DSM-5: A First Look

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Opening Considerations

- Brand NEW!
- Clinician’s Perspective
- Assumes familiarity with DSM-IV-TR

- Relax...we’ve got time.

- Good News: 947 vs.. 943 pages
Overview

- Rationale for revisions
- Specific Diagnostic Changes
- Controversies discussed throughout
Why Change?

“DSM must evolve....a too-rigid categorical system does not capture clinical experience or important scientific observations....[it] should accommodate ways to introduce dimensional approaches to mental disorders, including dimensions that cut across current categories.” (p5).
4 Revision Principles

- DSM5 is intended to be used by clinicians
- Revisions should be guided by research evidence
- Consistency with previous versions, where possible
- No constraints should be placed on the degree of change between IV-TR and 5
Organizational Structure

- Many categories have been refined and diagnoses have been re-assigned
- ICD and DSM collaboration to improve clarity and guide research
- Harmony with ICD-11
- Far easier to use (much less page flipping)
- Each d/o has associated differentials and rationales
Dimensional Approach

- Removal of narrow categorical schema
- “...the once plausible goal of identifying homogeneous populations for treatment and research resulted in narrow diagnostic categories that did not capture clinical reality, symptom heterogeneity within disorders, and significant sharing of symptoms across multiple disorders.” (p12)
Improvement Over Previous DSM

- The DSM-5 allows you to better capture the symptoms and severity of the illness.
- Assessments will be much more “dimensional”
- Clinicians will be able to rate both the presence and the severity of the symptoms, such as “Severe,” or “Moderate”
- This rating could also be done to track a patient’s progress in treatment, allowing a way to note improvements even if the symptoms don’t disappear entirely.
Dimensional Approach

- New Groupings were tied to scientific validators
  - Shared neural substrates, family traits, environmental factors, biomarkers, temperamental antecedents, abnormalities of emotional or cognitive processing, symptoms similarity, course of illness, high comorbidity and shared treatment response.
- Internalizing and Externalizing Factors
Developmental/Lifespan Considerations

- Organized by developmental processes
  - Both within and between categories
    - Neurodevelopmental disorders before Bipolar Disorders before Neurocognitive disorders
    - Separation Anxiety Disorder before Specific Phobia before Panic Disorder
DSM5 Categories

- Neurodevelopmental d/o
- Internalizing Group (Emotional and Somatic d/o)
  - Bipolar and Related
  - Depressive
  - Anxiety
  - Obsessive-Compulsive and Related
  - Trauma- and Stressor-Related
  - Dissociative
  - Somatic symptom and Related
DSM5 Categories

- Externalizing Group
  - Feeding and Eating
  - Elimination
  - Sleep-Wake
  - Sexual Dysfunction
  - Gender Dysphoria
  - Disruptive, Impulse-Control and Conduct
  - Substance Related and Addictive
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorders
- Other Mental Disorders/Conditions of Clinical Attention
DSM5 Categories

- Section III
  - Assessment Measures
    - Cross-Cutting Symptom Measures (Adult & child)
    - Clinician rated dimensions of Psychosis Symptom Severity
    - WHO Disability Assessment Schedule 2.0
  - Cultural Formulation
  - Alternative DSM5 Model for Personality Disorders
  - Conditions for Further Study
Attention to Gender, Race, and Ethnicity

- The process for developing the proposed diagnostic criteria for DSM-5 has included careful consideration of how gender, race and ethnicity may affect the diagnosis of mental illness.
What happened to NOS?

- We now have two options!
  - Other Specified D/o
    - Clinician communicates the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class.
    - E.g., “Other Depressive D/o, depressive episode with insufficient symptoms”
  - Unspecified D/o
    - No clinician specific reason
Farewell Multiaxial System

**DSM-IV-TR**
- “The multiaxial distinction among Axis I, II, and III disorders does not imply that there are fundamental differences in their conceptualization....”
- Axis IV problems were specifically defined by DSM-IV
- Axis V: GAF

**DSM-5**
- It’s gone.
- Psychosocial and Environmental problems are directly adopted from ICD-9-CM V codes and the new ICD-10 Z codes.
- WHODAS 2.0 (proposed for further study) Available at psychiatry.org/dsm5
Diagnostic example

Brief Psychotic D/o 298.8 ICD-9CM (F23) ICD-10
Stimulant Use disorder, severe, amphetamine type substance, 304.4 (F15.20)
Homelessness V60.0 (Z59.0)
Extreme Poverty V60.2 (Z59.5)
WHODAS: Average General Disability = 4 Severe
Highlights of Diagnostic Changes

DSM5 (New disorders are underlined)
Neurodevelopmental Disorders

- MR has been replaced with Intellectual Disability
- Communication D/O’s
  - Now include Language and Speech Sound d/o (Replaced mixed receptive-expressive d/o and phonological d/o); added Social (Pragmatic) Comm d/o.
- Autism Spectrum d/o
  - subsumes Asperger’s, Rett’s, Childhood Disintegrative d/o, and PDD NOS.
- ADHD
- Minimal changes to Learning and Motor d/o’s.
Schizophrenia Spectrum

- Schizophrenia
  - Eliminated special attribution of bizarre delusions and Schneiderian first rank AH
  - Added the requirement that at least one of Criterion A symptoms must be delusions, hallucinations or disorganized speech.
  - Eliminated all subtypes
- Schizoaffective d/o
  - Requires that a major mood episode be present for a majority of the illness’s duration
- Delusional D/o
  - No longer requires that delusions be nonbizarre
- Catatonia is now uniform throughout the DSM and may be used with a specifier
- Eliminated Shared Psychotic d/o
Bipolar and Related Disorders

- Diagnosis requires both changes in mood and changes in activity or energy
- Mixed episode is replaced with new specifier: “With mixed features.”
- Anxious Distress specifier was added; all other specifiers remain
- More flexibility for ‘orphaned’ patients whose spectrum of sx$s don’t fit perfectly.
Depressive Disorders

- **Disruptive Mood Dysregulation d/o**
  - Addresses overtreatment and over-dx of bipolar in children. Persistent irritability and episodes of extreme behavior dysregulation
- **PMDD** is now officially classified
- **Persistent Depressive d/o** subsumes dysthymia and chronic MDD
- **Mixed Features** specifier replaced Mixed Episode
- Bereavement symptom duration exclusion has been removed for MDD
- **Other Specified Depressive d/o**
  - can capture recurrent brief depression, short duration episodes, or episodes with insufficient sxs
Anxiety Disorders

- OCD and PTSD removed
- Specific Phobia and Social Anxiety d/o
  - Removed criterion that adults recognize their anxiety is excessive/unreasonable; instead level of anxiety must be disproportional to the actual danger
  - Generalized specifier for SAD has been replaced with ‘performance only’ specifier
- Panic Attacks specifier
  - Panic attacks and Agoraphobia are unlinked in DSM5
- Separation Anxiety d/o and Selective Mutism now are classified here
Obsessive-Compulsive and Related D/O

- New to DSM5
  - Hoarding d/o
  - Excoriation (skin-picking) d/o
  - Substance-induced Obsessive-Compulsive d/o
  - Obsessive-Compulsive and related d/o due to another medical condition
  - Trichotillomania has been reclassified from DSM-IV Impulse-Control d/o category
  - Body Dysmorphic d/o

- Specifiers
  - Good or Fair Insight, Poor Insight and Absent insight/delusional
  - OCD now includes ‘tic-related’ specifier
  - ‘Muscle dysphoria’ added to BDD
  - Delusional variant of BDD is coded with absent insight specifier instead of an additional delusional d/o, somatic type
Trauma- and Stressor-Related Disorders

- Adjustment d/o are reclassified here
- Reactive Attachment d/o and Disinhibited Social Engagement d/o
- PTSD criteria differ significantly
PTSD

- What constitutes ‘traumatic’ is more explicit
- Criterion A2 (DSM-IV) referencing intense-negative subjective reaction has been removed
- DSM-IV had 3 symptoms clusters; DSM5 has 4
  - Re-experiencing
  - Avoidance
  - Persistent negative alterations in cognitions and mood
  - Arousal
    - As with DSM-IV but now includes irritable beh or angry outbursts and reckless or self-destructive beh.
- Dx thresholds have been lowered for children and adolescents.
- Separate criteria have been added for children age 6 or younger.
- Specifier for dissociative symptoms has been added
Definition of Trauma

**DSM-IV Criterion A**

- “1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
- 2) the person’s response involved intense fear, helplessness, or horror.” p467

**DSM-5 Criterion A**

- “Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
  - 1) Directly experiencing the traumatic event(s)
  - 2) Witnessing, in person, the event(s) as it occurred to others.
  - 3) Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental
  - 4) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)....” p271
Dissociative Disorders

- Depersonalization d/o is now Depersonalization/Derealization d/o
- Dissociative Fugue is now a specifier of Dissociative Amnesia
- Dissociative Identity d/o
  - Disruptions of identity may be reported as well as observed
  - Gaps in recall for events may occur for everyday, not just traumatic events.
Somatic Symptom and Related Disorders

- New name for Somatoform d/o
- Very likely to be identified/treated by the PCP and NOT by psychiatry
- Reduces number of d/o to avoid problematic overlap
- Somatization, hypochondriasis, pain, and undiff. somatoform d/o have been removed
- Somatic Symptom d/o = somatization d/o
- Illness Anxiety d/o = hypochondriasis
- Psychological factors affecting other medical conditions
- Conversion d/o (Functional Neurological Symptom d/o)
Feeding and Eating Disorders

- Avoidant/restrictive food intake d/o for infants
- Anorexia nervosa
  - requirement for amenorrhea was eliminated.
- Bulimia nervosa
  - Average frequency of binge/compensatory beh reduced to once weekly
- Binge Eating d/o
  - Criteria as proposed in DSM-IV appendix is unchanged substantially
Sleep-Wake Disorders

- Narcolepsy (associated with hypocretin deficiency) is now distinguished from hypersomnolence d/o
- Breathing-related sleep d/o
  - Obstructive sleep apnea
  - Hypopnea
  - Central sleep apnea
  - Sleep-related hypoventilation
- Expanded circadian rhythm sleep disorders
- REM sleep Behavior d/o
- Restless Legs syndrome
Sexual Dysfunctions

- Female arousal and desire d/o have been combined: Female sexual interest/arousal d/o
- Genito-pelvis pain/penetration d/o
- Sexual Aversion d/o removed
- 2 subtypes:
  - Lifelong vs. acquired
  - Generalized vs. situational
Gender Dysphoria

- Emphasizes the phenomenon of gender incongruence rather than cross-gender identification, as in DSM-IV Gender Identity d/o
- Criteria for Child diagnosis has been made more restrictive and conservative
- Subtyping on the basis of sexual orientation was removed
- Posttransition specifier
Disruptive, Impulse-Control, and Conduct Disorders

- ODD criteria grouped in 3 types:
  - Angry/irritable mood
  - Argumentative/defiant behavior
  - Vindictiveness

- Conduct d/o now requires limited prosocial emotions

- Intermittent Explosive d/o criteria is not limited to physical aggression
Substance-Related and Addictive Disorders

- **Gambling d/o**
- Abuse and Dependence replaced with **Substance Use d/o**
  - Criteria included for Intoxication, Withdrawal, Substance-Induced and Unspecified Substance-Related d/o
  - New criterion: **Craving**
  - Threshold for Dx set at 2 criteria
- **Cannabis and Caffeine Withdrawals**
Substance-Related and Addictive Disorders

- Severity of SUD is based on number of endorsed criteria
  - Mild 2-3
  - Moderate 4-5
  - Severe 6+
- Specifiers
  - Early remission
  - Sustained remission
  - In a controlled environment
  - On maintenance therapy
- Eliminated from DSM-5
  - With/Without Physiological dependence
  - Partial/Full remissions specifiers
  - Polysubstance Dependence
SUD Criteria

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 2 (or more) of the following, occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

2. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

3. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

4. tolerance, as defined by either of the following:
   a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b. markedly diminished effect with continued use of the same amount of the substance

(Note: Tolerance is not counted for those taking medications under medical supervision such as analgesics, antidepressants, ant-anxiety medications or beta-blockers.)
SUD Criteria Continued

5. withdrawal, as manifested by either of the following:
   a. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
   b. the same or a closely related substance is taken to relieve or avoid withdrawal symptoms

6. the substance is often taken in larger amounts or over a longer period than was intended

7. there is a persistent desire or unsuccessful efforts to cut down or control substance use

8. a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects

9. important social, occupational, or recreational activities are given up or reduced because of substance use

10. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

11. Craving or a strong desire or urge to use a specific substance.
Neurocognitive Disorders

- Dementia and Amnestic d/o are subsumed under **Major or mild Neurocognitive d/o**.
  - Specific criteria for various etiologies are incorporated
Personality Disorders

- The criteria for the 10 DSM-5 PD’s have not changed.
- Alternative approach was field tested
Personality Disorder (Proposed)

- Criteria similar to current understanding
  - i.e., pervasive and relatively stable pattern of behavior, cognitions, affect and social interaction that are maladaptive

- Conceptualizes functioning based on dimensions of healthy vs. pathological personality domains & traits
  - Adopted from over a century of Personality Research
PD Proposed

- Impairment in functioning areas (2 or more):
  - Identity
  - Self-Direction
  - Empathy
  - Intimacy

- Presence of Pathological Personality Trait domains (or facets) (1 or more):
  - Negative Affectivity (vs. Emotional Stability)
  - Detachment (vs. Extraversion)
  - Antagonism (vs. Agreeableness)
  - Disinhibition (vs. Conscientiousness)
  - Psychoticism (vs. Lucidity)
Negative Affectivity (vs. Emotional Stability)
- Emotional Lability
- Anxiousness
- Separation Insecurity
- Submissiveness
- Hostility
- Perseveration
- Depressivity
- Suspiciousness
- Restricted Affectivity

Detachment (vs. Extraversion)
- Withdrawal
- Intimacy Avoidance
- Anhedonia
- Depressivity
- Restricted Affectivity
- Suspiciousness

Antagonism (vs. Agreeableness)
- Agreeableness
- Manipulativeness
- Deceitfulness
- Grandiosity
- Attention Seeking
- Callousness
- Hostility

Disinhibition (vs. Conscientiousness)
- Irresponsibility
- Impulsivity
- Distractibility
- Risk Taking
- Rigid Perfectionism

Psychoticism (vs. Lucidity)
- Unusual Beliefs/experiences
- Eccentricity
- Cognitive and Perceptual Dysregulation
Conclusions

- DSM-5 has been a work in progress for 12 years and represents the most current understanding of psychiatric, psychological, and neurologic literature.
- Discrete classification has been tempered by dimensional conceptualization regarding symptoms and severity of presentation.
- Developmental and Cultural implications are woven throughout for clarity, parsimony and to incorporate the broadest global understanding of mental disorders.
- Designed with the clinician in mind for ease of use.
Thank You!
Questions?
Comments?
Concerns?