    – Claimed grief will be diagnosed as “Major Depressive Disorder”
    – Tempter tantrums as “Disruptive Mood Dysregulation Disorder”
    – Normal forgetting diagnosed as “mild neurocognitive disorder”
    – Worrying about medical illnesses will be labeled “Somatic symptom Disorder”
REVIEW QUESTIONS/DISCUSSION

• What are your thoughts about the change in organization?
  – The biological basis?
  – The spectrum disorders?
  – Moving some of the “childhood” disorders to chapters with “adult” disorders based on similarity of symptoms and etiological factors?

• DSM-5 as a dynamic document responsive to latest research findings?

• Controversy over its development?
  – Openness, reliability of new criteria in the field trials, increasing the boundaries of mental disorder?
Additional Changes

- **Name changes - DSM-IV terms remain in parentheses**
  - **Chapters:** e.g., Neurodevelopmental Disorders; Neurocognitive Disorders: reflect biological basis of the disorders, biological focus of DSM-5
  - **Diagnoses:** e.g., Persistent Depressive Disorder (Dysthymia) also: *chronic MDD*
  - **NOS:** replaced by “Other Specified” and “Unspecified”
    - e.g., Other Specified Anxiety Disorder and Unspecified Anxiety Disorder

- **New Disorders in DSM-5: goal not to increase number of diagnoses**
  - **From DSM-IV appendix**
    - Premenstrual dysphoric disorder and Binge-eating disorder
  - **New diagnoses in DSM-5**
    - Excoriation (skin picking) disorder and Hoarding disorder
    - Disruptive mood dysregulation disorder
    - Disinhibited social engagement disorder (was subtype of reactive attachment)
    - Avoidant/restrictive food intake disorder (broadened feeding disorder)
Nonaxial Diagnostic Format

• Eliminated the multiaxial system:
  – uses the nonaxial format which was an option in the DSM-IV-TR (p. 37)
  – combined Axes I, II and III: each diagnosis is listed, in order of significance (like medicine)
  – one diagnosis per line: code followed by diagnostic label
  – rationale: DSM-IV noted that separation into axes did not imply a fundamental difference between personality disorders and other mental disorders or between mental disorders and general medical conditions
  – continue to list relevant medical conditions using ICD-9-CM codes
    • note that ICD-9-CM medical conditions and codes are not included in the DSM-5 (are listed in DSM-IV appendix)
    • Also, ICD-10 codes in effect starting Oct 1, 2014
Nonaxial Diagnostic Format

- Eliminated Axis IV and Axis V: rationale:
  - consistent with ICD and WHO practice of coding context and disability separate from diagnoses
  - Axis IV and V not always used
  - Axis IV was useful, but Axis V confounded symptoms with disability, question of reliability and validity, lack of conceptual clarity
- Axis IV: now use selected set of ICD-9 CM “V codes” (Z codes in the upcoming ICD-10); much expanded set of psychosocial and contextual issues; list under diagnoses when focus of clinical attention
- Axis V: dropped; WHO Disability Assessment Schedule (WHODAS) included in section III
  - However, not comparable – is a self-report measure
  - other scales for measuring disability available online (DSM-5 limited the inclusion of rating and assessment scales in the manual): online resources: [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5)
Examples of Diagnoses

<table>
<thead>
<tr>
<th>DSM-IV Diagnosis</th>
<th>DSM-5 Diagnosis</th>
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<tbody>
<tr>
<td><strong>Axis I</strong></td>
<td></td>
</tr>
<tr>
<td>296.22</td>
<td>296.22</td>
</tr>
<tr>
<td>Major Depressive Disorder, Single Episode, Moderate</td>
<td>Major Depressive Disorder, Single Episode, Moderate</td>
</tr>
<tr>
<td>V61.10</td>
<td>V61.10</td>
</tr>
<tr>
<td>Partner Relational Problem</td>
<td>Relationship Distress With Spouse or Intimate Partner</td>
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<tr>
<td><strong>Axis II</strong></td>
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<tr>
<td>V71.09</td>
<td></td>
</tr>
<tr>
<td>No Diagnosis</td>
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<tr>
<td><strong>Axis III</strong></td>
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<tr>
<td></td>
<td>None reported</td>
</tr>
<tr>
<td><strong>Axis IV</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marital conflict</td>
</tr>
<tr>
<td><strong>Axis V</strong></td>
<td></td>
</tr>
<tr>
<td>GAF=71</td>
<td></td>
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<tr>
<td>(current)</td>
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# Examples of Diagnoses

### DSM-IV Diagnosis

<table>
<thead>
<tr>
<th>Axis</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>300.02</td>
<td>Generalized Anxiety Disorder</td>
</tr>
<tr>
<td></td>
<td>V62.2</td>
<td>Occupational Problem*</td>
</tr>
<tr>
<td>II</td>
<td>301.82</td>
<td>Avoidant Personality Disorder</td>
</tr>
<tr>
<td>III</td>
<td>714.0</td>
<td>Arthritis, rheumatoid (medical records)</td>
</tr>
<tr>
<td>IV</td>
<td></td>
<td>Unemployment</td>
</tr>
<tr>
<td>V</td>
<td>GAF=75</td>
<td>(current)</td>
</tr>
</tbody>
</table>

### DSM-5 Diagnosis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>300.02</td>
<td>Generalized Anxiety Disorder</td>
</tr>
<tr>
<td>301.82</td>
<td>Avoidant Personality Disorder</td>
</tr>
<tr>
<td>714.0</td>
<td>Arthritis, rheumatoid (medical records)</td>
</tr>
<tr>
<td>V62.29</td>
<td>Other Problem Related to Employment*</td>
</tr>
</tbody>
</table>

*only if focus of clinical attention

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**App A: Case A Nonaxial Diagnosis Practice**
Overview of DSM-5 Changes Specific to Children/Teens

• **Neurodevelopmental Disorders**: name change reflects increased biological focus and developmental perspective in chapter organization
  – are disorders with onset early in development—typically before age 5.
  – Includes Intellectual Disabilities, Communication Disorders, Autism Spectrum, ADHD, Specific Learning Disorder, Motor Disorders
  – Clinical presentation may involve symptoms of excess as well as deficits or delays in meeting expected developmental milestones

• **Several new names for disorders:**
  – Communication Disorders (e.g., childhood-onset fluency disorder)
  – New names for reading disorder and other LDs (specific learning disorder with impairment in reading)
  – Mental retardation renamed intellectual disability
Overview of DSM-5 Changes Specific to Children/Teens

• **Organization and criteria:**
  – Autism Spectrum Disorder: autism, Asperger’s, PDD
  – Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) moved to “Disruptive, Impulse Control and Conduct Disorders” with Antisocial PD (cross-listed)
  • Added “limited prosocial emotions” specifier for CD

• **ADHD:** minor changes in criteria

• **New diagnoses:**
  – Social (pragmatic) Communication Disorder - in Communication Disorders
  – Disruptive Mood Dysregulation Disorder - in Depressive Disorders
Neurodevelopmental Disorders

– **Intellectual disability** (intellectual developmental disorder): new name for MR; ICD-11 name in parentheses
  
  - Harris (2013): accepted terminology, consistent with description - is a group of developmental disorders
  
  - **Specifiers**: Mild, moderate, severe, profound – no specific code (is for ICD-10)
    
    - Based on adaptive functioning (not IQ): table with description for each level in 3 domains: conceptual, social, practical domains

– **Communication disorders**: several new names
  
  - **language disorder** (DSM-IV expressive language + mixed receptive-expressive language disorder)
  
  - **speech sound disorder** (DSM-IV phonological disorder)
  
  - **Childhood-onset fluency disorder** (DSM-IV stuttering)

  - **New** social (pragmatic) communication disorder: difficulties in social use of verbal and nonverbal communication (differentiates from autism spectrum)
Neurodevelopmental Disorders

– Autism spectrum disorder:
  • Single autism spectrum that subsumes previous subtypes as well as Asperger’s
  • Includes DSM-IV autism, Asperger’s, childhood disintegrative disorder, Rett’s, PDD NOS
  • Language delay removed as a criterion
  • Requires deficits in 2 domains:
    1) Social communication and interactions: requires deficits in all 3 categories:
      » Social-emotional reciprocity
      » Nonverbal communication
      » Interpersonal relationships
    2) Restricted, repetitive patterns of behavior
  • Relaxes age of onset (3 years old in DSM-IV vs. “early developmental period” in DSM-5) and allows for symptoms that may not yet have fully emerged (“may not become fully manifest…”).
DSM-IV and 5 Criteria for ASD

**DSM-IV-TR**

Requires 6/12 symptoms across 3 categories

1) Impairment in social interaction, includes nonverbal behavior (2/4)
2) Impairment in communication (1/4)
3) Restricted and repetitive behavior, interests (1/4)

**DSM-V**

Requires 5/7 symptoms across 2 categories

1) Persistent deficits in social communication/interaction (3/3)
   - Deficits in social-emotional reciprocity (e.g., conversation, or failure to initiate social interactions)
   - Deficits in nonverbal communicative behaviors
   - Deficits in developing, maintaining, and understanding relationships (ranges from adjusting behavior in various social contexts to absence of interest in peers)

2) Restricted, repetitive pattern of behavior, interests or activities (2/4)

**App A: Case B DSM-IV and DSM-5 Examples**
DSM-5 Criteria for ASD

– **Severity: specified for both domains**
  – Provides a table with descriptions of levels for each domain:
    » Level 3: Requiring very substantial support
    » Level 2: Requiring substantial support
    » Level 1: Requiring support

• **Specify:** With or Without accompanying intellectual impairment, language impairment

• **Specify if:** Associated with a known medical or genetic condition or environmental factor; Associated with another neurodevelopmental, mental, or behavioral disorder

• **Note:** social (pragmatic) communication disorder: used if only deficit in social communication domain
Implications of ASD Changes

• Biggest concern is possible reduced rate of diagnosis, resulting in children not getting needed services, or delay in services
  – Child with social-communication impairment who don’t have RRB would receive communication disorder diagnosis
  – Funding/reimbursement likely lower for CD vs. ASD

• Another complaint—is loss of the Asperger’s diagnosis
  – Many identify with being an “Aspie”
  – Feel that “autism” label carries more stigma
  – Inclusion of higher functioning individuals in “Autism” spectrum may alter public’s view of the disorder
Research on Changes in Rate of Diagnosis

• Matson et al. (2012): 30 - 45 % of children/adolescent/adults classified with ASDs based on DSM-IV-TR criteria will not meet DSM-5 criteria for ASD (many end up in communication diagnostic category)

• Huerta et al. (2012): DSM-5 criteria identified 91% of children with clinical DSM-IV PDD diagnoses.

• Taheri et al. (2012): among 131 diagnosed ASD based on DSM-IV
  – 63 % met the new DSM-5 ASD criteria
  – 81 % previously diagnosed with Autistic Disorder
  – only 17 % of those with PDD-NOS
Implications of ASD changes

• Evidence in regard to change in rate of diagnosis is mixed. Biggest concern seems to be high functioning autism (HFA) and PDD-NOS—which may not meet new ASD criteria
  – Volkmar (Child Study Center at Yale) found that 75% of Asperger’s and 85% of those with PDD-NOS diagnosis would not meet DSM-5 ASD criteria (Lutz, 2013; Slate.com)
  - [Autism Speaks Survey](#) (for parents and clinicians)

• Some clinicians feel new criteria better captures the nuances of ASD, feel older criteria were too broad (Kanne, 2013)
Neurodevelopmental Disorders

- **Attention-Deficit/Hyperactivity disorder**: changes to help diagnose across lifespan: increased recognition of ADHD older ages
  - Age of onset increased from 7 to age 12
    - requires several hyperactive-impulsivity sx prior to age 12 (was before age 7)
  - Reduced number of symptoms required for individual aged 17 and older: from 6 in DSM-IV to 5 in DSM-5 (versus 6 sx required for children)
  - Added examples in criteria more applicable to teens and adult (versus younger child focus)
    - e.g., difficulty staying focused during lengthy reading
Attention-Deficit/Hyperactivity disorder

• Removed exclusion for individuals with ASD, thus possible to diagnose both ADHD and ASD – allows for comorbid diagnoses

• Got rid of ADHD NOS; if symptoms previously present, could use “in partial remission”

• Added severity specifier: mild, moderate, severe (note subtypes replaced with specifiers (e.g., Combined, Predominantly inattentive, or Predominantly hyperactive/impulsive presentation)
  • Specify current severity: Mild, Moderate, Severe
  • mild still requires 6 or more symptoms for children
Possible Implications of Changes to ADHD Criteria

• Overall minimal changes anticipated

• Frances (2012): included changes to ADHD in “10 worst changes” list, feels changes will contribute to ‘fad’ of ADHD dx in adulthood and misuse of stimulant meds for “performance enhancement”

• Achenbach (2009): argues that from a developmental perspective it makes no sense for the same criteria to apply to children, teens and adults.

• Lilienfeld (2013): “Are doctors diagnosing too many kids with ADHD?”
Neurodevelopmental Disorders

- **Specific learning disorder**
  - Combines DSM-IV reading disorder, mathematics disorder, disorder of written expression, and NOS
  - *uses specifiers*: e.g., *With impairment in reading (with word reading accuracy, reading rate or fluency, reading comprehension), mathematics, etc.*
  - recognizes alternative names – e.g., dyslexia, dyscalculia

- **Motor disorders**:  
  - few changes; more consistent definition of tics
  - *Developmental Coordination Disorder, Stereotypic Movement Disorder, Tourette's Disorder, several tic disorders*

- Other “childhood” disorders moved to other chapters based on shared sx, shared underlying pathology
  - e.g., conduct disorder, ODD
Schizophrenia and other psychotic disorders

Schizophrenic spectrum and other psychotic disorders:

• name emphasizes spectrum — schizotypal PD cross-listed (criteria with PDs)
• Includes: Schizophrenia, Schizophreniform Disorder, Brief Psychotic Disorder, Delusional Disorder, Schizoaffective Disorder, Catatonia Associated With [Another Mental Disorder/Medical Condition], Substance/Medication Induced, Due to [Another Medical Condition], Other Specified and Unspecified Schiz Spectrum
• Eliminated shared psychotic disorder - rare
• Starts with definitions of “Key features” for psychotic disorders (e.g., delusions, hallucinations)
Schizophrenia

• **decreased emphasis on first rank sx:**
  – criterion A: need 2 sx regardless if bizarre (so-called Schneiderian sx) and 1 must be delusions, hallucinations or disorganized speech (DSM-IV 1 sx if bizarre)
  – **Tandon et al. (2013):** emphasis on Schneiderian sx was misplaced

• **elimination of subtypes:**
  – due to poor reliability, validity, and stability - subtypes change (Jablensky, 2006; Korver-Nieberg et al., 2011)
  – not used in research literature past 20 years (Braff et al., 2013)
  – dimensions for capturing heterogeneity and severity – in section III: **Clinician-Rated Dimensions of Psychosis Symptom Severity Scale**
  – Did not use the alternative dimensional model in DSM-IV appendix: psychotic dimension; disorganized dimension; negative (deficit) dimension – surprising since have considerable support
Schizophrenia

- Clinician-Rated Dimensions of Psychosis Symptom Severity Scale: in section III (optional)
  - Rating of 8 symptom domains:
    - Hallucinations, Delusions, Disorganized speech, Abnormal psychomotor behavior, Negative symptoms, Impaired cognition, Depression, Mania
    - Scale: 0: Not present; 1: Equivocal; 2: Present, but mild; 3: Present and moderate; 4: Present and severe
  - Can use for other psychotic disorders and mood disorders
  - Ritsner et al. (2013): results of field trials: good reliability, internal consistency of the scale
Schizophrenia

• Course specifiers:
  • only to be used after a 1-year duration of the disorder
  • changed to clarify nature of the episode:
    • First episode, currently in acute episode/partial remission/full remission (was single episode)
    • Multiple episodes, currently in acute episode/partial remission/full remission (was episodic)
  • kept: Continuous
  • eliminated: with/with no interepisode residual symptoms, with prominent negative sx
  • new specifier replaced catatonic subtype:
    • With catatonia (note: also add the diagnosis of: 293.89 Catatonia Associated [With Another Mental Disorder])
    • can apply across the psychotic and mood disorders
Schizophrenia spectrum and other psychotic disorders

• **Delusional disorder:** allows bizarre delusions – noted in specifier
  – *Specify type:* Erotomanic type, Grandiose type, etc.
  – *course specifiers are only to be used after a 1-year duration of the disorder*
  – *Specify if:* With bizarre content
    • Shared psychotic disorder (eliminated); might fit here, or “Other specified”

• **Schizoaffective disorder:** changes in criteria and text to improve differentiation from mood disorders, more longitudinal emphasis – requires presence of major mood episode for majority of duration of active and residual portion of the disorder
  – *Specify whether:* Bipolar type or Depressive type
  – *course specifiers: are only to be used after a 1-year duration of the disorder:* e.g., First episode, currently in acute episode, etc.
  – *Specifier: With catatonia* (note: also add the diagnosis of: 293.89 Catatonia Associated With [Another Mental Disorder])
  – **Malaspina et al. (2013):** will more clearly separate SA from Schiz
    • likely decrease the rate of diagnosis of SA and increase stability of SA as a diagnosis
Schizophrenia spectrum and other psychotic disorders

- Brief Psychotic Disorder:
  - Specify: With or without marked stressor

- Schizophreniform Disorder: only change: criterion A
  Schizophrenia
    - Specify With or without good prognostic features

- Catatonia Associated With [Another Mental Disorder]; ...
  [Medical Disorder]:
    - Is a diagnosis, but also a specifier for a number of psychotic, mood and general medical disorders; also, the criteria were slightly modified

- Substance/Medication-Induced; Due to [Another Medical Condition]; Other Specified; Unspecified: Schizophrenia spectrum and other psychotic disorder

App A: Case C Psychotic Disorder
Schizophrenia spectrum and other psychotic disorders

• **Attenuated Psychotic Syndrome**: proposed for DSM-5 but placed in section III: Conditions for Further Study
• psychotic symptoms in attenuated form, at least once per week for the past month
• goal to identify individuals likely to develop Schizophrenia
• controversial:
  – McLaren (2010): will increase boundaries of mental disorders
  – Frances (2009): early identification of those at risk is a worthy goal, but do not have sufficient information; there is also a cost of false positives
  – Frances (2011): proposed criteria have a high rate of false positives and diagnosis is especially difficult in teens; this dx is “far too risky”
Mood Disorders

• Bipolar and Related Disorders separated from Depressive disorders
  – Goldberg et al. (2009): review of literature suggests bipolar more related to psychotic disorders (e.g., genetics, temperament, course, comorbidity) than depression

• Streamlined the classification so it is easier to use – all elements of the diagnostic criteria included for each disorder (symptoms of the episodes)

• Mixed specifier instead of mixed episode, bipolar and depressive disorders
  – Sneck (2009): increased recognition of mixed mood symptoms – depression, manic - not adequately addressed by mixed episode
  – Vieta (2013): not as narrow as mixed episode but might complicate diagnosis of Major Depressive disorder from Bipolar
  – McIntyre (2013): support for mixed specifier for bipolar disorder
Mood Disorders

- **With anxious distress**: new specifier, bipolar and depressive disorders
  - recognized was common with mood disorder – keyed up, restless, fear of losing control, motor agitation
  - severity: mild (2 sx), moderate (3 sx); moderate-severe (4-5 sx); severe (4-5 sx w/ motor agitation)

- **Name change for specifier**: with *peripartum onset* (was postpartum): includes during pregnancy as well as within 4 weeks of delivery

- **Separated out specification of severity from psychotic features**
Mood Disorders

- Tables with ICD-9 and ICD-10 codes based on type of episodes, severity
- Section on “Suicide Risk” in text: help clinicians with assessment, management
- Can use the Clinician-Rated Dimensions of Psychosis Symptom Severity Scale (section III) with mood disorders
- Removal of bereavement exclusion for MDD - controversial
Bipolar and Related Disorders

• Includes: Bipolar I, Bipolar II, Cyclothymic Disorder

• Bipolar I Disorder:
  – more emphasis on changes in activity and energy and as well as mood
    (criterion A)
  – Specify current or most recent episode: Hypomanic, Depressed
  – Severity: Mild, Moderate, Severe, Partial remission, Full remission

• Bipolar II Disorder: few changes

• Specifiers for Bipolar Disorders:
  – With anxious distress; With mixed features; With rapid cycling; With
    melancholic features; With atypical features;
  – With mood-congruent psychotic features; With mood-incongruent psychotic
    features;
  – With peripartum onset; With seasonal pattern
  – With catatonia (use additional code 293.89)

• Cyclothymic Disorder: few changes; Specify if: With anxious distress

• Substance/Medication-Induced; Due to [Another Medical Condition]; Other
  Specified; Unspecified Bipolar and related disorders
Depressive Disorders

• **Includes:** Major Depressive Disorder, Persistent Depressive Disorder, Premenstrual Dysphoric Disorder, Disruptive Mood Dysregulation Disorder

• **Specifiers for Depressive Disorders:** (same as bipolar)
  • With anxious distress (specify current severity: mild, moderate, moderate-severe, severe)
  • With mixed features; With melancholic features; With atypical features; With mood congruent psychotic features; With mood-incongruent psychotic features
  • With peripartum onset; With seasonal pattern
  • With catatonia (use additional code 293.89)

• **Premenstrual Dysphoric Disorder**
  – From DSM-IV appendix; now an “official” dx
  – 5 or more symptoms of depressed mood, anxiety/tension, anger, affective lability week before menses
  – similar to criteria in DSM-IV appendix, but re-grouped sx for clarification
    • need 1 or more of 1st 4 sx, 1 or more of next 7 sx, total of 5 or more
  – research support for the diagnosis, but not all endorse (Kornstein, 2010; Johnson & Stewart, 2010; Wittchen, 2010) – might be stigmatizing
Depressive Disorders

- **Major Depressive Disorder**
  - *Single or Recurrent episode*
  - *Severity: Mild, Moderate, Severe, With psychotic features, In partial or full remission*
  - only major change: removal of bereavement exclusion for MDD for sx lasting less than 2 mos after death of loved one (recognition that 1-2 years bereavement is common)
    - Extensive note at bottom of criteria and more information in text differentiating grief (and reaction to other losses) from depression
    - Proposed category in section III (persistent complex bereavement disorder)
    - **Parker (2013):** one of most controversial changes
    - **Porter et al. (2013):** may result in increased diagnosis of MDD
    - **Wakefield (2013):** faulty logic, on follow-up, those with MDD sx during bereavement no more depressed on follow-up than those who never met criteria for MDD
    - **Frances (2013):** normal grief will be labeled as a disorder
Depressive Disorders

• Persistent Depressive Disorder (Dysthymia) – includes chronic MDD
  – Consolidation of chronic MDD with Dysthymic disorder: **Klein & Santiago (2003):** no meaningful distinction in terms of prognosis between the two
  – Specify current severity: Mild, Moderate, Severe; In partial remission, In full remission
  – Specify if: Early onset, Late onset
  – Course specifiers more clearly articulate relationship of dysthymic disorder with MDD:
    • Specify if: With pure dysthymic syndrome; With persistent major depressive episode; With intermittent major depressive episodes, with current episode; With intermittent major depressive episodes, without current episode

App A: Case D Mood Disorder
Depressive Disorders: Changes Specific to Children/Teens

• Disruptive Mood Dysregulation Disorder (DMDD)
  – Formerly called temper dysregulation disorder with dysphoria
  – Intent of new diagnosis was to decrease frequency of pediatric Bipolar disorder dx
  – Focus is on severe non-episodic irritability
  – Excludes children who display abnormally elevated or expansive mood (i.e., mania) for longer than 1 day, if other manic sx’s present
DMDD Diagnostic Criteria

A. Severe recurrent temper outbursts manifested verbally or behaviorally, out of proportion to sit
B. Temper outbursts inconsistent with developmental level
C. Outbursts occur, on average, 3 or more time/week
D. Mood between outbursts is persistently irritable or angry most of the day, for most days, as observed by others
E. Criteria A-D present for 12 or more months and present in 2/3 settings (home, school, peers) and severe in at least one setting
F. Dx should not be made before age 6 or after 18
G. Age of onset A-E before age 10
H. Does not meet criteria for manic or hypomanic episode
I-J Behaviors do not occur exclusively during episode of major depression and not better explained by other disorder (ASD, anxiety)
K. Symptoms are not attributable to effects of a substance or other medical or neurological condition

(American Psychiatric Association, 2013)
Implications of DMDD

• **Frances (2012)** lists DMDD #1 on his “worst changes” of DSM-5 list
  – “will turn temper tantrums in to a mental disorder” and result in even more inappropriate medication use with children

• Others also feel the diagnosis may contribute to increased use of antipsychotic medication with children (e.g., risperdone)

• Some feel children with actual Bipolar may be misdiagnosed with DMDD resulting in less effective treatment (Friedman, Sadhu, & Jellinek, 2012)

• Interesting that DMDD was placed with Depressive Disorders rather than Bipolar Disorder (as some expected) or the Impulse Control Disorders
Anxiety Disorders

- Removed OCD: new chapter: Obsessive-Compulsive and Related Disorders
- Removed PTSD and Acute Stress Disorder: new chapter: Trauma- and Stressor-Related Disorders
- Stein et al. (2010): joint literature review by DSM-5 Anxiety, OC Spectrum, Post-Traumatic and Dissociative Disorder work groups:
  - examined links and differentiation of these disorders from each other; reviewed research on validators (psychobiological, sx, tx response)
  - OCD differs from anxiety disorders on a number of validators
  - support for an OCD spectrum with Body Dysmorphic Disorder, trichotillomania and tic disorders
- Retained: Specific Phobia, Generalized Anxiety Disorder, Panic Disorder, Agoraphobia, Social Anxiety Disorder (social phobia)
- moved in from “childhood” disorders: Separation Anxiety Disorder, Selective Mutism
Anxiety Disorders

• **Specific Phobia**: not require recognition that fear is unreasonable (nor for the other phobic disorders)
  - Zimmerman et al. (2010): little effect: almost no patients did not meet this criterion
• **Generalized Anxiety Disorder**: few changes
• **Panic Disorder**: few changes
• **panic attack specifier**: not limited to anxiety disorders
• **Agoraphobia** (eliminated with and without panic disorder)
• **Social Anxiety Disorder (social phobia)**: name more consistent with terminology in literature and implies the severity of the disorder (Ralevski et al., 2005)
  - eliminated generalized specifier; added performance only specifier
    - Specify if: Performance only
• **Separation Anxiety Disorder and Selective Mutism**: few changes
Obsessive-compulsive and related Disorders

• New chapter: based on common symptoms, underlying pathology
• Includes: OCD, 2 new disorders (hoarding & excoriation disorders), 2 from other chapters (body dysmorphic disorder, trichotillomania)

  – Obsessive Compulsive Disorder
    • specify if: With good or fair insight, With poor insight, With absent insight/delusional beliefs; specify if: Tic-related (recognition of the relationship)

  – Hoarding disorder – new; was a dimension of OCD
    • Evidence hoarding was a distinct syndrome with different genetic and neural subsystems (Mataix-Cols et al., 2005)
    • specify if: With good or fair insight, With poor insight, With absent insight/delusional beliefs; specify if: With excessive acquisition

  – Excoriation (skin-picking) disorder - new

  – Body Dysmorphic Disorder - from Somatoform Disorders
    • specify if: With good or fair insight, With poor insight, With absent insight/delusional beliefs; Specify if: With muscle dysmorphia

  – Trichotillomania (Hair-Pulling Disorder) – from Impulse control Disorders

See App B: Hoarding & Excoriation Disorders
Trauma- and Stressor-Related Disorders

• New chapter based on response to environmental stressors
• includes PTSD, Acute Stress Disorder; Adjustment disorder (was own chapter); Reactive Attachment Disorder (from “childhood” disorders); and new diagnosis: Disinhibited Social Engagement Disorder

• Posttraumatic Stress Disorder
  – Specify whether: With dissociative symptoms; Specify if: With delayed expression
  – eliminated: requirement had response of intense fear, helplessness or horror
  – revised definition of trauma/stressor criterion: increased specificity, broadened to include vicarious trauma (but not in the media!)
  – Revised 3 symptom cluster to 4 clusters: intrusion, persistent avoidance, negative alterations of cognitions and mood, hyperarousal and reactivity
  – added 3 sx: erroneous self or other blame regarding the trauma, negative mood states, reckless or self destructive behavior
  – Friedman et al. (2011): lit review and factor analysis support a 4 factor model
  – Also section at end: PTSD criteria for children 6 years and younger
  – Should increase applicability of criteria to children, wider group of individuals, - original criteria in DSM-III based on work with male combat veterans
  – likely increase the diagnosis of this disorder
Trauma- and Stressor-Related Disorders

- **Acute Stress Disorder:**
  - like PTSD: eliminated subjective response; revised stressor criterion;
  - increased range of symptoms rather than emphasis on dissociative symptoms

- **Adjustment Disorders (was own chapter)**
  - *Same specifiers as DSM-IV: With depressed mood, With anxiety, etc.*
  - Same criteria: onset emotional of behavioral sx in response to identifiable stressor, with 3 mos of stressor, not last more than 6 mos

- **Reactive Attachment Disorder (from “childhood disorders”)**
  - *specify if: Persistent*
  - *Specify current severity: Severe*

- **Disinhibited Social Engagement Disorder**
  - New
  - Was disinhibited subtype of reactive attachment disorder (from “childhood disorders”)
  - *"a pattern of behavior in which the child actively approaches and interacts with unfamiliar adults." The child must have experienced some form of pathogenic care that is responsible for this behavior. The pathogenic care can include persistent exposure to unsafe environments, frequently unmet basic needs, overly harsh punishment, etc.*

**App A: Case E Trauma-Related Disorder**
Dissociative Disorders

• **Dissociative Identity Disorder**
  – Added that symptoms may be reported as well as observed
  – Added there may be gaps in recall of everyday events
    – not just traumatic events

• **Dissociative Amnesia**
  – *Specify if: With dissociative fugue* (specifier rather than a diagnosis)
    • **Dissociative Fugue eliminated** - rare

• **Depersonalization/Derealization Disorder**
  – Name change to recognize derealization symptoms
Somatic Symptom and Related Disorders

- Combined chapters with disorders with physical symptoms: Somatoform, Psychological Factors Affecting Medical Condition, Factitious Disorder
- **Somatic Symptom Disorder**: new, broader category with specifiers, combines Somatization, Pain Disorder, and Undifferentiated Disorders: considerable overlap between them
  - Specify if: With predominant pain; Specify if: Persistent
  - Specify current severity: Mild, Moderate, Severe
  - Includes more psychological symptoms:
    - Voigt et al. (2012): inclusion of psychological sx enhanced the predictive validity and clinical utility of the diagnosis; identified more impaired patients; however, might increase prevalence
  - Frances (2013), Frances & Chapman (2013): too broad, will result in increased diagnosis; questionable validity
Somatic Symptom and Related Disorders

- **Illness Anxiety Disorder**: was Hypochondriasis
  - Specify whether: Care seeking type, Care avoidant type

- **Conversion Disorder (Functional Neurological Symptom Disorder):** ICD-10 term in parentheses
  - Specify symptom type: With weakness or paralysis, With abnormal movement, etc.
  - Specify if: Acute episode, Persistent
  - Specify if: With psychological stressor (specify stressor), Without psychological stressor

- **Psychological Factors Affecting Other Medical Conditions**
  - Specify current severity: Mild, Moderate, Severe, Extreme

- **Factitious Disorder** (includes Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another – was: by proxy in DSM-IV appendix)
  - Specify Single episode, Recurrent episodes
Feeding and Eating Disorders; Elimination Disorders

- **Feeding and Eating Disorders:**
  - **Pica:** In children; In adults
  - **Rumination Disorder**
  - **Anorexia Nervosa**
    - Requirement for amenorrhea eliminated; expanded criterion of fear of weight gain to include behavior that interferes with weight gain
    - *Specify whether: Restricting type, Binge eating/purging type*
  - **Bulimia Nervosa:**
    - Reduced minimum average frequency of binge eating and compensatory behavior from twice to once a week

- **Binge-Eating Disorder (from DSM-IV appendix):** change in criteria from binge eating a minimum of twice a week to once a week

- **Avoidant/Restrictive Food Intake Disorder:**
  - Was feeding disorder of infancy or early childhood – expanded to include range of ages
    - DSM-5: Resulted in improvement in classification of children, adolescents and adults (Birgegand et al., 2010)

- **Elimination Disorders:** **Enuresis; Encopresis;** no significant changes
Sleep-wake disorders

- Greatly expanded set of disorders, subtypes, and specifiers (general overview below)
- relates diagnoses to *International Classification of Sleep Disorders*; many diagnosed based on sleep studies – more biologically based
- **Insomnia Disorder**
  - Specify if: With non-sleep disorder mental comorbidity, With other medical comorbidity, With other sleep disorder
- **Hypersomnolence Disorder**
  - Specify if: With mental disorder, With medical condition, With another sleep disorder
- **Narcolepsy**
- **Breathing-Related Sleep Disorders**
  - Obstructive Sleep Apnea Hypopnea
  - Central Sleep Apnea
  - Sleep-Related Hypoventilation
  - Circadian Rhythm Sleep-Wake Disorders:
- **Parasomnias**
  - Non-Rapid Eye Movement Sleep Arousal Disorders:
    - Specifier: Sleepwalking type - was a separate disorder
    - Specifier: Sleep terror type - was a separate disorder
  - Nightmare Disorder
- **Rapid Eye Movement Sleep Behavior Disorder**: new; used NOS
- **Restless Legs Syndrome**: new; used NOS
Sexual and Gender Identity Disorders

• Sexual Disorders divided into 2 chapters - Sexual Dysfunctions and Paraphilic Disorder
• Gender Identity Disorder put in separate chapter and renamed Gender Dysphoria
• Sexual Dysfunctions:
  – Delayed Ejaculation
  – Female Orgasmic Disorder
  – Genito-Pelvic Pain/Penetration Disorder
  – Premature (Early) Ejaculation
  – Female Sexual Interest/ Arousal Disorder
  – Male Hypoactive Sexual Desire Disorder
• Paraphilic Disorders: (near end, after Personality Disorders):
  – separates paraphilia (ideation) from paraphilic disorder (behavior): 1st criterion not sufficient for the diagnosis
  – Voyeuristic Disorder
  – Frotteuristic Disorder
  – Sexual Sadism Disorder
  – Fetishistic Disorder
  – Exhibitionistic Disorder
  – Sexual Masochism Disorder
  – Pedophilic Disorder
  – Transvestic Disorder
• Gender Dysphoria:
  – Gender Dysphoria in Children
    • Specify if: With a disorder of sex development
  – Gender Dysphoria in Adolescents and Adults
    • Specify if: With a disorder of sex development; Specify if: Posttransition
Disruptive, Impulse-Control, and Conduct Disorder

- Broadened to include oppositional defiant disorder and conduct disorder; Antisocial PD is cross-listed
- Includes: Pyromania, Kleptomania, Intermittent Explosive Disorder
- Pathological Gambling: removed - moved with substance related disorders and re-named Gambling Disorder
- Intermittent Explosive Disorder
  - allows for verbal aggression and non-destructive physical aggression
- Antisocial Personality Disorder (cross listed here; criteria in Personality Disorder chapter)
- Pyromania: few changes
- Kleptomania: few changes
Oppositional Defiant Disorder

- Eliminated exclusion criterion for conduct disorder
- Severity rating and more information on differentiating from normative behaviors: *Specify current severity*: Mild, Moderate, Severe
- Symptoms in only one setting (i.e., home) rated “mild” in terms of severity
- No changes in diagnostic criteria
- Symptoms grouped into 3 types: angry/irritable, argumentative/defiant, vindictiveness
- Note added in regard to children under 5 (Sx’s should occur most days for 6 months)
- Added more information regarding developmental course (more symptoms in preschool and adolescence)
- Info added on temperamental, environmental factors as well as neurobiological markers (i.e., reduced basal cortisol reactivity).
- More info on differential diagnosis (includes consideration of social anxiety, DMDD).
Conduct Disorder

- No significant changes: same criteria
- **Specify whether: Childhood-onset type, Adolescent-onset type, Unspecified onset**
- **Specify current severity: Mild, Moderate, Severe**
- **Specify if: With limited prosocial emotions**
  - “limited prosocial emotions” (need 2/4)
    - Lack of remorse or guilt
    - Callous-lack of empathy
    - Unconcerned about performance
    - Shallow or deficient affect
  - Notes that individuals with limited prosocial emotions may be more likely to engage in “aggression that is planned for instrumental gain”
Implications of ODD/CD changes

• Limited prosocial emotions (LPE) criteria: includes “callous/unemotional” (C/U) which is a strong predictor of antisocial PD and psychopathy

• Adult psychopaths are assumed to be untreatable—the LPE specifier may imply that the child cannot be treated successfully (LPE rather than C/U due to concerns about labeling)

• Research shows that a significant number of clinic-referred children without CD showed high rates of C/U traits (especially those with ODD diagnosis)

• Strength of C/U traits and antisocial behavior based on research with Caucasian boys, less information in regard to girls and ethnic minority youth
Implications ODD/CD

• Children with callous/unemotional (C/U) traits:
  – found not to benefit from punishment-oriented behavioral interventions
  – Reward-oriented parenting found to reduce conduct problems
  – More heritability of antisocial behavior
  – Less responsive to typical parental socialization practices, perhaps because less aware/concerned about impact of behavior on others
  – (Kahn, Frick, Youngstrom, Findling, & Youngstrom, 2012; Moffitt et al., 2008)

• Thus, definite treatment implications for children with C/U traits versus those without
Substance-Related and Addictive Disorders

- **Added Non-Substance-Related Disorders**: includes only one diagnosis:
  - Gambling Disorder (was Pathological Gambling in Impulse Control)

- **Substance-Related Disorders**: divided by substances, with substance use and substance-induced disorders listed for each substance group: for example:
  - **Alcohol-Related Disorders**:
    - Alcohol Use Disorder
      - Specify current severity: Mild, Moderate, Severe
    - Alcohol Intoxication
      - Specify: With use disorder, mild, With use disorder, moderate or severe, Without use disorder
    - Alcohol Withdrawal
      - Specify: With or Without perceptual disturbances
Substance-Related and Addictive Disorders

• Substance-Related Disorders (cont’d)
  – Alcohol-Related Disorders
  – Caffeine-Related Disorders: expanded, withdrawal and intoxication
  – Cannabis-Related Disorders
  – Hallucinogen-Related Disorders
  – Inhalant-Related Disorders
  – Opioid-Related Disorders
  – Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
  – Stimulant-Related Disorders
  – Tobacco-Related Disorders (name change from nicotine)

• Non-Substance-Related Disorders
  – Gambling Disorder (was Pathological Gambling in Impulse Control); moved here because addiction-like symptoms)
    • Specify if: Episodic, Persistent
    • Specify current severity: Mild, Moderate
Substance-Related and Addictive Disorders

- **Substance Use Disorder:**
  - combines substance abuse and dependence diagnoses
  - more stringent criteria than DSM-IV substance abuse disorder (mild requires 2-3 sx vs. 1 for substance abuse in DSM-IV)
    - *Specifiers: In early remission, In sustained remission, In a controlled environment*
    - *Severity specified by number of sx met: 2-3: mild; 4-5: moderate; 6 or more: severe*
  - Research suggests will have minimal impact but may result in modest change in prevalence of substance use disorders
  - Peer et al. (2013): able to catch those who did not meet criteria for abuse or dependence – may slightly increase diagnosis
    - elimination of “legal criterion” supported – no diagnostic utility
    - adding “craving criterion” did not effect likelihood of diagnosis
  - Dawson et al. (2013): DSM-IV vs. DSM-5 criteria for alcohol use disorders: similar, but more difference at milder end of spectrum (80.5% those with alcohol dependence met criteria for alcohol use disorder vs. 58.0% of those with alcohol abuse)
  - Compton et al. (2013): “excellent correspondence” between DSM-IV and DSM-5 for alcohol, opioid, and cocaine dx, but less for cannabis – maximum concordance when 6 or more criteria

**App A: Case F Substance Disorder**
Substance-Related and Addictive Disorders

- Non-Substance-Related Disorders: only 1 category:
- Gambling Disorder
  - *Specify if: Episodic, Persistent*
  - *Specify current severity: Mild, Moderate*
  - Included because addiction-like symptoms
  - 1st time non-substance addictive behavior included
  - **Petry (2013):** DSM-5 substance use disorder work group: concluded none of the other “behavioral addictions” had sufficient literature support (internet gaming disorder included in section III for further study)
  - **Petry et al. (2013):** examined internal consistency and factor structure of DSM-IV criteria vs. criteria in DSM-5
    - DSM-5: 4 of 9 criteria - slightly better classification accuracy than 5 of 10 (illegal acts criterion eliminated)
Neurocognitive Disorders

- **Name change to emphasis biological basis**
- More emphasis on levels of severity: major and mild disorders
- Starts with table of cognitive domains, symptom examples, assessments
- **Delirium**
  - Substance intoxication, Substance withdrawal, Medication-induced, due to another medical condition, multiple etiologies
- **Major and Mild Neurocognitive Disorders:**
  - subsumes dementia and amnestic disorders; divided by etiologies:
  - Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease
  - Major or Mild Frontotemporal Neurocognitive Disorder
  - Major or Mild Neurocognitive Disorder Due to Lewy bodies
  - Vascular disease; Traumatic brain injury; Substance/medication use, HIV infection; Prion disease; Parkinson's disease; Huntington's disease; Another medical condition; Multiple etiologies
- **Specifiers:**
  - With or Without behavioral disturbance
  - current severity (only for major neurocognitive Disorders): Mild, Moderate, Severe
- Detailed coding notes and charts with ICD-9-CM and ICD-10-CM codes
**Neurocognitive Disorders**

- **Ganguli et al. (2011):** neurocognitive disorders work group: changes based on lit review: not clear distinction between amnestic disorder and dementia
  - New name of chapter: to differentiate from other disorders with cognitive sx (e.g., Schizophrenia); because disorders clearly linked to brain regions and pathology; parallels the distinction of neuropsychology from psychology
  - eliminated the term “dementia” – most controversial
    - New category - Major Neurocognitive Disorders: subsumes different types of dementia, does not mean “dementia” should never be used
    - Dementia typically has not been not used younger adults who meet criteria for dementia due to stroke, head injury
    - “Dementia” is a pejorative term, stigmatizing
- **Bajenaru et al. (2012):** improved; more consistent with current research; better classified according to etiology

**App A: Case G Neurocognitive Disorder**
Personality Disorders

- Unexpectedly maintained the 3 clusters and 10 categories, their criteria, and the general criteria for a PD, virtually unchanged
- cited lack of consensus and acceptance of proposed trait model
- Criticisms of which categories kept, deleted; which trait dimensions used; system time-consuming and difficult to use
- new alternative trait methodology in section III for further research
  - Transition in conceptualization of personality disorders
- Added a section for Other Personality Disorders:
  - includes Personality Change Due to Another Medical Condition:
    - was in separate chapter (Mental Disorders Due to a General Medical Condition Not Elsewhere Classified) along with Catatonic Disorder
    - Other Specified and Unspecified Personality Disorder
- Removed Passive-Aggressive (Negativistic) PD from the appendix – little commentary
- Other Specified Personality Disorder and Unspecified Personality Disorder for NOS (can use for passive-aggressive)
Personality Disorders

- Cluster A Personality Disorders
  - Paranoid; Schizoid; Schizotypal
- Cluster B Personality Disorders
  - Antisocial; Borderline; Histrionic; Narcissistic
- Cluster C Personality Disorders
  - Avoidant; Dependent; Obsessive-Compulsive
- Other Personality Disorders
  - Personality Change Due to Another Medical Condition
    - Specify: Labile type, Disinhibited type, Aggressive type, Apathetic type, Paranoid type, Other type, Combined type, Unspecified type
Other Disorders and Other Conditions That May Be a Focus of Clinical Attention

• Psychological Factors Affecting Other Medical Conditions: moved into Somatic Symptom and Related Disorders
• Other Mental Disorders: moved into own chapter; includes Other Specified and Unspecified mental disorders
• Medication-Induced Movement Disorders and Other Adverse Effects of Medication: moved into own chapter
• Other Conditions That May Be a Focus of Clinical Attention
  – Greatly expanded list of V Codes (and ICD-10 Z codes): increased number of categories and specific conditions under each
  – Sample of V Codes follows; are actually much more specified than in the slide
Other Conditions That May Be a Focus of Clinical Attention

Relational Problems
• Problems Related to Family Upbringing:
  – e.g., Parent-Child Relational Problem; Upbringing Away From Parents
• Other Problems Related to Primary Support Group:
  – e.g., Relationship Distress With Spouse or Intimate Partner; Disruption of Family by Separation or Divorce; High Expressed Emotion Level Within Family; Uncomplicated Bereavement

Abuse and Neglect: each subset much further specified
• Child Maltreatment and Neglect Problems (e.g., child physical abuse, child sexual abuse)
• Adult Maltreatment and Neglect Problems (number of categories)

Educational and Occupational Problems:
• Educational Problems
• Occupational Problems: Problem Related to Current Military Deployment Status

Housing and Economic Problems: Housing Problems; Homelessness; Inadequate Housing

Other Problems Related to the Social Environment
• Phase of Life Problem; Problem Related to Living Alone; Acculturation Difficulty
Other Conditions That May Be a Focus of Clinical Attention

Problems Related to Crime or Interaction With the Legal System
Other Health Service Encounters for Counseling and Medical Advice
Problems Related to Other Psychosocial, Personal and Environmental Circumstances
• Religious or Spiritual Problem; Problems Related to Unwanted Pregnancy; Discord With Social Service Provider

Other Circumstances of Personal History
• Personal History of Self-Harm; Personal History of Military Deployment; Adult Antisocial Behavior; Child or Adolescent Antisocial Behavior

Problems Related to Access to Medical and Other Health Care
Nonadherence to Medical Treatment
• Overweight or Obesity; Malingering; Wandering Associated With a Mental Disorder; Borderline Intellectual Functioning
Section III: Emerging Measures and Models

• **Assessment Measures**
  – Cross-Cutting Symptom Measures
  – DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult
  – Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure – Child Age 6-17
  – Clinician-Rated Dimensions of Psychosis Symptom Severity
  – World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)

• **Cultural Formulation**

• **Alternative DSM-5 Model for Personality Disorders**

• **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 Associated with Prenatal Alcohol Exposure
  – Suicidal Behavior Disorder
  – Nonsuicidal Self-Injury

• **Glossary; and Glossary of Cultural Concepts of Distress**

• **Listing of ICD-9-CM and ICD-10-CM codes and other information**
Assessment Measures

• To supplement categorical diagnoses, clinical and research purposes:
  – **Cross-Cutting Symptom Measures:** cross diagnostic boundaries: self-report
    • DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult
    • Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure – Child Age 6-17
      – Level 1 (broader screening measures)
      – Level 2 (more specific) measures available online to follow-up reported symptoms
  – **Clinician-Rated Dimensions of Psychosis Symptom Severity**
    • rating of 8 symptom domains (Hallucinations, Delusions, Disorganized speech, Abnormal psychomotor behavior, Negative symptoms, Impaired cognition, Depression, Mania)
    • 4 pt scale: 0 Not present; 1 Equivocal; 2 Present, but mild; 3 Present and moderate; 4 Present and severe
  – **World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0):**
    • Suggested as alternative to GAF but is a self-report measure
    • In past 30 days, how much difficulty did you have, on a scale of 1 (none) to 5 (extreme or cannot do) on a series of questions assessing:
      – Understanding and communicating -- Getting around -- Self-care
      – Getting along with people -- Life activities - Household
      – Life activities - School/Work -- Participation in Society
  – **Cultural Formulation:** Cultural Formulation Interview (CFI) and CFI - Informant Version

Limited the number of measures; rest available online: [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5)
Alternative DSM-5 Model for Personality Disorders

• Separates the evaluation of dysfunction from manifestation of traits

• General Criteria for Personality Disorder
  – Elements of personality functioning: evaluated in 4 areas:
    • Self: Identity, Self-direction
    • Interpersonal: Empathy, Intimacy
    • Table with descriptions of level of impairment:
      – from 0 (Little or No impairment) to 3 (Severe impairment) for each

• Trait Model:
  – 5 broad domains:
    • NEGATIVE AFFECTIVITY (vs. Emotional Stability)
    • DETACHMENT (vs. Extraversion)
    • ANTAGONISM (vs. Agreeableness)
    • DISINHIBITION (vs. Conscientiousness)
    • PSYCHOTICISM (vs. Lucidity)
  – Trait facets: 3 - 9 trait facets per domain, some shared in domains
    • e.g., ANTAGONISM: manipulativeness, deceitfulness, grandiosity, attention seeking, callousness, hostility (hostility also in NEGATIVE AFFECTIVITY)
Alternative DSM-5 Model for Personality Disorders

• Personality Disorders:
  – Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive, Schizotypal
  – Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the four areas:
    • Identity, Self-direction, Empathy, Intimacy
  – Specific aspects described for each of the 5 Personality Disorders:
    • e.g., Antisocial: Identity characterized by egocentrism; self-esteem derived from personal gain, power, or pleasure
  – Also requires specific number of the trait facets:
    • e.g., Antisocial: 6 or more of the following 7 pathological traits: manipulativeness, callousness, deceitfulness, hostility, risk taking, impulsivity, irresponsibility

• Personality Disorder-Trait Specified: replaces other personality disorders
  – Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the four areas
    • Identity, Self-direction, Empathy, Intimacy
  – One or more pathological trait domains or specific trait facets
Conditions for Further Study

- **Attenuated Psychosis Syndrome**
  - Delusions, hallucinations or disorganized speech, attenuated form, once per week, past month

- **Depressive Episodes with Short-Duration Hypomania**
  - Lifetime: 1 or more MDD episodes and 2 or more short hypomaniac episodes

- **Persistent Complex Bereavement Disorder**
  - At least 12 months since death, preoccupation with deceased, distress to death, other sx

- **Caffeine Use Disorder**
  - Problematic pattern of use, distress, impairment, tolerance, etc.

- **Internet Gaming Disorder**
  - Persistent use of Internet games, distress, impairment, etc.

- **Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure**
  - More than minimal exposure, neurocognitive symptoms, impaired self-regulation, adaptive functioning and social communication

- **Suicidal Behavior Disorder**
  - Suicide attempt past 24 months, not meet criteria for below dx; current: past 12 months, early remission: 12-24 months

- **Nonsuicidal Self-Injury**
  - Intentional self-inflicted injury to relieve negative/induce positive feelings, resolve interpersonal difficulties
DSM-5 Resources

Desk Reference to the Diagnostic Criteria from DSM-5
American Psychiatric Association

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
American Psychiatric Association

DSM-5 Self-Exam Questions for the Diagnostic Criteria
Philip R.WD, M.D.

The Pocket Guide to the DSM-5 Diagnostic Exam
Abraham M. Nussbaum, M.D.

The Essential Companion to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

DSM-5 Guidebook
Donald W. Black, M.D.
Jon E. Grant, M.D., M.P.H., J.D.

DSM-5 Clinical Cases
John W. Bennett, M.D.

Study Guide to DSM-5
Laura Weiss Roberts, M.D., M.A.
Allen K. Frances, M.D.

DSM-5 Handbook of Differential Diagnosis
Michael B. First, M.D.