

DSM-5 Training for DJJ Clinicians and Staff

Preparing for DSM-5

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Disclosure Information

NO RELEVANT FINANCIAL CONFLICTS OF INTEREST

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CLINICIAN AND CLINICAL RESEARCHER

DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS

FIFTH EDITION

DSM-5

AMERICAN PSYCHIATRIC ASSOCIATION

Program Outline

- **Introduction**
 - Evolution of DSM and Why DSM-5
- **Major Changes in DSM-5**
 - Structure
 - Content
 - Implications for Clinical Practice

What Characteristics Must A Medical Disorder Have?

➤ VALIDITY

- ❖ Must define a “Real” entity with distinctive etiology, pathophysiology, clinical expression, treatment, & outcome

➤ UTILITY

- ❖ Must be useful in addressing needs of various stakeholders, particularly patients and clinicians
- ❖ Must predict treatment response, guide treatment selection, and predict course and outcome
- ❖ Must be simple and easy to apply

➤ RELIABILITY

- ❖ Different groups of people who need to diagnose this condition must be able to do so in a consistent manner

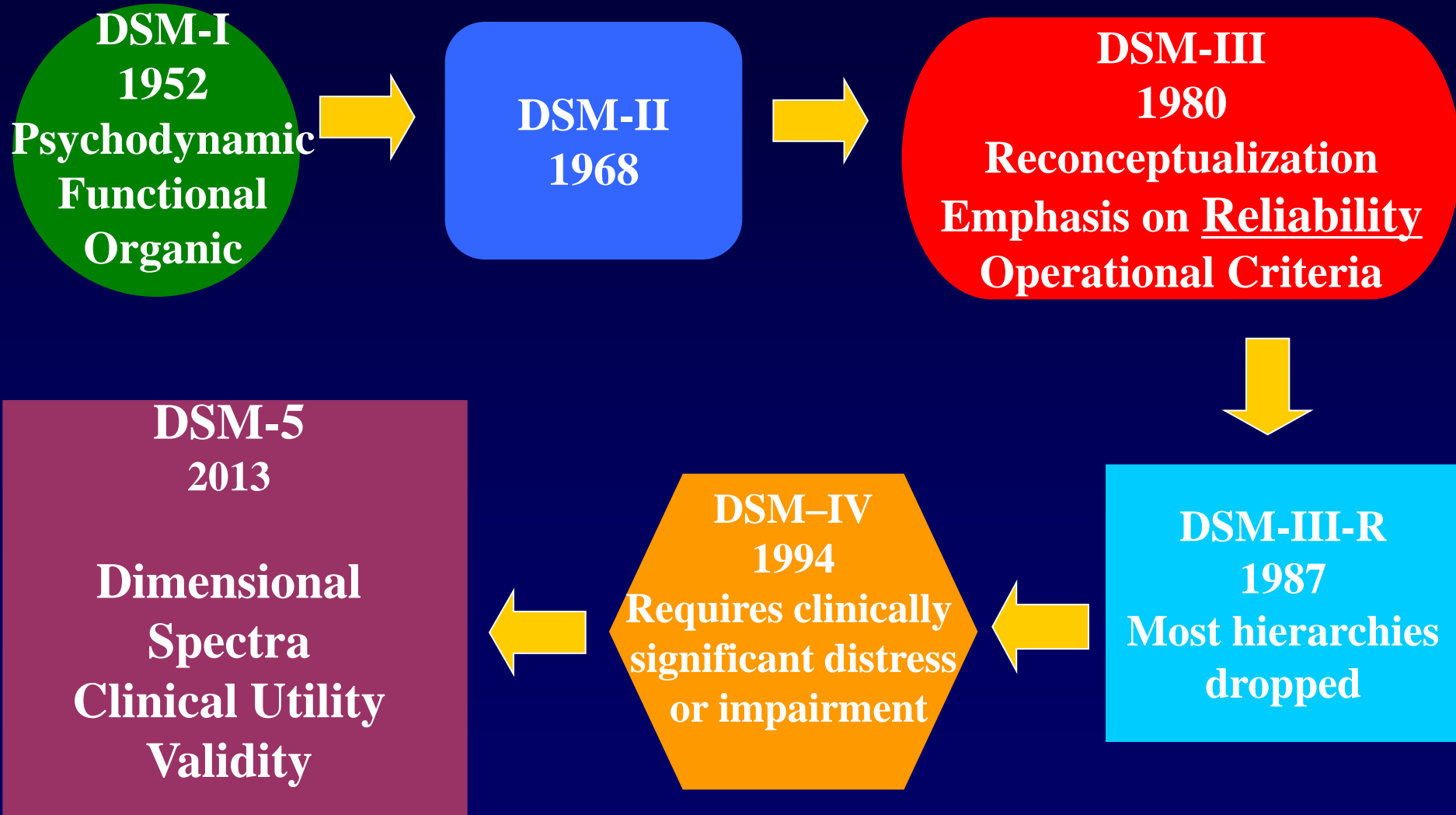
Validating a Mental Disorder

- Approaches to validating diagnostic criteria for discrete categorical mental disorders have included the following types of evidence:
 - **antecedent validators** (unique genetic markers, family traits, temperament, and environmental exposure); [ETIOLOGY]
 - **concurrent validators** (defined neural substrates, biomarkers, emotional and cognitive processing, symptom similarity); [PATHOPHYSIOLOGY/CLIN.]
 - and **predictive validators** (similar clinical course & treatment response [TREATMENT/PROGNOSIS])

History of Classifying Mental Disorders

- ◆ **1800s-1940**
 - ◆ **1 condition in 1840 (“idiocy/insanity”)**
 - ◆ **7 in 1880 (mania, melancholia, monomania, paresis, epilepsy, dementia, dipsomania)**
 - ◆ **22 in 1917 for use in Institutions for the Insane”**
- ◆ **Currently Two Major Systems**
 - ◆ **International Classification of Diseases (ICD); 1st time as Section 5 in ICD-6 in 1949**
 - ◆ **Diagnostic and Statistical Manual of Mental Disorders (DSM); 1st time in 1952**

Conceptual Development of DSM



Perceived Shortcomings in DSM-IV

- ◆ High rates of comorbidity
- ◆ High use of NOS category
- ◆ Incredible Complexity
- ◆ Unclear distinctions between several different disorders

**Limiting clinical utility and
Impeding research progress**

Key Objectives for DSM-5

- ◆ Incorporate research into the revision and evolution of the classification
- ◆ **IMPROVE VALIDITY**
- ◆ Maintain (when possible, *improve*) Reliability
- ◆ **IMPROVE CLINICAL UTILITY**
 - Reduce NOS
 - Reduce Artificial Comorbidity
 - Simplify
 - Address specific issues in disorders

DSM-5

Task Force

- ◆ **Workgroup chairs**
- ◆ **Health professionals from stakeholder groups**

13 Workgroups

- ◆ **Members work in specific diagnostic areas**
- ◆ **Advisors for workgroups**

Review & Oversight Groups

ITERATIVE PROCESS

- ◆ **Task Force**
 - ◆ Initial and Ongoing review of All Proposals
- ◆ **Scientific Review Committee**
 - ◆ Review of validity of recommendations
- ◆ **Clinical and Public Health Committee**
 - ◆ Impact on public health and clinical practice
- ◆ **Forensic Committee**
 - ◆ Clarity of language with regard to forensic implications
- ◆ **Summit Group**
 - ◆ Chairs and Co-Chairs of Various Initial Review Groups
- ◆ **Board of Trustees**
 - ◆ Final Approval

Revisions to DSM-5

Major Changes

Overall Changes

- ◆ **Removal of Multi-axial system**
- ◆ **Changes in Overall Structure**
 - ◆ **Addition of Section 3**
 - ◆ **Section 2: Twenty sections organized to describe inter-relationship**
- ◆ **Diagnosis is a 3-step process**
 - ◆ **Diagnosis**
 - ◆ **Specifiers**
 - ◆ **Severity**

Removal of Multi-axial System

- ◆ Move to a non-axial documentation of diagnosis
- ◆ Combines Axes 1-3
- ◆ Psychosocial and contextual factors (formerly Axis 4) captured via V codes (Z codes in ICD-10) or in narrative
- ◆ Disability (formerly Axis 5) now described separately via WHODAS-II and/or in narrative
- ◆ Partly replaced by addition of severity measures to diagnostic categories

Overall Changes

- ◆ **Restructuring Overall Organization**
 - ◆ **Sections 1-3**
 - ◆ **1: Introduction, guidance on use, definition of mental disorder**
 - ◆ **2. Various Chapters (20)**
 - ◆ Chapter organization which incorporates our understanding of the underlying vulnerabilities as well as symptom characteristics of disorders (how genes and environment interact to influence mental health and behavior)
 - ◆ Chapter order reflecting above
 - ◆ **3. Conditions for Further Study and Measurement Instruments**
 - ◆ (Content may be clinically useful and warrants attention, but not yet part of official diagnosis)
 - ◆ **Appendix**

Section III: Content

- Section III: Emerging Measures and Models
 - Assessment Measures
 - Level 1 and 2 cross-cutting measures
 - Diagnosis-specific severity measures
 - Cultural Formulation
 - Alternative DSM-5 Model for Personality Disorders
 - Conditions for Further Study

Diagnosis-Specific Severity Measures

- For documenting the severity of a specific disorder using, for example, the frequency and intensity of its component symptoms
- Some clinician-rated, some patient-rated
- Enables measurement-based, targeted treatment

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

Section 2

Definitions of Disorders

Section II

Definition and Description of Disorders

TWO MAJOR HIGH-LEVEL CHANGES

- Diagnosis involves three levels
 - Name of Disorder; Specifier of disorder; Severity of Disorder
- Order of groupings of disorders provides important information about inter-relationships with reference to etiology, pathophysiology, clinical expression, and outcome

Section II

Definition and Description of Disorders

DIAGNOSIS INVOLVES THREE STEPS

1st Level: Diagnose Disorder using criteria

2nd Level: Describe specific nature of disorder using
Specifiers

3rd Level: Describe current severity of disorder
utilizing simple and clinically useful scales

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 II: Chapters

- A. Neurodevelopmental Disorders
- B. Schizophrenia Spectrum and Other Psychotic Disorders
- C. Bipolar and Related Disorders
- D. Depressive Disorders
- E. Anxiety Disorders
- F. Obsessive-Compulsive and Related Disorders
- G. Trauma- and Stressor-Related Disorders
- H. Dissociative Disorders

Section II: Chapters

- J. Somatic Symptom and Related Disorders
- K. Feeding and Eating Disorders
- L. Elimination Disorders
- M. Sleep-Wake Disorders
- N. Sexual Dysfunctions
- P. Gender Dysphoria

Section II: Chapters

Q. Disruptive, Impulse-Control, and Conduct Disorders

R. Substance-Related and Addictive Disorders

S. Neurocognitive Disorders

T. Personality Disorders

U. Paraphilic Disorders

V. Other Disorders

Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Other Conditions That May Be a Focus of Clinical Attention

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

Neurodevelopmental Disorders in DSM-5

- ◆ **Intellectual Disabilities**
- ◆ **Communication Disorders**
- ◆ **Autism Spectrum Disorder**
- ◆ **Attention Deficit / Hyperactivity Disorder**
- ◆ **Specific Learning Disorders**
- ◆ **Motor Disorders**
- ◆ **Other Neurodevelopmental Disorders**
 - ◆ **Other Specified Neurodevelopmental Disorder**
 - ◆ **Other Unspecified Neurodevelopmental Disorder**

Intellectual Disability (Intellectual Developmental Disorder)

- Mental retardation 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.

Intellectual Disability (Intellectual Developmental Disorder)

Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

C. Onset of intellectual and adaptive deficits during **developmental period**.

Intellectual Disability

(Intellectual Developmental Disorder)

◆ Coding of Severity

- ◆ Based on adaptive functioning in 3 domains
- ◆ Age-relevant descriptors for different severity levels provided for each domain
 - **Conceptual**: ability to learn; information processing, approach to problem-solving;
 - **Social**: social interaction, communication, social cues, emotional regulation, social judgment
 - **Practical**: personal care, daily living tasks, ability to perform age-appropriate roles

Based on degree of needed assistance and support

Autism Spectrum Disorder

- ◆ **Replaces DSM-IV's autistic disorder, Asperger's disorder, childhood disintegration disorder, and pervasive developmental disorder NOS**
 - **Extremely poor reliability for distinctions, in part because clinicians have been applying DSM-IV criteria inconsistently and incorrectly**

Two Dimensions

- **Deficits in social communication and interaction**
- **Restrictive and repetitive behavior patterns**

Autism Spectrum Disorder

◆ **Specifiers**

- With or without accompanying intellectual impairment
- With or without accompanying structural language impairment
- Associated with known medical or genetic condition or environmental factor (eg., Rett's)
- Associated with another neurodevelopmental, mental, or behavioral disorder
- With catatonia

Three Levels of Severity (based on Need for Supportive Services- Support/Substantial Support/Very Substantial Support

Autism Spectrum Disorder (ASD) (Neurodevelopmental Disorders)

- ASD replaces DSM-IV's autistic disorder, Asperger's disorder, childhood disintegration disorder, and pervasive developmental disorder not otherwise specified
 - 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.
 - 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).

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.

Specific Learning Disorder

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

Other Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

- Eliminate or subsume elsewhere: pica, separation anxiety disorder, selective mutism, Rett's, etc
- Addition of preschool PTSD (Trauma and Stress-Related Disorders)
- Addition of disruptive mood dysregulation disorder (Mood Disorders section)
- Conduct Disorder and Oppositional Defiant Disorder combined with Impulse Control Disorders
- No changes for Motor Disorder
- Separate sections on Elimination Disorders and Feeding and Eating Disorders

Psychotic Disorders

Changes from DSM-IV

- ◆ **Concept**
 - ◆ Definition of psychosis
 - ◆ Relationship between different psychotic disorders
 - ◆ Dimensions of psychosis and their measurement
- ◆ **Addition and Deletion of Disorders**
 - ◆ Catatonia NEC;
 - ◆ Schizophrenia subtypes; Shared psychotic disorder
- ◆ **Changes in Criteria**
 - ◆ Schizophrenia, Schizoaffective Disorder; Delusional Disorder;

Definition of Psychosis

◆ Core Features

- ◆ Delusions
- ◆ Hallucinations
- ◆ Disorganized speech (thought disorder)

◆ Accompanying Features

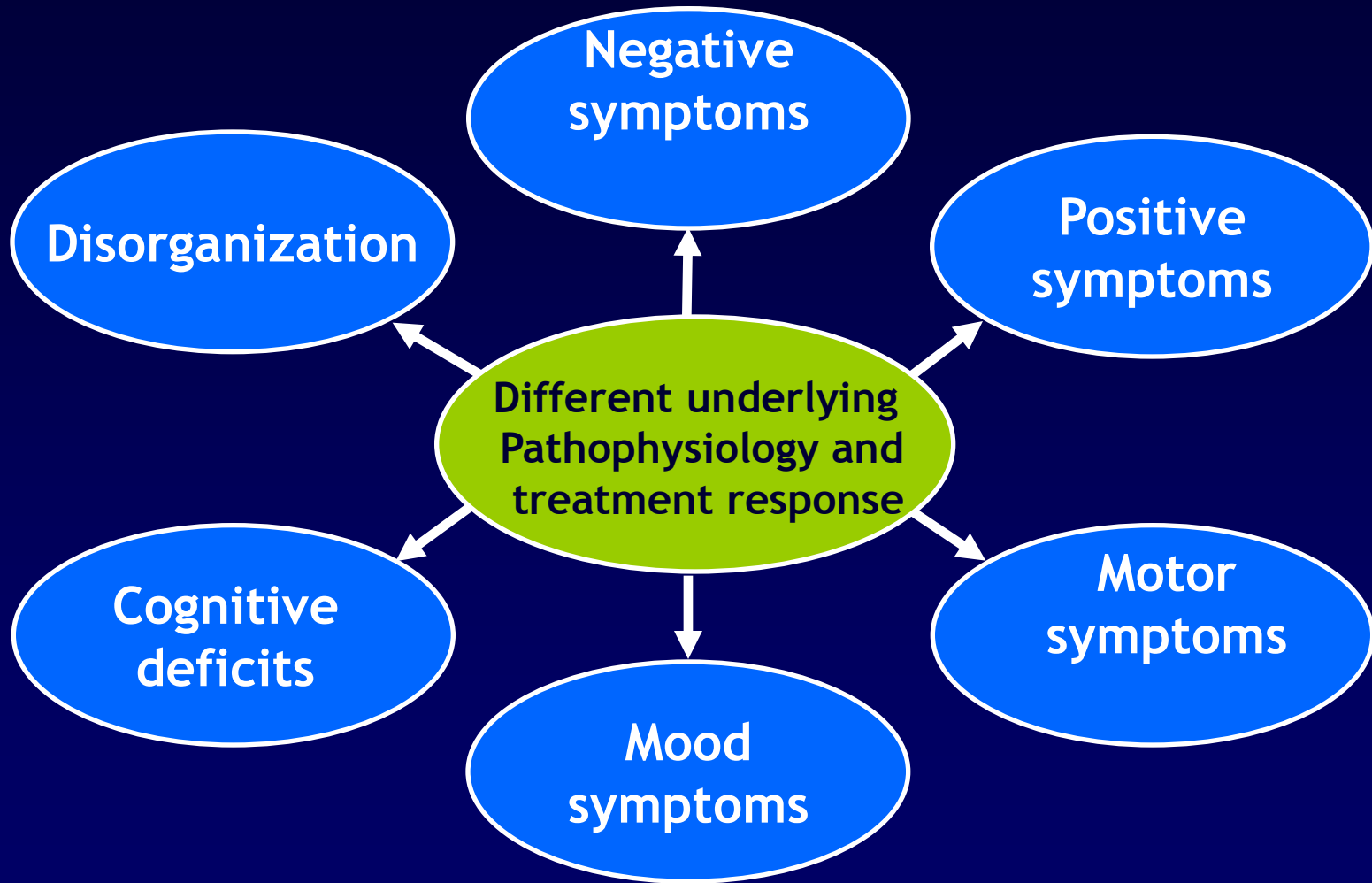
- ◆ Catatonia
- ◆ Disorganized behavior
- ◆ Negative symptoms
- ◆ Mood Symptoms

Psychotic Disorders in DSM-5

Schizophrenia & Related Disorders

- Add dimensional measures to assessment
- Eliminate current subtypes of schizophrenia
- Modify criteria for Schizoaffective Disorder
- Treat catatonia uniformly across the manual
- “Attenuated Psychosis Syndrome” as condition for further study

DIMENSIONS OF SCHIZOPHRENIA



Schizophrenia Subtypes in DSM-V

- **ELIMINATE SUBTYPES**
 - No long-term stability
 - No diagnostic utility
 - No research utility
 - Poor reliability and validity
- **INTRODUCE DIMENSIONS (To be rated on 0-4 scale)**
 - Reality distortion (delusions, hallucinations)
 - Negative symptoms
 - Disorganization
 - Impaired cognition
 - Depression
 - Mania
 - Psychomotor symptoms, including catatonia

Diagnosis-Specific Severity Assessment: Symptom Domains

- Hallucinations
- Delusions
- Disorganized Speech
- Abnormal Psychomotor Beh
- Negative Symptoms
(Restricted Emotional Expression or Avolition)
- Impaired Cognition
- Depression
- Mania

0 = Not Present

1 = Equivocal

2 = Present, but mild

3 = Present & moderate

4 = Present & severe

Clinical Application

Dimensions of Psychotic Disorders

- Precision in measurement-based care
- Specific targeting of distinct dimensions of schizophrenia and other psychotic disorders
- Individualizing treatment with more precise response-based treatment adjustments

Key Changes in Criterion A of Schizophrenia

- Eliminate special treatment of Schneiderian “first-rank” symptoms
 - Poor reliability of diagnosing “bizarre” delusions
 - No special prognostic or diagnostic value
- Add requirement that at least one characteristic symptom be a core psychotic symptom
 - Delusions, hallucinations, disorganized speech

Schizoaffective Disorder in DSM-IV-TR

- Poor reliability
- Poor validity
- Low diagnostic stability
- Low utility

Schizoaffective Disorder

Now based on the lifetime (rather than episodic) duration of illness in which the mood and psychotic symptoms described in Criterion A occur

✱ Rationale: The criteria in DSM-IV have demonstrated poor reliability and clinical utility, in part because the language in DSM-IV regarding the duration of illness is ambiguous. This revision is consistent with the language in schizophrenia and in mood episodes, which explicitly describe a longitudinal rather than episodic course. Similarly applying a longitudinal course to schizoaffective disorder will aid in its differential diagnosis from these related disorders.

DSM-IV-TR Criteria Schizoaffective Disorder

- A. Uninterrupted period of illness during which there is a major mood episode [major depressive, manic, or mixed] concurrent with criterion A of schizophrenia
- B. Delusions and hallucinations for 2 or more weeks in absence of prominent mood symptoms
- C. Symptoms that meet criteria for a major mood episode are present for a substantial portion of the total duration of the active and residual portion of the illness
- D. Disturbance not due to direct physiological effects of a substance or a general medical condition

DSM-5 Criteria Schizoaffective Disorder

- A. An uninterrupted period of illness during which there is a major mood disorder (major depressive or manic) concurrent with Criterion A symptoms of schizophrenia.
- B. Delusions and/or hallucinations are present at least for 2 weeks in the absence of a major mood episode during the **lifetime duration** of the illness.
- C. A major mood episode is present for the **majority** of the total duration of the illness. (Note periods of successfully treated mood symptoms count towards the cumulative duration of the major mood episode)
- D. No Change

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.

Mood Disorder Now Two Sections

1. Bipolar & 2. Depressive Disorders

Bipolar and related disorders

- Bipolar disorder now a free standing category
 - Taken out of the broad mood disorder category
- Emphasis on changes in activity and energy (equivalent in importance to mood)
- Addition of an anxious distress specifier
- Elimination of “Mixed episode” category
- Replaced by “mixed features” specifier

Mania and Hypomania (Bipolar and Related Disorders)

- Inclusion of increased energy/activity as a Criterion A symptom of mania and hypomania
 - ✳ Rationale: This will make explicit the requirement of increased energy/activity in order to diagnose bipolar I or II disorder (which is not required under DSM-IV) and will improve the specificity of the diagnosis.

Mania and Hypomania

- “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.


Mixed Features Specifier: Definition

- Applies to both manic/hypomanic, and major depressive episodes
- To Manic/Hypomanic Episodes
 - ≥ 3 depressive symptoms for most days: depressed mood, diminished interest/pleasure, psychomotor retardation, fatigue, worthlessness, thoughts of death
- To Major Depressive Episodes
 - ≥ 3 manic symptoms for most days: elevated mood, increased self-esteem, more talkative, flight of ideas, increased energy or activity, decreased need for sleep

Mixed Features Specifier: Implications

- More inclusive diagnosis of mixed features improves ability to note this important clinical phenomenon
- Manic/Hypomanic Episode with Mixed Features
 - Less likely to respond to lithium
 - If antipsychotics utilized, low-EPS antipsychotics preferred
- Major Depressive Episodes with Mixed Features
 - May become unstable when taking antidepressants
 - Likely benefit from a “mood-stabilizer”

Mania and Hypomania

 “With anxious distress” also added as a specifier for bipolar (and depressive) disorders

✱ **Rationale:** Co-occurrence of anxiety with depression is one of the most commonly seen comorbidities in clinical populations. Addition of this specifier allows clinicians to indicate presence of anxiety symptoms that are not reflected in the core criteria for depression and mania but may be meaningful for treatment planning.

Anxious Distress Specifier: Definition

- Anxiety symptoms: ≥ 2 symptoms
 - Keyed up/tense; unusually restless, difficulty concentrating because of worry, fear that something awful might happen, feeling of losing control
- Anxiety Severity
 - Mild: 2 symptoms
 - Moderate: 3 symptoms
 - Moderately Severe: 4 symptoms
 - Severe: 4-5 symptoms with motor agitation

Anxiety Features Specifier: Implications

- Comorbid severe anxiety is associated with poorer clinical outcomes across all mood disorders
 - Increased risk of suicide
 - Increased risk of substance use disorder
 - Worse functional and social outcomes
 - Possible differentially better response to 5HT/NE agents than NE/DA agents

Depressive Disorders

- Elimination of bereavement exclusion
- Multiple specifiers added
 - Mixed
 - Anxious distress
- Dysthymia now called Persistent Depressive Disorder
- Added Premenstrual Dysphoric Disorder
- Added Disruptive Mood Dysregulation Disorder

Bereavement Exclusion (Depressive Disorders)

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

Removing the bereavement exclusion helps prevent major depression from being overlooked and facilitates the possibility of appropriate treatment

SUMMARY OF THE SITUATION FOR MAJOR DEPRESSION

- The risks of leaving early bereavement-related depression untreated outweigh the benefits
 - Bereavement does not protect against the well documented negative health consequences of bereavement
 - An untreated depression is a risk factor for the development of complicated grief
 - Data suggests that treatment of depression improves grief, though grief may also need to be treated
- Diagnosis of depression does not necessarily mean a person should be treated with medication, though medication **MIGHT** be helpful

Detailed footnote provides ways to differentiate features of bereavement from symptoms of major depression (quality of symptoms, content, etc.)

Persistent Depressive Disorder

- ❖ Includes both DSM-IV dysthymic disorder and chronic MDD and all cases of “double depression”
- ❖ Higher risk of anxiety disorders, substance use disorders, cluster B and C personality disorders, and other psychiatric comorbidities
 - ✱ **Rationale:** More precise description of clinical presentation, greater attention to severity of functional consequences, absence of difference between dysthymic disorder and MDD in terms of family history, genetics, brain abnormalities, etc. .

Persistent Depressive Disorder

Clinical Implications

- Minimum 2-year duration in adults and 1-year duration in children/adolescents

Two or more of the following:

- Poor appetite or overeating, insomnia or hypersomnia, low energy/fatigue, low self-esteem, poor concentration, hopelessness
- Same specifiers as other mood disorders

Important functional and treatment implications

Disruptive Mood Dysregulation Disorder



- **Persistent irritability and severe behavioral outbursts 3 or more times per week for more than 1 year.**
- **The mood in between temper outbursts is persistently negative (irritable, angry, or sad), observable by others, and the tantrums and negative mood are present in at least 2 settings.**
- **Onset has to be before age 10 years**
- **DMDD is intended to capture children with frequent temper tantrums and irritability, in part to prevent the overdiagnosis of bipolar disorder in youth with prepubertal onset of these symptoms.**

Disruptive Mood Dysregulation Disorder (DMDD)- New Addition

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

Disruptive Mood Dysregulation Disorder

- 6-18 years
- Verbal or behavioral angry outbursts, out of proportion, inconsistent with developmental level, 3 or more times weekly with general irritable mood most of the time for at least 12 months, with no 3-month period free of episodes, in at least 2 of three settings (home, at school, and with peers)

Disruptive Mood Dysregulation Disorder

- Family history, neurobiology, and course suggest relationship to Depressive Disorder and NOT Bipolar disorder
- Treatment
 - More likely to respond to antidepressants
 - Not very responsive to antipsychotics or anticonvulsants
- Course
 - Often develop depressive disorders or anxiety disorders
 - Unlikely to develop bipolar disorder

Premenstrual Dysphoric Disorder (PMDD)

- Promoted from appendix where it has lived since DSM-III-R
- While most controversial diagnosis in DSM-III-R and DSM-IV, no controversy in DSM-5
 - FDA-approved treatments
 - In majority of menstrual cycles in week before menses
 - Mood lability OR irritability OR depression OR anxiety
 - Other depressive/physical symptoms- Total ≥ 5

Specifiers for Depressive Disorders

- With Anxious Distress
- With Mixed Features
- With catatonic features
- With melancholic features
- With psychotic features
- With atypical features
- With peripartum onset
- With seasonal pattern

Catatonia is no longer a part of schizophrenia alone

- A single set of criteria will be utilized to diagnose catatonia across the diagnostic manual
- catatonia will be a specifier for bipolar and depressive disorders.
- A new residual category of catatonia not otherwise specified will be added



Specifiers for Depressive Disorders

Clinical Implications

- With melancholic features
 - ECT, SNRIs, TCAs,
- With psychotic features
 - Antidepressant + Antipsychotic, ECT
- With atypical features
 - SSRIs, MAOIs
- With peripartum onset
- With seasonal pattern
 - Light therapy, phase advance therapy

Anxiety Disorders

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

Anxiety Disorders

Anxiety Disorders

- PTSD and OCD in separate categories
- Social Phobia now called Social Anxiety Disorder
- Panic Disorder delinked from Agoraphobia
- Separation Anxiety Disorder and Selective Mutism are included here
- Minor changes in criteria for various conditions

Obsessive-Compulsive and Related Disorders

OCD is now a stand alone category

- Delusional specifier included
- Body Dysmorphic Disorder listed under OCD
 - Repetitive behaviors are the key feature of BDD
- Added Hoarding under category of OCD
- Trichotillomania now called Hair-Pulling Disorder is listed under OCD
- Skin Picking Disorder (Excoriation) moved under OCD

Trauma and Stressor Related Disorders

Trauma related disorders are now a stand alone category

- Reactive Attachment Disorder is now listed here
- Added Disinhibited Social Engagement Disorder
- Added PTSD in Preschool Children
- Acute Stress Disorder is now listed here
- **PTSD** is now listed here
 - Diminished emphasis on dissociative symptoms
 - Need ≥ 9 of 14 symptoms across four clusters:
avoidance/numbing/altered arousal/persistent negative emotional state
- Adjustment Disorders are now listed here

Posttraumatic Stress Disorder (Trauma- and Stress-Related Disorders)

- Stressor criterion (Criterion A) is more precise
 - (elimination of “non-violent death of a loved one” as a trigger)
 - subjective reaction (Criterion A2) is eliminated

Rationale: Direct and indirect exposure to trauma are still reflected in 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 (cont' d)

- Expansion to four symptom clusters (intrusion symptoms; avoidance symptoms; negative alterations in mood and cognition; alterations in arousal and reactivity), with the avoidance/numbing cluster divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood
 - **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).

Somatic Symptom Disorder (SSD)

- Replaces somatoform disorder, undifferentiated somatoform disorder, hypochondriasis, and the pain disorders
 - ✱ Rationale: DSM-IV's somatoform disorders have been shown to be rarely used in most clinics and across numerous countries, due in part to criteria and terminology that are confusing, unreliable, and not valid.
 - ✱ SSD is projected to cover the majority of patients previously diagnosed with its subsumed DSM-IV disorders, with illness anxiety disorder (new to DSM-5) likely covering the remainder.

Somatic Symptom and Related Disorders

- The central focus of medically unexplained symptoms has been de-emphasized throughout the chapter, and instead emphasis is placed on disproportionate thoughts, feelings, and behaviors that accompany symptoms
 - Rationale: The reliability of medically unexplained symptoms is low. Further, presence of medically explained symptoms *does not* rule out the possibility of a somatic symptom or related disorder being present.

Somatic Symptom and Related Disorders

Replaced Somatoform Disorders with this category

- Eliminated the following: Somatization Disorder; Pain Disorder; and Hypochondriasis
- Added Complex Somatic Symptom Disorder
- Added Simple Somatic Symptom Disorder
- Added Illness Anxiety Disorder
- Conversion Disorder renamed Functional Neurological Symptom Disorder

Substance Use Disorder (SUD) (Substance-Related and Addictive Disorders)

- Consolidate substance abuse with substance dependence into a single disorder called substance use disorder
 - Studies from clinical and general populations indicate DSM-IV substance abuse and dependence criteria represent a singular phenomenon which encompass different levels of severity.

Added Gambling to category

Substance Use Disorder (cont' d)

- Removal of one of the DSM-IV abuse criteria (legal consequences), and addition of a new criterion for SUD diagnosis (craving or strong desire or urge to use the substance)
 - Rationales: The legal criterion had poor clinical utility and its relevance to patients varied based on local laws and enforcement of those laws. Addition of craving as a symptom is highly validated, based on clinical trials and brain imaging data, and may hold potential as a future biomarker for the diagnosis of SUD.

Substance Use Disorder

DSM-5

- Tolerance*
- Withdrawal*
- More use than intended
- Craving for the substance
- Unsuccessful efforts to cut down
- Spends excessive time in acquisition
- Activities given up because of use
- Uses despite negative effects
- Failure to fulfill major role obligations
- Recurrent use in hazardous situations
- Continued use despite consistent social or interpersonal problems

**Severity measured by
number of symptoms:**

2-3 mild

4-5 moderate

6-11 severe

*not counted if prescribed by a health care provider

Neurocognitive Disorders

- Category replaces Delirium, Dementia, and Amnesic and Other Cognitive Disorders Category
- Now distinguishes between Minor and Major Disorders
- Replace wording of Dementia due to ... with Major Neurocognitive Disorder Associated with for all conditions listed
- Added Fronto-Temporal Lobar Degeneration; Traumatic Brain Injury; Lewy Body Disease
- Renamed Head Trauma as Traumatic Brain Injury
- Renamed Creutzfeldt-Jakob Disease as Prion Disease

Neurocognitive Disorders (NCD)

- 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 NCD refers to a broad range of possible etiologies that can occur even in young adults, such as major NCD due to traumatic brain injury or HIV infection.

Mild NCD

- Newly added to DSM-5
 - Rationale: Patients with mild NCD 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.

Personality Disorders

- Ten Personality Disorders from DSM-IV remain in this category: Borderline; Obsessive-Compulsive; Avoidant; Schizotypal; Antisocial; Narcissistic; Histrionic; Schizoid, Paranoid, and Dependent
- This category no longer stands alone as another AXIS II but rather as a diagnosed category with dimensions
- Relationship of specific personality disorders to other conditions clarified
 - Schizotypal Personality Disorder also under Schizophrenia and Other Psychotic Disorders
 - Antisocial Personality Disorder also under Disruptive Impulse Control & Conduct Disorders as Dyssocial Personality Disorder
- New Trait-specific based typology in Section 3

Use of DSM-5

- Diagnosis is given
 - Apply Criteria
 - Specifiers and/or Subtypes as appropriate
 - Administer severity assessments (suggested)
- Apply codes and follow instructions as per coding and recording procedures
- Develop treatment plan and outcome monitoring approach

New DSM-5 Diagnoses Code Issues

- Dual coding (ICD-9 and -10) provided to account for lag between DSM-5's publication and official implementation of ICD-10-CM codes (October 1, 2014)
- Codes accompany each criteria set
 - Some codes are used for multiple disorders
- In select places, unique codes are given for subtypes, specifiers, and severity

New DSM-5 Diagnoses Code Issues

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- Codes accompany each criteria set
 - ✦ *Some codes are used for multiple disorders*
- In select places, unique codes are given for subtypes, specifiers, and severity
- For neurocognitive and substance/medication-induced disorders, coding depends on further specification

Important Insurance Considerations

- There may be some delay for certain insurance carriers to update their coding systems
- Similar delays may exist for removing the multiaxial format from forms and computer systems
 - Place all mental and other medical disorders on a single list—with ICD code and name of disorder
 - In place of Axis IV, use DSM-5' s v/z/t codes
 - WHODAS 2.0 provided for disability rating (formerly Axis V), but no replacement for the GAF has been approved as of yet

SECTION 2

Changes in Specific DSM Disorder Numbers; Combination of New, Eliminated, and Combined Disorders (Net difference = -15)

	DSM-IV	DSM-5
Specific Mental Disorders*	172	157

*NOS (DSM-IV) and Other Specified/Unspecified (DSM-5) conditions are counted separately.

General Guidance on DSM-5 Changes

- Diagnostic codes (former Axes I, II, III) should be listed together, followed by codes for contributing factors (current V codes, former Axis IV)
- GAF (former Axis V) is no longer a component of formal diagnosis and its use is discouraged (special cases: MHICM, PRRC)
- Use of Emerging Measures and Models (Section III) is not required but should be considered where appropriate
 - E.g. WHODAS 2.0, Cross-cutting Measures, Cultural Formulation Interview
 - In time, some measures may become required (or be discontinued) in certain settings/programs
 - Note, however, that Conditions for Future Study are not yet ready for clinical use

MY RECOMMENDATION

- Understand DSM-5
 - Its structure [Some Important Changes!!]
 - Its content [Areas of major and minor change]
- Use it rigorously
 - In context of your practice
 - In cultural and situational context
- Document & report limitations in its application

Conceptual Development of DSM-5. From Aspiration to Reality

INITIAL ASPIRATION

Paradigm Shift

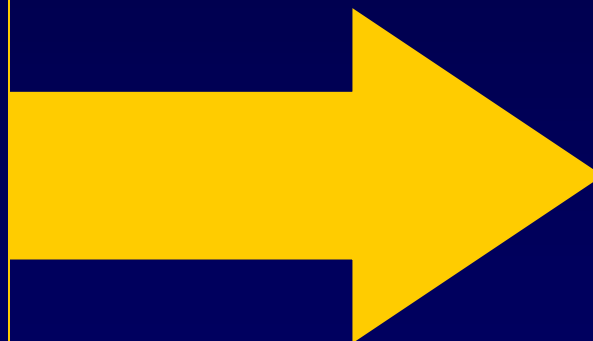
Etio-pathological basis
Multiple validators with
biological markers

Dimensional
Spectra

Developmental
Simplification

Living document

Validity



CURRENT REALITY

More Modest Scope

Iterative criteria changes
Some simplification
Addition of Dimensions
Significant text revisions
to incorporate advances in
neurobiology of disorders

Improve Clinical Utility +
Establish better foundation
for desired etiopathological
nosology in future

Where to find more info

☀ www.dsm5.org

☀ www.psychiatryonline.org

THANK YOU

Questions?