Introduction to DSM-5- Part I

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Historical Perspective of DSM-5

How we arrived at this edition of the DSM

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Historical Perspective

- A predecessor of the DSM was published by APA in 1844
  - Established to classify institutionalized patients / promote communication
- Four major editions after 1945
  - Developed to describe essential features of mental disorders
- DSM-5 is built on DSM-IV
  - Revisions began in 1999, DSM-5 was published May 18, 2013
  - Use DSM-5/ICD-9 CM codes through September 30, 2014
  - Use DSM-5/ICD-10 CM codes starting October 1, 2014
- APA and NIMH leadership agreed that DSM-5 will harmonize with ICD-11

The DSM-5 Development Process

- **1999-2002:** The American Psychiatric Association (APA), National Institutes of Mental Health (NIMH), World Health Organization (WHO), and the World Psychiatric Association sponsored conferences to develop the research agenda for DSM-5
  - 13 diagnostic work groups convened
  - 90 academic and mental health institutions – 30% international – participated.
  - Multidisciplinary participation included: 100 psychiatrists, 47 psychologists, two pediatric neurologists, three epidemiologists, pediatrician, speech and hearing specialist, social worker, psychiatric nurse, consumer and family representatives
- **2004-2008:** APA, WHO, NIMH: 13 conferences
  - 400 participants from 39 countries
  - 10 monographs and hundreds of articles

The DSM-5 Development Process

- APA worked with WHO for consistency with ICD-11
- Scientific review committee: guidance on strength of evidence supporting changes
- Clinical utility, consistency and public health impact assessed
- Draft criteria released to public for comment three times – 11,000 comments
- Large academic medical centers and investigators tested DSM-5 feasibility and utility

What Is Included in DSM-5?

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DSM-5 Definition of a Mental Disorder

All elements must be included

- Mental disorder – syndrome characterized by a clinically significant disturbance in cognition, emotion regulation or behavior – reflects dysfunction in psychological, biological or developmental processes underlying mental functioning.
- Associated with significant distress or disability in social, occupational or other important activities. Expected cultural response to a common stressor or loss – not a mental disorder.
- Socially deviant behavior (political, religious, sexual) and conflicts between the individual and society – not mental disorders unless the deviance results from dysfunction described above.

Diagnoses

- Much of DSM-5 is unchanged from DSM IV-TR
- Approximately the same number of diagnoses
- Some diagnoses reclassified
- Some diagnostic criteria clarified
- Only 15 new diagnoses added
- NO MORE AXES!

No more axes in DSM-5

DSM-5 – non-axial documentation of diagnosis

Axis III – combined with Axes I and II; physical health conditions are to be listed

Axis IV – eliminated; psychosocial and environmental issues – use ICD-9 V codes and ICD-10 Z codes

Axis V GAF – eliminated; scale developed by WHO (WHODAS) is recommended by DSM-5 task force – best global measure of disability

Scientifically-validated Assessment Measures Encouraged!

- DSM-5 recommends scientifically validated assessment measures, rating scales in diagnosis, monitoring and measuring treatment progress and assessing impact of culture of key aspects of clinical presentation and care
- Examples included in DSM-5
  - Adult or parent/guardian DSM-5 self-rated cross-cutting symptom measure
  - Disorder-specific severity measure (e.g., PHQ-9)
  - Cultural Formulation Interview (CFI)

DSM-5 Guiding Principles

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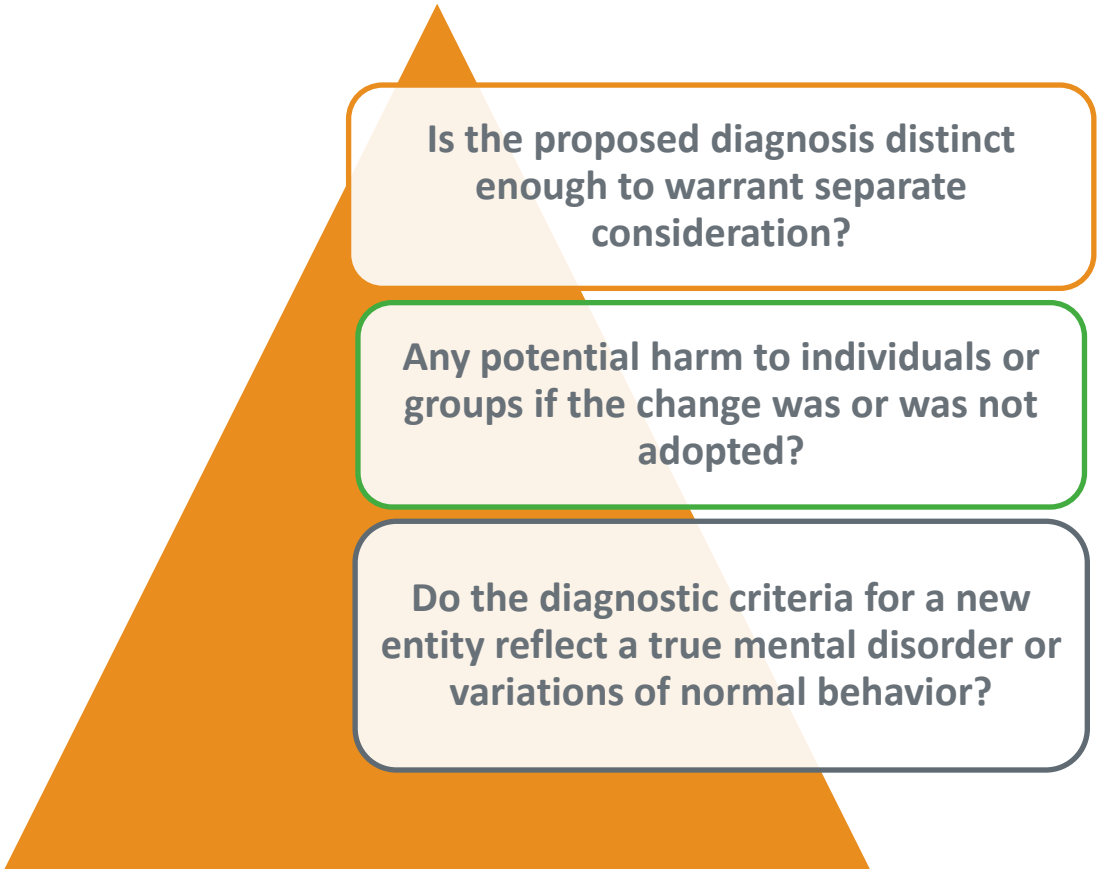
All criteria are based on an extensive review of the literature

- Research evidence to support any addition or modification
- Maintain continuity with DSM-IV-TR if possible
- Routine clinical practices must be able to implement changes
- No restraints in limiting degree of change between DSM-5 and earlier editions

Evidence to support changes must meet these tests:



DSM-5 Organization and Other Changes

- DSM-5 organized by the developmental lifespan
  - Neurodevelopmental disorders in childhood
  - Neurocognitive disorders in older adulthood
- Restructuring of chapters based on disorders' relatedness to one another
- Restructuring based on symptom vulnerabilities and symptom characteristics
- Moves away from categorical model – required clinician to determine whether disorder present or absent

DSM-5 Organization and Other Changes

- Sex differences – when variations are attributed to the presence of XX or XY chromosome or reproductive organs
- Gender differences – variations result from biological sex and perceived gender
- Uses dimensional approach – allows more latitude in assessing severity – no concrete threshold between normality and disorder
- Replaces NOS designation
  - Other specified disorder – used when reason specified
  - Unspecified disorder– reason not specified

DSM-5 Chapters and Sequence

1. Neurodevelopmental Disorders
2. Schizophrenia Spectrum and Other Psychotic Disorders
3. Bipolar and Related Disorders
4. Depressive Disorders
5. Anxiety Disorders
6. Obsessive-Compulsive and Related Disorders
7. Trauma- and Stressor-Related Disorder
8. Dissociative Disorders
9. Somatic Symptom Disorders
10. Feeding and Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse Control and Conduct Disorders
16. Substance-Use and Addictive Disorders
17. Neurocognitive Disorders
18. Personality Disorders
19. Paraphilic Disorders
20. Other Disorders

Highlights of Changes

DSM IV-TR to DSM-5

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Neurodevelopmental Disorders

- Intellectual Disabilities
- Communication Disorders
- Autism Spectrum Disorders
- Attention-deficit Hyperactivity Disorder
- Specific Learning Disorder
- Motor Disorders
- Other Specified Neurodevelopmental Disorder
- Unspecified Neurodevelopmental Disorder

- 319 (F70, F71, F72, F73)
- 315.39 (F80.9, F80.0, F80.81)
- 299.00 (F84.0)
- 314.00, 314.01 (F90.0, 90.1, 90.2)
- 315.00, 315.1, 315.2 (F81.0)
- 315.4, 307.xx (F82), 307.3 (F98.4)
- 315.8 (F88)
- 315.9 (F89)

Intellectual Disability (Intellectual Developmental Disorder)

- Replaces the term “mental retardation”
- Requires adaptive-functioning assessments and cognitive capacity (IQ) for diagnosis
- Considered to be two standard deviations below the population (IQ~70)
- Codes: ICD-9 319

Communication Disorders

- Language Disorder (combines DSM-IV expressive and mixed receptive-expressive language disorders) 315.39 (F80.9)
- Speech Sound Disorder (new name for phonological disorder) 315.39 (F80.0)
- Childhood-onset Fluency Disorder (formerly stuttering) 315.35 (F80.81)
- Social (Pragmatic) Communication Disorder – *new disorder* – persistent difficulties in social uses of verbal and non-verbal communication 315.39 (F80.89)

Autism Spectrum Disorder (ASD) 299.00 (F84.0)

- New name for DSM-5
- Encompasses autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett Syndrome, PDD-NOS
- Single disorder with differing levels of severity based on level of support required
- Must show deficits in BOTH
  - (Criterion A) social communication and social interaction and
  - (Criterion B) restricted repetitive behaviors, interests and activities
- Includes expanded specifiers associated with known medical or genetic conditions
- Symptoms from early childhood

Specific Learning Disorder

- Specifiers related to deficits in reading, written expression and mathematics with severity ratings
- Learning deficits commonly occur together – allows for all academic domains and subskills that are impaired
  - with impairment in reading 315.00 (F81.0)
  - with impairment in written expression 315.2 (F81.81)
  - with impairment in mathematics 315.1 (F81.2)

Attention-Deficit/Hyperactivity Disorder (ADHD)

- Largely unchanged from DSM-IV
- Same 18 symptoms used in DSM-IV with additional examples applying to adults
- Two symptom domains – inattention and hyperactivity/impulsivity
  - 314.01 (F90.2) Combined presentation
  - 314.00 (F90.0) Predominantly inattentive presentation
  - 314.01 (F 90.1) Predominantly hyperactive/impulsive presentation
- Onset criterion changed from symptoms present before age 7 to several symptoms present prior to age 12

Attention-Deficit/Hyperactivity Disorder (ADHD)

- ***Inattentive, hyperactive*** and ***combined*** are used to describe the current presentation rather than the subtype
- Comorbid diagnosis with ADHD allowed
- Threshold for adult diagnosis – adjusted to five symptoms in either domain

Motor Disorders – Largely Unchanged from DSM-IV

- Developmental Coordination Disorder 315.4 (F82)
- Stereotypic Movement Disorder 307.3 (F98.4)
- Tic Disorders
  - Tourette's Disorder 307.23 (F95.2)
  - Persistent Chronic Motor or Vocal Tic Disorder 307.22 (F95.1)
- Tics may "wax and wane in frequency, but have persisted for more than a year."

Schizophrenia and Other Psychotic Disorders

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Schizophrenia Spectrum and Other Psychotic Disorders

- Schizotypal (Personality) Disorder 301.22 (F21)
- Delusional Disorder 297.1 (F22)
- Brief Psychotic Disorder 298.8 (F23)
- Schizophreniform Disorder 295.40 (F20.81)
- Schizophrenia 295.90 (F20.9)
- Schizoaffective Disorder (bipolar or depressive type) 295.70 (F25.0, F25.1)
- Substance/Medication-Induced Psychotic Disorder – see substance-specific codes
- Psychotic Disorder Due to Another Medical Condition (with delusions or with hallucinations) 293.81, 293.82 (F06.2, F06.0)

Schizophrenia Spectrum and Other Psychotic Disorders

- **Catatonia Associated with Another Mental Disorder 293.89 (F06.1)**
- **Catatonic Disorder Due to Another Medical Condition 293.89 (F06.1)**
- **Unspecified Catatonia 293.89 (F06.1)**
- **Other Schizophrenia Spectrum and Other Psychotic Disorder (other specified or unspecified) 298.8 (F28)**

General Changes in This Section

- Eliminates subtypes of schizophrenia such as paranoid, disorganized, catatonic, undifferentiated and residual types
- Limited diagnostic stability, low reliability and poor validity
- Catatonia specifier – can be used for psychotic, depressive and bipolar disorders. Requires three catatonic symptoms for this designation:
  - **Stupor**
  - **Catalepsy**
  - **Waxy flexibility**
  - **Mutism**
  - **Negativism**
  - **Posturing**
  - **Stereotypy**
  - **Agitation, not influenced by internal stimuli**
  - **Grimacing**
  - **Echolalia**
  - **Echopraxia**
  - **Mannerism**

General Changes in This Section

- Schizoaffective Disorder
  - Requires a major mood episode be present for the majority of the disorder's duration
  - Bipolar type 295.70 (F25.0)
  - Depressive type 295.70 (F25.1)

- Delusional Disorder 297.1 (F22)
  - No longer requires that delusions must be non-bizarre
  - No longer separates Delusional Disorder from Shared Delusional Disorder

Bipolar and Related Disorders

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Bipolar and Related Disorders Categories

- Bipolar I Disorder 296.40-296.46 (F31 series), 296.50-56 (F31 series)
- Bipolar II Disorder 296.89 (F31.81)
- Cyclothymic Disorder 301.13 (F34.0)
- Substance/Medication-Induced Bipolar and Related Disorder – see substance abuse section
- Bipolar Disorder Due to Another Medical Condition 293.83 (F06.33, F06.34)
- Other Bipolar and Related Disorder 296.89 (F31.89)
- Unspecified Bipolar and Related Disorder 296.80 (F31.9)

General Changes in This Section

- Bipolar and related disorders
  - Bipolar disorder includes emphasis on changes in activity and energy; not just mood
  - Anxious distress specifier for bipolar disorder
- Bipolar I Disorder
  - Mixed type has been eliminated
  - Now includes “mixed state” specifier when mania episodes include depressive symptoms and for depression that includes mania or hypomania

General Changes in This Section

- Other Specified Bipolar and Related Disorders
  - This designation – individuals with history of major depressive disorder who meet all criteria for hypomania except duration (four days)
  - Too few symptoms of hypomania to meet criteria for full bipolar II

QUESTIONS?