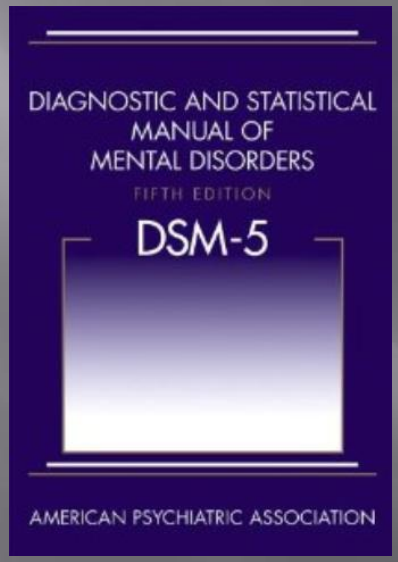
AN OVERVIEW OF DSM-5



Charles J. Vella, PhD
November 20, 2014

Thanks to Arden Dingle, Allen Frances, Steve Franklin
Shelly Justison, Kathleen McMullan, Aaron Norton, D. Black, & J. Grant

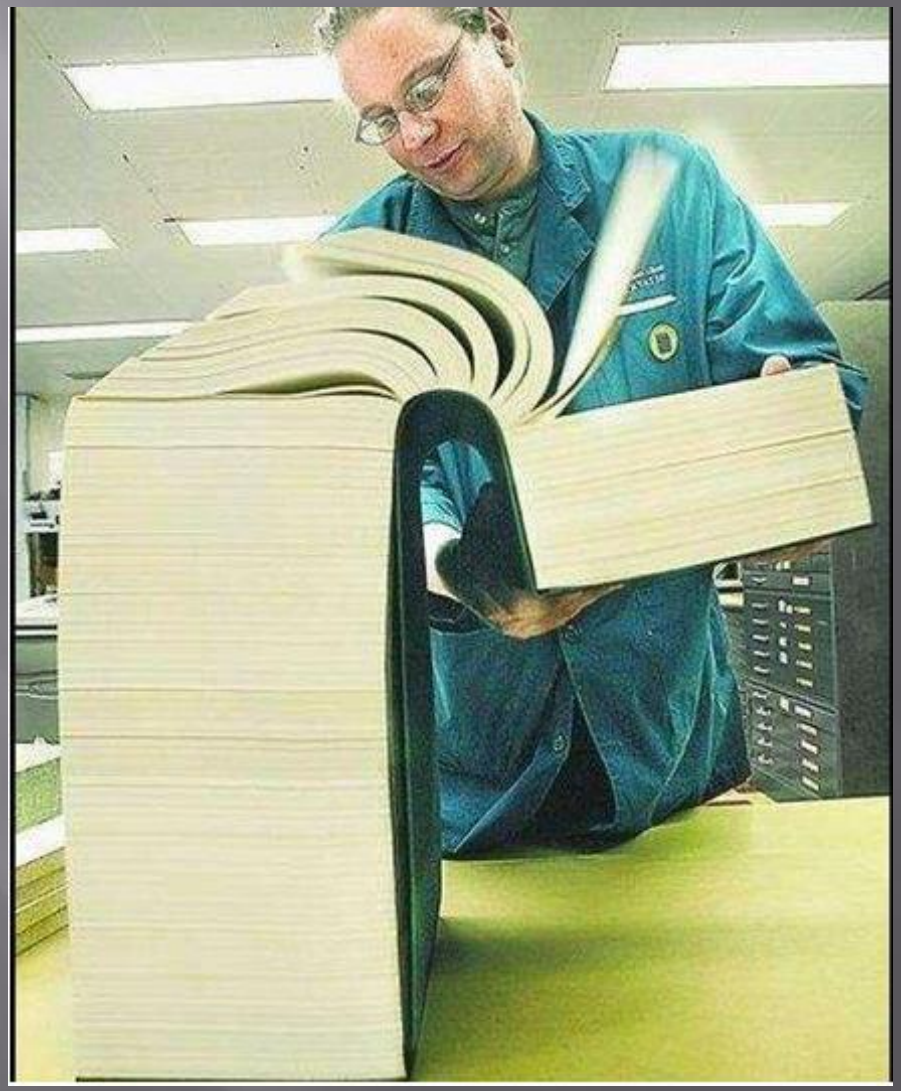
Complete Overview of DSM-5 PDF online

www.charlesjvellaphd.com

- Logon: Kaiser
- Password: Kaiser

Also there: History of San Francisco Psychiatry Dept.
Vella 2014 Pumpkins

Objective: Summary Overview of DSM-5



DSM-5 Overview: Impossible in 1 hour

- The DSM-5 was introduced in May 2013 with some significant changes from the DSM-IV-TR.

- This lecture: Highlight differences between the DSM-5 and the DSM-IV-TR

Learning Objectives

- List new categories of DSM-5 diagnoses
- Describe new DSM-5 disorders
- Learn which DSM-5 disorders have been eliminated or renamed
- Compare diagnostic criteria for disorders that have been modified from DSM-IV-TR to DSM-5

Time is limited: What I have left out

- Most full reviews of DSM-5 are 4-5 hours

- Have left out (but is in online version):
  - All diagnoses with no change
  - Most pediatric diagnoses
  - All diagnoses “Due to Another Medical Condition”
  - Substance/Medication-Induced Versions of Disorders

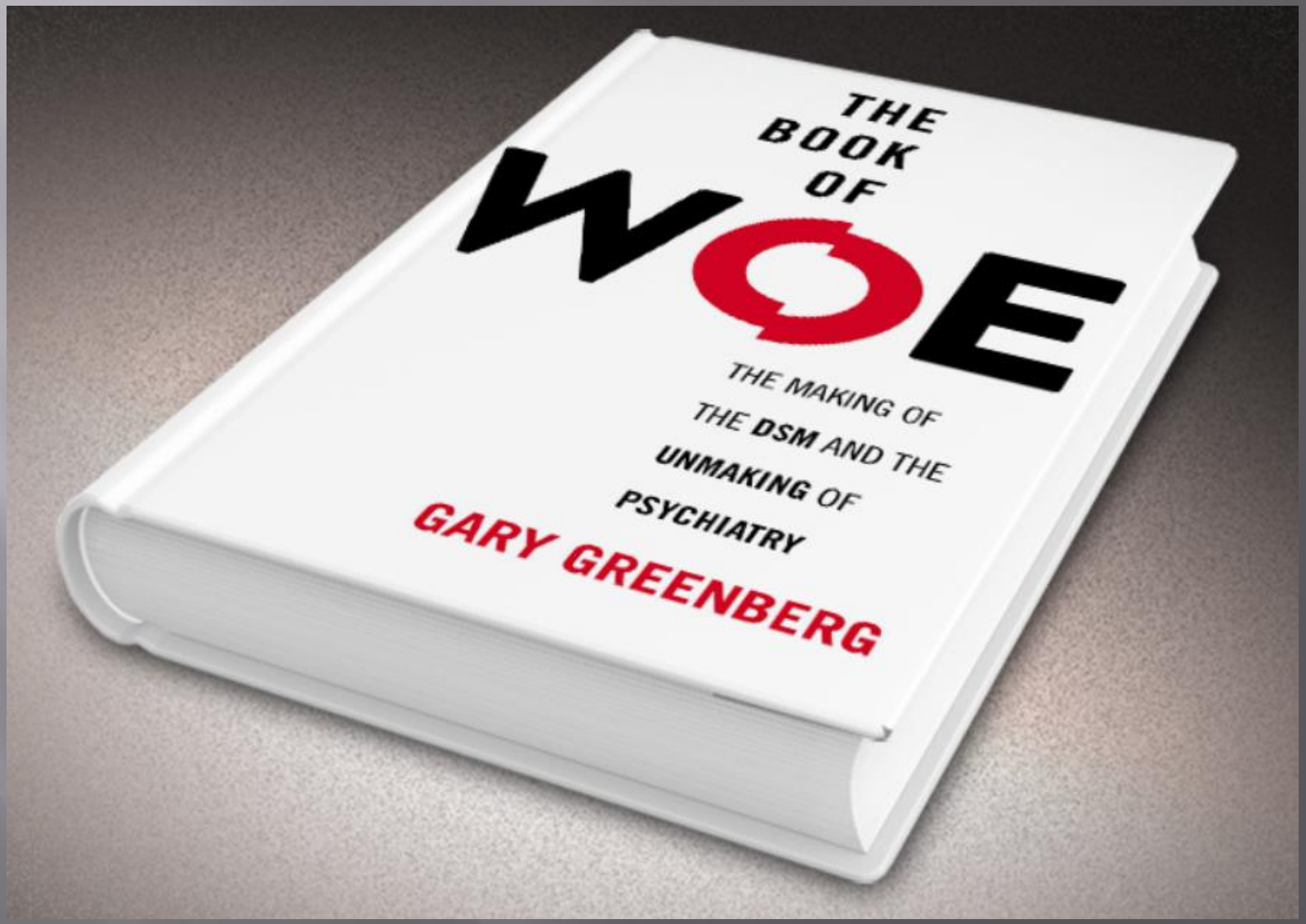
- Very fast; sorry, no questions

- All info is in Overview of DSM-5 pdf file (220 slides) on S drive or my site (330 slides)

DSM-5 Principles and Issues

- DSM-5: expert opinion backed by some research
- No biological markers or tests exist for any DSM-5 diagnosis (except for NCDs).
- Harmonization of text with ICD
- Reduction of use of old NOS specifier

Controversies



DSM-5: Controversy; some opinions

- Francis Allen (Chairman, DSM-IV): "Authoritarian Drug Delivery Manual That Unfairly Labels Ever More Unusual People"

- DSM-5: Diagnoses are still based on a consensus about clusters of clinical symptoms, not any objective laboratory/biological measures

- Problematic overlapping symptomology of its categorical method and near-universal co-morbidity

- **"Orwellian bilge"**

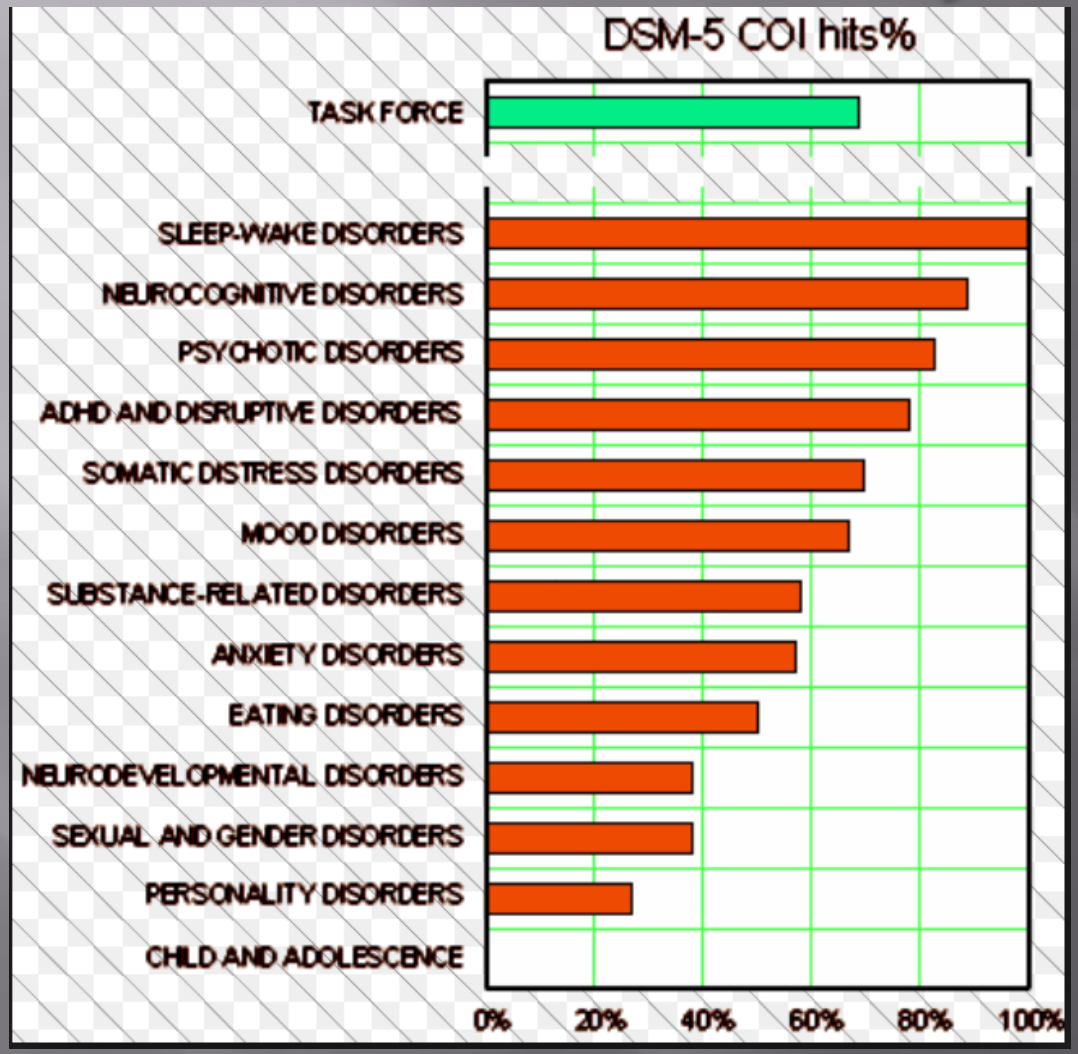
Real world rates unknown

- APA refused a request by 30 Mental Health Agencies for an independent scientific peer review.
- No study the impact of DSM on rates in real world settings.
- Many DSM-5 revisions or additions lack empirical support
- Test-retest reliability is low for many disorders (MDD, GAD)

Possibility of Overpathologization

- Possibility of "mission creep" in expansive diagnoses resulting in false positives and overuse of medication
- Except for autism, most of the DSM 5 changes loosen diagnoses; risk of diagnostic hyperinflation.
- Prevalence rates may increase because of thresholds for certain dxs (ADHD, M-NCD, DMDD) are too loose
- With more diagnosed pathology comes more medication

Conflict of Interest: Extensive connections between DSM-5 workgroup members and the pharmaceutical industry



APA responded that 72% had no connections.

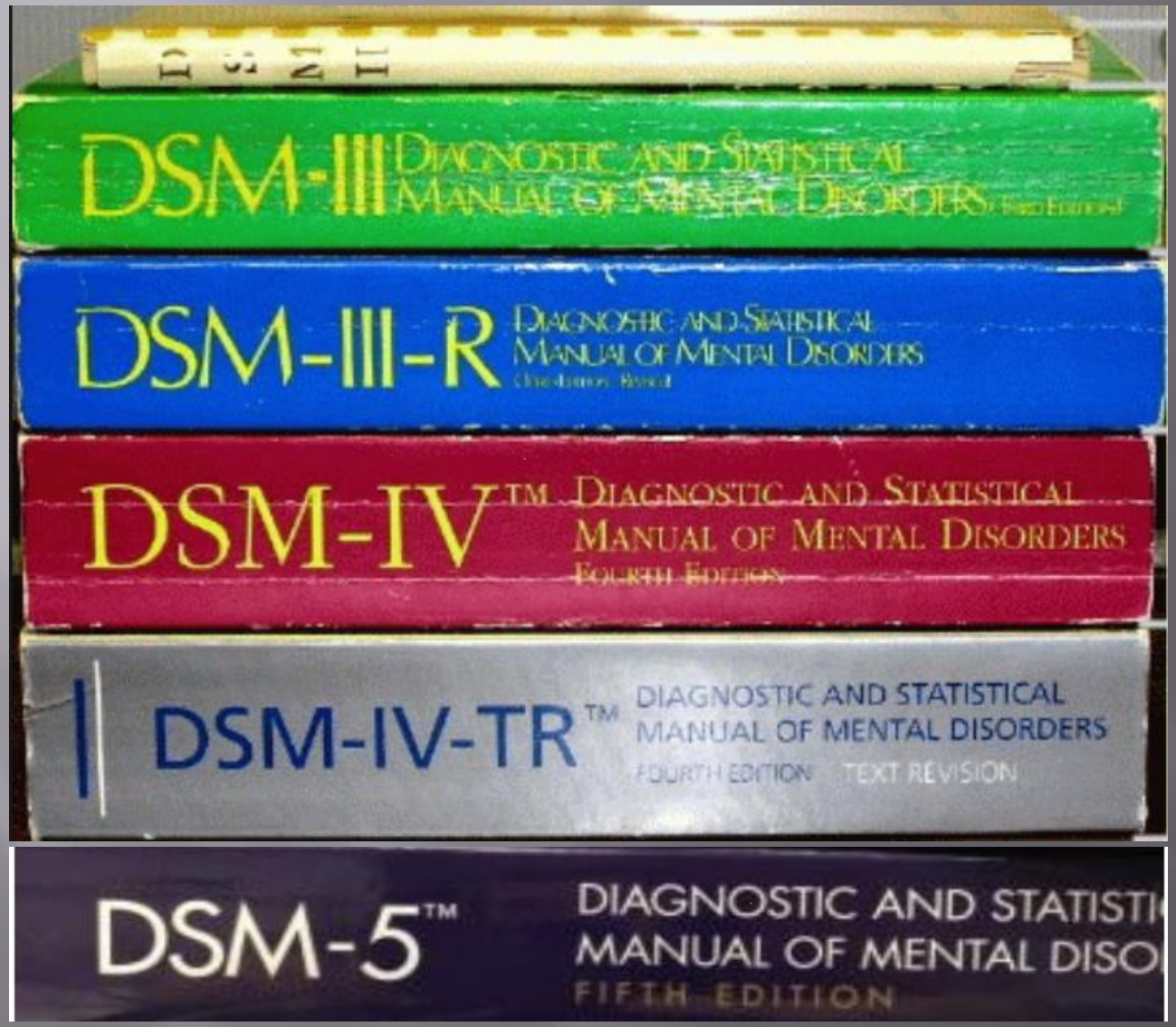
- L Cosgrove and S Krimsky, 2012

Biggest concerns

- Introduction of Autism Spectrum Disorder (& no more Asperger's)
- Removal of "bereavement exclusion" for MDD
- Disruptive Mood Dysregulation Disorder
- Attenuated psychosis syndrome (moved to S-III)
- Dimensional nature of Personality Disorders (moved to S-III)
- Despite criticisms, you are stuck with it given its universal usage for insurance coding in USA

Official US Coding is not DSM-5; it's ICD-9

- ICD-9-CM is the HIPAA-compliant code set for billing purposes in the USA
- Old DSM-IV coding numbers were ICD-9:
  - ###.## = 296.22 (Major Depression, Moderate)
- DSM-5 coding will be ICD-10: Letter + ##.# (F32.1) in grey
- DSM-5 lists both ICD-9-CM and ICD-10-CM codes alongside the diagnostic names: 296.22 (F32.1)
- DSM-IV/ICD-9 codes disappear in Oct., 2015; only F32.1; then rest of world converts to ICD-11
- ICD names listed in () on my slides



1952: DSM-I
1968: DSM-II

1980: DSM-III

1987: DSM-III-R

1994: DSM-IV

2000: DSM-IVTR

2013: DSM-5

7 Versions in 62 years; 14 years since last

A Short History of the DSM

- The DSM-1 (1952), 106 disorders, 132 pp, psychodynamic perspective on etiology
- DSM II (1968), 182 disorders, 134 pp, lacked specification of specific symptoms of many disorders
- DSM-III (1980) and DSM-III-R (1987), 265/292 disorders, 494/567 pp, which focused on standardization of diagnostic categories by linking them to specific criteria or symptom clusters; Multiaxial classification system.
- DSM-IV (1994) and DSM-IV-TR (2000), 297 disorders, 886 pp, relatively minor changes
- DSM-5 (2013): 157 disorders (+65 other & unspecified), 947 pp

Why?

- A shared vocabulary: A help to assessment of patients, not just labeling
- Efficient evaluations
- Summarized knowledge of different disorders
- Atheoretical descriptor from an etiological standpoint; not from biological, genetic marker description: i.e. not why schizophrenia, just sxs
- DSM-5 gives no treatment guidelines; but clearly starts process
- Focus on Psychiatric orientation; no neuropsychological deficits i.e. psychosis in schizophrenia, not its cognitive deficits which predict outcome

Arabic 5 instead of Roman V

- DSM-5 (not -V): allows for revision numbering

- Cost:
  - *DSM-5*: $103 paperback on Amazon (but used already for $33)
  - Check for correct # codes before purchase
  - *Desk Reference*: $18

Order of Chapters

- DSM-5's 22 chapters (19 major diagnoses) restructured based on disorders' apparent relatedness to one another, as reflected by similarities in disorders' underlying vulnerabilities and symptom characteristics.

- DSM-5 arranged to align with ICD-11

3 Sections + Appendix

- Section I – Basics: intro, how to use manual
- II – Diagnostic Criteria & Codes:
  - 22 categorical sections with diagnostic criteria
- III – Emerging Measures & Models:
  - assessment tools,
  - cultural formulation,
  - dimensional model of Personality Disorders,
  - further study psych. conditions
- Appendix: Summary of changes from DSM-IV, 2 glossaries, tables of diagnoses

Section II (22 chapters, 19 diagnostic classes): Grouping of Diagnostic Categories

(** = double red asterisks = new dx)

1. Neurodevelopmental disorders **
2. Schizophrenia and primary psychotic disorders
3. Bipolar and Related Disorders **
4. Depressive Disorders **
5. Anxiety Disorders
6. Obsessive Compulsive Spectrum **
7. Trauma- & Stressor- Related Disorders **
8. Dissociative Disorders

Section II

9. Somatic Symptom & Related Disorders
10. Feeding & Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria **
15. Disruptive, Impulse-Control, & Conduct Disorders

Section 2

16. Substance-Related & Addictive Disorders **
17. Neurocognitive Disorders **
18. Personality Disorders
19. Paraphilic Disorders
20. Other Mental Disorders
21. Medication-Induced Movement Disorders & other Adverse Effects of Medication
22. Other Conditions That May Be a Focus of Clinical Attention

Category 22: Other Conditions (Old Axis IV; V codes; new Z codes):

- Relational Problems
- Abuse and Neglect
- Educational & Occupational Problems
- Housing & Economic Problems
- Other Problems related to Social Environment
- Problems Related to Crime or Interaction with Legal System
- Other Health Service Encounters
- Problems Related to Other Psychosocial, Personal, and Environmental Circumstances
- Other Circumstances of Personal History

Section III Disorders: More Research needed for 8 diagnoses

- Attenuated psychosis syndrome
- Depressive episodes with short-duration hypomania
- Persistent complex bereavement disorder
- Internet gaming disorder
- Caffeine use disorder
- Neurobehavioral disorder associated with prenatal alcohol exposure
- Suicidal behavioral disorder
- Non-suicidal self-injury

- Section 3 disorders generally won't be reimbursed by insurance companies for treatment, since they are still undergoing research and revision to their criteria.

DSM-5 Information Layout for Each Diagnosis

- Diagnostic features
- Recording procedures
- Subtypes/specifiers
- Associated features supporting diagnosis
- Prevalence
- Development and course
- Risk and prognostic factors
- Culture-related diagnostic issues
- Gender-related diagnostic issues
- Diagnostic markers
- Suicide risk
- Functional consequences
- Differential diagnosis
- Comorbidity

Charlie's Recommendations

- Read DSM-5 diagnoses that you diagnose the most; most clinicians only do 1st impression dx, not criteria list
- Use *DSM-5 Guidebook* for fast lookup
- Best searchable tool: *DSM-5 Diagnostic Criteria Mobile App* by APA ($70) app for iPad
- Best critical and reasonable approach: *The Intelligent Clinician's Guide to the DSM-5* by Joel *Paris*

Most Significant Changes

- Added new disorders (** or * on my screens)
- Changed diagnostic criteria for many disorders
- Added many new specifiers and subgroups
- Deleted some disorders and subtypes

DSM-5 Shifts

- Depathologization (i.e. Paraphilias vs. Paraphilic Disorders)
- More Developmental Perspective
- More Dimensional Perspective
- Cultural & Gender Awareness
- Wanted to reduce NOS designation
- Cut back on number of disorders per individual by use of specifiers

Most Significant Changes

- Free downloadable diagnostic measurement tools (section III)
- Change in chapters focusing on relatedness of diagnoses (i.e. schizophrenia & bipolar)
- Move toward a "living" document with more frequent updates
- Attempt to make it evidence based

Developmental Perspective

- Within each diagnostic class, disorders arranged so that those typically diagnosed in childhood listed first.
- No more: "Disorders usually first diagnosed in infancy, childhood, or adolescence" section; Many more diagnoses with both child and adult version
- Instead developmental adjustments (child vs. adult) added to criteria
- The "Development and Course" section for each disorder reflects a lifespan approach

Dimensional Approach

- DSM-5 is shifting toward a more dimensional approach, not just categorization
- Many disorders are dimensional not just categorical: "How much" vs. "yes or no"; severity ratings
- Failed where needed most: Overly complex attempt at dimensional assessment of Personality Disorders; put in Section III

Spectrum emphasis

- Disorders in several groups are structured or discussed as spectrum disorders based on known causes
  - Autism Spectrum: 3 levels of severity
  - Schizophrenia Spectrum and Other Psychotic Disorders
  - Trauma- and Stressor-Related Disorders
  - Mild and Major Neurocognitive Disorders
- Diagnoses that are related are placed close together, i.e. bipolar follows schizophrenia, dissociation & somatic disorders
- Addition of severity specifiers: Mild, Moderate, Severe

Beware Textual & Coding Errors

- Errors in ~ 20 code numbers
  - i.e. Intellectual disability is 317, not 319
  - See www.DSM5.org for corrections & print out corrections

- i.e. Pedophilia is not an “orientation”: should read “sexual interest.”

Multiaxial System Gone: Use Z codes

- No more multiaxial system (& no more axis II PDs)
- Replaces old I-III with
  - Nonaxial listing of diagnoses in sequential listing
  - and old IV problem list with ICD-9 V or ICD-10 Z codes
- Reasons:
  - Axis 1 vs. Axis II
  - Axis III inconsistently used
  - Axis V unreliable and arbitrary

No more GAF

- No more GAF (1-100) disability rating (formerly Axis V):
  - Replaced with optional separate severity and disability/level of function measures for individual disorders (Sect III).

- Option: World Health Organization's Disability Assessment Schedule (WHODAS) – WHO Disability Scale available in assessment section
  - 6 disability rating domains (client's perspective)

No more NOS: now Unspecified Disorder

- No more NOS (Not otherwise specified);
- Now use either of 2 new specifiers placed ahead of diagnosis:
  - "Other specified" disorder: if you state reason why full criteria not met, i.e. insufficient sxs, duration not met
    - Other Specified Depressive Disorder 311 (F32.8), does not meet duration criteria
  - "Unspecified" disorder: if clinician does not provide reason
    - Unspecified Personality Disorder 301.9 (F60.9)

Sample: DSM-IV vs. DSM-5

	DSM-IV		DSV-5	
Axis I	299.80	Pervasive Developmental Disorder- Not Otherwise Specified	315.39	Social (Pragmatic) Communication Disorder
	314.01	Attention Deficit/ Hyperactivity Disorder, Combined Type (Provisional)	314.01	Attention Deficit/Hyperactivity Disorder, Combined (Provisional)
	315.31	Expressive Language Disorder (Provisional)		
Axis II	none			
Axis III	none			
Axis IV		interpersonal difficulties		
Axis V	GAF = 65			

Sample: DSM-IV vs. DSM-5

	DSM-IV		DSM-5	
Axis I	295.30	Schizophrenia, Paranoid Type	295.90	Schizophrenia
Axis II	301.20	Schizoid Personality Disorder (premorbid)	301.20	Schizoid Personality Disorder (premorbid)
Axis III		None reported		
Axis IV		Unemployment, inadequate social support		
Axis V	GAF = 30 (current)			

Obvious Changes in DSM-5

- All diagnoses require presence of distress or impairment (not just presence of abnormality)
- Many more new specifiers (unique features); written after dx name, i.e.:
  - Conduct disorder, with limited prosocial emotions
  - Bipolar, with anxious distress
- Provisional dx (follows dx in (provisional); if not enough info available
- Exclusions, i.e. not due to substance abuse

Recording DSM-5 Diagnoses

- 2 types of subtypes:
  - Diagnosis specific, that are mutually exclusive (specify type)
  - Schizophrenia, First episode, currently in acute episode
  - vs. Schizophrenia, Multiple episodes, currently in acute episode
  - Specifiers are not mutually exclusive
  - with anxious distress,
  - with seasonal pattern, etc.

Recording DSM-5 Diagnoses

- Multiple diagnoses OK; on separate lines
- Rank order according to importance (add "(principal diagnosis" or "(reason for visit)" following the primary diagnosis)
  - Outpatient: reason for visit; also main focus of TX
  - Inpatient: principal dx; reason for admission
- Replaces ".x" (4, 5, 6th digit)
  - with subtype
    - Bipolar I, 296.41 (F31.11), Mild with rapid cycling
  - or level of severity
    - Intellectual Disability, 317 (F70), Mild

If Diagnostic Uncertainty: Read online

- Clinician can utilize:
  - Specific Diagnosis ”(provisional)” following dx
  - “Unspecified” diagnosis preferred rather than a deferred diagnosis, if clinically indicated.
  - 799.9 (deferred)
  - 300.9 (F99) Unspecified mental disorder (not psychotic, otherwise unclear)
  - 298.9 (F29) Unspecified Schizophrenia spectrum (psychotic, otherwise unclear)
  - V/Z-codes (insufficient info)
  - If a mental disorder is not present, V71.09 can be used.

Substance/Medication-Induced Versions of Disorder

- Almost every disorder has a Substance/Medication-Induced Version of Disorder
- Disorder Sxs present
- Evidence (hx, PE, lab):
  - Sxs developed during/soon after substance intoxication/withdrawal, medication exposure
  - Substance/medication capable of producing sx
- Code: with or without use disorder

AMC not GMC: Disorder due to Another Medical Disorder

- Now “Another Medical Condition“; No more "General Medical Condition”

- Before a dx can be made, medical condition must be excluded as causative. All psych disorders are medical in DSM-5.

- Disorder symptoms

- Evidence (hx, PE, lab):
  - Direct pathophysiological consequence of another medical condition

- Code: with or without use disorder

The (Dearly?)Departed:
Dropped or Consolidated Diagnoses

- **Somatization Disorder** (gone)
- **Amnestic Disorders** (now a feature of neurocognitive disorders)
- **Dissociative Fugue** (now a subtype of dissociative amnesia)
- **Pain Disorder** (gone)
- **Hypochondriasis** (cases now divided between Somatic Symptom Disorder and Illness Anxiety Disorder)
- **Asperger's Disorder** (gone; ASD)
- **Childhood Disintegrative Disorder** (gone: ASD)
- **Pervasive Developmental Disorder NOS** (gone; ASD)
- **Vaginismus and Dyspareunia** (now Genito-Pelvic Pain/Penetration Disorder)
- **Gender Identity Disorder** (now Gender Dysphoria)
- **Sexual Aversion Disorder** (gone)
- **Polysubstance-Related Disorder (gone)**

Graduation Day:
Moving On Up (and out of the Appendix)

- Newly included Diagnoses
  - Binge Eating Disorder
  - Premenstrual Dysphoric Mood Disorder
  - Mild Neurocognitive Disorder
  - Caffeine Withdrawal
  - Factitious Disorder by Proxy (now Factitious disorder imposed on another)

New Kids on the Block: 20 New Diagnoses

- Global Developmental Delay
- Disruptive Mood Dysregulation Disorder (DMDD)
- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Hoarding Disorder
- Excoriation (Skin-Picking Disorder)
- Disinhibited Social Engagement Disorder
- Avoidant/Restrictive Food Intake Disorder
- Social (Pragmatic) Communication Disorder
- Restless Leg Syndrome

New Kids on the Block:
New Diagnoses 2

- Premenstrual Dysphoric Disorder
- Binge Eating Disorder
- Rapid Eye Movement Sleep Behavior Disorder
- Central Sleep Apnea
- Sleep-Related Hypoventilation
- Restless Legs Syndrome
- Caffeine Withdrawal
- Caffeine Withdrawal
- Cannabis Withdrawal
- Major and Mild Neurocognitive Disorder

My Designation for Changes

- RN = diagnoses renamed - *
- ND = new diagnosis - **
- DCM = diagnostic criteria modified
- DC = diagnoses combined
- SS = Severity & feature specifiers added

Neurodevelopmental Disorders **

A: Manifest in early development

B: Characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning

Neurodevelopmental

- Chapter is reformulation of DSM-IV "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence"

- DSM-5 Increasing emphases on:
  - neurobiological bases of mental disorders
  - developing understanding that abnormal brain development underlies many types of disorders

Intellectual Disability * (Intellectual Developmental Disorder)

- RN; DCM
- No more “Mental retardation"
- Now: “Intellectual Disability (Intellectual Developmental Disorder).“
- ICD compliant and a federal statue in the United States (Public Law 111-256, Rosa’s Law) replaces the term “mental retardation” with intellectual disability.
- Decreased emphasis on IQ (old only <70 IQ criteria); increased emphasis on adaptive function
- Criteria
  - A. Deficits in intellectual functioning (must do IQ)
  - B. Deficits in adaptive functioning
  - C. Onset during developmental period
  - Severity level determined by adaptive functioning (not IQ);
    - Mild, Moderate, Severe, Profound (based on deficits in conceptual, social, practical domains)

Childhood-Onset Fluency Disorder * (Stuttering)

- RN; DCM

- Old = Stuttering
- Criteria:
  - A. Disturbance of in normal fluency and time patterning of speech that causes anxiety about speaking or limits effective communication, social participation, etc.
  - B. Causes anxiety
  - C. Onset in early development period
  - If later onset = Adult-onset Fluency Disorder

Social (Pragmatic) Communication Disorder **

- New Diagnosis
- Criteria:
  - A. Persistent difficulties in social use of verbal and nonverbal communication
  - B. Limit effective communication, social participation, acad. achievement, etc.
  - There are no repetitive patterns or restricted interests i.e. do not meet criteria for ASD
    - Not quite ASD, but ok except for social
    - Replaces PDD, NOS
  - C. Onset in early development period

Autism Spectrum Disorder
Communication Disorder **

- RN; DC;DCM
- Core dx stayed same

- 4 previously separate disorders are now a single condition with different levels of symptom severity in two core areas
- No more:
  - Autistic Disorder
  - Asperger's Disorder (no more)
  - Pervasive Developmental Disorder NOS
  - Childhood Disintegrative Disorder
  - Rett's Disorder (now neurological disorder)

Autism Spectrum Disorder Communication Disorder ** 2

- ASD Criteria:
  - A - Deficits in reciprocal social communication and interaction across multiple contexts
  - B - Restricted repetitive pattern of behavior, interests, & activities
  - C - In early developmental period

- Severity: (Level 1 (least) to 3 (most severe): how much support needed; level of intervention)
- Specifiers: with Intellectual impairment, language impairment, etc.

How Will DSM-5 Affect Autism Diagnosis? A Systematic Literature Review and Meta-analysis

- DSM-5 ASD comparison effects:
- 2013 study found a statistically significant :
  - decrease in ASD diagnosis of 31 percent using the new manual, DSM-5, vs DSM-IV-TR
  - decrease in ASD diagnosis of 22 percent, vs. DSM-IV
  - decrease of 70 percent in diagnosis of PDD-NOS

- Latest CDC stats: ASD = 1 in 68 children; 5 times more common among boys (1 in 42) than among girls (1 in 189).

Kristine M. Kulage, et al., 2013

Attention-Deficit/Hyperactivity Disorder

- DCM; severity specifiers
- Core dx stays same; across lifespan
- Criteria:
  - A. Inattention and/or Hyperactivity-impulsivity, # of sxs:
    - Children: same "Big 18": Minimum of 6 sxs of 9 inattention and/or 6 symptoms of 9 hyperactivity-impulsivity for children (more examples given)
    - Adult (17+): 5 sxs of inattention and/or 5 sxs of hyperactivity-impulsivity
  - B. Age of Onset: Onset prior to age 12 (not 7)
  - C. Cross-situational requirement increased to "several" sxs in 2 or more settings
- Specifiers for 3 types (no more subtypes): combined, inattentive, hyperactive/impulsive
- Code for severity (based on # of sxs) or remission
- Can diagnose with ASD

Specific Learning Disorder *

- RN, DC, DCM; specifiers
- No more:
  - Reading Disorder
  - Mathematics Disorder
  - Disorder of Written Expression
  - Learning Disorder NOS
- Criteria: A. 1 specific learning deficit for 6 months despite intervention, B. with sxs causing deficits in academic skills that are below what is expected for individual's chronological age and D. cannot be accounted for by intellectual disability, inadequate education, etc.
- Specify: reading, math, writing, etc.
- Severity: level of intervention needed
- Downplay older neurological terms (dyslexia, dyscalculia, etc.)
- Discrepancy from IQ formula no longer used

Many Motor Disorders

- The following motor disorders are included in the DSM-5 neurodevelopmental disorders chapter:
  - Developmental coordination disorder,
  - Stereotypic movement disorder,
  - Tourette's disorder,
  - Persistent (chronic) motor or vocal tic disorder,
  - Provisional tic disorder,
  - Other specified tic disorder,
  - Unspecified tic disorder.
  - Other or Unspecified Neurodevelopmental disorder
- The tic criteria have been standardized across all of these disorders in this chapter; no more maximum tic-free interval

Schizophrenia Spectrum and Other Psychotic Disorders

Abnormalities in 1 of 5 specified psychotic sxs:

- delusions,
- hallucinations,
- disorganized thinking,
- grossly disorganized or abnormal motor behavior,
- negative symptoms

Psychotic Spectrum

- Psychotic disorders are moving toward a thought disorder spectrum conception: arranged from least to most severe:
  - Schizotypal Personality Disorder
  - Delusional Disorder
  - Brief Psychotic Disorder
  - Schizophreniform
  - Schizophrenia
  - Schizoaffective Disorder
  - Catatonia

Schizotypal (Personality) Disorder

- Schizotypal Personality Disorder moved to this category
- Criteria listed in Personality Disorders Section
- Close relationship with schizophrenia

Delusional Disorder

- DCM; specifiers
- Criterion A no longer has the requirement that the delusions be non-bizarre. Use specifier if delusions are bizarre

- A. ≥ 1 delusion ≥ 1 month (can be bizarre ((implausible, not understandable, not from ordinary life))
- C. Adequate functioning/not bizarre
- Specify 1 of 7 types of delusion (erotomanic, grandiose, jealous, persecutory, etc. or with bizarre content)

- New exclusion criterion: These trump this dx: obsessive-compulsive or body dysmorphic disorder with absent insight or delusional beliefs.

- No more Shared psychotic Disorder

Schizophrenia

- DCM, course specifiers
  - All subtypes of schizophrenia were eliminated (no more paranoid, disorganized, catatonic, undifferentiated, and residual).[2]
  - Elimination of special attribution of certain symptoms (e.g., bizarre delusions, voices talking to each other) (under old = Crit A met)
- Criteria:
  - A. New symptom threshold: 2 or more of 5 specified sxs
    - with 1 "positive" sx: delusions, hallucinations or disorganized speech
  - B. Impaired functioning
  - C. Continuous signs of disturbance for 6 months & active-phase sxs have been present for significant portion of time during a 1 month period
- Dimensional approach to rating of Psychosis Symptom Severity is included in Section III (0-5 rating of 8 sxs); but not required; but this is only mention of impaired cognition in non NCD dxs
- 10 specifiers, esp. for progression course (1st, multiple, continuous, etc.)

Schizoaffective Disorder

- DCM, no subtypes; course specifiers
- Meets both schizophrenia and mood disorder criteria
- The primary change to schizoaffective disorder is that a major mood episode be present for the majority of the disorder's total duration after criterion A has been met; not just current episode
- Criteria (more longitudinal):
  - A. Uninterrupted period of illness involves a major mood episode concurrent with Crit A sxs of schizophrenia
  - B. Presence of delusions & hallucinations without prominent mood symptoms for at least 2 weeks during lifetime
  - C. Major mood episode present for majority of total duration of illness
- Specify: Bipolar type or Depression type, with catatonia, course

Catatonia Specifier

- Catatonia can be used as a specifier for all appropriate DSM-5 diagnoses or as separate diagnosis
- Criteria for catatonia are same regardless of the context in which it is used as a specifier (Schizophrenia, Bipolar Disorders, Depressive Disorders, or Other Medical Condition).
- Criteria A. Need 3 or more of 12 sxs: stupor, catalepsy, waxy flexibility, mutism, negativism, posturing, mannerism, stereotypy, agitation, grimacing, echolalia, echopraxia
- When etiology unknown: diagnose as Other Specified Catatonic Disorder

Catatonic Disorder Due to Another Medical Condition **

- New diagnosis
- Catatonia can be due to variety of diagnoses
- Criteria:
  - A. 3 or more of 12 specified sxs that are due to a medical condition
  - B. Caused by another medical condition (include in code)
  - D. Not during course of a delirium

Bipolar and Related Disorders **

Bipolar is now a free standing category

Taken out of the mood disorder category

Bridge between Schizophrenia & Depressive Disorders

Manic Episode

- Criterion A: Hallmark, primary criterion for mania and hypomania changed: is "persistently increased energy and activity" as well as altered elevated mood.
- Abnormal Mood: Distinct period of abnormal & persistently elevated, expansive or irritable mood
- A. Increased energy & activity: Abnormally & persistently increased goal directed activity
- A. ≥ 1 week, most of the day, nearly every day (any duration if hospitalized)
- B. ≥ 3 sxs (4 if irritable)
  - Grandiosity, less sleep, talkative, racing thoughts, distractibility, goal directed behavior, high risk behavior
- C. Impairment

Hypomanic Episode

- A. Increased energy & activity: Abnormally & persistently increased goal directed activity
- A. Abnormal Mood: Distinct period of abnormal & persistently elevated, expansive or irritable mood
- A. ≥ 4 days, most of the day, nearly every day (any duration if hospitalized)
- B. ≥ 3 sxs (4 if irritable)
  - Grandiosity, less sleep, talkative, racing thoughts, distractibility, goal directed behavior, high risk behavior
- C. Change in function, observable by others

Major Depressive Episode

- A. ≥ 5 sxs, same 2 week period, change in functioning
  - ≥ 1 = depressed mood, loss of interest/pleasure
  - Depressed Mood (kids = irritability), loss of interest/pleasure, weight loss (kids = failure to gain), sleep changes, agitation/retardation, fatigue, worthlessness/guilt, poor concentration, death/suicide thts
- B. Distress/impairment

- NEW: Can diagnosis in presence of major stressors, bereavement, disaster, illness, disability, etc.

- Poorer test-retest reliability (.32 kappa)
- For old Mood Disorder NOS: use Unspecified Depressive Disorder

With mixed features specifier

- Mixed Episode redefined.
-
- Mixed Anxiety-Depressive Disorder eliminated due to very poor inter-rater reliability.
- A “mixed state specifier” is added.
- Specifier "with mixed features" can be applied to bipolar I disorder, bipolar II disorder, and MDD.
- With mixed features specifier:
  - If primary diagnosis is depression, need presence of at least 3 symptoms of mania or hypomania that do not overlap with depressive symptoms.
  - If primary diagnosis is mania, need only 3 symptoms of depression that do not overlap.

Anxious distress in MDD or Bipolar

- An "anxious distress" modifier for bipolar disorder and depressive disorders added.
- Identifies pts with anxiety sxs that are not part of bipolar diagnostic criteria
- Research: Predicts outcome and suicide risk.

Extension of Postpartum Onset Modifier

Postpartum Onset Modifier can be used when episode has onset within 6 months postpartum

"With Postpartum Onset" modifier can be applied to:

- Major Depressive episode
- Manic episode
- Mixed Features
- Brief Psychotic Disorder

Bipolar I Disorder

- DCM; severity, course, feature specifiers
- New emphasis on increased activity and energy as criterion A symptom for both Bipolar I and II
- Criteria:
  - 1 or more manic episodes
  - may have been preceded or followed by hypomanic or major depressive episodes

Bipolar I Disorder: Lots of specifiers

- A. at lease one manic episode
- Specifiers:
- Type of most recent/current episode
- Severity: mild, moderate, severe
- Presence of psychotic features
- Remission status
- With:
  - **anxious distress**
  - mixed features
  - rapid cycling
  - melancholic features
  - atypical features
  - mood-congruent psychotic features
  - mood-incongruent psychotic features
  - catatonia.
  - **peripartum onset** (*during* pregnancy or in *the 4 weeks following* delivery)
  - **seasonal pattern** (recurrent at regular time of year)

Depressive Disorders

Presence of sad, empty, or irritable mood, accompanied by somatic & cognitive changes that impair functioning

Specific Changes

Changes in Depressive Disorders:

- New: Disruptive mood dysregulation disorder
- Added Prementrual Dysphoric Disorder
- Dysthymia now called Chronic Depressive Disorder

DMDD:
Disruptive Mood Dysregulation Disorder **

- New Diagnosis

- Concern: Bipolar diagnosis in angry children increased 40x since 2000. Misdiagnosis as bipolar; those diagnosed often did not go on to adult bipolar

- Purpose:
  - Decrease pediatric Bipolar dx & subsequent antipsychotic medication
  - To dx bipolar in child, must meet full Bipolar criteria
  - Here criteria are never met for manic or hypomanic episode

- New Danger: will now dx normal anger in kids as pathology

DMDD: Disruptive Mood Dysregulation Disorder **

- Criteria (mood instability, behavior dysregulation problems, persistent irritability/anger):
  - A. Severe recurrent temper outbursts, verbal or behavior, out of proportion in intensity/duration
  - B. temper outbursts inconsistent with developmental level
  - C. On average, occur 3+ per week
  - D. Intervening mood, consistently irritable/angry most of day
  - E. ≥ duration of 12 months; ≤ 3 mths without all sxs
  - G. Cannot dx for 1st time prior to age 6 or after age 18
  - F. Occur in at least 2 of 3 settings (home, school, peers)
  - H. Age of onset of Criteria A-E is before age 10

  - J. Not diagnosable with Oppositionally Defiant Disorder, Intermittent Explosive Disorder (which is "intermittent"), or Bipolar

Major Depressive Disorder

- Major Depressive Disorder remains intact although inter-rater reliability poor in field testing (see Sect III).
- Bereavement exclusion omitted
- Can be diagnosed in presence of major stressors, including bereavement
- More specifiers added (mixed sxs, anxious distress)
- If coexistence of MDD + 3 manic sxs = “with mixed features”

Removal of bereavement exclusion

- The exclusion criterion in DSM-IV applied to people experiencing depressive symptoms lasting less than two months following the death of a loved one has been removed and replaced by several notes within the text delineating the differences between grief and depression.
- Controversy: Pathologize and medicate normal grief
- Recognition that bereavement is a severe psychosocial stressor that can precipitate a major depressive episode; beginning soon after the loss of a loved one.
- But never normal to have MDD no matter when it occurs

Footnote Comparison of Grief and Depression

Symptom	Grief	Depression
Affect	Emptiness and loss	Depressed mood, inability to anticipate happiness or pleasure
Pattern	Dysphoria decreases in intensity over days-weeks, comes in waves associated with thoughts/reminders of deceased. Pain of grief associated with positive emotions and humor.	More persistent, not tied to specific thoughts or preoccupations. Pervasive unhappiness and misery.
Thought Content	Preoccupation with thoughts and memories of the deceased	Self-critical or pessimistic ruminations
Self-esteem	Generally preserved	Worthlessness, self-loathing
Thoughts of death & dying	If present, focused on deceased and joining deceased.	Thoughts of ending one's life because of worthlessness, undeserving, unable to cope with pain of depression

Persistent Depressive Disorder (Dysthymia) *

- RN; DC; specifiers
- No longer:
  - Dysthymic Disorder
  - Major Depressive Disorder, Chronic
- Depressed, chronic (2 years), don't currently meet full MDD dx
- 15 specifiers

Persistent Depressive Disorder (Old Dysthymia)

- A. Depressed mood, most of the day, most days, ≥ 2 years (kids = irritability 1 year)
- B. While depressed, ≥ 2 sxs:
  - Appetite change, sleep change, fatigue, low self esteem, poor concentration, hopelessness
- C. Never been without sxs, ≥ 2 months
- D. Criteria for MDD may be present for 2 years (previously excluded)

- Specifiers: 17

PMDD: Premenstrual Dysphoric Disorder **

- New Diagnosis; DCM
- Moved from Study Appendix of DSM-IV to Mood Disorder Section in DSM-5
- Criteria:
  - A. Mood disorder during most menstrual cycles in past year: At least 5 specified mood, behavioral, physical sxs in final week before onset of menses, with improvement in sxs after its onset & minimal or absent sxs in week post-menses
  - D. Clinical impairment and distress
  - F. Criteria A should be confirmed by prospective daily ratings during at least 2 symptomatic cycles.
- Controversy: Pathologizing menstruation; 2% of women

Anxiety Disorders

Excessive fear & anxiety with related behavioral disturbance

Major Reshuffle: OCD & PTSD no longer anxiety disorders

- Both OCD & PTSD moved out of Anxiety Disorders into Trauma related Disorders

- DSM-IV Anxiety Disorders separated into three DSM-5 categorical groups:
  - *Anxiety Disorders*
  - *Obsessive Compulsive and Related Disorders*
  - *Trauma- and Stressor-Related Disorders* (PTSD)

  - Sequential ordering reflects close relationship among these disorders.

  - Chapters are arranged developmentally.
    - Sequenced by age of onset

Changes

- Elimination of requirement that the patient (formerly, over 18 years old) "must recognize that their fear and anxiety are excessive or unreasonable".
- Instead anxiety must be “out of proportion to actual danger or threat”
- 6 month duration extended to all ages
- Panic attacks can now be added as a specifier to all other DSM-5 disorders:
  - Depressive
  - Bipolar
  - Eating
  - Psychotic
  - OCD

Separation Anxiety Disorder

- DCM; moved from childhood section
- No longer childhood only: applies to all ages (& removed onset before 18)
- Criteria: A. developmentally inappropriate and excessive fear about separation from those to whom the individual is attached, as evidenced by:
  - 3 of 8 specified sxs (separation, loss, harm, go out, being alone, sleep, nightmares, physical sxs)
  - B. Persistent: Duration for 4 weeks for children and adolescents, and 6 months for adults
  - No minimum age of onset
  - C. Impairment (not 1st day of daycare)

Selective Mutism

- Moved from childhood section
- No major change
- A. Consistent failure to speak in social situations where expected to despite speaking in other situations
  - Applies to all ages
  - Wording changed to “failure to speak in specific social situations”
  - C. ≥1 month (not first month of school)
  - Not language or speech problem
  - Anxiety is a significant component; considered a precursor to Social Anxiety Disorder
  - Can also be comorbid

Specific Phobia

- DCM
- Don't have to recognize that fear is excessive or unreasonable
- Criteria: A. marked fear or anxiety about specific object or situation
  - B. Fear, anxiety
  - C. Object or situation is actively avoided or endured with intense fear or anxiety
  - D. Out of proportion to actual danger
  - Chance of encountering phobic stimuli is no longer a determinant of dx
  - Impairing
  - Duration = 6 months for all ages
  - Specifier: object of fear, specific phobia types
    - Animal, natural environment, blood-injection-injury, situation, other

Social Anxiety Disorder (Social Phobia)

- DCM; type specifier
- Criteria: A. marked fear or anxiety about 1 or more social situations in which individual is exposed to scrutiny by others (kids with peers, not adults):
  - B. Fears he/she will act in a way or show anxiety sxs that will be negatively evaluated
  - D. Social situation is avoided or endured with fear or anxiety;
  - E. Fear and anxiety are out of proportion to actual danger
  - F. Persistent, 6 months
  - Recognition that fear is excessive no longer required.

- Specifier:
  - "Generalized" specifier has been deleted
  - Replaced with "performance only" specifier ("only in speaking or performing in public")

Panic Disorder *

- RN; DCM
- Can now be specifier for any DSM disorder (rather than diagnose 2 separate disorders, just add specifier to the other disorder)
- But Panic Disorder and Agoraphobia have been delinked; if they co-occur, give two separate disorders.
- No longer:
  - Panic Disorder without agoraphobia
  - Panic Disorder with agoraphobia
- Criteria: A. Recurrent unexpected panic attacks
  - Panic: from calm or anxious state; abrupt surge of intense fear/discomfort, peak within minutes
  - A. 4 of 13 symptoms
  - B. 1 attack being followed by 1 month or more of persistent worry about additional attacks
  - B. And/or significant maladaptive behavior change related to attacks

Agoraphobia *

- RN; DCM; separated from panic disorder; many agoraphobics do not experience panic symptoms
- No longer:
  - Panic Disorder with Agoraphobia
  - Agoraphobia without History of Panic Attack
- Criteria: A. Marked fear or anxiety about 2 or more of 5 situations:
  - Public transportation, open spaces, enclosed spaces, in line/crowd, outside of home alone
  - Individual fears or avoids those situations because escape might be difficult or help unavailable if panic-like or other incapacitating symptoms develop;
  - Clinician judgment that fears are out of proportion to actual danger
  - Persistent, 6 months
  - Impairment

Generalized Anxiety Disorder

- No change
- A. Excessive anxiety (across the board), more days than not, longer than 6 months
- B. Difficult to control worry
- C. Associated with ≥ 3 (child 1) more:
  - Restlessness, fatigue, difficulty concentrating, irritability, muscle tension, sleep disturbance
- D. Impairment
- Worst test-retest reliability (kappa .20)

Obsessive-Compulsive and Related Disorders **

New chapter

OCD gets stand alone category

Major Changes

- Separated from DSM-IV Anxiety Disorders.
- Body Dysmorphic Disorder moved to this group from DSM-IV Somatoform Disorders.
- Trichotillomania Disorder moved here from DSM-IV Impulse Control Disorders.
- New Diagnoses:
  - Hoarding Disorder
  - Skin-Picking Disorder
  - Substance /Medication–induced OCD
  - OCD due to another medical condition

Obsessive-Compulsive Disorder

- A. Presence of obsessions, compulsions or both
- Clarification that obsessions are often urges, not impulses; they are intrusive and unwanted rather than merely inappropriate.
- Insight requirement removed (that obsessions & compulsions “are excessive or unreasonable”) for adults
- Specifiers (for more severe pathology)
  - with good or fair insight
  - with poor insight
  - with absent insight or delusional beliefs
  - Tic-related

Body Dysmorphic Disorder

- **DCM; feature specifiers; moved from old Somatoform**
- Criteria:
  - A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others
  - B. Performance of repetitive behaviors (mirror checking, etc.) or mental acts in response to appearance concerns
- Specifiers:
  - 3 Levels of insight (delusional variant no longer coded as delusional disorder; just use "with absent insight/delusional beliefs" specifier)
  - With muscle dysmorphia (feel not strong enough; serious sx: 50% SA; 80% are substance abusers; 25% anabolic steroid users)

Hoarding Disorder **

- New Diagnosis

- Hoarding:
  - not OCD,
  - more common than OCD,
  - genetically and neurologically distinct (ACC/Insula activation in hoarding)

- Criteria: A. Persistent difficulty parting with possessions regardless of actual value, resulting in accumulation of possessions that compromises use of living areas

- Distress/impairment
- Specify
  - Level of insight
  - With excessive acquisition

Trichotillomania (Hair-Pulling Disorder)

- DCM; moved from impulse control disorders

- No longer: Trichotillomania

- A. Recurrent pulling out of hair/hair loss
- B. Repeated attempts to stop/decrease
- C. Distress/impairment

Excoriation ** (Skin-Picking Disorder)

- New Diagnosis
- A. Recurrent skin picking, cause skin lesions
- B. Repeated attempts to decrease/stop
- C. Distress/impairment

Other Specified & Unspecified OC and Related Disorders

- PANDAs (Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections)

- Can include conditions such as body-focused repetitive behavior disorder
  - Recurrent behaviors (not hair/skin)
  - Repeated attempts to decrease/stop

- Can include conditions such as obsessional jealousy
  - Nondelusional preoccupation with partner's perceived infidelity

Trauma- and Stressor-Related Disorders **

New Category

Exposure to a
traumatic or stressful event

Specific Changes: Trauma and Stressor Related Disorders

- Trauma related disorders are now a stand alone category

- Now listed here:
  - PTSD
  - Reactive Attachment Disorder
  - Acute Stress Disorder
  - Adjustment Disorders

- Added
  - Disinhibited Social Engagement Disorder
  - Added PSTD in Preschool Children

Changes

- For acute stress disorder and PTSD, the stressor criteria (Criterion A1 in DSM-IV) was modified:
- specify stressor as:
  - directly experienced,
  - witnessed,
  - or indirect experience (i.e. 9/11 events phone message transcriber).

- The subjective reaction (A2) requirement for specific subjective emotional reactions ("of intense fear, helplessness, or horror") is eliminated.
  - Subjective response not required: Don't have to recognize you are in danger of dying.
  - Due to training, military personnel involved in combat, law enforcement officers and other first responders are trained not to react emotionally to traumatic events, but do have PTSD.

Posttraumatic Stress Disorder, Adult (≥ 6 years)

- DCM; separate age criteria (+/- age 6); specifiers
- A. Exposure to actual/threatened death, injury, serious violence; ≥1 sx
  - Sexual violence now specifically included as a trauma
  - Don't have to think you are in danger of dying
- A. Expansion to ≥ 1 of 4 Symptoms
- B. Presence ≥1 sx of 5, intrusion sxs
- C. Persistent avoidance of associated stimuli

- D. Persistent negative alterations in cognitions & mood
  - An additional category of negative mood, a persistent change in mood and thinking like dysphoria or anhedonia, has been added.

- E. Marked alterations in arousal/reactivity
  - adds irritability, angry outbursts, reckless/self-destructive behavior

- F. Duration ≥ 1 month, distress/impairment

- Specify
  - With dissociative sxs (depersonalization, derealization)
  - With delayed expression

Acute Stress Disorder

- DCM
- A. Exposure to actual/threatened death, injury, serious violence, ≥ 1 of 4 types of events
  - Experiencing, witnessing, learning about from close others, repeated/extreme exposures to aversive details
  - Not from watching TV (i.e. child & Challenger explosion)
- B. Any 9 of 14 sxs from 5 categories of intrusion, negative mood, dissociation, avoidance, arousal
- Dissociative Sxs no longer required for dx
- C. Duration, immediately after, 3 days to 1 mo
- D. Distress/impairment

- = brief version of PTSD

Adjustment Disorders

- No more separate chapter
- No change in dx

- Reconceptualized as stress response syndrome: Having a stress and being unable to manage the stress

- A. Emotional/behavioral sxs in response to identifiable stressor, within 3 months
- B. Distress out of proportion
- B. Impairment
- Exclusion: Not normal bereavement
- Trumped by MDD or Panic Disorder

Dissociative Disorders

Disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior

Dissociative Identity Disorder

- DCM
- A. Disruption of identity, ≥ 2 distinct personality states
- Symptoms of disruption of identity may be self reported as well as observed by others
- B. Recurrent gaps can involve everyday events (not just for traumatic experiences), personal information, traumatic events
- C. Distress/impairment
- D. Not just an accepted culture/religion phenomena
- Kids: not imaginary friends, fantasy play
- D. Criteria expanded to include certain possession-form phenomena as instance from some cultures

Dissociative Amnesia

- No longer:
  - Dissociate Amnesia
  - Dissociative Fugue (no longer)

- A. Inability to recall important autobiographical information, usually traumatic/stressful
  - Most often localized/selective for specific events; generalized for identity, life history
- B. Distress/impairment
- * Specify: "With dissociative fugue"
  - Dissociative fugue is now a specifier of Dissociative Amnesia and not a separate disorder

Depersonalization/Derealization Disorder *

- RN; DCM; Derealization has been added to the name due to common co-occurrence

- A. Presence of persistent/recurrent experiences of depersonalization, derealization or both
- B. Reality testing during episodes intact
- C. Distress/impairment

Depersonalization: Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, body

Derealization: Experiences of unreality or detachment with respect to one's surroundings

Somatic Symptom and Related Disorders *

Prominence of somatic symptoms associated with significant distress & impairment

Specific Changes: Somatic Symptom Disorder

- No more somatoform disorders; now they are Somatic Symptom and Related Disorders

- No more:
  - Somatization Disorder
  - Pain Disorder
  - Hypochondriasis

- Seen in medical settings:
  - Old = medically unexplained sxs; pt. had to prove they were actually sick
  - New = it's a real illness (due to anxiety and worry)

Medically Unexplained Sxs

- DSM IV overemphasized importance of an absence of medical explanation for somatic sxs
- DSM-5 defines disorders on basis of positive sxs: distressing somatic sxs + abnormal thoughts, feelings, & behaviors in response to sxs
- Medically unexplained sxs do remain key feature in conversion disorder (& pseudocyesis/false pregnancy) because it is possible to demonstrate definitively that sxs are not consistent with medical pathophysiology

Illness Anxiety Disorders

- Two distinct subgroups:
- Somatic Symptom Disorder (SSD): somatic symptoms predominate and are primary concern (75% of patients)
- Illness Anxiety Disorder (IAD): minimal somatic symptoms but who are highly anxious about and suspicious of having a undiagnosed, serious medical illness (25% of patients)

Somatic Symptom Disorder *

- RN, DC; DCM
- No longer:
  - Somatization Disorder
  - Hypochondriasis
  - Pain Disorder
  - Undifferentiated Somatization Disorder

- Maladaptive thoughts, feelings, and behaviors define this disorder, in addition to their somatic symptoms.
- Now emphasis is on positive symptoms (their response to illness perception), and not the medically unexplained symptoms
- Focus shifts from negative (*"medically unexplained"*) to positive sxs (*"excessive thoughts, behaviors and feelings"*)

Mislabeling Medical Illness As Mental Disorder

- Controversy:
- Somatic Symptom Disorder is potentially over-inclusive
- The SSD disorder section attracted more submissions than almost any other section

Illness Anxiety Disorder *

- RN; DCM
- No longer: Hypochondriasis (Woody Allen
- Describes anxious individuals without somatic sxs but a preoccupation with being medically ill.
- A. Preoccupation, having/acquiring serious illness
- B. No or mild somatic sxs
- C. High level anxiety about health
- D. Excessive health related behaviors
- E. Persistent, ≥ 6 months
- Specify
  - Care seeking type (see doctor)
  - Care avoidant type

Conversion Disorder
(Functional Neurological Symptom Disorder)

- DCM
- No longer: Conversion Disorder
- Example: non-epileptic seizures
- Modified to emphasize:
  - Importance of the neurological exam and
  - Recognizes that relevant psychological factors may not be present at the time of original diagnosis
- A. ≥ 1 sxs of altered voluntary motor or sensory function
- B. Clinical findings, evidence of no compatibility between sxs & recognized medical/neurological conditions

- Specifiers
  - Specify the symptom: weakness, seizures, etc.
  - With/without psychological stressor (old =required)

Psychological Factors Affecting Other Medical Conditions **

- New Diagnosis
- No change; moved from the study section
- A. Real medical sxs/disorder present
- B. Psychological/behavior factors adversely affect medical condition (i.e. diabetic won't take meds, person with heart attack still smoking)
- Specify
  - Severity: mild, moderate, severe, extreme

Factitious Disorder: no more Munchausen's

- DCM
- No Longer = Factitious Disorder, Factious disease by proxy, Munchausen's
- Example: deliberately make self or other sick for 2ndary gain
- Separate criteria for:
  - Factitious Disorder Imposed on Self
  - Factitious Disorder Imposed on Another (same criteria, except sxs falsified or induced in another person)
- A. Falsification of physical/psychological signs, sxs; induction of injury, disease associated with deception in self
- B. Presents as ill, impaired, injured
- C. Deceptive behavior evident even in absence of obvious external rewards
- Specify
  - Single/recurrent episodes
- Perpetrator, not victim, gets dx; but child may have medical problem (V/Z coded as victim of child abuse)

Feeding & Eating Disorders

Persistent disturbance of eating-related behavior

Often in impaired child-parental relationship

Now at any age

Avoidant/Restrictive Food Intake Disorder **

- NC; was Feeding Disorder of Infancy
- For pts who restrict food intake but don't meet Eating Disorder dx; at any age
- Failure to thrive; inadequate food intake
- A. Eating/feeding disturbance, persistent failure to meet nutritional/energy assoc with ≥ 1 sx:
  - Weight loss/failure to gain
  - Significant nutritional deficiency
  - Dependent on supplementary feedings
  - Interference with psychosocial functioning
- B. Not no available food/assoc cultural practice
- C. Not another eating disorder
- Specify if in remission

Anorexia Nervosa

- DCM
- Amenorrhea requirement eliminated (but can still be a sx)
- A. Restriction of energy intake; low body wgt, below minimal normal, minimum expected
- B. Intense fear of gaining wgt/becoming fat; added: persistent behavior interferes with wgt gain
- C. Disturbance in way body wgt/shape experienced, undue influence on self-esteem
- Lack of recognition of seriousness of low wgt
- Minimum of 3 months
- Specify
  - Restricting type/binge-eating/purging type
  - Partial/full remission
  - Severity based on BMI (Mild, ≥17; Moderate, ≥16, Severe ≥15, Extreme<15)

Bulimia Nervosa

- DCM
- A. Recurrent episodes of binge eating
  - Eating in discrete period of time, larger amount of food than most eat
  - Sense of lack of control
- B. Recurrent inappropriate compensatory behaviors, prevent wgt gain
- C. Frequency of binge-eating and compensatory behaviors has been decreased: Eating & compensation, on avg, (from twice to) once a week for 3 months
- Self evaluation unduly influenced by body shape & wgt
- Specify
  - Partial/full remission
  - Severity based on average frequency of episodes of inappropriate compensatory behaviors per week (vomit, laxatives, etc.)
- Subtypes eliminated.

Binge-Eating Disorder **

- New Diagnosis, DCM; moved from study section
- A. Recurrent episodes of binge eating without compensation (Bulimia without binge or purge)
- B. Episodes associated with ≥ 3 of 5 sxs
  - Eating more rapidly than normal, until uncomfortably full, not physically hungry, alone because embarrassed, disgusted with self
- C. Distress
- D. Reduced duration and frequency requirement: On avg, once a week (used to be twice), for 3 months
- Specify
  - Partial/full remission
  - Severity: number of binge eating episodes per week

Elimination Disorder **

Own category

Inappropriate elimination of urine or feces:
Encopresis
Enuresis
No changes

Sleep-Wake Disorders

Reorganized

Each Dx Treated as independent disorder

Present with sleep-wake complaints of dissatisfaction regarding the quality, timing, and amount of sleep

21 Sleep-Wake Disorders

- Insomnia Disorder (old Primary Insomnia)
- Primary Hypersomnolence
- Narcolepsy, with or without Cataplexy
- Breathing-related Sleep Disorders:
  - Obstructive Sleep Apnea (Hypopnea Syndrome)
  - Central Sleep Apnea
  - Sleep-Related Hypoventilation
- Circadian Rhythm Sleep-Wake Disorders (6 types)

Sleep-Wake Disorders 2

- Parasomnias
  - Non-Rapid Eye Movement Sleep Arousal Disorders
    - Sleepwalking Type (no longer own disorder)
    - Sleep terror type
  - Nightmare Disorder
  - Rapid Eye Movement Sleep Behavior Disorder**
  - Restless Leg Syndrome **
- Substance/Medication-Induced Sleep Disorder (9 types)
- Other Specified & Unspecified:
  - Insomnia Disorder
  - Hypersomnolence
  - Sleep-Wake Disorder

Narcolepsy

- DCM; separated from hypersomnolence disorder (due to known etiology of hypocretin deficiency)

- Recurrent episodes of irresistible need to sleep, lapsing into sleep, napping ≥ 3 times/week for 3 months
- Presence ≥ 1:
  - Cataplexy, few times a month
  - Hypocretin deficiency
  - Nocturnal sleep polysomnography, REM sleep latency ≤ 15 min, multiple sleep latency ≤ 8 min
- Specify (many)

Non-Rapid Eye Movement Sleep Arousal Disorder *

- RN; DCM
- No longer:
  - Sleep Terror Disorder
  - Sleepwalking Disorder
- Recurrent episodes of incomplete awakening from sleep, usually 1st third of sleep, with 1 of
  - Sleepwalking
  - Sleep terrors
- Little/no dream recall
- Amnesia for events
- Distress/impairment
- Specify: sleepwalking or sleep terror type

Rapid Eye Movement Sleep Behavior Disorder **

- New Disorder
- Repeated episodes of arousal during sleep associated with vocalization/complex motor behaviors
- Arise during REM, ≥ 90 minutes after onset
- On awakening, completely alert
- Either
  - REM sleep without atonia on polysomnography
  - History suggestive of REM sleep behavior and synucleinopthy diagnosis
- Distress/impairment

- Used as criminal defense; predictive of Lewy Body Dementia

Restless Legs Syndrome **

- New Diagnosis; moved from study section
- Urge to move legs, accompanied by/response to uncomfortable leg sensation
- Begins/worsens during rest/inactivity
- Relieved by movement
- Worse in evening
- ≥ times/week, ≥ 3 months
- Distress/impairment

Sexual Dysfunctions

Heterogeneous group of 23 disorders that are characterized by a clinically significant disturbance in person's ability to respond sexually or to experience sexual pleasure

Specific Changes: New Names

- Delayed Ejaculation (old Male orgasmic disorder)
- Early Ejaculation (old Premature Ejaculation)
- Genito-Pelvic Pain/Penetraion Disorder (old separate Dyspareunia and Vaginismus)
- Female sexual interest/arousal disorder (old separate sexual desire & sexual arousal disorders).
- Sexual Aversion Disorder deleted

Changes

- Gender-specific sexual dysfunctions have been added.
- All Disorders:
  - Minimal duration of 6 months
  - Required: severity as mild, moderate, or severe
  - Additional information in text on factors
    - Partner, relationship, individual vulnerability, cultural/religious, medical
- 2 subtypes
  - Lifelong/acquired
  - Generalized/situational
  - Factors: partner, relationship, individual vulnerability, cultural or religious, medical

Gender Dysphoria *

New category & name

Distress or marked impairment related to incongruence between one's experienced/expressed gender and assigned gender

Gender Dysphoria = In the wrong body

- Diagnosis but not a disorder. Diagnosis made by mental health care providers, although a large proportion of the treatment is endocrinological and surgical
- Name change was made in part due to stigmatization of the term "disorder“
- Emphasis on internal self perception, not external identification with opposite gender
- Emphasizes “gender incongruence” (dissatisfaction & distress with own gender) rather than the cross-gender identification.

Gender Dysphoria 2

- Gender nonconformity itself is not considered to be a mental disorder, a sexual dysfunction nor a paraphilia;
- Focus on dysphoria as the clinical problem, not identity per se
- Gender used not sex
- Creation of a separate gender dysphoria in children as well as one for adults and adolescents
- For children, Criterion A1 (“a strong desire to be of the other gender or an insistence that one is the other gender” is now necessary)

Gender Dysphoria *

- DCM
- No longer: Gender Identity Disorder
- A. Marked incongruence between experienced/expressed gender and gender assigned by others, ≥ 6 months,
  - In Children: ≥ 6 of 8 symptoms ; must include A1
  - In Adolescents & Adults: 2 of 6 sxs
- B. Distress or impairment
- Specify
  - With disorder of sex development (such as congenital adrenal hyperplasia; chromosomal or physical abnormality)
  - Posttransition (living in desired gender)
- No sexual orientation subtyping

Paraphilic Disorders

Intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners

In DSM-5, paraphilias are not ipso facto mental disorders

Destigmitization of Paraphilias: Not a disorder until it's a problem

- Distinguishes between paraphilic behaviors (paraphilias), and paraphilic disorders.

- Paraphilia (if not harming others or not in distress):
  - A. Any atypical erotic interests: Any intense and persistent sexual interest other than sexual interest, genital stimulation or preparatory fondling with phenotypically normal physically mature consenting human partners
  - Necessary but not sufficient for disorder

- Paraphilic Disorder:
  - Having a paraphilia is necessary but insufficient
  - Distress or impairment in individual
  - Satisfaction entails harm or risk of harm to others
  - Must meet both qualitative/erotic focus (criterion A) and negative consequences (criterion B) criteria to be diagnosed with a paraphilic disorder.
- Otherwise they have a paraphilia (and no diagnosis).

Specific Changes

- Demedicalizes and destigmatizes unusual sexual preferences and behaviors; does not automatically label non-normative sexual behavior as psychopathological.
- They all have new names: “Disorder” added to all
- New specifiers added for all:
  - "in a controlled environment" (i.e. jail)
  - "in remission"

Paraphilic Disorders

- Voyeuristic disorder
- Exhibitionistic disorder
- Frotteuristic disorder (rubbing)
- Sexual masochism disorder
- Sexual sadism disorder
- Pedophilic disorder
- Fetishistic disorder
- Transvestic disorder

Pedophilic Disorder *

- No longer: Pedophilia
- Text error: "Sexual orientation" is not a term used in the diagnostic criteria for pedophilic disorder and its use in the originally published DSM-5 text discussion is an error and should read "sexual interest." In fact, APA considers pedophilic disorder a "paraphilia," not a "sexual orientation."

- Recurrent and intense sexual arousing fantasies, sexual urges or behaviors involving sexual activity with a prepubescent child or children (≤ 13 years), ≥ 6 months
- Acted on urges or in distress
- ≥ 16 years old and ≥ 5 years older than child
- Specifiers:
  - Exclusively attracted to
    - Males, females, both
  - Limited to incest

Transvestic Disorder *

- No longer: Transvestic Fetishism
- Recurrent and intense sexual arousal from cross dressing as manifested by fantasies, urges, behaviors, ≥ 6 months
- Cause distress
- No longer specifies “In a heterosexual male”
- (Gender Dysphoria now separate section)
- Specifiers:
  - With fetishism
  - With autogynephilia (thts of self as female)
  - In controlled environment or in full remission

Disruptive, Impulse-Control & Conduct Disorders **

Own category

Conditions involving problems in the self-control of emotions and behaviors…that violate the rights of others and/or that bring the person into significant conflict with societal norms or authority figures

Disinhibition

- A developmental spectrum: at any age
- Multiple disorders characterized by problems in emotional and behavioral self-control
- Antisocial personality disorder has dual listing here & in Personality Disorders: some Conduct Disorder proceeds to ASPD
- ADHD frequently comorbid but listed elsewhere

Specific Changes: Disruptive Impulse Control and Conduct Disorders

- Moved here:
  - Oppositional Defiant Disorder
  - Conduct Disorder
  - Intermittent Explosive Disorder
  - Antisocial Personality Disorder (but also listed in Personality Disorders)
  - Pyromania
  - Kleptomania
- Removed:
  - Gambling
  - Trichotillomania

Oppositional Defiant Disorder

- DCM
- A. Symptoms are of three types:
  - angry/irritable mood
  - argumentative/defiant behavior
  - vindictiveness
- ODD and Conduct Disorder comorbidity is allowed. The old conduct disorder exclusion is deleted.

- Frequency: ≥ 4 sxs; if younger than 5 years, most days for 6 months; older than 5 years, weekly

- *Specifiers for current severity* have been added (mild, moderate, severe) and are based on the number of settings (1, 2, 3 or more) in which symptoms are present

Intermittent Explosive Disorder

- DCM
- A. Recurrent behavioral outbursts/rages, failure to control aggressive impulses, manifested by
  - (new) Verbal aggressiveness, on avg, 2x/week over 3 months
  - Behavioral outbursts: non-destructive physical aggression, property damage, injury ≥3 x over 12 months
- B. Out of proportion
- C. Not premeditated: impulsive, anger based outbursts
- D. Marked Distress or impairment
- D. Negative consequences (occupational, interpersonal, legal)
- E. 6 years or older
- Exclusion added: Disruptive Mood Dysregulation Disorder supersedes IED dx.
- People over the disorder's minimum age of 6 may be diagnosed without outbursts of physical aggression

Conduct Disorder

- A. Repetitive, persistent behavior pattern, ≥ 3 sxs, ≥ 12 months, 1 criterion in last 6 months
  - Aggression to people & animals
  - Destruction of property
  - Deceitfulness or theft
  - Serious violations of rules
- B. Impairment
- C. If ≥ 18 years, criteria are not met for ASPD

Conduct Disorder: Major new specifier

- Specify
  - Childhood (≤10)/adolescent onset/unspecified
  - Severity = mild, moderate, severe
  - Adds new specifier “With limited prosocial emotions” (lack of empathy), ≥ 2 sxs, ≥ 12 mths
    - Lack of Remorse / guilt
    - Callous—lack of empathy
    - Unconcerned about performance
    - Shallow or deficient affect
    - Represents a severer clinical presentation; more toward ASPD, child psychopath

Substance-Related & Addictive Disorders **

New category

Cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems

Specific Changes in Substance Use

- **Distinction is no longer made between abuse and dependence.
- Merged into single “Substance Use Disorder”
- Old Abuse & Dependence were severity ratings; now collapsed.
- Criteria:
  - Intoxication
  - Withdrawal
  - Use
- 51 listed disorders
- Tolerance & Withdrawal criteria are not met if substance use is under medical supervision

Changes

- Threshold increased to 2 or mote of 11 sxs
- “Craving/strong desire to use” criterion added; finally!
- Recurrent legal problems criterion deleted (due to response to ethnicity bias in arrests)
- Physiological (abuse/dependence) subtype eliminated (no more mind/body dualism)
- Polysubstance dependence eliminated
- Nicotine Related renamed Tobacco Use Disorder
- Added
  - Caffeine Withdrawal
  - Cannabis Withdrawal
  - Gambling

11 Substances

- Alcohol
- Caffeine (Intoxication/withdrawal) (Use Disorder only in Study section)
- Cannabis
- Phencyclidine
- Other Hallucinogen
- Inhalant
- Opioid
- Sedative, Hypnotic, Anxiolytic
- Stimulant
- Tobacco
- Other
- Note: no sexual addiction in DSM-5 (use unspecified impulse control disorder)

Specify

- Environment:
  - Controlled environment
  - Maintenance therapy (medication)

- Severity = by number of symptoms out of 11 criteria
  - Mild = 2-3
  - Moderate = 4-5
  - Severe= more than 6
  - in a given 12 month period

- Remission
  - Early = minimum of 90 days (≥ 3 but <12 months of not meeting sxs criteria (except craving)) (old = 30 days of lack of sxs)
  - Sustained = longer than 12 months of not meeting sxs criteria (except craving)

Alcohol Use Disorder **

- No longer:
  - Alcohol Dependence
  - Alcohol Abuse
- A. Problematic pattern of alcohol use leading to clinically significant impairment or distress; manifested by at least 2 of 11 symptoms within a 12 month period.

DSM-IV vs DSM-5: Severity: Abuse or Dependence

DSM-IV-TR	DSM-5
305.00 Alcohol abuse	305.00 (F10.10): 2-3 sxs Mild Alcohol Use Disorder
303.90 Alcohol Dependence	303.90 (F10.20): 4-5 sxs Moderate Alcohol Use Disorder
	303.90 (F10.20): 6+ sxs Severe Alcohol Use Disorder

Alcohol Use Disorder

- Specify if:
  - In early remission: 3 to 12 months
  - In sustained remission: 12 months or longer
- Specify if:
  - In a controlled environment: restricted alcohol
- Specify severity:
  - Mild: Presence of 2-3 symptoms
  - Moderate: 4-5 symptoms
  - Severe: 6 or more symptoms

51 Other DSM-5 Substance Abuse DXs

- Alcohol Intoxication
- Alcohol Withdrawal
- Caffeine Intoxication
- Caffeine Withdrawal **
- Cannabis Use Disorder * (Old = Cannabis Dependence; Cannabis Abuse)
- Cannabis Intoxication
- Cannabis Withdrawal **
- Phencyclidine Use Disorder * (No longer: Phencyclidine Dependence; Phencyclidine Abuse)

Other DSM-5 Substance Abuse DXs 2

- Other Hallucinogen Use Disorder * (No longer: Hallucinogen Dependence; Hallucinogen Abuse)
- Phencyclidine Intoxication
- Other Hallucinogen Intoxication * (No longer: Hallucinogen Persisting Perception Disorder)
- Inhalant Use Disorder * (No longer: Inhalant Use Dependence; Inhalant Use Abuse)
- Inhalant Intoxication
- Opioid Use Disorder * (No longer: Opioid Dependence; Opioid Abuse)
- Opioid Intoxication
- Opioid Withdrawal

Other DSM-5 Substance Abuse Dxs 3

- Sedative, Hypnotic, or Anxiolytic Use Disorder * (No longer: Sedative, Hypnotic, or Anxiolytic Dependence; Sedative, Hypnotic, or Anxiolytic Abuse)
- Sedative, Hypnotic, or Anxiolytic Intoxication
- Sedative, Hypnotic, or Anxiolytic Withdrawal
- Stimulant Use Disorder * (No longer: Amphetamine Dependence; Amphetamine Abuse; Cocaine Dependence; Cocaine Abuse)
- Stimulant Intoxication * (No longer: Amphetamine Intoxication; Cocaine Intoxication)
- Stimulant Withdrawal * (No longer: Amphetamine Withdrawal; Cocaine Withdrawal)
- Tobacco Use Disorder * (No longer: Nicotine Dependence)
- Tobacco Withdrawal * (No longer: Nicotine Withdrawal)

Gambling Disorder *

- Moved into this chapter
- No longer: Pathological Gambling
- Persistent, problematic gambling behavior
- Impairment/distress
- ≥ 4 sxs, 12 months
- Specify
  - Episodic/persistent
  - Early/sustained remission
  - Severity based on number of criteria met

Neurocognitive Disorders **

New category

Deficits in cognitive functioning as a core feature; underlying pathology and etiology can be determined

DSM-5 NCD

- Delirium (no change)
- Mild neurocognitive disorder
  (old MCI, Cog Disorder NOS)
- Major neurocognitive disorder
  (old dementia)

Changes

- New term: Neurocognitive disorder
- Category includes amnesia, dementia & any cognitive disorder
- New disorders
  - Broader range of etiologies
  - Expanded to cover wider range of function & ages
  - Includes less severe dysfunction
  - Previous dementia subtypes now separate disorders

NCD: Specific Changes

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

DSM-5 NCDs

- "Dementia" is replaced by "major NCD" (but not precluded from use in etiological subtypes in which that term is standard)
- Focus on decline (rather than deficit) from a previous level of performance.
- New list of neurocognitive domains
- Cognition, not just Memory, is central
- Eventual focus on early stage prognosis and TX

Neurocognitive Disorders

- NCD: The primary clinical deficit is in cognitive function. Only disorders whose core features are cognitive (not noted for Schizophrenia or Bipolar which have significant cognitive deficits)
- Acquired, not developmental: a decline from previous functioning
- These are only DSM-5 diagnoses with known pathologies

Major Neurocognitive Disorder **

- No longer:
  - Dementia
  - Amnestic Disorder
- Deficits in 6 cognitive domains

NCD: 6 Cognitive Domains **

- Complex Attention (Sustained, selective divided)
- Executive Function (Planning, decision making, working memory, feedback/error utilization, overriding habits/inhibition, cognitive flexibility
- Learning and memory

NCD: Cognitive Domains 2

- Language (expressive, grammar/syntax, receptive)
- Perceptual-motor (visual, visoconstructional, perceptual-motor, praxis, gnosis)
- Social cognition (recognition of emotions, theory of mind)

Major Neurocognitive Disorder

1. Significant Cognitive decline from previous level of performance in 1 or more cognitive domains
    1. Concern of individual, informant, or clinician of a significant cognitive decline
    2. Substantial cognitive impairment on NP testing
2. Deficits interfere with capacity for independence in everyday activities
3. Not in context of delirium
4. Not explained better by another mental disorder

Mild or Major NCD – Must specify etiology due to 1 of 13:

- Alzheimer's disease
- Frontotemporal lobar degeneration
- Lewy boy disease
- Vascular disease
- Traumatic brain injury
- Substance/medication use
- HIV infection
- Prion disease
- Parkinson's disease
- Huntington's disease
- Another medical condition (code other medical first)
- Multiple etiologies (code each)
- Unspecified

Major Neurocognitive Disorder (old dementia)

NP Testing: - 2 s.d. (3rd %tile, score ≥70)

Specify:

- with or without behavioral disturbance (specify which (psychotic, agitation, etc.)

Severity:

- Mild (difficulties in IADLs)
- Moderate (difficulties in ADLs)
- Severe (fully dependent)

Mild Neurocognitive Disorder

1. Modest Cognitive decline from previous level of performance in 1 or more cognitive domains
    1. Concern of person, informant, or clinician of a mild cognitive decline
    2. Modest cognitive impairment on NP testing
2. Deficits do not interfere with capacity for independence in everyday activities
3. Not in context of delirium
4. Not explained better by another mental disorder

Mild Neurocognitive Disorder (old MCI)

NP Testing: - 1-2 s.d. (3 to 16th %tile)

Specify whether due to 1 of 13 etiologies: AD, FTD, LBD, VD, etc.

Specify with or without behavioral disturbance

Controversy over Mild NCD: Normal Forgetting

- The everyday forgetting characteristic of old age will now be misdiagnosed as Minor Neurocognitive Disorder, creating a huge false positive population of people who are not at special risk for dementia.

- There is no effective treatment; creating great anxiety

Major or Mild NCD due to Alzheimer's Disease

- A. Criteria for Mild or Major NCD met
- B. There is insidious onset & gradual progression of impairment in 1 or more cognitive domains (2 for Major NCD)
- C. Criteria for Probable or Possible AD
  - For Major NCD:
  - Probable AD diagnosed if either of following (otherwise, possible AD)
  - 1. Evidence of causative AD genetic mutation from autosomal dominant family history confirmed by autopsy or genetic testing
  - 2. All 3 present:
    - Memory decline & decline in 1 other cognitive area (hx or serial testing)
    - Progressive gradual decline in cognition
    - No evidence of mixed etiology

Major or Mild NCD due to Alzheimer's Disease 2

- For Mild NCD:
- Probable AD diagnosed if evidence of causative AD genetic mutation from family hx or genetic testing
- Possible AD if no genetic evidence and all 3 of following present:
  - Memory decline
  - Progressive gradual decline in cognition
  - No evidence of mixed etiology

- D. Not better explained by CV disease, etc.

I -- NCD due to Alzheimer's Disease

- Progressive, age-related, irreversible, insidious loss of cognitive ability
- Specify: 80% of NCD due to AD have behavioral disturbance; Moderate Major NCD: psychotic, irritability, agitation, wandering common
- CJV prediction: "Possible AD" will become new norm; "NCD due to multiple etiologies" most likely

Personality Disorders

Enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, with onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment

Same 10 Personality Disorders

- People do not categorically have or not have certain problematic personality traits—rather, these characteristics vary in strength from person to person
- DSM-5 will maintain the categorical model and criteria for the 10 classical personality disorders included in DSM-IV
- No Axis II
- Code at same level as other disorders
- Includes the new trait-specific, dimensional methodology in a separate area of Section III
- NOS – Use Other specified PD or Unspecified PD

Dimensionality

- Major changes in personality disorders held over until next revision, the DSM 5.1 (or maybe 5.2)
- Section III includes the alternative dimensional model for personality disorders. This model, an alternative to the categorical approach, reflects a dimensional perspective that personality disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another.

10 Personality Disorders

- Paranoid -
- Schizoid -
- Schizotypal
- Antisocial
- Borderline
- Histrionic -
- Narcissistic
- Avoidant
- Dependent -
- Obsessive-Compulsive

- (-) These 4 disappear in new dimensional model

Personality Change due to Another Medical Condition **

- New
- Evidence that it is due to direct consequence of another medical condition
- Specify:
  - Labile type
  - Disinhibited type
  - Aggressive type
  - Apathetic type
  - Paranoid type
  - Other type
  - Combined type
  - Unspecified type

Other Mental Disorders

Other Mental Disorders: Not full Criteria

Four disorders in this chapter

"This residual category applies to presentation of symptoms characteristic of mental disorders, which cause clinically significant distress or impairment, but do not meet the full criteria for any other mental disorder"

-Other Specified Mental Disorder Due to Another Medical Condition

-Unspecified Mental Disorder Due to Another Medical Condition

-Other Specified Mental Disorder

-Unspecified Mental Disorder

Medication-Induced Movement Disorders and the Adverse Effects of Medication Disorders **

Own Category

Medication-induced Movement Disorder

- Neuroleptic-induced Parkinsonism & Other Medication-Induced Parkinsonism
- Neuroleptic Malignant Syndrome
- Medication-Induced Acute Dystonia
- Medication-Induced Acute Akathisia
- Tardive Dyskinesia
- Tardive Dystonia & Tardive Akathisisa
- Medication-Induced Postural Tremor
- Other Medication-Induced Movement Disorder
- Antidepressant Discontinuation Syndrome
- Other Adverse Effect of Medication

Other Conditions that may be a Focus of Clinical Attention

Other Conditions that may be a Focus of Clinical Attention

- These are not mental disorders

"They may be included in the medical record as useful information that may affect client's care. "

Inclusion in the DSM-5 draws attention to the scope of issues encountered in clinical practice

Other Conditions that may be a Focus of Clinical Attention

- Old Axis IV: V codes (Z codes in ICD 10)

- Relational Problems
- Abuse and Neglect – child or adult
- Educational Problems
- Occupational Problems
- Problems related to Social Environment
- Problems related to Crime or Interaction with Legal system
- Other Health Service Encounters for Counseling and Medical Advice
- Problems Related to Other Psychosocial, Personal, and Environmental Circumstances
- Other Circumstances of Personal History

Section III

Emerging Measures & Models

Conditions for further study

- Attenuated psychosis syndrome
- Depressive episodes with short-duration hypomania
- Persistent complex bereavement disorder
- Caffeine use disorder
- Internet gaming disorder
- Neurobehavioral disorder associated with prenatal alcohol exposure
- Suicidal behavior disorder
- Non-suicidal self-injury

Assessment Measures

- Sx cuts across disorders, i.e. attention; and same disorder manifests differently i.e. 2 ADHD kids

- Cross Cutting Symptom Measures (list of psych sxs)
  - Child (completed by adult) & adult versions
  - Symptoms relevant to most disorders
  - Self report
  - Level 1 (1-3 ?s) and Level 2 (if level 1 score of mild or greater)

- Clinician Rated Dimensions of Psychosis Symptom Severity

WHODAS 6 Domains of Disability

- World Health Organization Disability Assessment Schedule (WHODAS)
  - Scores – each 6 domain scored and overall
  - Adults, used worldwide
  - Child version developed by DSM5; not approved by WHO

- Domains:
  - Understanding and communicating
  - Getting around
  - Self Care
  - Getting along with people
  - Life Activities
    - Household
    - Work or school
  - Participation in society

Cultural Formulation

- Interview
- Interview - Informant version

Section III: Alternative DSM5 Model for Personality Disorders

- Hybrid – dimensional & categorical approaches
- Greater emphasis on impact on function
  - Personality functioning: how functional are you
  - Trait based criteria: what traits do you have
- General criteria
  - Personality functioning core impairments
  - Personality trait pattern of impairment
- 5 broad areas of pathological personality traits
- Can assess personality functioning and traits even in individuals without disorders
- CJV: Too complex for clinicians

Section III: 6 Personality Types

- 6 Personality Types:
  - Borderline
  - Obsessive-Compulsive
  - Avoidant
  - Schizotypal
  - Antisocial
  - Narcissistic
- Personality Disorder – Trait Specified

Appendix

Separate from Section III will be an Appendix, which will include:

- Highlights of Changes From DSM-IV to DSM-5
- Glossary of Technical Terms
- Glossary of Cultural Concepts of Distress
- Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)
- Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)
- Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM)
- DSM-5 Advisors and Other Contributors

Additional Information

- www.psychiatry.org/dsm5
- www.dsm5.org
  - Additional assessment measures
  - Cultural Formulation Interview
  - Supportive/additional references
  - Questions
  - Insurance/coding
- www.PsyiatryOnline.org
  - Online subscription
  - E-book
  - Modules
  - Assessment tools

DSM-5 Implementation and Support

The www.dsm5.org website has been reorganized to serve as a resource for clinicians, researchers, insurers, and patients. The site includes information on implementation of the manual, answers frequently asked questions, lists DSM-5 corrections, and provides a mechanism for submitting questions and feedback regarding implementation of the manual. Researchers and clinicians can also provide us with feedback on the usefulness of the **online assessment measures of cross-cutting symptoms**, disorder severity, personality, and disability. We also provide links to **educational webinars** about the DSM-5, and **listings of APA-endorsed training sessions on DSM-5** that are being conducted throughout the US and abroad. The site will continue to provide historical information about the development process and overall rationale for changes from DSM-IV.

IMPORTANT NOTICE: CODING UPDATES FOR DSM-5: UPDATED 3/24/14

NEW! DSM-5: Educational Webinar: Missed the **DSM-5: What You Need to Know** Master Course at the 2013 APA Annual Meeting in San

To the DSM-5 User Community:

When the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released at the American Psychiatric Association's Annual Meeting in May 2013, it marked the end of more than a decade's journey in revising the criteria for the diagnosis and classification of mental disorders. Although DSM-5 is now complete, a great deal of work remains, and we are hopeful that once again you will play an active role in this next important phase of refining the manual. Our highest priority is ensuring the proper use of DSM-5, including providing training materials; answering

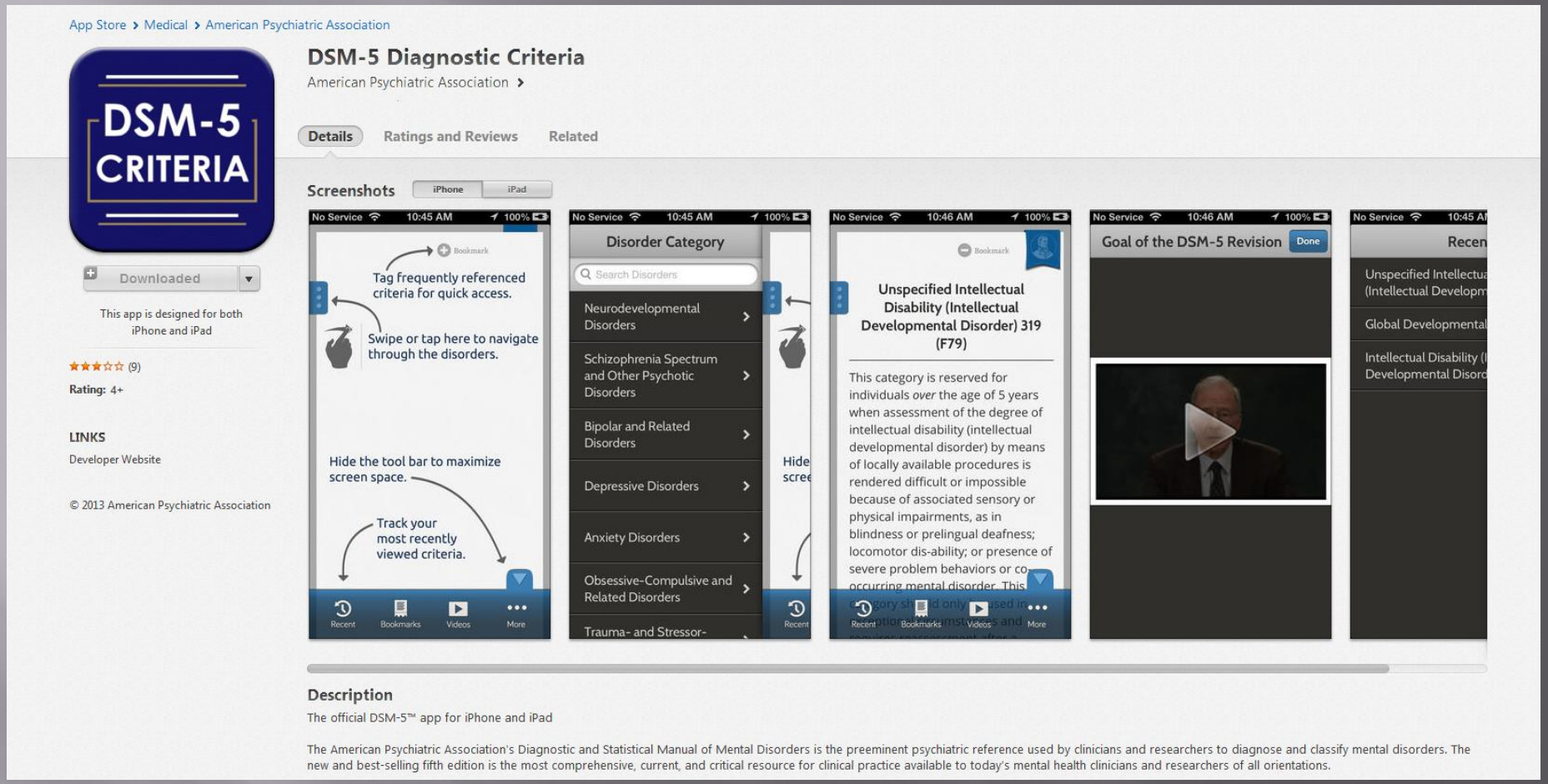
What's New

IMPORTANT: Coding Updates for DSM-5

DSM-5 and ICD-10-CM: A Quick Guide for Clinicians

DSM-5.org: Check out What's New on right

67 Downloadable Online Assessment Measures;
Highlight of Changes from DSM-IV-TR to DSM-5



- Mobile app:
  - DSM-5 Diagnostic Criteria Mobile App by APA ($70)
  - Instantly searchable

Biography

- *DSM-5* by APA
- *Desk Reference to the Diagnostic Criteria From DSM-5* by APA
- *** *DSM-5 Guidebook* by D. Black and J. Grant
- *The Pocket Guide to the DSM-5(TM) Diagnostic Exam* by A. Nussbaum
- *DSM-5™ Handbook of Differential Diagnosis* by Michael B. First
- *DSM-5™ Clinical Cases*, ed. John W. Barnhill
- *Essentials of Psychiatric Diagnosis*: Responding to the Challenge of DSM-5 by Allen Frances MD
- ***The Intelligent Clinician's Guide to the DSM-5* by Joel *Paris*
- *Saving Normal* by Allen Frances
- *Book of Woe* by Gary Greenburg

Do No Harm!

Avoid False Positives!

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