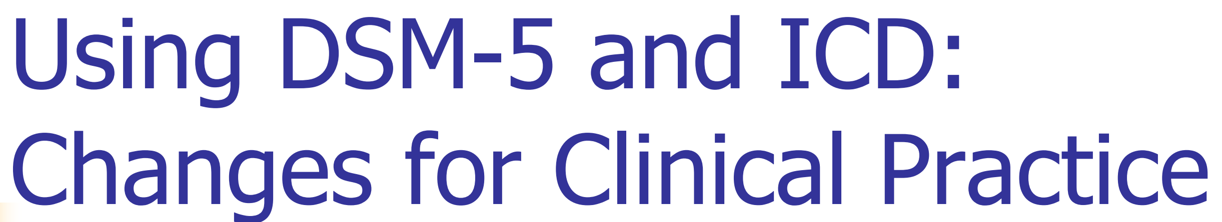

Using DSM-5 and ICD: Changes for Clinical Practice

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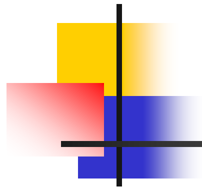
Overview

- Purpose of a classification
- Categorical vs Dimensional systems
- Changes to multiaxial system
- Highlights of child and adolescent disorders
- Highlights of adult disorders
- Optional dimensional systems



Why use a diagnostic classification system like the DSM or ICD?

What does it do for you?

Purpose of Classification

1. Communication
2. Organizing and retrieving information
3. Describing patterns of symptoms
4. Prediction
5. Discovering etiologies
6. Sociopolitical functions

DSM-5 Development Process

- Frances, A., & Widiger, T. (2012). Psychiatric diagnosis: Lessons from the DSM-IV past and cautions for the DSM-5 future. *Annual Review of Clinical Psychology*, *8*, 109-130.
- Greenberg, G. (2013). *The book of woe: The DSM and the unmaking of psychiatry*. New York: Blue Rider Press.
- Kraemer, H., Kupfer, D., Narrow, W., Clarke, D., & Regier, D. (2010). Moving toward DSM-5: The field trials. *American Journal of Psychiatry*, *167*, 1158-1160.
- Kupfer, D., & Regier, D. (2010). Why all of medicine should care about DSM-5. *JAMA*, *303*, 1974-1975.
- Paris, J., & Phillips, J. (2013). *Making the DSM-5: Concepts and controversies*. New York: Springer.

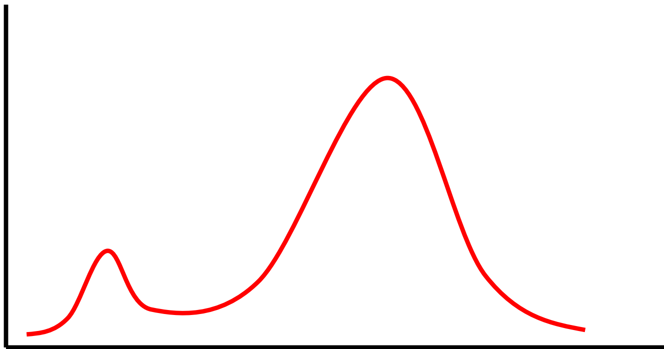
Categories vs. Dimensions

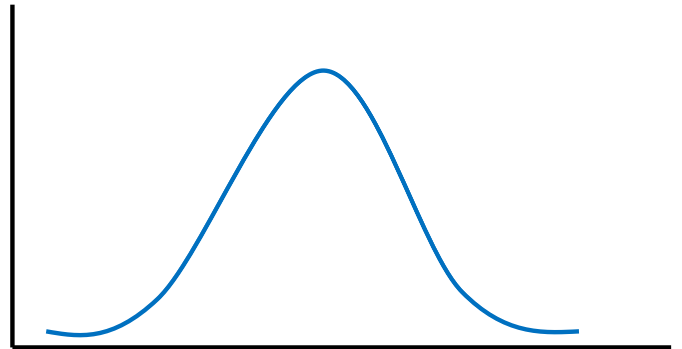
- Are people with disorders inherently different?
  - Qualitative difference = categories
- Are people with disorders inherently the same?
  - Difference of degree = dimensions

Categories vs. Dimensions

- CASE DESCRIPTION

Categories vs. Dimensions





Categories vs. Dimensions

- Simpler decision
- Less information
- Consistent with administrative realities
- Perhaps more natural for human cognition

- More information
- More complicated
- Deals with overlap
- Seems more consistent with more conditions

DSM-5 Organization

- Section I – introductory material
- Section II – disorder descriptions
- Section III – "emerging measures and models"
- Appendices

Multiaxial System

DSM-IV	DSM-5
Axis I	All in Section II
Axis II	
Axis III	
Axis IV	
Axis V	WHODAS 2.0

Multiaxial System-I,II,III

- "The multiaxial distinction among Axis I, Axis II, and Axis III disorders does not imply that there are fundamental differences in their conceptualization, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes."

(APA, 2000, p. 29)

NOS diagnoses

- Other specified disorder
  - Clinician writes in why the person does not meet criteria for some other disorder
- Unspecified disorder
  - No additional information

Multiaxial System-IV

- Psychosocial stressors now covered under V codes
  - More consistent reporting
- Adopted ICD system of Z codes to expand current V codes
- Expanded from 39 in DSM-IV to 133 in DSM-5

Multiaxial System-IV

- Relational Problems
- Abuse and Neglect
- Educational and Occupational Problems
- Housing and Economic Problems
- Other Problems Related to the Social Environment
- Problems Related to Crime or Interaction with the 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

Multiaxial System-V

- WHODAS 2.0 (Ustun, Kostanjsek, Chatterji, & Rehm, 2010)
  - 7 scales – cognition, mobility, self-care, getting along, life activities, household, participating in society
  - Test-retest reliability .93-.96
  - Internal consistencies all >.93
  - Sensitive to change!
  - Solid concurrent validity

http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Meta-structure for DSM-5

- Neurodevelopmental
- Schizophrenia Spectrum & Other Psychotic
- Bipolar & Related
- Depressive
- Anxiety
- Obsessive-Compulsive and Related
- Trauma and Stressor Related
- Dissociative
- Somatic Symptom & Related
- Feeding and Eating
- Elimination
- Sleep-Wake
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct
- Substance-Related and Addictive
- Neurocognitive
- Personality
- Paraphilic
- Other Mental Disorders
- Medication-Induced Movement and Other Adverse Effects
- Other Conditions that may be a Focus of Clinical Attention

Meta-structure for DSM-5

DSM-IV

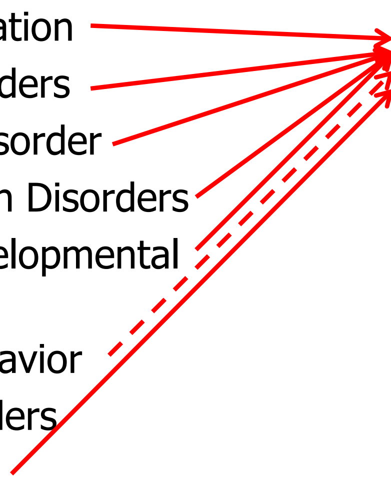
- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Pervasive Developmental Disorders
- Disruptive Behavior
- Feeding Disorders
- Tic Disorders
- Elimination Disorders
- Separation Anxiety
- Selective Mutism
- Reactive Attachment

DSM-5

- Neurodevelopmental
- Depressive Disorders
- Anxiety Disorders
- Trauma- and Stressor-Related Disorders
- Feeding and Eating
- Elimination Disorders
- Disruptive, Impulse-control & Conduct

Meta-structure for DSM-5

DSM-IV	DSM-5
Mental Retardation	Neurodevelopmental
Learning Disorders	Depressive Disorders
Motor Skills Disorder	Anxiety Disorders
Communication Disorders	Trauma- and Stressor-Related Disorders
Pervasive Developmental Disorders	Feeding and Eating
Disruptive Behavior	Elimination Disorders
Feeding Disorders	Disruptive, Impulse-control & Conduct
Tic Disorders	
Elimination Disorders	
Separation Anxiety	
Selective Mutism	
Reactive Attachment	



Meta-structure for DSM-5

DSM-IV

- Mental Retardation
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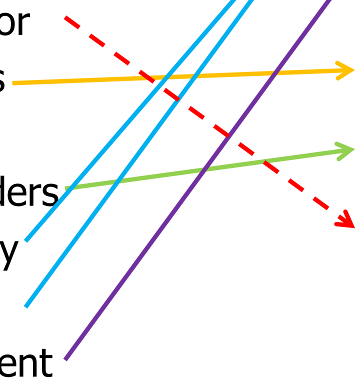

DSM-5

- Neurodevelopmental
- Depressive Disorders
- Anxiety Disorders
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Meta-structure for DSM-5

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- Personality
- Paraphilic
- Other Mental Disorders
- Medication-Induced Movement and Other Adverse Effects
- Other Conditions that may be a Focus of Clinical Attention

Metastructure for DSM-5

- Consistent with structural studies of psychopathology
  - Brown, Chorpita, Barlow, 1998
  - Kotov, Ruggero, Krueger, Watson, Yuan, & Zimmerman, 2011
  - Krueger, Markon, Patrick, & Iacono, 2005
- Consistent with clinicians implicit organizational structures
  - Flanagan, Keeley, & Blashfield, 2008
  - Roberts et al., 2012

Comparison to ICD-11

DSM-5	ICD-11
Produced by single national professional organization	Produced by global health agency of UN
Provides large proportion of APA revenue	Free and open resource to advance public good
For psychiatrists	For 1) countries, and 2) front-line service providers
Dominated by US, Anglophone perspective	Global, multidisciplinary, multilingual development
Approved by APA Board of Trustees	Approved by World Health Assembly
Covers only mental disorders	Covers all health conditions

Comparison to ICD-11

- ICD-11 diagnostic guidelines tend to be more flexible than DSM-5 criteria
- ICD produces multiple versions:
  - For clinical use
  - For research use
  - For primary care

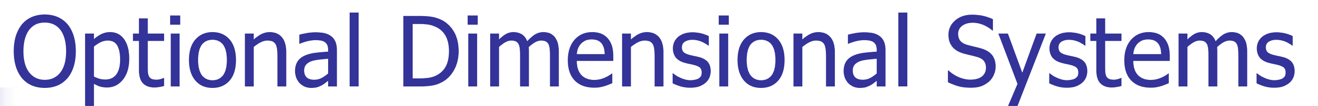
Select “Childhood” Disorders

- Autism Spectrum Disorder
- ADHD
- Specific Learning Disorder
- Attachment Disorders
- Disruptive Mood Dysregulation Disorder

Select “Adult” Disorders

- Schizophrenia
- Substance Use Disorder
- OCD/Hoarding
- ARFID/Binge Eating
- PTSD
- Neurocognitive Disorders

Optional Dimensional Systems



- Personality Disorders
  - In Section II, same as DSM-IV
  - In Section III, alternative hybrid categorical/dimensional system

General Criteria for PD

A. Moderate or greater impairment in personality functioning
B. One or more pathological personality traits
C. Inflexible and pervasive
D. Stable across time/present since adolescence

Personality Functioning

- Self
  - Identity
  - Self-direction
- Interpersonal
  - Empathy
  - Intimacy

Personality Functioning

Level of Impairment	Identity
0-little or no impairment	Has ongoing awareness of a unique self; maintains role-appropriate boundaries.
1-some impairment	Has relatively intact sense of self, with some decrease in clarity of boundaries when strong emotions and mental distress are experienced.
2-moderate impairment	Depends excessively on others for identity definition, with compromised boundary delineation.
3-severe impairment	Has a weak sense of autonomy/agency; experience of a lack of identity or emptiness. Boundary definition is poor or rigid: may show overidentification with others, overemphasis on independence from others, or vacillation between these.
4-extreme impairment	Experience of a unique self and sense of agency/autonomy are virtually absent, or are organized around perceived external persecution. Boundaries with others are confused or lacking.

- Negative Affectivity (vs Emotional Stability)
  - Emotional lability, Anxiousness, Separation insecurity, Submissiveness, Hostility, Perseveration

Personality Traits

- Detachment (vs Extraversion)
  - Withdrawal, Intimacy avoidance, Anhedonia, Depressivity, Restricted affectivity, Suspiciousness
- Antagonism (vs Agreeableness)
  - Manipulativeness, Deceitfulness, Grandiosity, Attention seeking, Callousness, Hostility

Personality Traits

- Disinhibition (vs Conscientiousness)
  - Irresponsibility, Impulsivity, Distractibility, Risk taking, Lack of rigid perfectionism
- Psychoticism (vs Lucidity)
  - Unusual beliefs and experiences, eccentricity, cognitive and perceptual dysregulation

PID-5

- Personality Inventory for DSM-5 (PID-5)
  - 220 items
  - 0 (*very false*) to 3 (*very true*) scale
  - Internal consistency of facets ranges from .73 to .96
  - Stable factor structure across samples

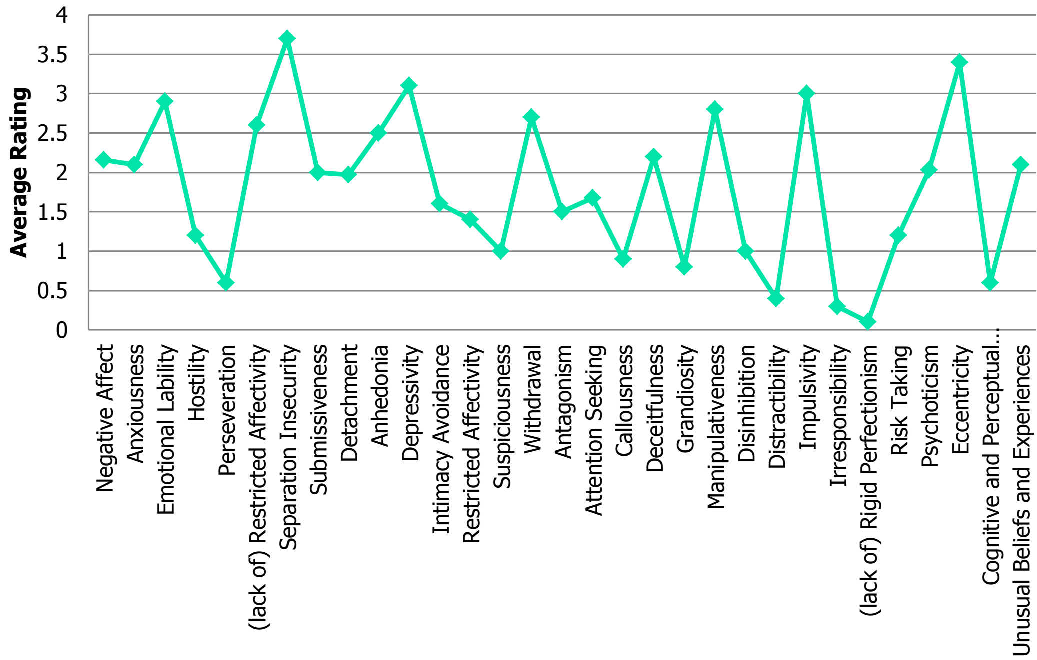
(Krueger, Derringer, Markon, Watson, & Skodol 2012; Wright, Thomas, Hopwood, Markon, Pincus, & Krueger, 2012)

http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PID-5

- There is a child version (ages 11-17)
  - Brief form (25-items) or full form (220-item)
- Also an informant version

PID-5



Cross-Cutting Symptom Measures

- Level 1 = short screener across most areas of psychopathology
- Available in adult, parent-rated (ages 6-17), and child-rated (ages 11-17) versions
- Any score of 2 or greater (on 0-4 scale) should complete Level 2 specific symptom questionnaire

http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Cross-Cutting Symptom Measures

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: ________________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:** ___________

Relationship with the child: ____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	

Cross-Cutting Symptom Measures

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: ______________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**__________

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		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1 (circled)	2	3	4	1
	2.	Said he/she was worried about his/her health or about getting sick?	0 (circled)	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1 (circled)	2	3	4	1
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0 (circled)	1	2	3	4	0
IV.	5.	Had less fun doing things than he/she used to?	0	1	2 (circled)	3	4	2
	6.	Seemed sad or depressed for several hours?	0	1 (circled)	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0 (circled)	1	2	3	4	0
	8.	Seemed angry or lost his/her temper?	0 (circled)	1	2	3	4	

LEVEL 2—Depression—Parent/Guardian of Child Age 6-17*

*PROMIS Emotional Distress—Depression—Parent Item Bank

Child's Name: ______________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**__________

What is your relationship with the child receiving care?____

<u>Instructions to parent/guardian:</u> On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "not finding interest or pleasure in doing things" and/or "seeming down, depressed, or hopeless" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **<u>during the past 7 days.</u>** **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) days, my child said he/she ...							**Item Score**
		Never	**Almost Never**	**Sometimes**	**Often**	**Almost Always**	
1.	Could not stop feeling sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	Felt alone.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	Felt like he/she couldn't do anything right.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	Felt lonely.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	Felt sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	Felt unhappy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	Thought that his/her life was bad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
8.	Didn't care about anything.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
9.	Felt stressed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
10.	Felt too sad to eat.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
11.	Wanted to be by himself/herself.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Depression—Parent/Guardian of Child Age 6-17*

*PROMIS Emotional Distress—Depression—Parent Item Bank

Child's Name: ________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**___________

What is your relationship with the child receiving care?____

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							Clinician Use
In the past SEVEN (7) days, my child said he/she ...							**Item Score**
		Never	**Almost Never**	**Sometimes**	**Often**	**Almost Always**	
1.	Could not stop feeling sad.	❑ 1	❑ 2	✓ 3	❑ 4	❑ 5	3
2.	Felt alone.	❑ 1	❑ 2	❑ 3	✓ 4	❑ 5	4
3.	Felt like he/she couldn't do anything right.	❑ 1	✓ 2	❑ 3	❑ 4	❑ 5	2
4.	Felt lonely.	❑ 1	❑ 2	❑ 3	✓ 4	❑ 5	4
5.	Felt sad.	❑ 1	❑ 2	❑ 3	❑ 4	✓ 5	5
6.	Felt unhappy.	❑ 1	❑ 2	✓ 3	❑ 4	❑ 5	3
7.	Thought that his/her life was bad.	✓ 1	❑ 2	❑ 3	❑ 4	❑ 5	1
8.	Didn't care about anything.	❑ 1	✓ 2	❑ 3	❑ 4	❑ 5	2
9.	Felt stressed.	❑ 1	❑ 2	✓ 3	❑ 4	❑ 5	3
10.	Felt too sad to eat.	❑ 1	❑ 2	❑ 3	✓ 4	❑ 5	4
11.	Wanted to be by himself/herself.	❑ 1	❑ 2	❑ 3	✓ 4	❑ 5	4
						Total/Partial Raw Score:	35
						Prorated Total Raw Score:	
						T-Score:	

Scoring and Interpretation

Each item on the measure is rated on a 5-point scale (1=never; 2=almost never; 3=sometimes; 4=often; and 5=almost always) with a range in score from 11 to 55 with higher scores indicating greater severity of depression. The clinician is asked to review the score on each item on the measure during the clinical interview and indicate the raw score for each item in the section provided for "Clinician Use." The raw scores on the 11 items should be summed to obtain a total raw score. Next, the T-score table should be used to identify the T-score associated with the total raw score and the information entered in the T-score row on the measure. Interpretations of the T-scores are:

Score	T-Score	SE
11	32.1	5.6
12	36	4.9
13	38.6	4.6
14	41.1	4.1
15	43.2	3.8
16	45.1	3.5
17	46.7	3.4
18	48.2	3.3
19	49.6	3.2
20	50.9	3.1
21	52.2	3
22	53.5	3
23	54.6	3
24	55.8	2.9
25	57	2.9
26	58.1	2.9
27	59.2	2.9
28	60.3	2.9
29	61.3	2.9
30	62.4	2.9
31	63.5	2.9
32	64.5	2.9
33	65.6	2.9

Score	T-Score	SE
34	66.6	2.9
35	67.7	2.8
36	68.7	2.8
37	69.7	2.8
38	70.7	2.8
39	71.7	2.8
40	72.7	2.8
41	73.8	2.8
42	74.8	2.8
43	75.8	2.8
44	76.9	2.9
45	78	2.9
46	79.1	2.9
47	80.2	3
48	81.4	3.1
49	82.6	3.2
50	83.8	3.3
51	85.2	3.4
52	86.5	3.5
53	87.9	3.5
54	89.3	3.4
55	90.5	3.2

Note: This look-up table works only if all items on the form are answered. If 75% or more of the questions have been answered, you are asked to prorate the raw score and then look up the conversion to T-Score. The formula to prorate the partial raw score to Total Raw Score is:

(Raw sum x number of items on the short form)
Number of items that were actually answered

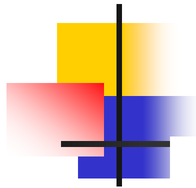
If the result is a fraction, round to the nearest whole number. For example, if 10 of 11 items were answered and the sum of those 10 responses was 30, the prorated raw score would be 30 X 11/10 = 33. The T-score in this example would be 65.6.

The T-scores are interpreted as follows:

Less than 55 = None to slight
55.0—59.9 = Mild
60.0—69.9 = Moderate
70 and over = Severe

If more than 25% of the total items (in this case more than 2) are missing a response, the scores should not be used. Therefore, the parent or guardian should be encouraged to complete all of the items on the measure.

Early Development and Home Background Form



Early Development and Home Background (EDHB) Form—Parent/Guardian

Child's Name: ________________________ **Age:** ____ **Sex:** ❑ Male ❑ Female **Date:**__________

Instructions to Parent or Guardian: Questions P1-P19 ask about the early development and early and current home experiences of your child. Some questions require that you think as far back as to the birth of your child. Your response to these questions will help your child's clinician better understand and care for your child. Answer each question to the best of your knowledge or memory.

What is your relationship with the child receiving care? ____

Please choose one response (✓ or x) for each question.					
Early Development		**No**	**Yes**	**Can't Remember**	**Don't Know**
P1.	Was he/she born before he/she was due (premature)?	☐	☐	☐	☐
P2.	Were the doctors worried about his/her medical condition immediately after he/she was born?	☐	☐	☐	☐
P3.	Did he/she have to spend any time in a neonatal intensive care unit (NICU)?	☐	☐	☐	☐
P4.	Could he/she walk on his/her own by the age of 18 months?	☐	☐	☐	☐
P5.	Has he/she ever had a seizure?	☐	☐	☐	☐
P6.	Did he/she ever lose consciousness for more than a few minutes after an accident?	☐	☐	☐	☐
Early Communication					
P7.	By the time he/she was age 2, could he/she put several words together when speaking?	☐	☐	☐	☐
P8.	Could people who didn't know him/her understand his/her speech by the time he/she reached age 4?	☐	☐	☐	☐

Cultural Formulation Interview

- Set of 16 interview questions clinicians may use to assess impact of culture on presenting complaint
- Gives goals for each interview domain and example wording of questions

Questions?

Thank you!

Jared Keeley

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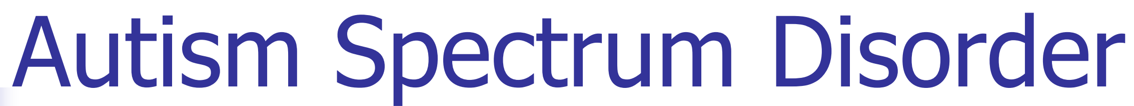
Autism Spectrum Disorder



- Encompasses Autism, Asperger's, Rett's, Childhood Disintegrative, and PDD-NOS
- Combined because evidence did not support separating the conditions

Autism Spectrum Disorder

- DSM-IV differentiated Autism from Asperger's via language impairment
- However, a large body of research has shown that individuals with Asperger's do have language impairment
- IQ is higher in Asperger's, but few differences from "high functioning autism"

Autism Spectrum Disorder

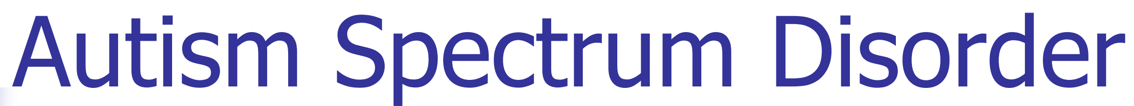
- Combined “social interaction” and “communication” domains from DSM-IV
- Need each(in multiple contexts) of:
  - Deficits in social-emotional reciprocity
  - Deficits in nonverbal communication
  - Deficits in developing, maintaining, and understanding relationships

Autism Spectrum Disorder

- Restricted, repetitive patterns of behavior stayed similar
  - Need 2 criteria instead of 1 from DSM-IV
  - Expanded hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of environment

Autism Spectrum Disorder

- Must occur in “early developmental period”
  - Prior wording was before age 3
  - Allows more flexibility when symptoms do not emerge until increase social demands are placed on child (e.g., school)
- Added explicit clinical significance criterion



Autism Spectrum Disorder

- Added specifiers
  - Severity of social and repetitive behavior domains (3 levels each)
  - With or without intellectual impairment
  - With or without language impairment
  - Association with medical or genetic condition
  - Association with other disorders
  - With catatonia

Autism Spectrum Disorder

- Previous diagnoses of Autism, Asperger’s or PDD should be given ASD diagnosis
- Individuals with social communication problems but no repetitive/restrictive behavior should consider “social (pragmatic) communication disorder”

END

ADHD

- Inattentive and hyperactive/impulsive criteria remain the same (still need 6 of one or both)
- CAVEAT: for age 17 and over, only need 5 of either

ADHD

- Age restriction is relaxed to 12 years (versus 7 in DSM-IV)
- The symptoms have to be present in two settings, but impairment only has to be present in at least one (used to be two as well)
- Mild/Moderate/Severe specifiers added

END

Specific Learning Disorder

- Combines Reading, Mathematics, and Written Expression
- For age 17 and up, a documented history of impairing learning difficulties can substitute for standardized assessment

Specific Learning Disorder

- Explicit mention that symptoms may not become evident until demands for those skills exceed the person's capacities
  - i.e., may not manifest until later in life for some
- Code together if multiple are present
- Specify Mild/Moderate/Severe

END

Reactive Attachment Disorder

- Former DSM-IV concept is split between two disorders in DSM-5:
  - Reactive Attachment Disorder
  - Disinhibited Social Engagement Disorder

Reactive Attachment Disorder

- A) Inhibited, emotionally withdrawn behavior towards caregivers; minimally seeking or responding to comfort
- B) Minimal social/emotional responsiveness, limited positive affect, unexplained episodes of irritability, sadness, or fear

Reactive Attachment Disorder

- Presumed to be caused by:
  - Social neglect or deprivation by adult caregivers
  - Repeated changes in primary caregiver
  - Reared in unusual settings that severely limit opportunities to form attachments

Disinhibited Social Engagement Disorder

- A) Child actively approaches and interacts with unfamiliar adults
  - Reduced reticence to interact with unfamiliar adults
  - Overly familiar verbal/physical behavior
  - Diminished checking back with caregiver
  - Willingness to go with stranger with little hesitation

Disinhibited Social Engagement Disorder

- B) Not limited to impulsivity
- C) Presumed to be due to same factors as listed with Reactive Attachment

Reactive Attachment

- Split is more consistent with current attachment literature
  - Anxious/avoidant vs ambivalent

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of Attachment: A Psychological Study of the Strange Situation*. Hillsdale, NJ: Erlbaum.

Cassidy, J., & Shaver, P. R. (1999). *Handbook of attachment: Theory, research, and clinical applications*. New York: The Guilford Press.

Finzi, R., Cohen, O., Sapir, Y., & Weizman, A. (2000). Attachment styles in maltreated children: A comparitive study. *Child Psychiatry and Human Development*, *31*, 113-128.

END

Disruptive Mood Dysregulation Disorder

- Severe temper outbursts “grossly” out of proportion for situation
- Inconsistent with developmental level
- Outbursts 3+ times per week
- Mood between outbursts is persistently irritable or angry most of day, nearly every day

Disruptive Mood Dysregulation Disorder

- Present 12 or more months, never a period of more than 3 months without all 4 symptoms
- Not diagnosed for first time before age 6 or after age 18
- Onset before age 10
- Outbursts and mood present in at least two settings

Disruptive Mood Dysregulation Disorder

- CANNOT be diagnosed if there has ever been a manic episode
- CANNOT diagnose Oppositional Defiant as well—DMDD trumps it
- Behaviors do not occur exclusively during a depressive episode

Disruptive Mood Dysregulation Disorder

- Could reduce diagnosis of childhood bipolar disorder, but depends upon method of diagnosis (self-report vs observation)

Margulies, D., Weintraub, S., Basile, J., Grover, P., & Carlson, G. (2012). Will disruptive mood dysregulation disorder reduce false diagnosis of bipolar disorder in children? *Bipolar Disorders*, *14*, 488-496.

Disruptive Mood Dysregulation Disorder

- Overlaps substantially with ODD (odds ratio 52.9 to 103.0)
  - If excluded, DMDD rates drop significantly
- Overlaps highly with MDD (odds ratio 9.9 to 23.5)

Copeland, W., Angold, A., Cosstello, E. J., & Egger, H. (2013). Prevalence, comorbidity, and correlates of DSM-5 proposed disruptive mood dysregulation disorder. *American Journal of Psychiatry*, *170*, 173-179.

END

Schizophrenia Spectrum

- Schizophrenia, Schizophreniform, Brief Psychotic, Schizoaffective, Delusional, & Schizotypal PD

Schizophrenia

- No more exception for “bizarre” delusions or hallucinations
- Need two symptoms; at least one must be delusions, hallucinations, or disorganized speech
- No more subtypes!
  - Instead, optional dimensional specifiers

Schizophrenia

- Rate highest severity in past 7 days
  - Hallucinations
  - Delusions
  - Disorganized Speech
  - Abnormal psychomotor behavior
  - Negative symptoms (emotion & volition)
  - Impaired cognition
  - Depression
  - Mania

Schizophrenia

Rating	Delusions
0	Not present
1	Equivocal (severity or duration not sufficient to be considered psychosis)
2	Present, but mild (little pressure to act upon delusional beliefs, not very bothered by beliefs)
3	Present and moderate (some pressure to act upon beliefs, or is somewhat bothered by beliefs)
4	Present and severe (severe pressure to act upon beliefs, or is very bothered by beliefs)

Schizophrenia

Hallucinations	3
Delusions	0
Disorganized Speech	2
Psychomotor	1
Negative Symptoms	4
Impaired Cognition	4
Depression	0
Mania	1

VS. Undifferentiated Subtype

END

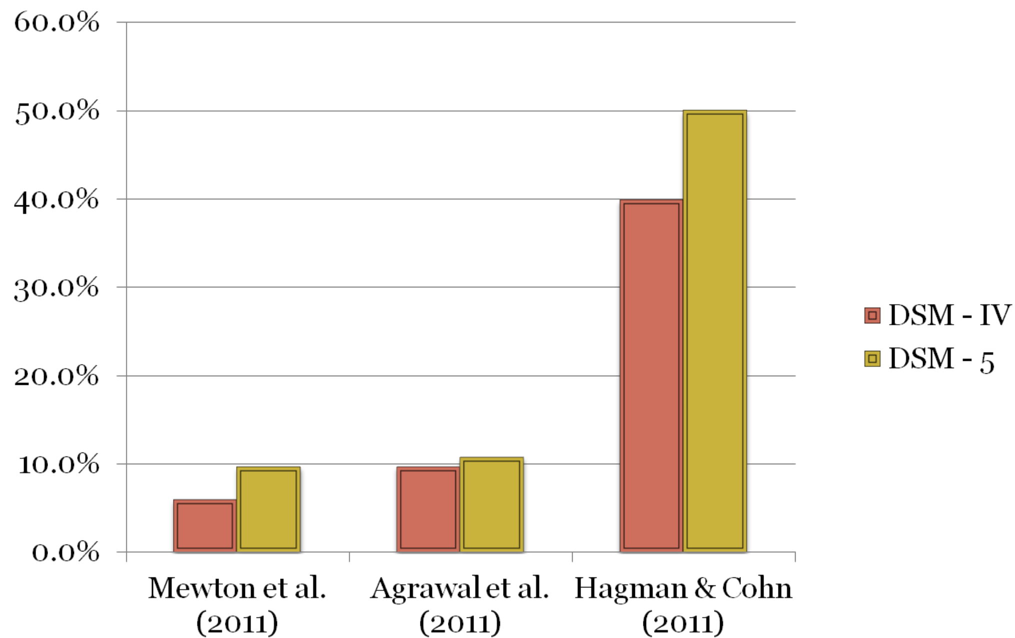
Substance Use Disorder

- Combined Dependence and Abuse into "Substance Use Disorder"
- Criteria are same except for:
  - Removed "legal problems" from abuse
  - Added "craving"
- Need presence of 2 of 11 criteria (instead of 3 of 7 for Dependence or 1 of 4 for Abuse)

Substance Use Disorder

- Specify severity:
  - 2-3 criteria = Mild
  - 4-5 criteria = Moderate
  - 6 or more = Severe

Substance Use Disorder



Substance Use Disorder

- Gambling Disorder (formerly Pathological Gambling) is now placed in this heading
  - Now need 4 instead of 5 symptoms in *12 month period*
  - Omitted "illegal acts to finance gambling" criterion
- Also has Mild/Moderate/Severe specifiers

END

OCD Spectrum

- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania
- Exoriation (Skin-picking) Disorder

Boyer, P., & Lienard, P. (2008). Ritual behavior in obsessive and normal individuals: Moderating anxiety and reorganizing the flow of action. *Current Directions in Psychological Science*, *17*, 291-294.

OCD

- Obsession criterion shortened
  - Removed “the thoughts, impulses, or images are not simply excessive worries about real-life problems” and “the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind”
- Caveat added for children not being able to articulate aims of behaviors

OCD

- Removed requirement that person recognize obsessions or compulsions are unreasonable
- Many more examples of rule out conditions than DSM-IV

OCD

- Specifiers
  - Good or fair insight
  - Poor insight
  - Absent insight/delusional beliefs
- Specify if Tic-related

Hoarding Disorder

- Difficulty discarding items, regardless of value
- Accumulation of possessions results in clutter that substantially compromises intended use of space
- Standard clinically significant distress/impairment statement

Hoarding Disorder

- Specifiers
  - With excessive acquisition
  - Good or fair insight
  - Poor insight
  - Absent insight/delusional beliefs

END

Avoidant/Restrictive Food Intake Disorder (ARFID)

- Apparent lack of interest in food (but not due to fear of getting fat)
- Avoid foods based on sensory characteristics
- Concern about aversive consequences of eating (feeling full, choking)

ARFID

- Results in:
  - Significant weight loss, or failure to achieve expected gains in children
  - Significant nutritional deficiency
  - Dependence on nutritional supplements or tube feeding
  - Marked interference with psychosocial functioning

ARFID

- Not explained by lack of available food or culturally sanctioned practice
- Does not occur exclusively with anorexia or bulimia
- No disturbance in evaluation of one's body shape or weight

Kreipe, R., & Palomaki, A. (2012). Beyond picky eating: Avoidant/Restrictive Food Intake Disorder. *Current Psychiatry Reports*, *14*, 421-431.

Binge Eating Disorder

- Eating Binge
  - In a discrete period of time
  - An amount of food definitely larger than what most people would eat under similar circumstances
  - Sense of loss of control over eating

Binge Eating Disorder

- Episodes associated with 3+ of:
  - Eating more rapidly than normal
  - Eating until uncomfortably full
  - Eating when not hungry
  - Eating alone because of embarrassment about amount
  - Feeling disgusted/depressed/guilty afterward

Binge Eating Disorder

- Marked distress about binges
- Binges occur at least once a week for 3 months
- Binge eating not associated with any compensatory behaviors
- Does not occur in course of bulimia or anorexia

END

PTSD

- Definition of trauma changed
- Split old avoidance criterion into avoidance and mood/cognition
- New specifiers
- Separate criteria for ages >6 and ≤6

Definition of Trauma

- Exposed to actual/threatened death, injury, violence:
  - Directly
  - Witness
  - Learning it happened to family member or close friend (must be violent or accidental)
  - Repeated exposure to aversive details of event (not through media unless work-related)

Definition of Trauma

- No more specifying an emotional reaction to the event

PTSD

- "re-experiencing" = "intrusion"
- If dreams, they must be related to the content of the trauma
- Other intrusion criteria stayed the same
- Still need 1 of 5

PTSD

- Avoidance need 1 of 2
  - Avoid distressing memories, thoughts, events associated with trauma
  - Avoid reminders that arouse memories, thoughts, feelings associated with trauma

PTSD

- Negative alterations in mood/cognition need 2 of 7
  - Inability to remember important part of event
  - *Persistent/exaggerated negative beliefs about self, others, world*
  - *Persistent distorted cognitions about cause/consequence of trauma*
  - *Persistent negative emotional state (fear, anger, guilt, etc.)*
  - Diminished interest/participation
  - Feeling detached/estranged from others
  - *Persistent inability to experience positive emotions*

PTSD

- Arousal need 2 of 6
  - Irritable behavior/angry outbursts
  - *Reckless/self-destructive behavior*
  - Hypervigilance
  - Exaggerated startle response
  - Problems concentrating
  - Sleep disturbance

PTSD

- Specifiers:
  - With dissociative symptoms
    - Depersonalization
    - Derealization
  - With delayed expression
    - >6 months after event

PTSD ≤6

- Removed options for trauma are limited to parents/caregivers
- Intrusions—not necessary to link content of dreams to trauma

PTSD ≤6

- Only need one avoidance or altered cognition
  - Increased negative emotional states
  - Diminished interest/participation, including constricted play
  - Socially withdrawn
  - Reduction in expression of positive emotions

PTSD ≤6

- Arousal
  - “reckless or self-destructive behavior” removed
  - Irritable/angry includes extreme tantrums

END

Neurocognitive Disorder

- Formerly called Dementia
- Split into Major and Mild Neurocognitive Disorder

Major Neurocognitive Disorder

- “Significant cognitive decline” from previous in
  - Complex attention, executive function, learning and memory, language, perceptual-motor, social cognition

Major Neurocognitive Disorder

- Evidence of decline based on:
  - Concern of individual, knowledgeable informant, or clinician over decline

AND

  - “Substantial” impairment in cognitive performance based on standardized neuropsychological tests or other clinical assessments

Major Neurocognitive Disorder

- Deficits interfere with independence in everyday activities (paying bills, managing meds)
- Do not occur exclusively during Delirium or explained by another mental disorder

Mild Neurocognitive Disorder

- "Modest cognitive decline" from previous level evidenced by
  - Concern of same three parties

AND

  - "Modest" impairment in cognitive performance on standardized neuropsychological tests

Mild Neurocognitive Disorder

- Deficits DO NOT interfere with capacity for independence in everyday activities

Neurocognitive Disorder

- Coding is complex!
- Code BOTH medical condition or substance that caused the disorder AND neurocognitive disorder code
- There is a helpful table on p. 603

Neurocognitive Disorder

- Alzheimer’s disease
- *Frontotemporal lobar degeneration*
- Lewy body disease
- Vascular disease
- Traumatic brain injury
- Substance/medication induced
- HIV
- Prion disease
- Parkinson’s disease
- Huntington’s disease
- Another medical condition
- Multiple etiologies

Debate over Mild NCD

- Catch decline earlier—some treatments may be able to slow or stop progression
- Is it different from normal aging?
  - There is no impairment as a result of the decline
  - Mild may not develop into Major

END

Ganguli, M., Blacker, D., Blazer, D. G., Grant, I., Jeste, D. V., Paulsen, J. S., Peterson, R. C., & Sachdev, P. S. (2011). *The American Journal of Geriatric Psychology, 19*, 205-210.

Rabins, P.V. & Lyketsos, C.G. (2011). A commentary on the proposed DSM revision regarding the classification of cognitive disorders. *The American Journal of Geriatric Psychology, 19*, 201-204.

Mitchell, A. J., & Shiri-Feshki, M. (2009). Rate of progression of mild cognitive impairment to dementia: Metaanalysis of robust inception cohort studies. *Acta-Psychiatrica Scandinavica, 119*, 252-265.