MASTERING THE DSM-5®
TO TRANSFORM
DIAGNOSIS AND
TREATMENT OF MENTAL DISORDERS

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Section I: DSM-5 Basics

David Kupfer, M.D.
DSM-5 Task Force Chair

1. “incorporation of a developmental approach to psychiatric disorders”
2. “a move toward the use of dimensional measures to rate severity and disaggregate symptoms that tend to occur across multiple disorders”
3. “harmonization of the text with ICD”
4. “integration of genetic and neurobiological findings by grouping clusters of disorders that share genetic or neurobiological substrates”
READ!

- Preface, Introduction, Use of the Manual, and Appendix
- Harmonization w/ ICD-11
- Coding and Billing
- Online Enhancements
- Online Assessment Measures
- Insurance Implications
- Summary of changes from DSM-IV-TR to DSM-5
- Changes and Updates since printed in May 2013
Dimensional Approach to Diagnosis


- The problems of DSM III and IV
  - Psychiatric illnesses are **categorical and discrete**
  - The multiaxial system **lacks conceptual rigor**
  - “Diagnosis” derives from the Greek ‘dia’, meaning through or across, and ‘gnosis’, meaning knowing
    - It is time for psychiatric diagnosis to grow out of the current ‘atetheoretical’ chaos of DSM, and to **adopt a developmental model based on evolutionary gene-environment interaction** (See DSM-5 pages xlii and 12)

- The diagnosis should be **dimensional, not categorical**
Dimensional Approach to Diagnosis

- **DSM-5** combines DSM-IV-TR Axes 1, 2, and 3
  - “The *multiaxial* distinction among Axis I, Axis II, and Axis III disorders does *not* imply that there are *fundamental differences* in their conceptualization, that mental disorders are *unrelated* to physical or biological factors or processes, or that general medical conditions are *unrelated* to behavioral or psychosocial factors or processes” (APA, 2000)
  - “(principle diagnosis)” or “(reason for visit)”
    - “The principle diagnosis is indicated by listing it first, and the remaining disorders are listed in order of focus of attention and treatment” (DSM-5, p. 23)
  - Provisional Dx

- **Contributing psychosocial and environmental factors or other reasons for visits** (replaces DSM-IV-TR Axis 4)
  - Over 130 V codes (use Z and T codes after October 1, 2014; DSM-5 pages 715-727)
  - The V code can be used when it is *more specific* to the care being rendered than a psychiatric diagnosis

- The DSM-5 includes separate measures of symptom *severity* and *disability* for individual disorders (replaces DSM-IV-TR Axis 5)
  - World Health Organization’s Disability Assessment Schedule (*WHODAS 2.0*; DSM-5 pages 745-748)
“In an interview with Psychiatric News, Katharine Phillips, M. D., chair of the Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group, said that the intention throughout DSM is to group together disorders that are similar to one another across a range of validators, including (1) symptoms, (2) neurobiological substrates, (3) familiarity, (4) course of illness, and (5) treatment response.”
Coding and Reporting Procedures

- Sample DSM-5 Diagnosis
  - 300.4 Persistent Depressive Disorder (Dysthymia), With limited-symptom panic attacks, In Partial Remission, Early Onset, Moderate (principle diagnosis)
  - V62.21 Problem Related to Current Military Deployment Status
  - Moderate disability (per self-administered WHODAS)
  - 303.90 Moderate Alcohol Use Disorder
  - 331.83 Possible Mild Neurocognitive Disorder Due to Traumatic Brain Injury (per I.E.D.), Without Behavioral Disturbance (provisional)
  - 301.89 Other Specified Personality Disorder (mixed personality features – dependent and avoidant symptoms)
  - 555.9 Crohn’s Disease (per patient self-report)
“The DSM-5 Neurodevelopmental Work Group spent a great deal of time evaluating the reliability and validity of the separate DSM-IV-TR diagnoses and concluded that there was no evidence to support continued separation of the diagnoses,” Susan Swedo, M.D., chair of the Work Group on Neurodevelopmental Disorders, told Psychiatric News.

Chapter 1: Neurodevelopmental Disorders

Susan E. Swedo, M.D.
Chair, DSM-5 Neurodevelopmental Disorders Work Group

1. “social communication and social reciprocity is main feature of autistic spectrum disorder”
2. “inclusion of number of specifiers to provide rich degree of information about the patient”
3. “field already moved to using single autism spectrum disorder: 95% of publications in the past 5 years using ASD”
Neurodevelopmental Disorders

- **Intellectual Disability**
  - Based on *adaptive functioning, not IQ*
    - “Problems with adaptive functioning more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute” (DSM-IV-TR, p. 42)
  - Adaptive functioning *(DSM-5 pages 34-36):*
    - *Conceptual* (academic skills)
    - *Social* (social judgment)
    - *Practical* (self-management of behavior)

- **Sample DSM-5 Diagnosis**
  - Intellectual Disability, with *Profound Conceptual Deficiencies*, with *Severe Practical Deficiencies*, with *Mild Social Deficiencies*

- **Global Developmental Delay**
  - *Under age 5 – unable to undergo systematic assessment of functioning*

- **Childhood/Adult-Onset Fluency Disorder (Stuttering)**
  - Removed Criterion A.3 “*interjections*”
  - Added to Criterion B. “…*anxiety about speaking or limitations in effective communication…”
  - Criterion D. regarding R/O is new for DSM-5

- **Social (Pragmatic) Communication Disorder**
  - Deficits in social use of communication

  *Dr. Courtenay Norbury*
Neurodevelopmental Disorders

- Autism Spectrum Disorder
  - The DSM-IV-TR category of PDD may be ideal for diagnosing "classic" autism, but it may be inadequate for diagnosing less severe forms of the disorder (see also DSM-5 page 53)
  - PDD-based diagnoses not consistently applied across different clinics
  - Adult textual narrative
    - Must show symptoms from early childhood and be “persistent” and “across multiple contexts”
    - Difficulties processing and responding to complex social cues
    - Suffer from the anxiety of consciously calculating what is socially intuitive for other adults
    - Difficulty in coordinating nonverbal communication with speech
    - Struggle to understand what behavior is considered appropriate in one situation but not another
    - Learn to suppress repetitive behavior in public
Neurodevelopmental Disorders

- Autism Spectrum Disorder
  - 1. Deficits in social communication and social interaction
    - 3 of 3 criteria addressing deficits in...
      - social-emotional reciprocity
      - nonverbal communicative behaviors used for social interaction
      - developing, maintaining, and understanding relationships

- Autism Spectrum Disorder
  - 2. Restricted repetitive behaviors, interests, and activities (RRBIAs)
    - 2 of 4 criteria addressing...
      - stereotyped or repetitive movements, use of objects, or speech
      - insistence on sameness, inflexible adherence to routines, ritualized patterns
      - abnormal, highly restricted, fixated interests
      - hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects

**CLINICIAN-RATED SEVERITY OF AUTISM SPECTRUM AND SOCIAL COMMUNICATION DISORDERS** *(DSM-5 page 52)* Recognize these may vary by context and fluctuate over time as intervention, compensation, and current support may mask difficulties.
Neurodevelopmental Disorders

- Autism Spectrum Disorder
  - 5 new descriptive specifiers
    - Provide clinicians with an opportunity to *individualize the diagnosis* and communicate a *richer clinical description* of affected individuals
  - *With Catatonia*
    - Pediatric catatonia occurs regularly in patients with autistic and developmental disorders, tic disorders and Tourette’s syndrome, and various other disorders outside of major psychotic, affective and medical disorders
- The former DSM-IV-TR diagnosis of Asperger’s Disorder is now DSM-5:
  - *Autism Spectrum Disorder, Without Accompanying Intellectual Impairment and Without Accompanying Language Impairment; Requiring Substantial Support with Social Communication and Social Interaction; Requiring Support with Restricted Repetitive Behaviors, Interests, and Activities*
Neurodevelopmental Disorders

- Autism Spectrum Disorder
  - Latest research
    - Results:
      - No significant differences were observed between the DSM-5 and DSM-IV-TR groups with respect to composite and subscale scores on the externalizing, behavior severity index and adaptive behavior domains of the Behavior Assessment System for Children, 2nd Ed.
    - Results:
      - Based on just parent data, the proposed DSM-5 criteria identified 91% of children with clinical DSM-IV-TR PDD diagnoses.
      - Sensitivity remained high in specific subgroups, including girls and children under 4.
      - The specificity of DSM-5 ASD was 0.53 overall, while the specificity of DSM-IV-TR ranged from 0.24, for clinically diagnosed PDD-NOS, to 0.53, for autistic disorder.
Neurodevelopmental Disorders

- **Autism Spectrum Disorder**
  - Latest research
    - Results:
      - Utilizing combined Autism Diagnostic Observation Schedule & Autism Diagnostic Interview-Revised (ADOS/ADI-R data, 93% of participants met DSM-5 criteria.
      - Highlighting the impact of diagnostic methodology on ability to document DSM-5 symptoms.
    - Results:
      - While the Childhood Autism Rating Scale, ADOS, and Social Responsiveness Scale-T/P are reliable and valid measures, there is some disagreement between measures with regard to child classification and the categorization of autism symptom severity.
Neurodevelopmental Disorders

- **Attention-Deficit/Hyperactivity Disorder**
  - New to DSM-5: “The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions”
  - Still 18 symptoms, cross-situational requirement strengthened to “several” symptoms in each setting
    - 6 for children, 5 for adults, age 17+ (sufficient for a reliable diagnosis)
      - This revision is based on nearly two decades of research showing that ADHD, although a disorder that begins in childhood, can continue through adulthood for some people
      - DSM-5: “Substantial clinical presentation during childhood”
        - Symptoms vary depending on context
Neurodevelopmental Disorders

- **Attention-Deficit/Hyperactivity Disorder**
  - Diagnostic criterion updated to more accurately characterize the experience of adults
  - **Inattention**
    - “focus during lectures, conversations, or lengthy reading; messy disorganized work; fails to meet deadlines; preparing reports, completing forms, reviewing papers; distracted by unrelated thoughts; returning calls, paying bills, keeping appointments; work is inaccurate”
    - Dr. David Feifel’s “F-I-S-C-A-L D-R-O-P” to screen for adults (4.5% of Americans)

- **Attention-Deficit/Hyperactivity Disorder**
  - Diagnostic criterion updated to accurately characterize the experience of adults
  - **Hyperactivity/Impulsivity**
    - “feeling restless; unable to be still at restaurants and meetings; difficulty to keep up with; intrude into or take over what others are doing; wearing others out with their activity”
    - *Increased risk of suicide in early adulthood*, especially w/comorbid mood, conduct, or substance use disorders
Neurodevelopmental Disorders

- **Attention-Deficit/Hyperactivity Disorder**
  - New age of onset: present by age 12
  - Research since 1994 found *no clinical differences* between children identified by 7 years versus later in terms of course, severity, outcome, or treatment response
  - Watch for:
    - low frustration tolerance, irritability, or mood liability
    - peer rejection, neglect, and teasing
  - May *appear* as “lazy, irresponsible, or uncooperative”

- **Attention-Deficit/Hyperactivity Disorder**
  - “Presentations” instead of “Subtypes”
  - Comorbid diagnosis with ASD is now allowed – no exclusion
  - New specifiers
    - In partial remission
    - Mild, moderate, severe

- **Motor Disorders**
  - Developmental Coordination Disorder
  - Stereotypic Movement Disorder
  - Tic Disorders
    - Tourette’s Disorder
    - Persistent (Chronic) Motor or Vocal Tic Disorder
Neurodevelopmental Disorders

Specific Learning Disorder

- Combines the following DSM-IV diagnoses:
  - Reading Disorder, Mathematics Disorder, Disorder of Written Expression, Learning Disorder NOS) are now used as specifiers
  - Broadening the category to increase diagnostic accuracy and effectively target treatment
    - Yet requires: “clinical synthesis of developmental, medical, family, and educational reports”
- Criterion A.: “…despite the provision of interventions…”
- Commonly referred to as “Response to Intervention” (RTI)
  - Individuals with Disabilities Education Improvement Act (IDEA)
  - The National Association of State Directors of Special Education (NASDSE)
  - The National Joint Committee on Learning Disabilities (NJCLD)
  - DSM-5 does not limit LD identification to RTI methods but provides for the inclusion of both standardized measures and RTI and does not limit assessment or evaluation options
“In an interview with Psychiatric News, William Carpenter, M.D., chair of the Psychotic Disorders Work Group, said while maintaining high reliability and improving validity were important considerations in the development of DSM-5, the principal objective was to facilitate clinical assessment and treatment.”

Chapter 2: Schizophrenia Spectrum and Other Psychotic Disorders

William T. Carpenter, M.D.
Psychotic Disorders Work Group Chair

1. “schizophrenia paradigm disorder in the group”
2. “catatonia found in depression and other disorders”
3. “dimensional rating is an idea based on a lot of research around ‘deconstructing’ schizophrenia, and nearly everyone agrees this is sensible”
Schizotypal (Personality) Disorder

- Catatonia specifier - a syndrome of disturbed motor, mood, and systemic signs (see DSM-5 page 119)
  - 1. Use for neurodevelopmental, depressive, bipolar, and all psychotic disorders
  - 2. Separate diagnosis in the context of a known medical condition
  - 3 or more of 12 symptoms

New to DSM-5: Course specifiers (after 1 year; not applicable to Brief Psychotic and Schizophreniform Dx)

- First/Multiple episode(s), currently in acute episode
- First/Multiple episode(s), currently in partial remission
- First/Multiple episode(s), currently in full remission
- Continuous or Unspecified

Delusional Disorder

Brief Psychotic Disorder

- Now must have disorganized or catatonic behavior
Schizophrenia Spectrum and Other Psychotic Disorders

- **Schizophreniform Disorder and Schizophrenia**
  - “Clinical neuropsychological assessment can help guide diagnosis and treatment”
  - “The assessment of cognition, depression, and mania symptom domains is vital for making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders” (DSM-5 page 98; see also page 100)
  - “Severity is rated by quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms.”

- **CLINICIAN-RATED DIMENSIONS OF PSYCHOSIS SYMPTOM SEVERITY**
  
  (DSM-5 pages 742-744)

- Dr. Rajiv Tandon (Professor of Psychiatry, University of Florida, Gainesville, FL)
  - "The clinical implications of adding dimensional assessments for schizophrenia will be significant, allowing clinicians to target specific symptoms instead of treating schizophrenia globally."
  - *treatment planning and prognostic decision-making*

- David Thompson
Schizophrenia Spectrum and Other Psychotic Disorders

- Schizophreniform Disorder and Schizophrenia
  - Elimination of the five Schizophrenia subtypes
    - Paranoid type
    - Disorganized type
    - Catatonic type
    - Undifferentiated type
    - Residual type
  - No differences between subtypes on:
    - IQ, processing speed, working memory, and problem-solving; ventricular enlargement or cerebral asymmetry and course of illness; all subtypes are unstable over 10-year duration
  - Retains DSM-IV-TR requirements of at least 2 of 5 symptoms; however removed DSM-IV-TR exception that:
    - “Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the persons’ behavior or thoughts, or two or more voices conversing with each other”
Schizophrenia Spectrum and Other Psychotic Disorders

- **Schizophreniform Disorder and Schizophrenia**
  - Must consider cultural factors *(page 103)*
    - “Assessment of affect requires sensitivity to differences in styles of emotional expression, eye contact, and body language, which vary across cultures”
    - “In some cultures, visual or auditory hallucinations with a religious content are a normal part of religious experience”
  - Lifespan developmental focus *(page 102)*
    - “In children, delusions and hallucinations may be less elaborate than in adults, and visual hallucinations are more common and should be distinguished from normal fantasy play”

- **Overall…**
  - “These changes should improve diagnosis and characterization of individuals with schizophrenia and facilitate measurement-based treatment” *(Tandon, et al., 2013)*.

- **Sample DSM-5 Diagnosis**
  - Schizophrenia, Severe Hallucinations, Moderate Delusions (erotomanic and persecutory), Equivocal Disorganized Speech, Moderate Abnormal Psychomotor Behavior, Moderate Negative Symptoms, Continuous Episode, Currently in Partial Remission, Without Catatonia
Schizoaffective Disorder

“There is growing evidence that schizoaffective disorder is not a distinct nosological category” (DSM-5, pages 89-90)

- Remains controversial because of poor reliability, low stability, weak validity, and excessive application in practice
  - However, the DSM-5 recognizes the clinical utility in maintaining a diagnosis that is important to clinicians addressing the middle ground

In DSM-5, Schizoaffective Disorder is more stringently defined

- Criterion B.: “Lifetime duration of the illness”
- Criterion C.: Major mood episode must be present for the “majority of the total duration“ for the active and residual portion of the illness versus DSM-IV-TR “substantial portion”
Chapter 3: Bipolar and Related Disorders

Ellen Frank, Ph.D.
Mood Disorders Work Group

1. “changes in activity and energy much more objectiviable and memorable than elevated mood”
2. “individuals rarely meet full criteria” “mixed episode diagnosis”
3. “more consistent and meaningful in prognostic and treatment planning decisions”


“For DSM-5, existing nosological boundaries between bipolar disorder and schizophrenia were retained and schizoaffective disorder preserved as an independent diagnosis since the biological data are not yet compelling enough to justify a move to a more neurodevelopmentally continuous model of psychosis.”
Bipolar and Related Disorders

- Do not diagnose a personality disorder during an untreated mood episode!
- New specifiers (DSM-5 pages 149-154)
- Criterion A.: “…and abnormally and persistently increased goal-directed activity or energy…” ALTMAN SELF-RATING MANIA SCALE (ASRM)
- Criterion B.: “…represent a noticeable change from usual behavior…”
  - “Sex Addiction???” - Manic Episode Criterion B.6. and B.7.:
    - “goal directed, excessive involvement, high potential for painful consequences; sexuality and sexual indiscretions, increased sexual drive, fantasies, and behavior are often present; often disregarding the risk of sexually transmitted disease or interpersonal consequences; sexual promiscuity, infidelity or indiscriminate sexual encounters; poor judgment, loss of insight, and hyperactivity”
  - Hypersexuality listed as comorbid with all DSM-5 Paraphilic Disorders; Bipolar listed with 4 of the 8!
- Hypersexual Disorder
Bipolar and Related Disorders

- Textual narrative and examples differentiate signs and symptoms in children
  - Ellen Leibenluft, M.D.
    - Tracked a large group of young teens into their thirties and found no evidence that chronic irritability was a predictor of bipolar disorder in adults
- Replaces “mixed episode” diagnosis with a “mixed-features” specifier
  - Full criteria, then three symptoms
  - Can be applied to episodes of major depression, hypomania, or mania
  - This is especially important since many patients with mixed features demonstrate poor response to lithium or become less stable when taking antidepressants
  - Significant risk factor for the development of Bipolar I or II Disorders
    - Note about episode emerging during antidepressant treatment

Cyclothymic Disorder
- Criterion A. “…that do not meet criteria for a hypomanic episode…”
- Criterion B. “…the hypomanic and depressive periods have been present for at least half the time…”
- Criterion C. “Criteria for a major depressive, manic, or hypomanic episode have never been met.”
- Removed DSM-IV-TR “Note” that allowed this after initial 2 years
In an interview with Psychiatric News, Jan Fawcett, M.D., chair of the Mood Disorders Work Group, said “This came from the child and developmental group of researchers we worked with, and we accepted their recommendation to include these criteria in the hope that it will be an alternative to diagnosing bipolar disorder in a group of children who have persistent irritability and frequent episodes of extreme behavioral dyscontrol but who do not experience mania.”

Chapter 4: Depressive Disorders

David J. Kupfer, M.D.
Chair, DSM-5 Task Force

1. “appropriate diagnosis and correct intervention without being constrained by a period of time”

2. “we hope that this will focus research on a significant clinical reality—that chronicity is a significant factor in treatment outcome”
Depressive Disorders

- **Disruptive Mood Dysregulation Disorder**
  - Hallmark symptom is “very severe, non-episodic irritability”
    - DSM-IV-TR depression in children: “increased irritability/persistent anger, a tendency to respond to events with angry outbursts or blaming others, or an exaggerated sense of frustration of minor matters” (p. 349)
  - AFFECTIVE REACTIVITY INDEX (ARI)
  - Anger outbursts occur three or more times per week
    - Extreme dyscontrol / information-processing deficits (e.g., dangerous behavior, suicidal ideation or suicide attempts, severe aggression, and psychiatric hospitalization are common)
  - PROMIS EMOTIONAL DISTRESS—CALIBRATED ANGER MEASURE—PARENT
  - Symptoms in at least two settings (home, school, peers/must be severe in one setting)
  - Age 6 years or older, onset before 10 years of age; not after age 18
  - 12 months duration - “persistent, frequent, extreme”
  - Mutually exclusive with bipolar, intermittent explosive, post-traumatic, autism spectrum, and oppositional defiant disorders – and it trumps ODD (15%)
    - but it can coexist with attention-deficit/hyperactivity, conduct disorder, substance use disorders, major depression – “clear-cut changes”
Depressive Disorders

- **Disruptive Mood Dysregulation Disorder**
  - Latest research

  □ **Results:**
    - Prevalence rates for meeting criteria ranged from 0.8% to 3.3%, with the highest rate in preschoolers.
    - Children displayed elevated rates of social impairments, school suspension, service use, and poverty.

  □ **Conclusions:**
    - *Relatively uncommon* after early childhood, frequently co-occurs with other psychiatric disorders, and meets common standards for psychiatric “caseness.”
    - Identifies children with severe levels of both emotional and behavioral dysregulation.
Depressive Disorders

- Disruptive Mood Dysregulation Disorder
  - Latest research

  - Results:
    - 26% of participants met the operational DMDD criteria.
    - DMDD participants had higher rates of and more severe symptoms of oppositional defiant disorder (58%) and conduct disorder (61%)
    - but did not differ in the rates and severity of mood, anxiety, or attention-deficit/hyperactivity disorders.
    - DMDD was not associated with new onset of mood or anxiety disorders; or with parental psychiatric history.

  - Conclusions:
    - DMDD could not be delimited from ODD and CD and had limited diagnostic stability.
Depressive Disorders

- Disruptive Mood Dysregulation Disorder

  Latest research


  □ Results:

  □ Overall, 30.5% of inpatient children met criteria for DMDD by parent report, and 15.9% by inpatient unit observation; *56% of inpatient children had parent-reported manic symptoms*. Of those, *45.7% met criteria for DMDD by parent-report, though only 17.4% did when observed on the inpatient unit.*

  □ Conclusions:

  □ Although DMDD *does decrease the rate of diagnosis of bipolar disorder in children*, how much depends on whether history or observation is used.
Depressive Disorders

- **Disruptive Mood Dysregulation Disorder**

  - Latest research

  - Results:
    - The most prevalent concurrent diagnoses were *oppositional defiant disorder* (ODD) (43.6%), *minor depression/dysthymic disorder* (MDDD) (18.8%), and generalized anxiety (13.2%)/overanxious disorder (12.4%).

  - Conclusions:
    - The prominence of an MDDD pattern suggests this *irritable mood group is appropriate in the DSM 5's proposed chronic depressive disorder*, possibly with or without temper dysregulation.
    - A new diagnosis of disruptive mood dysregulation disorder *may be unwarranted*. 
Depressive Disorders

- **Major Depressive Disorder**
  - Added “hopeless” to Criterion A “…(e.g., feels sad, empty, hopeless)…”
  - DSM-IV-TR Criterion E. bereavement exclusion removed (see page 356)
    - Marked functional impairment, Morbid preoccupation with worthlessness, Suicidal ideation, Psychotic symptoms, Psychomotor retardation
  - DSM-5 page 161 provides differential guidance for normal grief from a major depressive episode
    - Clinical judgment and cultural norms
    - Significant loss: “financial ruin, natural disaster, a serious medical illness or disability”
  - V-code: Uncomplicated Bereavement (see DSM-5 pages 716-717)

- **Persistent Depressive Disorder** (Dysthymia)
  - Encompasses DSM-IV-TR Chronic Specifier for a Major Depressive Episode (see DSM-IV-TR page 417)
  - New specifiers:
    - 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

- **Premenstrual Dysphoric Disorder**
  - DSM-IV-TR Appendix B: Criteria Sets and Axes Provided for Further Study (pages 771-774)
  - SEVERITY MEASURE FOR DEPRESSION
“Since individuals with anxiety disorders typically overestimate the danger in situations they fear or avoid, the primary determination of whether the fear or anxiety is excessive or out of proportion is made by the clinician, taking cultural contextual factors into account” (DSM-5, p. 189)
Anxiety Disorders

- All DSM-5 anxiety disorders...
  - Require 6 months \textit{minimum} symptom duration
  - \textit{Culture specific} symptoms should \textit{not} count for required symptoms
  - Anxiety \textit{must be out of proportion} to the actual danger or threat in the situation
  - Clinically significant distress
  - Removal of all age 18 requirements

- Separation Anxiety Disorder
  - Under-diagnosed in adults as many report first onset in adulthood
  - Prevalent in adulthood and often comorbid and debilitating

- Separation Anxiety Disorder
  - Adults
    - Typically over concerned about their \textit{offspring and spouses} – marked discomfort
    - Uncomfortable when traveling independently
  - Added the following diagnostic criterion language:
    - “…such as illness, injury, disease or death...having an accident, becoming ill...go out, away from home, to work…”
  - 4 weeks in children and adolescents and “\textit{developmentally inappropriate}”
  - \textbf{SEVERITY MEASURE FOR SEPARATION ANXIETY DISORDER—ADULT}

- Selective Mutism
  - Consistent with current research, it is best understood as a childhood social communication anxiety disorder
Anxiety Disorders

- **Specific Phobia**
  - Assessment focus on client *phobic stimulus* and *active avoidance*
    - Removed DSM-IV-TR Criterion B “…which may take the form of a situationally bound or situationally predisposed Panic Attack”
  - Lifespan focus
    - *Children*: crying, tantrums, freezing, or clinging and they often do not understand the concept of avoidance
    - *Adolescents*: tend to endorse a broader pattern of fear and avoidance
    - *Younger adults*: express higher levels of anxiety for specific situations
    - *Older adults*: lower levels of anxiety but across a broader range of situations
      - caregiving duties and volunteer activities, reduced mobility, and reduced physical and social functioning - resulting in formal home support
  - Sample DSM-5 diagnosis
    - Specific Phobia, Situational (elevators), Moderate
    - [SEVERITY MEASURE FOR SPECIFIC PHOBIA—ADULT](#)
Anxiety Disorders

- **Social Anxiety Disorder (Social Phobia)**
  - **SEVERITY MEASURE FOR SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)—ADULT**
  - Replaces DSM-IV-TR Criterion B “Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack” with “The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated”
  - Performance only specifier (e.g., dancers, speakers, musicians, or athletes; discussed on page 455 in DSM-IV-TR)

- **Panic Disorder**
  - Exclusion for culture-specific symptoms (e.g., neck soreness, headache, screaming, crying)
  - Careful questioning of older adults is required to avoid underdiagnoses
  - DSM-IV-TR “cued, uncued, situational, and situationally predisposed” now become DSM-5 “expected and unexpected”

- **Panic Attack Specifier**
  - Panic attacks can occur in any mental disorder and some medical conditions
    - 4+ of 13 symptoms (<4 = limited symptom attacks)
    - **SEVERITY MEASURE FOR PANIC DISORDER—ADULT**
Anxiety Disorders

- **Agoraphobia**
  - Diagnosed *irrespective* of the presence of panic disorder
  - DSM-IV-TR: “Agoraphobia is not a codable disorder” (page 433)
  - Represent and “upgrade” of DSM-IV-TR Agoraphobia Without History of Panic Disorder (pages 441-443)
  - This change recognizes that a substantial number of individuals with agoraphobia do not experience panic symptoms
  - Diagnosed only if the fear, anxiety, avoidance *persists*
  - Endorsement of fears from 2 or more of 5 agoraphobia situations is now required, because this is a *robust means* for distinguishing agoraphobia from specific phobias
    - Using public transportation
    - Being in open spaces
    - Being enclosed in spaces
    - Standing in line or being in a crowd
    - Being outside of the home alone

- **SEVERITY MEASURE FOR AGORAPHOBIA—ADULT**
Anxiety Disorders

- Generalized Anxiety Disorder
  - SEVERITY MEASURE FOR GENERALIZED ANXIETY DISORDER—ADULT
  - High comorbidity
    - Depressive disorders
  - To avoid over-diagnosis:
    1. Must assess: “intensity, duration, or frequency”
    2. Symptoms must be: “pervasive, pronounced, and distressing”
    3. Determine that “worries are excessive and typically interfere significantly with psychosocial functioning”
  - “May be over-diagnosed in children” (DSM-5, page 224)
  - Rule out separation anxiety, social anxiety, and OCD
  - Children and adolescents = compensate or quality of their performance; over conforming, perfectionistic, unsure of themselves, and tend to redo tasks
  - Younger adults and older adults = everyday, routine life circumstances
“Clinical experience suggests that patients with delusional beliefs as a symptom of one of these disorders are sometimes diagnosed with a psychotic disorder, which may lead to inappropriate treatment with antipsychotic medication only,” Phillips told Psychiatric News. “The specifier will emphasize that patients with delusional beliefs that may occur as a symptom of these disorders do have OCD or body dysmorphic disorder or hoarding disorder. Those with OCD and body dysmorphic disorder should be treated with an SSRI rather than antipsychotic monotherapy.”

Chapter 6: Obsessive Compulsive and Related Disorders

Katharine Phillips, M.D.
Chair, Anxiety Disorders Work Group

1. “in 1990’s researchers and clinicians started thinking of grouping behaviors with common features”
2. “excoriation disorder – extensive research: 1-5% = greater prevalence than anorexia nervosa”
3. “hoarding disorder – purposeful behavior = clinically significant distress”
Obsessive Compulsive and Related Disorders

- Obsessive-Compulsive Disorder
  - Requires assessment of a number of factors
    - “Excessive or persisting beyond developmentally appropriate periods”
  - Changed DSM-IV-TR Criterion A.1. “…thoughts, impulses, or images…” and “intrusive and inappropriate” to DSM-5 “thoughts, urges, or images…” and “intrusive and unwanted”
  - Removed DSM-IV-TR Criterion A.2. and A.4.:
    2. The thoughts, impulses, or images are not simply excessive worries about real-life problems
    4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)
  - Clarifies that client behavioral “action” is a “compulsion”
  - Lifetime tic-related specifier (30%)
  - Insight specifiers
    - “good or fair insight” (probably not true)
    - “poor insight” (probably true)
    - “absent insight/delusional beliefs” (convinced are true; 4% or less)
  - LEVEL 2—REPETITIVE THOUGHTS AND BEHAVIORS—ADULT
Obsessive Compulsive and Related Disorders

- **Hoarder Disorder**
  - **Persistent difficulty** discarding/parting with possessions –
    - “clinically significant, intentional accumulation, excessive, long standing difficulty, substantially compromised”
  - “Clutter” is defined
    - Collections are organized, individuals who hoard are totally disorganized
  - **Harmful effects**
    - Emotional, physical, social, financial, legal
  - Includes animal hoarding
    - Disease, starvation, death, severe overcrowding, unsanitary conditions
  - **Excessive acquisition specifier (80%-90%)**
    - Buying and free items
  - Same OCD insight specifiers
Obsessive Compulsive and Related Disorders

- **Trichotillomania (Hair-Pulling) Disorder**
  - Added Criterion B “repeated attempts to decrease or stop hair pulling”

- **Excoriation (Skin-Picking) Disorder**
  - Picking, rubbing, squeezing, lancing, biting
  - Does not include cutting or nail, lip, or cheek biting (coded as Other Specified OCD, see DSM-5 page 263)
  - Face, arms, and hands, skin irregularities, pimples, calluses, or scabs
  - Using objects such as tweezers, pins, scissors, and fingernails
  - Triggers: anxiety, boredom, distress, tension
  - Rituals, damage, scaring, infection, life-threatening

- **Excoriation (Skin-Picking) Disorder**
  - Several hours per day for months and years
    - 1 hour minimum per day: 1) picking, 2) thinking about picking, 3) and resisting urges to pick
  - Pain is not routinely reported
  - Work interference, missed school, difficulty managing school tasks and studying
  - Avoid social or entertainment events
  - Celina Greene

- **Body Dysmorphic Disorder**
  - Focus on “performed repetitive behaviors or mental acts”
  - With muscle dysmorphia specifier
“When PTSD was first proposed in 1980 for DSM-III, the major scientific model was that it was a fear-based anxiety disorder,” Friedman told Psychiatric News. “So the A2 criteria in DSM-IV-TR called for a fear-based reaction of fear, helplessness, or horror. But a lot of research now indicates that for many people who have intense emotional reactions to a traumatic event and go on to develop PTSD, their reaction is not fear based, but more likely to be dysphoria or anhedonia.”
Trauma and Stressor-Related Disorders

Reactive Attachment Disorder & Disinhibited Social Engagement Disorder

- Why the split between DSM-IV-TR Reactive Attachment Inhibited and Disinhibited subtypes?
  - Evidence-derived criteria define two statistically and clinically distinct syndromes
  - Inhibited = *internalizing* (avoidant – absence of expected comfort seeking; markedly disturbed attachment behaviors)
  - Disinhibited = *externalizing* (indiscriminant – violate social boundaries of their culture; yet common to have children with no signs of disturbed attachment)

- Quality of caregiving environment *after social neglect (repeated patterns of insufficient care)*
  - EARLY DEVELOPMENT AND HOME BACKGROUND (EDHB) FORM—PARENT/GUARDIAN
  - Still prior age 5, now at least 9 months of age – “selective attachments”
  - Both have *reorganized, expanded* (from 2/5 to 5/8 & 5/7), and *restrictive* diagnostic criterion
  - New specifiers for both: *Persistent* (12+ months) and severe (all symptoms) specifier
Trauma and Stressor-Related Disorders

- **Posttraumatic Stress Disorder**
  - Criterion A 1: “Actual or threatened death, serious injury, or sexual violence” (removed DSM-IV-TR “…threat to the physical integrity of self or others”)
  - Eliminated DSM-IV-TR Criterion A.2. “subjective fear-based distress”
    - Anhedonic, dysphoric, aggressive, phobic, arousal and reactive-externalizing, or dissociative
  - Exposure sources:
    - Same three from DSM-IV-TR (direct, witness, close loss)
    - New for DSM-5: Repeated exposure to traumatic details of events
  - 4 symptom clusters (20 possible symptoms, must have at least one in each):
    - Intrusion
    - Persistent avoidance of stimuli
    - Negative alterations in cognitions and mood
    - Marked alterations in arousal and reactivity
Trauma and Stressor-Related Disorders

- **Posttraumatic Stress Disorder**
  - Separate criteria for children age 6 years or younger
    - Experience co-occurring traumas, re-exposure to trauma, or childhood adversity
    - Developmental regression, trauma-specific play re-enactment, frightening dreams without recognizable content
  - Risk and Prognostic factors
    - Pretraumatic, Peritraumatic, and Posttraumatic (DSM-5 pages 277-278)
  - Specifier
    - DSM-IV-TR “delayed onset” becomes DSM-5 “delayed expression”
    - With dissociative symptoms (e.g., depersonalization and/or derealization)
      - SEVERITY OF DISSOCIATIVE SYMPTOMS—ADULT
  - Sample DSM-5 diagnosis
    - Extreme Posttraumatic Stress Disorder (per human trafficking), With Delayed Expression, With Moderate Dissociative Symptoms (derealization)
      - SEVERITY OF POSTTRAUMATIC STRESS SYMPTOMS—ADULT
Trauma and Stressor-Related Disorders

- **Acute Stress Disorder**
  - SEVERITY OF ACUTE STRESS SYMPTOMS—ADULT
    - Same criterion as PTSD but…
      - Strong anger response, irritable reactivity, aggressive responses
      - Chaotic or impulsive behaviors
  - New for DSM-5
    - 3 days instead of 2 days
    - 9 of 14 symptoms
      - Intrusion
      - Negative Mood
      - Dissociative
      - Avoidance
      - Arousal

- **Adjustment Disorders**
  - Reputation:
    - “marginal or transitional illness category,” “cryptic form of disease entity,” or “wastebasket” (Carol, 2008)
  - Most common diagnosis in psychiatric hospital settings
    - Increased risk of suicide attempts and completed suicide
  - New for DSM-5:
    - “…taking into account the external context and the cultural factors that might influence symptom severity and presentation.”
  - **Other Specified Trauma-and Stressor-Related Disorder: Persistent Complex Bereavement Disorder** (see DSM-5 pages 289; 789-792)
Chapter 8: Dissociative Disorders

“Characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, perception, body representation, motor control, and behavior” (DSM-5, p. 291)
Dissociative Disorders

- **Dissociative Identity Disorder**
  - Criterion A expanded
    - Symptoms of disruption of identity may be *reported, as well as observed*
    - Discontinuity in sense of agency and alterations in sensory-motor functioning, affect, behavior, consciousness, memory, perception, or cognition
    - Includes experiences of *pathological possession* in some cultures
  - Gaps in the recall of events may occur for everyday
  - Text modifications clarify the nature and course of disruptions
    - Children, adolescents, older individuals

- **Dissociative Amnesia**
  - **Note:** “Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history”
  - With dissociative fugue

- **Depersonalization/Derealization Disorder**
  - DSM-5 “…with respect to one’s thoughts, feelings, sensations, body, or actions” instead of DSM-IV-TR “mental processes”
“The heart of these disorders is a disproportionate and excessive response to somatic symptoms,” Dimsdale said. “We are talking about persistent symptoms lasting six months including thoughts, feelings, and behaviors that are disproportionate to somatic symptoms. Patients may catastrophize about fairly minor somatic symptoms, become very anxious and constantly scan for information about an illness, or avoid situations and behaviors they believe are related to illness.”
Somatic Symptom and Related Disorders

  - “Our data fail to provide empirical support for the designated symptom clusters in the DSM-IV”
  - “Our data underline the validity of a dimensional approach of diagnosing”

**Somatic Symptom Disorder**

- *(DSM-IV-TR Somatization Disorder, Undifferentiated Somatoform Disorder, & Pain Disorder)*
  - Encompasses about 75% of DSM-IV-TR hypochondriasis diagnoses
  - Health status scores more than 2 standard deviations below population norms
  - Excludes irritable bowel syndrome and fibromyalgia

- Somatic symptoms and psychopathology exists along a spectrum
  - In *children*, most common symptoms are abdominal pain, headaches, fatigue, and nausea
  - In *older adults*, somatic symptoms and concurrent medial illnesses are common

- **Criterion language**
  - “Significant disruption, marked impairment, disproportionate, persistently, excessive”

- **Specifiers**
  - With predominant pain
  - Persistent (> 6 months)
  - *Mild* (one symptom), *moderate* (two+ symptoms), *severe* (multiple)
Somatic Symptom and Related Disorders

- **Illness Anxiety Disorder**
  - 25% of DSM-IV-TR hypochondriasis diagnosis encompassed
  - Individuals with high health anxiety without somatic symptoms receive this diagnosis
  - Illness-related preoccupation – “incessant worrying”
  - New specifiers: care seeking type (excessive health-related behaviors) or care avoidant type (maladaptive avoidance)

- **Conversion Disorder (Functional Neurological Symptom Disorder)**
  - Criteria modified strongly recommending neurological examination so there must be clinical findings that show clear evidence of incompatibility with neurological disease
  - With 12 additional and enhanced descriptive and course specifiers
    - Motor and sensory symptoms indicative of central nervous system functioning

- **Psychological Factors Affecting Other Medical Conditions**
  - (was DSM-IV-TR Other Conditions That May Be a Focus of Clinical Attention, pages 731-734)
  - Changes Criterion B.4. “stress-related physiological responses precipitate or exacerbate…” to “The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms…”
  - New specifiers: mild, moderate, severe (hospitalization/ER), extreme (life-threatening risk)

- **Factitious Disorder (imposed on self or on another/Munchausen syndrome)**
  - Replaces three DSM-IV-TR types with two specifiers: single episode and recurrent episode
In an interview with Psychiatric News, Timothy Walsh, M.D., chair of the Work Group on Feeding and Eating Disorders, said an enormous amount of research in the last several decades—more than 1,000 published papers—justifies the inclusion of binge eating disorder. He said its inclusion will help to significantly decrease the use of “eating disorder—not otherwise specified.”

Chapter 10: Feeding and Eating Disorders

B. Timothy Walsh, M.D.
Chair, Eating Disorders Work Group

1. “people with BED are more anxious, more depressed, and respond differently to treatment”
2. “some word clarifications”
3. “major problem was prominence of EDNOS — clinical characteristics, course, and outcome guided philosophy”
Feeding and Eating Disorders

- **Obesity**
  - Not considered a mental disorder (results from long-term excess of energy intake relative to energy expenditure); yet robust associations w/ mental Dx

- **Avoidant/Restrictive Food Intake Disorder**
  - Replaces and expands DSM-IV-TR *Feeding Disorder of Infancy or Early Childhood*
  - Manifest in *children and adults*
  - Requires broad clinical assessment
    - “assessment of dietary intake, physical examination, and laboratory testing”
  - Key features
    - May represent a conditioned negative response or be based on the sensory characteristics of qualities of food
    - Significant weight loss, significant nutritional deficiency, dependence on enteral feeding or oral nutritional supplements, or marked interference with psychosocial functioning
  - In remission specifier
Feeding and Eating Disorders

- **Overall**
  - Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder all place greater emphasis on observable, recurrent, and quantifiable persistent client behaviors

- **Anorexia Nervosa**
  - Deleted DSM-IV-TR Criterion D requiring amenorrhea
  - The wording of the criterion is changed for clarity, and guidance – children, adolescents, and adults
  - BMI specifiers (see DSM-5 page 339)
    - mild, moderate, severe, extreme
  - Remission specifiers
    - partial and full

- **Bulimia Nervosa and Binge-Eating Disorder**
  - The EDNOS problem
    - Reduced the duration and frequency of disordered eating and compensatory behaviors that people must exhibit
      - from twice weekly to once per week
      - from six months to three months
  - Specifiers
    - Remission: partial or full
    - Mild = 1-3 episodes per week
    - Moderate = 4-7 episodes per week
    - Severe = 8-13 episodes per week
    - Extreme = 14+ episodes per week

- **Pica**
- **Rumination Disorder**
Feeding and Eating Disorders

Latest research


Results:

- Eating disorder *prevalence rates were significantly greater when using DSM-5 than DSM–IV–TR criteria, at all time points for females and at age 17 only for males.*
- “Unspecified”/“other” eating disorder diagnoses were *significantly less common when applying DSM-5 than DSM–IV–TR criteria, but still formed 15% to 30% of the DSM-5 cases.*
- Cross-over from binge eating disorder to bulimia nervosa was particularly high.

Discussion:

- Regardless of the diagnostic classification system used, all eating disorder diagnoses were *associated with depressive symptoms and poor mental health quality of life.*
- These results provide *further support for the clinical utility of DSM-5 eating disorder criteria,* and for the significance of binge eating disorder and purging disorder.
Chapter 11: Elimination Disorders
Elimination Disorders

- **Enuresis**
  - Recommended reading:

- **Encopresis**
  - My client story…
“This speaks to the concept of measurement-based care, a pervasive theme that has informed the entire DSM-5,” Reynolds told Psychiatric News. “Clinicians will see in the accompanying text a listing of useful dimensional measures of sleep impairment to help them understand how troublesome the symptoms are and to measure improvement as patients go through treatment. The dimensional measures will also help researchers correlate measures of severity with underlying brain dysfunction.”

Chapter 12: Sleep-Wake Disorders

Charles F. Reynolds III, M.D.
Chair, Sleep/Wake Disorders Work Group

1. “bi-directional theme between sleep/wake disorders and psychiatric disorders: comorbid depression and insomnia”
2. “include dimensional assessments to capture severity to facilitate measurement based clinical care”
3. “established risk factors or prodromal expression for other disorders – help to attenuate full blown episode”
Sleep-Wake Disorders

- International Classification of Sleep Disorders 2nd Edition (ICSD-2)
  - DSM-IV-TR did not use sleep medicine experts
  - Now use LEVEL 2—SLEEP DISTURBANCE—ADULT
- Increased emphasis on medical testing
  - Polysomnography, quantitative electroencephalographic analysis, hypocretin (orexin) deficiency
- Pediatric, developmental criteria, and text are integrated based on existing neurobiological and genetic evidence and biological validators
- Use of the terminology "coexisting with" or "comorbidity" instead of DSM-IV-TR "related to" or "due to"
- Greater emphasis is placed on the dynamic relationship between sleep-wake disorders and certain mental or medical conditions
  - Depression, anxiety, and cognitive changes must be addressed in treatment planning
- New specifiers
  - Episodic, persistent, recurrent, acute, subacute
  - With mental disorder, with medical condition, with another sleep disorder
  - Mild, moderate, severe
Sleep-Wake Disorders

- **Circadian Rhythm Sleep-Wake Disorders**
  - 6 types
- **Insomnias** *(problems with initiating/maintaining sleep)*
  - Insomnia Disorder
    - (DSM-IV-TR Primary Insomnia & Insomnia Related to Another Mental Disorder)
  - Hypersomnolence Disorder
    - (DSM-IV-TR Primary Hypersomnia & Hypersomnia Related to Another Mental Disorder)
- **Narcolepsy**
  - Either cataplexy, hypocretin deficiency, or REM sleep latency deficiency
  - 5 new descriptive specifiers

- **Breathing-Related Sleep Disorders**
  - Obstructive Sleep Apnea Hypopnea
  - Central Sleep Apnea
  - Sleep-Related Hypoventilation
- **Parasomnias** *(abnormal behavior/physiological events)*
  - Non–Rapid Eye Movement Sleep Arousal Disorder
    - (DSM-IV-TR Sleepwalking Disorder & Sleep Terror Disorder)
  - Nightmare Disorder
  - Rapid Eye Movement Sleep Behavior Disorder
    - (DSM-IV-TR Parasomnia NOS)
  - Restless Legs Syndrome
    - (DSM-IV-TR Dyssomnia NOS)
“Clinical judgment…should take into consideration cultural factors that may influence expectations or engender prohibitions about the experience of sexual pleasure”

“Sexual response…is usually experienced in an intrapersonal, interpersonal, and cultural context” (DSM-5, p. 423)
Sexual Dysfunctions

- >6 months duration/“desire discrepancy”
- “…experienced on almost or all occasions (75%-100%) of partnered sexual activity”
- Removed sexual response cycle language
  - Desire, excitement, orgasm, resolution
- Must consider the following factors:
  - Partner
  - Relationship
    - If severe relationship distress, partner violence, or significant stressors better explain the sexual difficulties, then a sexual dysfunction diagnosis is not made, but an appropriate V or Z code for the relationship problem or stressor may be listed (see DSM-5 pages 715-727)
  - Individual vulnerability
  - Psychiatric comorbidity
  - Cultural/religious

- Premature (Early) Ejaculation
  - Mild (30-60 seconds), moderate (15-30 seconds), severe (<15 seconds)
- Delayed Ejaculation
  - DSM-IV-TR Male Orgasmic Disorder
- Male Hypoactive Sexual Desire Disorder
- Genito-Pelvic Pain/Penetration Disorder
  - Merging of DSM-IV-TR Vaginismus and Dyspareunia because highly comorbid and difficult to distinguish
- Female Sexual Interest/Arousal Disorder
  - Combined DSM-IV-TR Female Hypoactive Desire Dysfunction and Female Arousal Dysfunction
- Sexual Aversion Disorder
  - Removed this DSM-IV-TR disorder due to lack of supporting research
“A central tension in discussions about the diagnosis was between the possibly *stigmatizing effect* of retaining a category for gender conflicts among a list of mental disorders and the *need to maintain access to care* for individuals who do experience distress or impairment in function with regard to gender conflicts.” “We decided the access-to-care issue was very important,” Drescher told Psychiatric News. “*If you take out the diagnosis, you don’t have a code for treatment.*”
Gender Dysphoria

- Formally *Gender Identity Disorder* in DSM-IV-TR
  - The presence of *clinically significant* distress >6 months
  - Emphasizes “*gender incongruence*” rather than cross-gender identification per se
  - Defines terms: *cross-sex, gender assignment, gender-atypical, gender-nonconforming, gender reassignment, gender dysphoria, gender identity, transgender, transsexual*
  - Merged DSM-IV-TR’s Criterion A “cross-gender identification” and Criterion B “aversion toward one’s gender”
    - No factor analytic studies supported keeping the two separate
  - Language changes
    - DSM-IV-TR “the other sex” is replaced by DSM-5 “some alternative gender”
    - DSM-5 “strong desire to be of the other gender” replaces DSM-IV-TR “repeatedly stated desire”
      - Some children who, in a coercive environment, may *not* verbalize the desire
      - Is now necessary *but not* sufficient - making the diagnosis *more restrictive* and conservative
Gender Dysphoria

- Child criteria (6 of 8)
  - Aversive attitudes…
    - Desire to be of other gender
    - Dislike of anatomy
    - Desire to have other sex characteristics
  - Aversive behaviors…
    - Cross-dressing
    - Cross-gender fantasy
    - Cross-gender play
    - Cross-gender playmates
    - Rejection of toys, games, and activities typically associated with the other gender
      - "Jazz Jennings"

- Adolescent & Adult criteria (2 of 6)
  - Mental fixation about…
    - Incongruence
    - Conviction that one has feelings of other gender
  - Strong desires…
    - To change
    - To have sex characteristics of other gender
    - To be other gender
    - To be treated as other gender

- Specifiers
  - With a disorder of sex development
    - Congenital adrenogenital disorder
  - Posttransition
    - At least one cross-sex medical procedure
“All of these disorders have previously been identified as ‘externalizing’ as compared to ‘internalizing’ disorders,” explained Darrel Regier, M.D., M.P.H., APA director of research and vice chair of the DSM-5 Task Force. “Since we eliminated a section that included only disorders of childhood and adolescence in order to distribute these to disorder sections that would cover the entire lifespan, putting ODD and conduct disorder together with antisocial personality disorder, intermittent explosive disorder, pyromania, and kleptomania was appropriate.”
Disruptive, Impulse-Control, and Conduct Disorders

- **Oppositional Defiant Disorder**
  - **CLINICIAN-RATED SEVERITY OF OPPOSITIONAL DEFIANT DISORDER**
  - **New symptom clustering:** angry/irritable mood; argumentative/defiant behavior; vindictiveness
    - “It is critical that the frequency, persistence, pervasiveness and impairment associated with the behaviors indicative of the diagnosis be considered relative to what is normative for a person’s age, gender, and culture” (DSM-5 pages 461-462)
    - “…exhibited during interaction with at least one individual who is not a sibling.”
  - Children < age 5 behavior must occur on most days for 6 months
  - Children > age 5 behavior must occur at least once per week for 6 months
  - **Severity specifiers identify if behaviors occur at various settings**
    - Such as home, at school, at work, or with peers
      - Mild = one setting
      - Moderate = two settings
      - Severe = three+ settings
Disruptive, Impulse-Control, and Conduct Disorders

- **Intermittent Explosive Disorder**
  - Individuals must be at least 6 years old to receive the diagnosis
  - For children ages 6-18 years, aggressive behavior that occurs as part of an Adjustment Disorder should not be considered for this diagnosis
  - In DSM-IV-TR, physical aggression was required to meet criteria for the disorder,
    - but this criteria was modified in the DSM-5 to include verbal aggression and nondestructive/noninjurious physical aggression
  - **Updated frequency criteria**
    - Verbal aggression: twice weekly, on average, for a period of 3 months; or
    - Damage, destruction, physical injury: three behavioral outbursts with a 12-month period
  - Aggressive outbursts are now required to be impulsive in nature, and must cause marked distress, impairment, or negative consequences for the individual
  - Comorbidity: ASD, ADHD, ODD, CD, SUD, APD, BPD
Disruptive, Impulse-Control, and Conduct Disorders

- **Conduct Disorder**
  - **CLINICIAN-RATED SEVERITY OF CONDUCT DISORDER**
  - New specifiers
    - **Mild**
      - e.g., lying, truancy, staying out after dark without permission, other rule breaking
    - **Moderate**
      - e.g., stealing without confronting victim, vandalism
    - **Severe**
      - e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting victim, breaking and entering

- **Conduct Disorder**
  - “*With limited prosocial emotions*” specifier *(DSM-5 pages 470-471)*
    - Diagnose youth who need *more intensive and individualized treatment*
    - Persistent *over 12 months* in *multiple settings* and relationships with *two* of the following:
      - Lack of remorse or guilt
      - Callous-lack of empathy
      - Unconcerned about performance
      - Shallow or deficient affect

- **Antisocial Personality Disorder**
- **Pyromania**
- **Kleptomania**
Disruptive, Impulse-Control, and Conduct Disorders

- Conduct Disorder
- Latest research

  - Results:
    - Girls with the *CU subtype of CD* had higher levels of externalizing disorder symptoms, bullying, relational aggression, and global impairment than girls with CD alone.
    - Girls with CD alone tended to have *more anxiety* problems than girls with the *CU subtype of CD*.

  - Conclusions:
    - The proposed DSM-5 *CU subtype of CD identifies young girls* who exhibit lower anxiety problems and more severe aggression, CD symptoms, academic problems and global impairment across time than girls with CD alone.
Disruptive, Impulse-Control, and Conduct Disorders

- Conduct Disorder
- Latest research

  - Results:
    - Overall, analyses revealed significant unique associations of personality trait/temperament dimensions with CU total and subscale scores.
    - Furthermore, specific personality dimensions differentially and uniquely predicted various CU subscales, indicating marked specificity in association such that these traits should be considered separately rather than as a single unit.

  - Discussion:
    - Taken together, these results confirm the importance of considering traditional personality trait models to understand “callous and unemotional” traits and risk for psychopathy more fully.
“Eliminating the category of dependence will better differentiate between the compulsive drug-seeking behavior of addiction and normal responses of tolerance and withdrawal that some patients experience when using prescribed medications that affect the central nervous system” And O’Brien said the term ‘abuse’ is clinically meaningless, noting that “abuse, dependence, and addiction are all one continuous variable.”

Chapter 16: Substance-Related and Addictive Disorders

Charles O'Brien, M.D., Ph.D.
Chair, Substance-Related Disorders Work Group

1. “diagnosed with a clinical interview”
2. “abuse not milder than dependence”
3. “dependence does not = addiction as long as follow doctor’s orders”
Substance-Related and Addictive Disorders

- **Substance Use Disorders**
  - *Addiction*: “uncertain definition and its potentially negative connotation”
  - *Abuse* and *Dependence* combined into *Use*
    - Continued use despite significant substance-related problems
      - “Pathological patterns, significant problems, repeated relapses, intense drug cravings”
  - **Criteria**
    - **Removed**: recurrent legal problems criterion
    - **Added**: craving or a strong desire or urge to use a substance
      - Craving involves *classical conditioning* and associated with activation of specific brain *reward structures*
      - Relapse prediction and treatment outcome measure
      - DSM-IV-TR: “Although not specifically listed as a criterion item, ‘craving’ (a strong subjective drive to use the substance) is likely to be experienced by most (if not all) individuals with Substance Dependence” (page 192)
      - "Have you ever wanted alcohol so badly you couldn't think of anything else?“
      - "Have you ever felt a strong desire or urge to drink?“
Substance-Related and Addictive Disorders

- **Substance Use Disorders**
  - Threshold = **2 of 11** symptoms
    - Impaired control
      - criteria 1-4
    - Social impairment
      - criteria 5-7
    - Risky use
      - criteria 8-9
    - Pharmacological
      - criteria 10-11
      - *Tolerance and withdrawal:*
        - Appropriate medical treatment w/ prescribed medications

- **Substance Use Disorders**
  - Severity ratings
    - Based on:
      - Individual’s own report
      - Report of knowledgeable others
      - Clinician’s observations
      - Biological testing
    - 2–3 criteria indicate = a *mild* disorder
      - An important marker is continued use despite a clear risk of negative consequences to other valued activities or relationships
    - 4–5 criteria = *moderate* disorder
    - 6 or more = a *severe* disorder
Substance-Related and Addictive Disorders

- **Substance Use Disorders**
  - Removed
    - Polysubstance-Related Disorder
      - DSM-IV-TR pages 293-294
    - Specifier for a physiological subtype
    - Cocaine and Amphetamine
  - Added
    - Stimulant Use Disorder
    - Caffeine Withdrawal
    - Cannabis Withdrawal
  - Changed
    - Nicotine to Tobacco
    - Agonist therapy replaced by *maintenance* therapy

- **Miscellaneous classification**
  - LEVEL 2—SUBSTANCE USE—ADULT
    - Recording procedures = record the name of the specific substance
    - Table 1: Diagnoses associated with substance class (see DSM-5 page 482)
    - Synthetic cannabinoid compounds
    - Ecstasy and ketamine
    - Other (or Unknown) Substance Use Disorder
      - Bath salts (“synthetic chemical derivatives”)
      - Anabolic steroids
      - Nitrous oxide
      - New, black market drugs
Substance-Related and Addictive Disorders

- **Substance Use Disorders**
  - Remission specifiers
    - *Early* - at least 3 but less than 12 months w/o substance use disorder criteria (except craving)
    - *Sustained* - at least 12 months w/o criteria (except craving)
  - **Sample DSM-5 diagnosis**
    - Severe Opioid Use Disorder, On Maintenance Therapy (Suboxone), In Controlled Environment (principle diagnosis); *Moderate* Cannabis Use Disorder (synthetic cannabinoid) – Early Remission; *Mild* Cocaine Use Disorder – Sustained Remission

- **Substance-Induced Disorders**
  - Substance *Intoxication and Withdrawal*
    - Does not apply to Tobacco
  - Substance/Medication-Induced Mental Disorders
    - Mood disturbances
    - Anxiety syndromes
    - Psychotic symptoms
    - Suicide attempts
    - Sexual dysfunctions
    - Disturbed sleep
  - **Addictive (Behavioral) Disorders**
    - Gambling Disorder
  - (see DSM-5 page 481)
Substance-Related and Addictive Disorders

Latest research


Results:

- The profiles of individuals with DSM-IV-TR dependence and DSM-5 severe AUD were almost identical.
- In contrast, the profiles of individuals with DSM-5 moderate AUD and DSM-IV-TR abuse differed substantially.
- The former endorsed more AUD criteria, had higher rates of physiological dependence, were less likely to be White individuals and men, had lower incomes, were less likely to have private and more likely to have public health insurance, and had higher levels of comorbid anxiety disorders than the latter.

Conclusions:

- Similarities between the profiles of DSM-IV-TR and DSM-5 AUD far outweigh differences; however, clinicians may face some changes with respect to appropriate screening and referral for cases at the milder end of the AUD severity spectrum.
Substance-Related and Addictive Disorders

Latest research


Results:
- For DSM-IV-TR alcohol, cocaine and opioid dependence, optimal concordance occurred when 4+DSM-5 criteria were endorsed, corresponding to the threshold for moderate DSM-5.
- Maximal concordance of DSM-IV-TR cannabis dependence and DSM-5 cannabis use disorder occurred when 6+ criteria were endorsed, corresponding to the threshold for severe DSM-5.
- Sensitivity and specificity, generally exceeded 85%(>75% for cannabis).

Conclusions:
- Overall, excellent correspondence of DSM-IV-TR dependence with DSM-5 substance use disorders.
Substance-Related and Addictive Disorders

- Latest research

Results:
- Modestly greater prevalence for DSM-5 SUDs
  - based largely on the assignment of DSM-5 diagnoses to DSM-IV-TR “diagnostic orphans.”
  - The vast majority of these diagnostic switches were attributable to the requirement that only two of 11 criteria be met for a DSM-5 SUD diagnosis.
  - We found evidence to support the omission from DSM-5 of the legal criterion.
  - The addition of craving as a criterion in DSM-5 did not substantially affect SUD diagnosis.

Conclusion:
- The greatest advantage of DSM-5 for the diagnosis of SUDs appears to be its ability to capture diagnostic orphans.
- In this sample, changes reflected in DSM-5 had a minimal impact on the prevalence of SUD diagnoses.
“In the Alzheimer’s field, where it goes by the name of ‘mild cognitive impairment,’ this is a train that has already left the station,” Blazer said. “Our work group included a neurologist [Ronald Peterson, M.D., Ph.D.], who informed us that if we did not have this category, we would be very much behind what is going on in the mainstream of Alzheimer’s treatment and research.”

Chapter 17: Neurocognitive Disorders

Dan Blazer, M.D., Ph.D., M.P.H.
Co-Chair, Neurocognitive Disorders Work Group

1. “older persons seeking help for this real problem”
2. “moving upstream by biological markers - identify early on”
3. “these are individuals who, if you submit them to neuropsychological tests, clearly have abnormalities”
Neurocognitive Disorders

- Neuropsychological testing critical to the evaluation process (except for Delirium)
  - Clear changes, not lifelong patterns
  - Cognitive decline in 32 areas
    - Table 1: Neurocognitive Domains (see DSM-5 pages 593-595)

- Mild NCD
  - Upgraded from DSM-IV-TR Appendix B: Criteria Sets and Axes Provided for Further Study, page 764
  - “Modest” cognitive decline
  - Does not interfere with ADLs
  - 1-2 SD (16th%-3rd) (see DSM-5 page 607)

- Major NCD
  - “Significant” cognitive decline
  - Interferes with ADLs
  - 2+ SD (3rd% or below)
  - DSM-IV-TR “dementia”
  - Specifiers
    - Mild - Difficulties with instrumental activities of daily living such as housework or managing money
    - Moderate - Difficulties with basic activities of daily living such as feeding and dressing
    - Severe - Fully dependent
Neurocognitive Disorders

Presentations

“Probable”: evidence of a causative disease genetic mutation from family history or genetic testing

“Possible”: does not include this objective evidence

10 etiological specifiers

Changed…

- DSM-IV-TR *Pick’s disease* to DSM-5 *Frontotemporal lobar degeneration*
- DSM-IV-TR *Creutzfeldt–Jakob disease* to DSM-5 *Prion disease*

Added…

- Lewy body disease
- Multiple etiologies

10 etiological specifiers

Merged…

- DSM-IV-TR *Dementia due to head trauma and Postconcussional Disorder* (found in Appendix B: Criteria Sets and Axes Provided for Further Study) to DSM-5 *Traumatic Brain Injury*
  - See DSM-5 pages 624-627

Delirium

Sample DSM-5 diagnosis

- Probable (per blood testing) Mild Neurocognitive Disorder Due to HIV Infection, With Behavioral Disturbance (psychomotor agitation and apathy)
Chapter 18: Personality Disorders

John Oldham, M.D.
Past APA president, member Personality Disorders Work Group

1. “from the beginning of the development process for DSM-5, the personality disorders were identified as a place where we needed to move beyond the categorical diagnostic system of discrete disorders in DSM-IV-TR toward a more dimensional system”

2. “personality types, traits, and disorders are on a continuous spectrum, much like blood pressure and hypertension.

3. “too much of a useful, adaptive trait may become a problem”
Personality Disorders

- Same 10 disorders from DSM-IV-TR
- Personality Change Due to Another Medical Condition (see DSM-5 page 682)
  - Labile type
  - Disinhibited type
  - Aggressive type
  - Apathetic type
  - Paranoid type
  - Other type
  - Combined type
  - Unspecified type

- Alternative DSM-5 Model for Personality Disorders (see DSM-5 pages 761-781)
  - THE PERSONALITY INVENTORY FOR DSM-5—INFORMANT FORM (PID-5-IRF)—ADULT
  - 6 personality disorders
  - Elements of personality functioning
    - Self
      - Identity and Self-direction
    - Interpersonal
      - Empathy and Intimacy
  - Psychopathology
    - 5 broad trait domains and 25 specific trait facets
Chapter 19: Paraphilic Disorders

Ray Blanchard, Ph.D.
Chair, Paraphilic Disorders work Group

1. “distinction between paraphilias and paraphilic disorders is a crucial one acknowledging that many people engage in atypical sexual practices”

2. “a paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder”

3. “a logical absurdity in the DSM-IV-TR: The previous criteria require that a person having a paraphilia be in distress”
Paraphilic Disorders

- **Major changes**
  - All require 6 months symptom duration (general guideline - not a strict threshold)
  - There is a distinction between paraphilias and paraphilic disorders
    - A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder
  - Now requires *subjective distress* (e.g., anxiety, obsessions, guilt, loneliness, intense sexual frustration, or shame) manifest in either of the following:
    - Involves another person’s psychological distress, injury, or death, or a desire for sexual behaviors involving unwilling persons or persons unable to give consent
      - This two-pronged nature of diagnosing requires
        - (1) clinician-rated or self-rated measures and
        - (2) severity assessments that address the *strength* of the paraphilia itself or the *seriousness* of its consequences
  - **Specifyers**
    - In a controlled environment
    - In remission
Paraphilic Disorders

- New clustering
  - Anomalous Activity Preferences
    - Courtship Disorders
      - Voyeuristic Disorder (age 18+)
      - Exhibitionistic Disorder
      - Frotteuristic Disorder
    - Algolagnic Disorders
      - Sexual Masochism Disorder
      - Sexual Sadism Disorder
  - Anomalous Target Preferences
    - Pedophilic Disorder
    - Fetishistic Disorder
    - Transvestic Disorder

- Transvestic Disorder
  - DSM-IV-TR limited this behavior to heterosexual males
  - DSM-5 has no such restriction, opening the diagnosis to women or men who have this sexual interest
  - While the change could increase the number of people diagnosed with transvestic disorder, the requirement remains that individuals must experience significant distress or impairment because of their behavior
Chapter 20: Other Mental Disorders
Other Mental Disorders

- Other Mental Disorders
  - This residual category applies to presentations in which symptoms characteristic of a mental disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any other mental disorder in DSM-5

- Other Specified Mental Disorder Due to Another Medical Condition
  - e.g., dissociative symptoms due to complex partial seizures

- Unspecified Mental Disorder Due to Another Medical Condition

- Other Specified Mental Disorder

- Unspecified Mental Disorder
  - e.g., in emergency room settings

- Antidepressant Discontinuation Syndrome
  - discontinuation reactions that happen when use of a medication is reduced or terminated
  - unsuccessful discontinuation reactions that occur when the client experiences disturbing side effects during termination and, therefore, feels compelled to resume taking the drug
References
References

References

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