Overview of DSM-5 Changes

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DSM-5 Revisions

- DSM-IV's organizational structure failed to reflect shared features or symptoms of related disorders and diagnostic groups (like psychotic disorders with bipolar disorders, or internalizing (depressive, anxiety, somatic) and externalizing (impulse control, conduct, substance use) disorders.
- DSM-5 restructuring better reflects these interrelationships, within and across diagnostic chapters

DSM-5 Revisions

- DSM-IV does not adequately address the lifespan perspective, including variations of symptom presentations across the developmental trajectory, or cultural perspectives
- DSM-5's chapter structure, criteria revisions, and text outline actively address age and development as part of diagnosis and classification
- Culture is similarly discussed more explicitly to bring greater attention to cultural variations in symptom presentations

DSM-5 Revisions

- DSM-5 represents an opportunity to better integrate neuroscience and the wealth of findings from neuroimaging, genetics, cognitive research, and the like, that have emerged over the past several decades – all of which are vital to diagnosis and treatment development
- DSM-5 will be more amenable to updates in psychiatry and neuroscience, making it a "living document" and less susceptible to becoming outdated than its predecessors

DSM-5 Revisions

- The multiaxial system in DSM-IV is not required to make a mental disorder diagnosis and has not been universally used
- DSM-5 has moved to a nonaxial documentation of diagnosis (formerly Axes I, II, and III), with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V)
- This approach is consistent with established WHO and ICD guidance to consider the individual's functional status separately from his or her diagnoses or symptom status

Elimination of Multi-Axial Diagnosis

- Axis IV - psychosocial and environmental factors - are now covered through an expanded set of V codes. V codes allow clinicians to indicate other conditions that may be a focus of clinical attention or affect diagnosis, course, prognosis or treatment of a mental disorder
- Axis V - CGAS and GAF - are replaced by separate measures of symptoms severity and disability for individual disorders. An eventual change to the World Health Organization Disability Assessment Schedule (WHO DAS 2.0) is anticipated for measurement of disability, however it is not yet recommended for use by APA until it has been studied further.

Clustering of Chapters

- Neurodevelopmental Disorders
- Emotional (Internalizing) Disorders
- Somatic Disorders
- Externalizing Disorders
- Neurocognitive Disorders
- Personality Disorders

DSM-5 Chapters

Neurodevelopmental Disorders

Schizophrenia Spectrum and Other Psychotic Disorders

Bipolar and Related Disorders

Depressive Disorders

Anxiety Disorders

Obsessive-Compulsive and Related Disorders

Trauma-and Stressor-Related Disorders

Dissociative Disorders

Somatic Symptom Disorders

Feeding and Eating Disorders

DSM-5 Chapters (continued)

Elimination Disorders

Sleep-Wake Disorders

Sexual Dysfunctions

Gender Dysphoria

Disruptive, Impulse Control and Conduct Disorders

Substance Use and Addictive Disorders

Neurocognitive Disorders

Personality Disorders

Paraphilic Disorders

Other Disorders

Changes in Terminology

- Not Otherwise Specified (NOS) has been used as a "catch-all" for patients who didn't fit into the more specific categories. NOS language is eliminated in DSM-5.
- There will now be an option for designating Not Elsewhere Classified (NEC) which will typically include a list of specifiers as to why the patient's clinical condition doesn't meet a more specific disorder.
- The phrase "general medical condition" is replaced in DSM-5 with "another medical condition" where relevant across all disorders.
- These classification changes will help providers with the transition to ICD-10 in October 2014. DSM-5 includes the ICD-10 diagnoses in parentheses.

299.00 (F84.0)

Highlights: Neurodevelopmental Disorders

Intellectual Disability

(Intellectual Developmental Disorder)

- Diagnostic criteria for intellectual disability (intellectual developmental disorder) emphasize the need for an assessment of both cognitive capacity (IQ) and adaptive functioning. Severity is determined by adaptive functioning rather than IQ score.
- Despite the name change, the deficits in cognitive capacity beginning in the developmental period, with the accompanying diagnostic criteria, are considered to constitute a mental disorder.
- No longer use of term “mental retardation.”

Criteria: Neurodevelopmental Disorders

Intellectual Disability (Intellectual Developmental Disorder)

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 the developmental period.

Specify severity (based on adaptive function, not IQ): Mild, Moderate, Severe, Profound

Criteria: Neurodevelopmental Disorders

Global Developmental Delay

Diagnosed reserved for individuals under 5 when clinical severity level cannot be reliably assessed. Diagnosed when an individual fails to meet expected developmental milestones in several areas of intellectual functioning, and applies to individuals who are unable to undergo systematic assessments of intellectual functioning, including children who are too young to participate in standardized testing. Requires reassessment after a period of time.

Unspecified Intellectual Disability

Diagnosed in individuals over 5 when assessment of the degree of intellectual disability by means of locally available procedures is difficult or impossible because of associated sensory or physical impairments, as in blindness or prelingual deafness; locomotor disability; or presence of severe problem behaviors or co-occurring mental disorder. Should only be used in exceptional circumstances and requires reassessment after a period of time.

Criteria: Neurodevelopmental Disorders

Communication Disorders

The DSM-5 communication disorders include new and revised conditions:

- Language Disorder (which combines DSM-IV expressive and mixed receptive-expressive language disorders)
- Speech Sound Disorder (a new name for phonological disorder)
- Childhood-Onset Fluency Disorder (a new name for stuttering)
- Social (pragmatic) Communication Disorder, a new condition for persistent difficulties in the social uses of verbal and nonverbal communication (ASD is an obligate rule-out).

Social (Pragmatic) Communication Disorder (315.39) Diagnostic Checklist

Check the box next to the following criteria that are present for this patient:

Yes	No	DSM-5 Diagnostic Criteria
☐	☐	A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by **all** of the following: ☐ 1. Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context. ☐ 2. Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on a playground, talking differently to a child than to an adult, and avoiding use of overly formal language. ☐ 3. Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction. ☐ 4. Difficulties understanding what is not explicitly stated (e.g. making inferences) and non literal or ambiguous meanings of language (e.g., idioms, humor, metaphors, multiple meanings that depend on the context for interpretation).
☐	☐	B. The deficits result in functional imitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.
☐	☐	C. The onset of the symptoms is in the early developmental period (but deficits may not become fully manifest until social communication demands exceed limited capacities).
☐	☐	D. The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains of word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability (intellectual developmental disorder), global developmental delay, or another mental disorder.

DSM-5 and Autism: Kicking the Tires and Making the Grade

Bryan H. King, M.D., Jeremy Veenstra-VanderWeele, M.D., Catherine Lord, Ph.D.

Like a new car, the *DSM-5* will have some updated features that are welcome, some changes that we lament, and some problems that we will argue should have been anticipated. Our new manual is slated to roll off the presses and we will be able to take ownership in mid-May. In anticipation of its arrival, an important issue that deserves our attention is how to break it in.

Indeed, our field long ago embraced the term *autism spectrum disorders* over the term *pervasive developmental disorders*. A Medline title search of the past 5 years showed that investigators have used *ASD* over *PDD* by a ratio of nearly 10 to 1. What we have also learned is that the distinction between Asperger disorder and autistic disorder is more firmly rooted in the eyes of the beholder than in biology. As Lord *et al.* found in an

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About

We, the undersigned, will *not* purchase nor will we use the new DSM-5 when it is published by the American Psychiatric Association. Further, those of us associated with professionals who use the DSM – as persons receiving services from them or as family members, friends or advocates – will urge service providers not to use the DSM-5:

- **DSM-5 is unsafe and scientifically unsound.**

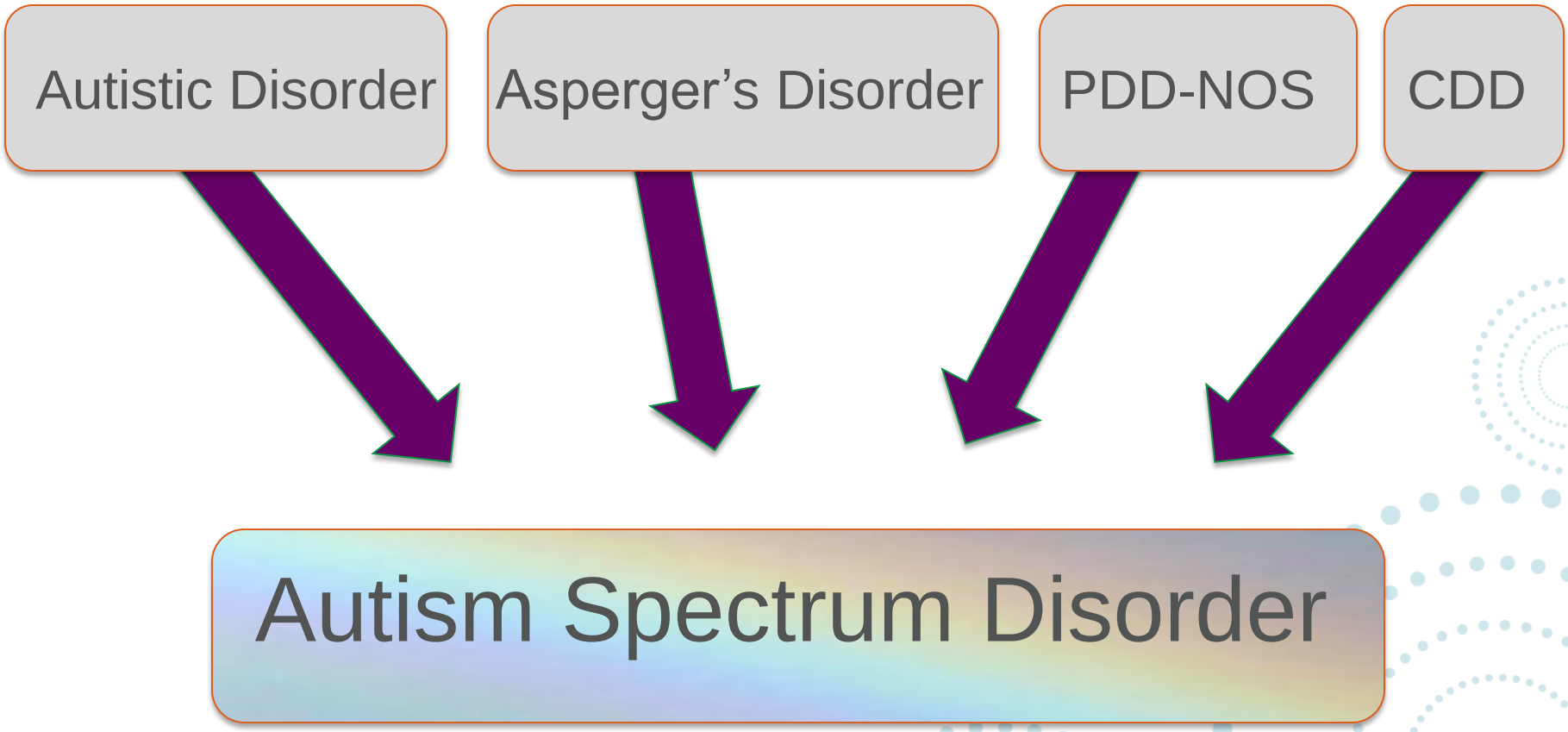
PETITION

- Sign the Petition!

BLOGGERS

- Boycott 5 Committee (3)
- Jack Carney (2)
- Wendy Langacker (1)

DSM-5:


Autistic Disorder
Asperger's Disorder
PDD-NOS
CDD
Autism Spectrum Disorder

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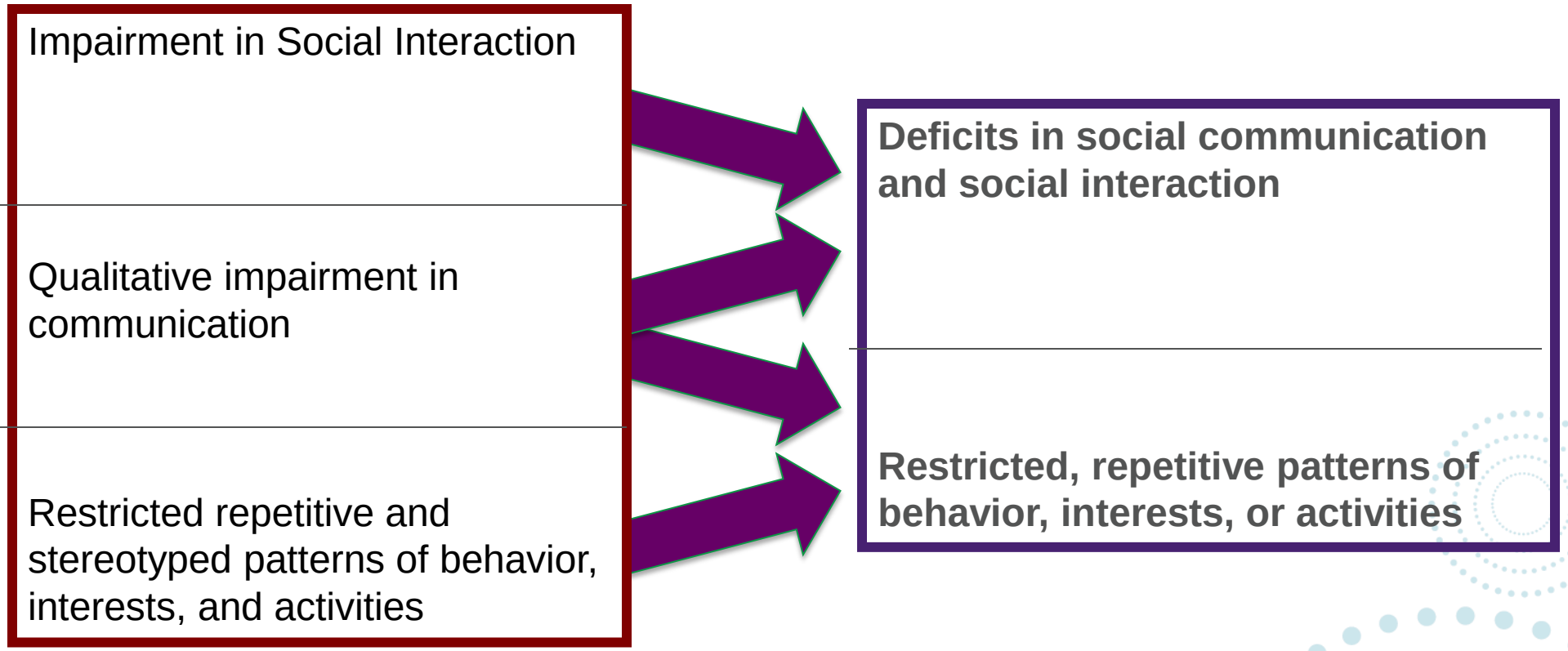
Impairment in Social Interaction
Qualitative impairment in communication
Restricted repetitive and stereotyped patterns of behavior, interests, and activities
Deficits in social communication and social interaction
Restricted, repetitive patterns of behavior, interests, or activities

Autism Spectrum Disorder

Diagnostic Criteria

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A. Persistent deficits in social communication and social interaction *across multiple contexts, manifested by the following, currently or by history (examples are illustrative not exhaustive; see text):*

1. Deficits in social-emotional reciprocity; ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities; or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV TR diagnosis of Autistic disorder, Asperger's disorder, or Pervasive Developmental Disorder Not Otherwise Specified should be given the diagnosis of Autism Spectrum Disorder.

Autism Spectrum Disorder: Specifiers

- With/without accompanying intellectual impairment.
- With/without accompanying language impairment.
- Associated with a known medical or genetic condition or environmental factor.
- Associated with another neurodevelopmental, mental, or behavioral disorder.
- With catatonia.

Autism Spectrum Disorder: Severity

- Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 2 in text).

Severity Level	Social Communication	Restricted, repetitive behaviors
Level 3 'Requiring very substantial support'	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others. E.g. someone with around 20 words of intelligible speech, rarely initiates interaction, and when does so makes unusual approach to meet needs only, responds to only very direct social approach.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 'Requiring substantial support'	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others. E.g., a person who speaks simple sentences, interaction limited to narrow special interests, markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 'Requiring support'	Without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. E.g., a person able to speak in full sentences, engages in communication but to-and-fro of conversation fails, attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

Highlights: Neurodevelopmental Disorders

Attention Deficit/Hyperactivity Disorder

- Several changes in DSM-5:
- 1) examples have been added to the criterion items to facilitate application across the life span;
- 2) the cross-situational requirement has been strengthened to “several” symptoms in each setting;
- 3) the onset criterion has been changed from “symptoms that caused impairment were present before age 7 years” to “several inattentive or hyperactive-impulsive symptoms were present prior to age 12”;
- 4) subtypes have been replaced with presentation specifiers that map directly to the prior subtypes;
- 5) a comorbid diagnosis with autism spectrum disorder is now allowed;
- 6) a symptom threshold change has been made for adults, with the cutoff of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity/impulsivity.
- ADHD now falls under the Neurodevelopmental Disorders Chapter

Highlights: Neurodevelopmental Disorders

Specific Learning Disorder

- Specific Learning Disorder combines the DSM-IV TR diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified.
- Because learning deficits in the areas of reading, written expression, and mathematics commonly occur together, coded specifiers for the deficit types in each area are included.

Highlights: Other Neurodevelopmental Disorders

Developmental Coordination Disorder

Stereotypic Movement Disorder

Tic Disorders

- **Tourette's Disorder**
- **Persistent Motor or Vocal Tic Disorder**
- **Provisional Tic Disorder** *(1 year)*

Other Specified Neurodevelopmental Disorder

e.g. Neurodevelopmental disorder associated with prenatal alcohol exposure (section 3).

Unspecified Neurodevelopmental Disorder

Highlights: Schizophrenia Spectrum Disorders

- Two Criterion A symptoms are now required for any diagnosis of schizophrenia in DSM-5 *(cf single bizarre).*

- Also, the individual must have at least one of these three "positive" symptoms: delusions, hallucinations, and disorganized speech.

- The DSM-IV TR subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) are eliminated due to their limited diagnostic stability, low reliability, and poor validity.

Highlights: Schizoaffective Disorder

- The primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder's total duration after Criterion A has been met.

- This change makes schizoaffective disorder a longitudinal instead of a cross-sectional diagnosis—more comparable to schizophrenia, bipolar disorder, and major depressive disorder, which are bridged by this condition.

Highlights: Delusional Disorder

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

- A specifier for bizarre type delusions provides continuity with DSM-IV TR.

- The demarcation of delusional disorder from psychotic variants of obsessive-compulsive disorder and body dysmorphic disorder is explicitly noted with a new exclusion criterion, which states that the symptoms must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs.

Highlights: Catatonia

- In DSM-5, all contexts require three catatonic symptoms (from a total of 12 characteristic symptoms).

- In DSM-5, catatonia may be diagnosed as a specifier for depressive, bipolar, and psychotic disorders; as a separate diagnosis in the context of another medical condition; or as an other specified diagnosis.

Highlights: Bipolar and Related Disorders

Bipolar Disorders

To enhance the accuracy of diagnosis and facilitate earlier detection in clinical settings, Criterion A for manic and hypomanic episodes now includes an emphasis on changes in activity and energy as well as mood.

The DSM-IV TR diagnosis of Bipolar I Disorder, mixed episode, requiring that the individual simultaneously meet full criteria for both mania and major depressive episode, has been removed. Instead, a new specifier, “with mixed features,” has been added that can be applied to episodes of mania or hypomania when depressive features are present, and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present.

Highlights: Bipolar and Related Disorders

Other Specified Bipolar and Related Disorder
DSM-5 allows the specification of particular conditions for other specified bipolar and related disorder, including categorization for individuals with a past history of a major depressive disorder who meet all criteria for hypomania except the duration criterion (i.e., at least 4 consecutive days).

A second condition constituting an other specified bipolar and related disorder is that too few symptoms of hypomania are present to meet criteria for the full bipolar II syndrome, although the duration is sufficient at 4 or more days.

Highlights: Anxious Distress Specifier

In the chapter on bipolar and related disorders and the chapter on depressive disorders, a specifier for anxious distress is delineated. This specifier is intended to identify patients with anxiety symptoms that are not part of the bipolar diagnostic criteria.

Highlights: Depressive Disorders

- To address concerns about potential over diagnosis and overtreatment of bipolar disorder in children, a new diagnosis, Disruptive Mood Dysregulation Disorder, is included for children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol.
- What was referred to as Dysthymia in DSM-IV TR now falls under the category of Persistent Depressive Disorder, which includes both chronic major depressive disorder and the previous dysthymic disorder.
- Premenstrual Dysphoric Disorder is now a distinct diagnosis in the Depressive Disorders chapter.

Criteria: New Disruptive Mood Dysregulation Disorder

A. Severe recurrent temper outbursts manifested verbally and/or behaviorally that are grossly out of proportion in intensity or duration to the situation or provocation.
B. The temper outbursts are inconsistent with developmental level.
C. The temper outbursts occur, on average, ≥ 3X per week.
D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and as observable by others.
E. Criteria A-D have been present for ≥12 mo. Throughout that time, the individual has not had a period ≥ 3 consecutive months without all of the symptoms in A-D.
F. Criteria A and D are present in at least two of three settings and are severe in at least one of these.
G. The diagnosis should not be made for the first time before age 6 or after age 18.

Criteria: Disruptive Mood Dysregulation Disorder (continued)

H. By history or observation, the age at onset of Criteria A-E is before 10 years.

I. There has never been a distinct period lasting more than one day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder.

K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

Disruptive Mood Dysregulation Disorder (296.99) Diagnostic Checklist

Check the box next to the following criteria that are present for this patient:

Yes	No	DSM-5 Diagnostic Criteria
☐	☐	A. Severe recurrent temper outbursts manifested verbally (e.g. verbal rages) and/or behaviorally (e.g. physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
☐	☐	B. The temper outbursts are inconsistent with developmental level.
☐	☐	C. The temper outbursts occur, on average, three or more times per week.
☐	☐	D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g. parents, teachers, peers).
☐	☐	E. Criteria A-D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A-D.
☐	☐	F. Criteria A and D are present in at least two of three settings (i.e. at home, at school, with peers) and are severe in at least one of these.
☐	☐	G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.
☐	☐	H. By history or observation, the age at onset of Criteria A-E is before 10 years.
☐	☐	I. There has never been a distinct period of time lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met. *Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.*
☐	☐	J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]). *NOTE: This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder. It can coexist with major depressive disorder, attention deficit/hyperactivity disorder, conduct disorder, and substance use disorders. Individuals who meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.*
☐	☐	K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

Highlights: Bereavement exclusion for Depression

In DSM-IV TR, there was an exclusion criterion for a major depressive episode that was applied to depressive symptoms lasting less than 2 months following the death of a loved one (i.e., the bereavement exclusion). This exclusion is omitted in DSM-5 to remove the implication that bereavement typically lasts only 2 months when clinicians recognize that the duration is more commonly 1–2 years.

Bereavement is recognized as a severe psychosocial stressor that can precipitate a major depressive episode in a vulnerable individual, generally beginning soon after the loss. Bereavement-related major depression is genetically influenced and is associated with similar personality characteristics, patterns of comorbidity, and risks of chronicity and/or recurrence as non–bereavement-related major depressive episodes.

The depressive symptoms associated with bereavement-related depression respond to the same psychosocial and medication treatments as non–bereavement-related depression.

Persistent Depressive Disorder [Dysthymia] (300.4) Diagnostic Checklist

Check the box next to the following criteria that are present for this patient:

Yes	No	DSM-5 Diagnostic Criteria
☐	☐	A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years. *NOTE: In children and adolescents, mood can be irritable and duration must be at least 1 year.*
☐	☐	B. Presence, while depressed of two (or more) of the following: ☐ 1. Poor appetite or overeating. ☐ 2. Insomnia of hypersomnia. ☐ 3. Low energy or fatigue. ☐ 4. Low self-esteem. ☐ 5. Poor concentration or difficulty making decisions. ☐ 6. Feelings of hopelessness.
☐	☐	C. During the 2 year period (or 1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.
☐	☐	D. Criteria for a major depressive disorder may be continuously present for 2 years.
☐	☐	E. There has never been a manic episode of a hypomanic episode, and criteria have never been met for cyclothymic disorder.
☐	☐	F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
☐	☐	G. The symptoms are not attributable to the physiological effects of a substance (e.g. a drug of abuse, a medication) or another medication condition (e.g. hypothyroidism).
☐	☐	H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if: With anxious distress With mixed features With melancholic features With atypical features With mood-congruent psychotic features With mood-incongruent psychotic features With peripartum onset	**Specify if:** With pure dysthymic syndrome With persistent major depressive episode With intermittent major depressive episodes, with current episode With intermittent major depressive episodes, without current episode
Specify if: In partial remission In full remission	**Specify if:** Mild, Moderate, Severe

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Highlights: Anxiety Disorders

- Panic Disorder and Agoraphobia are now unlinked in DSM-5 as many patients experience Agoraphobia without panic symptoms
- For Agoraphobia, Specific Phobia, and Social Anxiety Disorder (Social Phobia):
  - the 6 month duration criterion has been extended to all ages (formerly just individuals under age 18) to minimize over diagnosis of transient fears.
  - The anxiety must be out of proportion to the actual danger or threat, but the requirement that individuals over age 18 years recognize their anxiety as excessive or unreasonable has been eliminated.

Highlights: Anxiety Disorders (continued)

- Panic attack descriptors have changed to identify “unexpected and expected” panic attacks. Panic attacks function as a prognostic factor for severity of diagnosis, course, and comorbidity across many anxiety and other disorders, and thus can be listed as a specifier that is applicable to all DSM-5 disorders.
- Separation Anxiety Disorder and Selective Mutism now fall under the Anxiety Disorders chapter instead of the Disorders of Infancy, Childhood or Adolescence (this chapter has been eliminated).
- Age criteria for Separation Anxiety Disorder have been changed to allow onset after age 18, with a duration criterion added of “typically lasting 6 months or more”.

Highlights: Obsessive-Compulsive and Related Disorders

- A new chapter has been developed to include Obsessive-Compulsive Disorder along with four new disorders:
  - Hoarding Disorder
  - Excoriation Disorder (skin picking)
  - Substance-medication induced obsessive-compulsive and related disorder
  - Obsessive-compulsive and related disorder due to another medical condition
- Body Dysmorphic Disorder and Trichotillomania now fall under Obsessive-Compulsive and Related Disorders
- Insight specifiers have been refined to distinguish between levels of insight of patients with these disorders.

Highlights: Trauma- and Stressor- Related Disorders

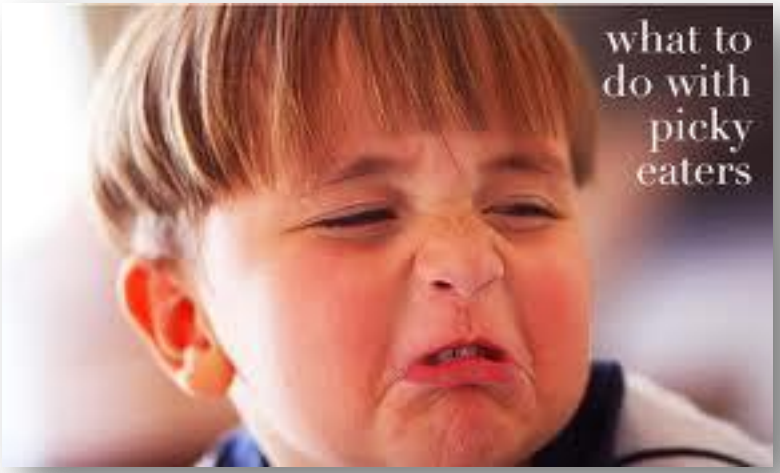
- A new chapter called Trauma- and Stressor- Related Disorders has been made which includes:
  - Reactive Attachment Disorder (emotionally withdrawn/inhibited)
  - New diagnosis of Disinhibited Social Engagement Disorder (formerly the indiscriminately social/disinhibited version of Reactive Attachment Disorder)
  - Posttraumatic Stress Disorder and Acute Stress Disorder (moved from the Anxiety Disorders Chapter)
  - Adjustment Disorders (formerly in a separate chapter)
- Acute Stress Disorder has a change in stressor criterion being explicit as to whether the traumatic event was experienced directly or indirectly, or witnessed

Highlights: Trauma- and Stressor- Related Disorders (continued)

- Posttraumatic Stress Disorder has also had changes in the stressor criterion being explicit as to whether the traumatic event was experienced directly or indirectly, or witnessed
- The criterion for subjective reaction is eliminated.
- There are now four symptom clusters instead of three because avoidance/numbing is divided into two clusters: avoidance and persistent negative emotional states.
- Arousal/reactivity cluster includes irritable or aggressive behavior and reckless/self-destructive behavior.
- Diagnostic thresholds lowered for children/adolescents and separate criteria for children ages 6 and younger.

Highlights: Somatic Symptom and Related Disorders

- DSM-5 has reduced the number of somatoform disorders and subcategories to avoid problematic overlap with medical conditions.
- Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed.
- Patients with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their anxiety symptoms are better explained by a primary anxiety disorder such as GAD).
- Patients formerly diagnosed with Pain Disorder may now be diagnosed with Somatic Symptom Disorder with predominant pain.


what to
do with
picky
eaters

Highlights: Feeding and Eating Disorders

- Criteria for Pica and Rumination Disorder have been revised for clarity and to indicate that diagnoses can be made for individuals of any age.
- The diagnosis “Feeding Disorder of Infancy or Early Childhood” has been renamed “Avoidant/Restrictive Food Intake Disorder” and criteria have been expanded.
- The requirement of amenorrhea has been eliminated from Anorexia Nervosa for several reasons (e.g. for males, females taking contraceptives)
- Binge Eating Disorder is a distinct diagnosis and binge eating criteria is at least once weekly for 3 months which is identical to criteria for Bulimia Nervosa.

Highlights: Disruptive, Impulse-Control and Conduct Disorders

- This is a new chapter for DSM-5 bringing together disorders that fell under two categories in DSM-IV (Disorders of Infancy, Childhood or Adolescence and Impulse-Control Disorders Not Otherwise Specified)
- These disorders are all characterized by problems in emotional and behavioral self-control.
- Because of the close association with Conduct Disorder, the diagnosis of Antisocial Personality Disorder now has a dual listing in this chapter and the Personality Disorder chapter.
- ADHD is frequently co-morbid with disorders in this chapter but is listed with neurodevelopmental disorders

Highlights: Disruptive, Impulse-Control and Conduct Disorders (continued)

- Four refinements are made for Oppositional Defiant Disorder criteria:
  - Symptoms are grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness
  - Exclusion criteria for conduct disorder have been removed
  - Because many typically developing children and adolescents have symptoms that fall under this diagnosis, a note has been added about frequency needed for a behavior to be symptomatic of the disorder
  - Severity rating has been added reflecting pervasiveness as an important indicator of severity
- A minimum age of 6 years has been set for Intermittent Explosive Disorder to distinguish from normal tantrums

Highlights: Substance-Related and Addictive Disorders

- New diagnosis of Gambling Disorder has been added, reflecting research that some behaviors such as gambling activate the brain reward system similar to drugs of abuse.
- Substance Abuse Disorders will no longer separate out "abuse" versus "dependence" as these disorders occur on a continuum. The categories are described as "substance use disorders" with criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders.
- New criterion of craving or strong desire or urge to use.
- Recurrent legal problems criterion has been deleted.

DSM-5 to ICD-9 Crosswalk for Psychiatric Disorders

- This crosswalk is designed to help providers match the DSM-5 and ICD-9 diagnosis codes which are used currently in billing. Under the Health Insurance Portability and Accessibility Act (HIPPA), insurance companies are only required to accept ICD-9 diagnosis. The descriptions in ICD 9 do not always match directly to descriptions in DSM 5, so options are provided below under ICD 9 Diagnosis Description to help providers choose the best match.
- Disorders chapters that not included in this crosswalk include Sleep-Wake Disorders, Sexual Dysfunction, Neurocognitive Disorders, Personality Disorders, Paraphilic Disorders, and Other Mental Disorders.

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Neurodevelopmental Disorders

Intellectual Disabilities

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
319 (no longer use 317, 318)	Intellectual Disability (Intellectual Developmental Disorder) -specify current severity of mild, moderate, severe, profound	319	Unspecified Intellectual Disabilities NO LONGER USE Mental Retardation
315.8	Global Developmental Delay	315.8	Other Specified Delays in Development
319	Unspecified Intellectual Disability	319	

Communication Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
315.39	Language Disorder	315.39	Other Developmental Speech Disorder
315.39	Speech Sound Disorder (previously Phonological Disorder)	315.39	Other Developmental Speech Disorder
315.35	Childhood Onset Fluency Disorder(Stuttering)	315.35	
315.39	Social (Pragmatic) Communication Disorder	315.39	Other Developmental Speech Disorder
307.9	Unspecified Communication Disorder	307.9	Other and Unspecified Special Symptoms or Syndromes, Not Elsewhere Classified

Autism Spectrum Disorder

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
299.00 (no longer use 299.80)	Autism Spectrum Disorder	299.00	NO LONGER USE Pervasive Developmental Disorder Not Otherwise Specified, Asperger's Disorder, Rett's Disorder, or Childhood Disintegrative Disorder

Attention-Deficit/Hyperactivity Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
314.01 314.00 314.01	Attention-Deficit/Hyperactivity Disorder -combined presentation -predominantly inattentive presentation -Predominantly hyperactive/ impulsive presentation		
314.01	Other Specified Attention-Deficit/Hyperactivity Disorder		
314.01	Unspecified Attention-Deficit Hyperactivity Disorder		

Specific Learning Disorder

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
315.00 315.2 315.1	Specific Learning Disorder -with impairment in reading -with impairment in written expression -with impairment in mathematics	315.00 315.2 315.1	Developmental Reading Disorder, Unspecified Written expression disorder Developmental Mathematics Disorder

Motor Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
315.4	Developmental Coordination Disorder	315.4	Motor skills developmental delay
307.3	Stereotypic Movement Disorder	307.3	
307.23	Tourette's Disorder	307.23	
307.22	Persistent (Chronic) Motor or Vocal Tic Disorder	307.22	Chronic Motor or Vocal Tic Disorder
307.21	Provisional Tic Disorder	307.21	Transient Tic Disorder
307.20	Other Specified Tic Disorder	307.20	Childhood Tic Disorder
307.20	Unspecified Tic Disorder	307.20	Childhood Tic Disorder

Other Neurodevelopmental Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
315.8	Other Specified Neurodevelopmental Disorder	315.8	Other Specified Delays in Development
315.9	Unspecified Neurodevelopmental Disorder	315.9	Unspecified Delay in Development

Schizophrenia Spectrum & Other Psychotic Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
301.22	Schizotypical Personality Disorder (also found in Personality Disorder chapter)	301.22	
297.1	Delusional Disorder	297.1	
298.8	Brief Psychotic Disorder	298.8	
295.40	Schizophreniform Disorder	295.40	
295.90	Schizophrenia	295.90	
295.70	Schizoaffective Disorder (specify Bipolar Type or Depressive Type)	295.70	
293.81 293.82	Psychotic Disorder Due to Another Medical Condition -with delusions -with hallucinations	293.81 293.82	
293.89	Catatonia Associated with Another Mental Disorder (Catatonia Specifier)	293.89	Catatonic disorder due to known physiological condition
293.89	Catatonic Disorder Due to Another Medical Condition	293.89	Catatonic disorder in conditions classified elsewhere
781.99 + 293.89	Unspecified Catatonia -code first 781.99 followed by 293.89	781.99 + 293.89	Catatonia Other Specified Transient Mental Disorders Due to Conditions Classified Elsewhere
298.8	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	298.8	Other and Unspecified Reactive Psychosis
298.9	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	298.9	Unspecified Psychosis

Bipolar and Related Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
296.XX (range from 296.41 to 296.56)	Bipolar I Disorder -see DSM 5 for specifiers for severity, manic or depressed, psychotic features, and remission status	296.XX	
296.89	Bipolar II Disorder	296.89	
301.13	Cyclothymic Disorder	301.13	
293.83	Bipolar and Related Disorder Due to Another Medication Condition	293.83	Mood Disorder Due to a General Medical Condition
296.89	Other Specified Bipolar and Related Disorder	296.89	Other and Unspecified Bipolar Disorders
296.80	Unspecified Bipolar and Related Disorder	296.80	Bipolar Disorder, Unspecified

Depressive Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
296.99	Disruptive Mood Dysregulation Disorder	296.99	Other Specified Episodic Mood Disorder
296.21-296.26	Major Depressive Disorder, Single and Recurrent Episodes	296.21-296.26	
300.4	Persistent Depressive Disorder (Dysthymia)	300.4	Dysthymic Disorder
625.4	Premenstrual Dysphoric Disorder	NOT IN CIS	NOT IN CIS
293.83	Depressive Disorder Due to Another Medical Condition	293.83	Mood Disorder Due to a General Medical Condition
311	Other Specified Depressive Disorder	311	Depressive Disorder, Not Elsewhere Classified
311	Unspecified Depressive Disorder	311	Depressive Disorder, Not Elsewhere Classified

Anxiety Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
309.21	Separation Anxiety Disorder	309.21	
313.23	Selective Mutism	313.23	
300.29	Specific Phobia -specify in note the phobic stimulus	300.29	
300.23	Social Anxiety Disorder (Social Phobia)	300.23	
300.01	Panic Disorder	300.01	
300.22	Agoraphobia	300.22	
300.02	Generalized Anxiety Disorder	300.02	
293.84	Anxiety Disorder Due to Another Medical Condition	293.84	Anxiety Disorder in Conditions Classified Elsewhere
300.09	Other Specified Anxiety Disorder	300.09	Other Anxiety States
300.0	Unspecified Anxiety Disorder	300.00	Anxiety State, Unspecified

Obsessive-Compulsive and Related Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
300.3	Obsessive-Compulsive Disorder	300.3	
300.7	Body Dysmorphic Disorder	300.7	
300.3	Hoarding Disorder	300.3	Obsessive-Compulsive Disorders
312.39	Trichotillomania (Hair-Pulling Disorder)	312.39	
698.4	Excoriation (Skin-Picking) Disorder	698.4	Excoriation, neurotic
294.8	Obsessive-Compulsive and Related Disorder Due to Another Medical Condition	294.8	Other Persistent Mental Disorders Due to Conditions Classified Elsewhere
300.3	Other Specified Obsessive-Compulsive and Related Disorder	300.3	Obsessive-Compulsive Disorders
300.3	Unspecified Obsessive-Compulsive and Related Disorder	300.3	Obsessive-Compulsive Disorders

Trauma- and Stressor- Related Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
313.89	Reactive Attachment Disorder	313.89	Reactive Attachment Disorder of infancy or early childhood, inhibited type
313.89	Disinhibited Social Engagement Disorder	313.89	Reactive Attachment Disorder of infancy or early childhood, disinhibited type
309.81	Posttraumatic Stress Disorder	309.81	
308.3	Acute Stress Disorder	308.3	
309.0 – 309.9	Adjustment Disorders	309.0 – 309.9	
309.89	Other Specified Trauma- and Stressor- Related Disorder	309.89	Other Specified Adjustment Reactions
309.9	Unspecified Trauma- and Stressor- Related Disorder	309.9	Unspecified Adjustment Reaction

Dissociative Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
300.14	Dissociative Identity Disorder	300.14	
300.12	Dissociative Amnesia	300.12	
300.6	Depersonalization/Derealization Disorder	300.6	
300.15	Other Specified Dissociative Disorder	300.15	Dissociative Disorder or Reaction, Unspecified
300.15	Unspecified Dissociative Disorder	300.15	Dissociative Disorder or Reaction, Unspecified

Somatic Symptom and Related Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
300.82	Somatic Symptom Disorder	300.82	Somatoform Disorder
300.7	Illness Anxiety Disorder	300.7	Hypochondriasis
300.11	Conversion Disorder (Functional Neurological Symptom Disorder)	300.11	
316	Psychological Factors Affecting Other Medical Conditions	316	
300.19	Factitious Disorder	300.19	
300.89	Other Specified Somatic Symptom and Related Disorder	300.89	Other Somatoform Disorders
300.82	Unspecified Somatic Symptom and Related Disorder	300.82	Undifferentiated Somatoform Disorder

Feeding and Eating Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
307.52	Pica	307.52	
307.53	Rumination Disorder	307.53	
307.59	Avoidant/Restrictive Food Intake Disorder	307.59	Other Disorders of Eating
307.1	Anorexia Nervosa	307.1	
307.51	Bulimia Nervosa	307.51	
307.51	Binge Eating Disorder	307.51	Compulsive overeating
307.59	Other Specified Feeding and Eating Disorder	307.59	Other Disorders of Eating
307.50	Unspecified Feeding and Eating Disorder	307.50	Eating Disorder, Unspecified

Elimination Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
307.6	Enuresis	307.6	
307.7	Encopresis	307.7	
788.39 787.60	Other Specified Elimination Disorders -with urinary symptoms -with fecal symptoms	788.39 787.60	Other Urinary Incontinence Incontinence of Feces
788.30 787.60	Unspecified Elimination Disorder -with urinary symptoms -with fecal symptoms	788.30 787.60	Incontinence of Urine Incontinence of Feces

Gender Dysphoria

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
302.6 302.85	Gender Dysphoria -in children -in adolescents and adults	302.6 302.85	Gender Identity Disorder of Childhood Gender Identity Disorder of Adolescent and Adulthood
302.6	Other Specified Gender Dysphoria	302.6	Gender Identity Disorder of Childhood
302.6	Unspecified Gender Dysphoria	302.6	Gender Identity Disorder of Childhood

Disruptive, Impulse-Control, and Conduct Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
313.81	Oppositional Defiant Disorder	313.81	
312.34	Intermittent Explosive Disorder	312.34	
312.81 312.82 312.89	Conduct Disorder -Childhood-onset -Adolescent onset -Unspecified onset	312.81 312.82 312.89	
301.7	Antisocial Personality Disorder	301.7	
312.33	Pyromania	312.33	
312.32	Kleptomania	312.32	
312.89	Other Specified Disruptive, Impulse-Control, and Conduct Disorder	312.89	Conduct Disorder of Unspecified Onset
312.9	Unspecified Disruptive, Impulse-Control, and Conduct Disorder	312.9	Unspecified Disturbance of Conduct

Substance-Related and Addictive Disorders (partial listing)

Alcohol-Related Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
	Alcohol Use Disorders		
305.00	-mild	305.00	Alcohol Abuse
303.90	-moderate or severe	303.90	Alcohol Dependence
291.9	Unspecified Alcohol-Related Disorder	291.9	Alcohol Related Disease or Syndrome

Cannabis-Related Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
	Cannabis Use Disorders		
305.20	-mild	305.20	Cannabis Abuse
304.30	-moderate or severe	304.30	Cannabis Dependence
292.9	Unspecified Cannabis-Related Disorder	292.9	Cannabis Related Disorder

Cannabis-Related Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
319 (no longer use 317, 318)	Intellectual Disability (Intellectual Developmental Disorder) -specify current severity of mild, moderate, severe, profound	319	Unspecified Intellectual Disabilities NO LONGER USE Mental Retardation
315.8	Global Developmental Delay	315.8	Other Specified Delays in Development
319	Unspecified Intellectual Disability	319	

Other (or Unknown) Substance-Related Disorders

DSM 5 Code	DSM 5 Diagnosis Description	ICD 9 Code	ICD 9 Diagnosis Description
305.90 304.90	Other or Unknown Substance Use Disorders -mild -moderate or severe	305.90 304.90	Other, Mixed, or Unspecified Drug Abuse Unspecified Drug Dependence
292.9	Unspecified Other (or Unknown) Substance-Related Disorder	292.9	Unspecified Drug-Induced Mental Disorder

See DSM-5 for additional substance-related and addictive disorders codes.

Diagnostic Code Changes: Insurance Implications

- The APA expects that it may take until end of 2013 for insurance companies to make changes in their forms and billing systems to adjust to DSM 5.
- This means that some insurance companies will still require providers to use the multi-axial diagnosis terminology when requesting authorization, even though it is no longer clinically relevant per DSM-5.

Diagnostic Code Changes: Documentation Implications- Approach at Seattle Children's Hospital

- The Psychiatry Department will be updating forms and templates in the next several months.
- 3M/Chartscript MD intake template will be updated soon to remove the multi-axial terminology.
- Providers should update the diagnosis/target symptoms of their notes in 3M to not carry-forward "old" diagnoses or terminology into future notes.
- Diagnostic checklists will be available on the Sharepoint under Patient Care folder, DSM 5 Roll-Out May 2013 sub-folder to help with the transition.

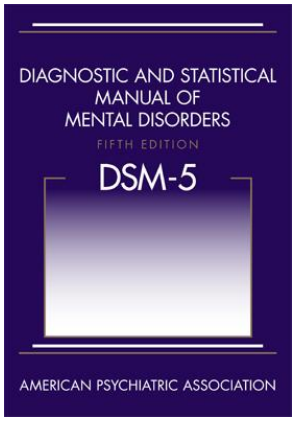
Diagnostic Code Changes: DSM 5 and ICD 9 interface

- All new and revised DSM 5 diagnoses had to be mapped to an existing ICD 9 code. So some disorders must ***share*** codes for recording and billing purposes.
- Because there may be several disorders associated with an DSM 5/ICD 9 code, the DSM 5 diagnosis description should always be recorded by name in the medical record **in addition to listing the code**.

SUMMARY
-Approach at Seattle Children's Hospital

- DSM 5 is now in effect and new criteria should be used in clinical practice. Desk reference manuals have been ordered for all outpatient psychiatry providers.
- We will no longer use the Multi-axial diagnosis. This language will be removed from 3M Templates and providers who dictate should stop using this format.
- Insurance companies and other payers may take several months to get caught up to changes. Only use old terminology if required by a payor.
- Use the DSM 5 – ICD 9 code crosswalk to help with correct coding in CIS for fee sheets.
- Use diagnostic checklists to help with fidelity during the diagnostic process.

A DSM-5 To-Do List
SUMMARY



- Acknowledge controversies
- Focus on evidence & goals
- Will require frequent communication among & some inservices
- Will require communication between departments, medical records, clinicians, etc.

NORTH STAR BHS - CME ACTIVITY COURSE EVALUATION FORM

- Date: 08/21/2013 Starting Time: 12:00 pm Ending Time: 1:00 pm
- Topic: **Overview of the DSM 5 Changes**
- Presenter(s): **Christopher K. Varley, MD – University of WA School of Medicine**

At the conclusion of this activity, participants should be able to:	**Not at All**	**Slightly**	**Moderately**	**Mostly**	**Completely**
Analyze and categorize the significant changes in the DSM 5 over the prior version.					
Cite the major current practice gaps.					
Organize an implementation strategy to revise the identified practice gaps in their practice.					

Was the presentation commercially biased in any manner? Yes [] No []

Based on this activity, what will you do differently in your practice? _____

Topics of Interest for future Seminars: _____

Printed Name of CME participant: _____ Physician Yes [ ] No [ ]

Signature of CME participant: _____

Agency/Organization: _____

Email: _____

Are you on our email distribution list? Yes [ ] No [ ]

If not – do you wish to be added for future CME events? Yes [ ] No [ ]