DSM-5
an overview of core differences

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What's different? Pp. xii-xiiv, 5-17

- The numbering system of the text itself
  - No more roman numerals 5.1/ 5.2, etc.
- The organization of disorders
- Coordination with ICD-9 codes (and soon to be ICD-10)

DSM-5
What's different? Pp. xii-xiiv, 5-17

- The organization of disorders in the text
  - Follows a lifespan approach (kind of)
  - Several diagnoses have shifted into new chapters; trauma, ODD, depression
  - Some additional diagnoses
- No multiaxial system
  - Everything is recorded "on axis 1"
  - No GAF
  - No psychosocial or environmental stressors are listed with the diagnosis
  - No medical conditions unless they are a part of the diagnosis itself

DSM-IV-TR

- I. 296.22 Major Depression, single episode moderate, with melancholic features
- II. V 71.09 No dx
- III. Hypothyroidism
- IV. Problems related to primary support (recent divorce)
- V. 67/82

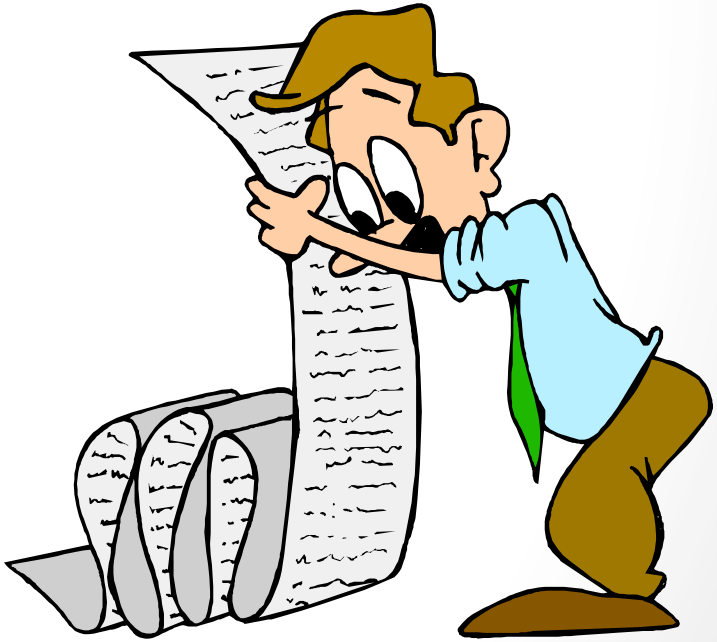
DSM-5

- 296.22 Major Depression, single episode, moderate, with melancholic features

What's the same?

- Guidelines pp. 19-24
- Principal diagnosis
  - Listed first
- Provisional diagnosis
  - May still be used
- May assign as many DSM-5 diagnoses as are indicated in ***current*** presentation: if a previous dx is listed it is to be noted as ***previous***

The DSM-5 Continues to use criteria lists; many of these criteria lists have not changed at all: some have minimal changes



DSM-5: What's sort of the same and a little different? P 16

- ***Other specified (depressive) disorder***
  - Which allows clinicians to communicate the specific reason a client doesn't meet the diagnostic criteria (duration, etc.)
- ***Unspecified (depressive) disorder***
  - No need to clarify further
- These two options take the place of ***(depressive disorder) not otherwise specified NOS***

Chapter to chapter changes (briefly)

- Childhood disorders chapter does not exist; but we begin with Neurodevelopmental disorders
- MR is eliminated
  - Now it is IDD
- Autism spectrum reflects 4 previous dx
  - Aspergers
  - Pervasive developmental disorder nos
  - Childhood disintegrative disorder
  - Autism

319 Intellectual Disability (Intellectual Developmental Disorder)

Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by *both clinical assessment and individualized, standardized intelligence testing.*

B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

C. Onset of intellectual and adaptive deficits during the developmental period.

(F70) Intellectual Disability, Mild
(F71) Intellectual Disability, Moderate
(F72) Intellectual Disability, Severe
(F73) Intellectual Disability, Profound

A coding and criteria update has already been released by the APA: (March 2014 dsm.org)

- Intellectual Disability
- Listed as:
  - **319** (70) Mild
  - **319** (71) Moderate
  - **319** (72) Severe
  - **319** (73) Profound

- **Change to:**
  - **317** (70) Mild
  - **318.0** (71) Moderate
  - **318.1** (72) Severe
  - **318.2** (73) Profound

Make changes in the DSM 5 on the following pages:
33, 848, 872
(also delete coding note on page 33)

Communication disorders pp 41-49

- 315.32 Language disorder (which combines DSM-IV expressive and mixed receptive-expressive language disorders)
- 315.39 Speech sound disorder (a new name for phonological disorder)
- 315.36 Childhood-onset fluency disorder (a new name for stuttering)
- 315.39 Social (pragmatic) communication disorder
  - a new condition for persistent difficulties in the social uses of verbal and nonverbal communication

299.00 (F84.0) Autism Spectrum Disorder p 50-52

A. Persistent deficits in *social communication and social interaction* (**used to be separate in DSM-IV-TR**) across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

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

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see table 2)

Autism Spectrum Disorder, continued

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

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see table 2)

Autism criteria continued

- C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder ((pp47-49, DSM-5)).

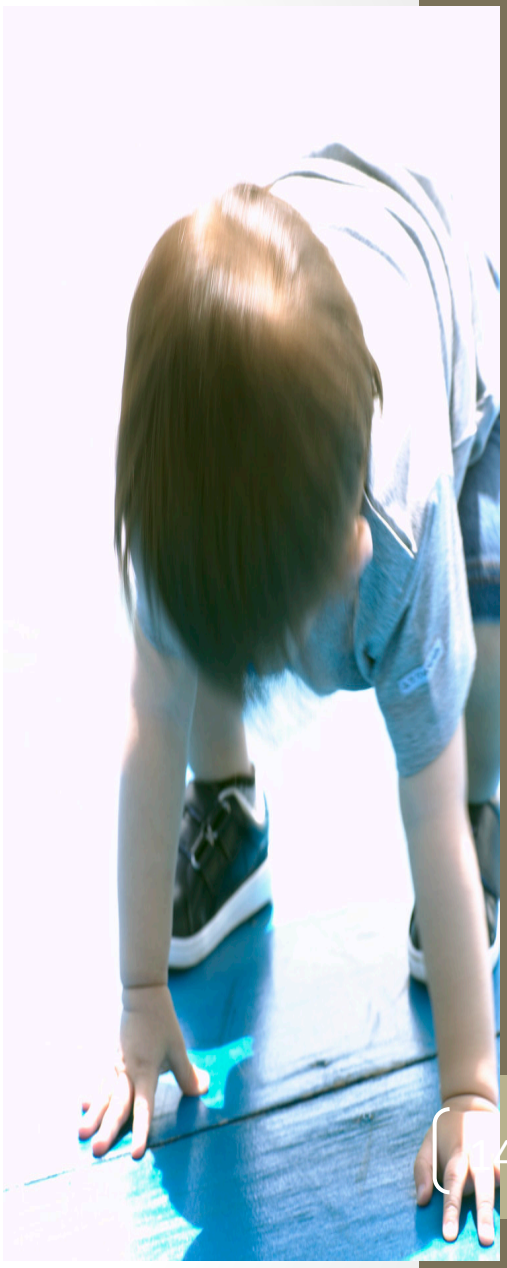
Specify if: **With or without accompanying intellectual impairment**

With or without accompanying language impairment

Associated with a known medical or genetic condition or environmental factor (**Coding note:** Use additional code to identify the associated medical or genetic condition.)

Associated with another neurodevelopmental, mental, or behavioral disorder (**Coding note:** Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)

With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp.. 119–120, for definition) (**Coding note:** Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)



Autism Spectrum Disorder (continued)

- Recording procedures (page 51)
- "Severity should be recorded as level of support needed for each of the 2 psychosocial domains"
  - Social communication
  - Restricted repetitive behaviors
    - Table on page 52

- Level 3 requiring very substantial support
- Level 2 requiring substantial support
- Level 1 requiring support

- 299.00 (F84.0) Autism Spectrum Disorder, requiring substantial support for deficits in social communication and requiring support for restricted repetitive behaviors, without accompanying intellectual impairment, with accompanying language impairment – phrase speech

314.00/ 314.01/ ADHD

predominantly the same (P 59-60)

- **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: (9 symptom list has not changed)
  - **Note:** The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least ***five*** symptoms are required.
- **Hyperactivity and impulsivity:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: (9 symptom list has not changed)
  - **Note:** The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least ***five*** symptoms are required.

ADHD changes continued

B. Symptoms before 12 years of age (*used to be 7 years in DSM-IV-TR*)

C. Present in 2 settings

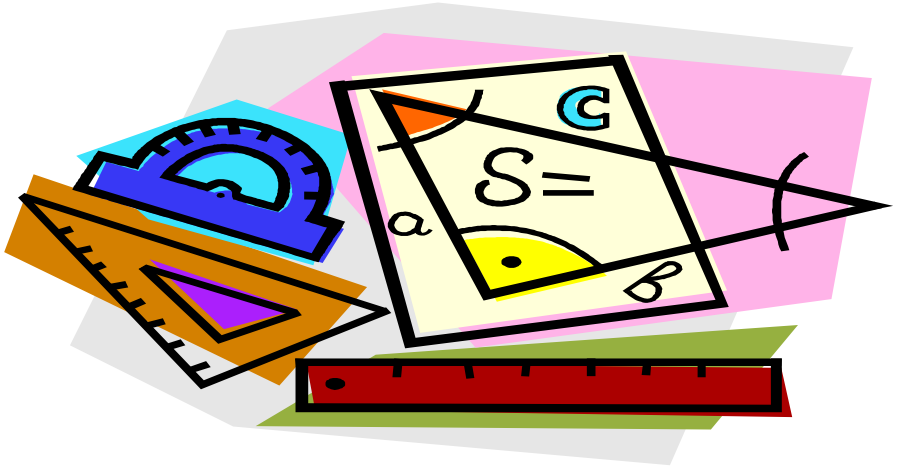
D. Symptoms interfere with functioning

E. Rule out psychosis, mood, anxiety, substance , dissociative and personality disorder

- There is a specifier for ***partial remission***
- and a severity specifier:
- ***Mild, moderate, severe***

Specific Learning Disorder p 66

- Specific learning disorder combines the DSM-IV learning disorder diagnoses to reflect their co-occurrence
  - 315.00 with impairment in reading
  - 315.2 with impairment in written expression
  - 315.1 with impairment in mathematics



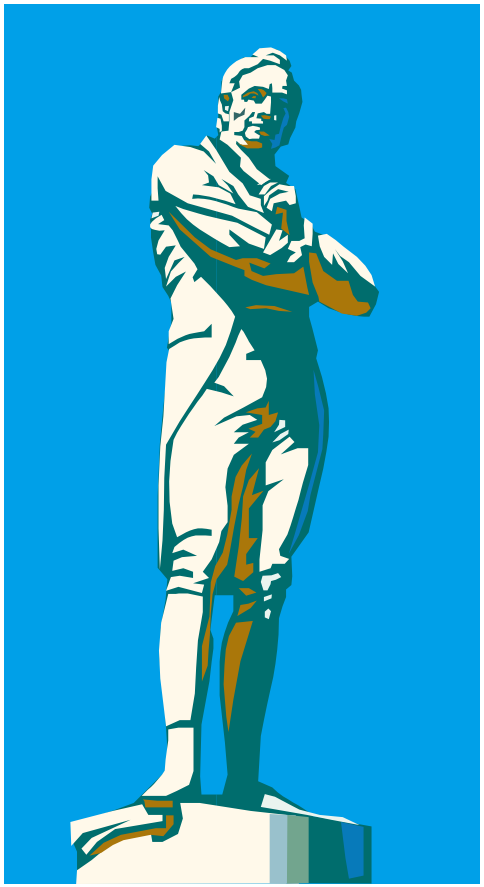
Tic disorders (P 81)

- 307.23 Tourette's
  - Both motor and vocal
- 307.22 Persistent (chronic)motor or vocal tic disorder
  - **Either** motor or vocal tics, but NOT both
  - Criteria not met for Tourette's
- 307.21 Provisional tic disorder
  - Tics present for less than 1 year
  - Criteria not met for Tourette's

Schizophrenia
p 99-100 DSM

- NO subtypes, all coded as:
- 295.90 Schizophrenia
  - Catatonia as a specifier (which is also used in other chapters)
  - Each symptom can be rated on a 5 point scale (0= not present to 4= present and severe p 743)
    - Delusions
    - Hallucinations
    - Disorganized speech
    - Disorganized behavior
    - Negative symptoms

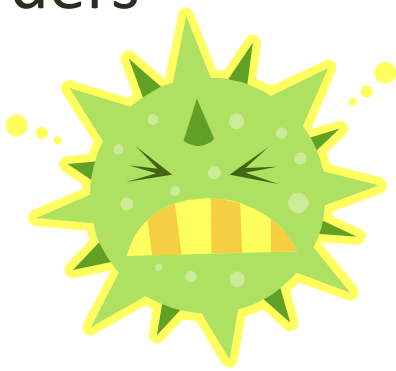
Catatonia p 119 & 120



- Can be used as a specifier for several diagnoses
- 293.89 catatonia associated with another mental disorder
- 293.89 catatonia associated with another medical condition
  - Indicate the name of the disorder or condition when coding

Bipolar disorders

- Is the next chapter following schizophrenia specifically “to recognize their place as a bridge between the psychotic disorders and depressive disorders”
  - DSM-5 p 123



- The mood episodes are embedded in the diagnostic criteria
- No mixed episode
  - But there is a “mixed features” specifier
- There is a chart for ease of coding
- 1 New specifier
- Psychotic features are listed with specifiers

Bipolar I Disorder Coding chart pages 126-127

Bipolar I disorder	Current or most recent episode manic	Current or most recent episode hypomanic*	Current or most recent episode depressed	Current or most recent episode unspecified**
Mild	296.41 (F31.11)	NA	296.51 (F31.31)	NA
Moderate	296.42 (F31.12)	NA	296.52 (F31.32)	NA
Severe	296.43 (F31.13)	NA	296.53 (F31.4)	NA
With psychotic features***	296.44 (F31.2)	NA	296.54 (F31.5)	NA
In partial remission	296.45 (F31.73)	296.45 (F31.71)	296.55 (F31.75)	NA
In full remission	296.46 (F31.74)	296.46 (F31.72)	296.56 (F31.76)	NA
Unspecified	296.40 (F31.9)	296.40 (F31.9)	296.50 (F31.9)	NA

Bipolar I disorder continued

- *Specify*: (page 127 DSM-5)
- **With anxious distress**
- **With mixed features**
- **With rapid cycling** *(no mixed episode)*
- **With melancholic features**
- **With atypical features**
- **With mood-congruent psychotic features**
- **With mood-incongruent psychotic features**
- **With catatonia. Coding note:** Use additional code 293.89 (F06.1).
- **With peripartum onset**
- **With seasonal pattern**

- 296.42 (F31.11) Bipolar I disorder, most recent episode (MRE) manic, moderate with mood-congruent psychotic features, with anxious distress (mild)*
  - *some of the specifiers now have specifiers like this

Depressive disorders separate chapter

- 2 new disorders:
  - Disruptive Mood Dysregulation Disorder
  - Premenstrual Dysphoric disorder

  New name for dysthmia:

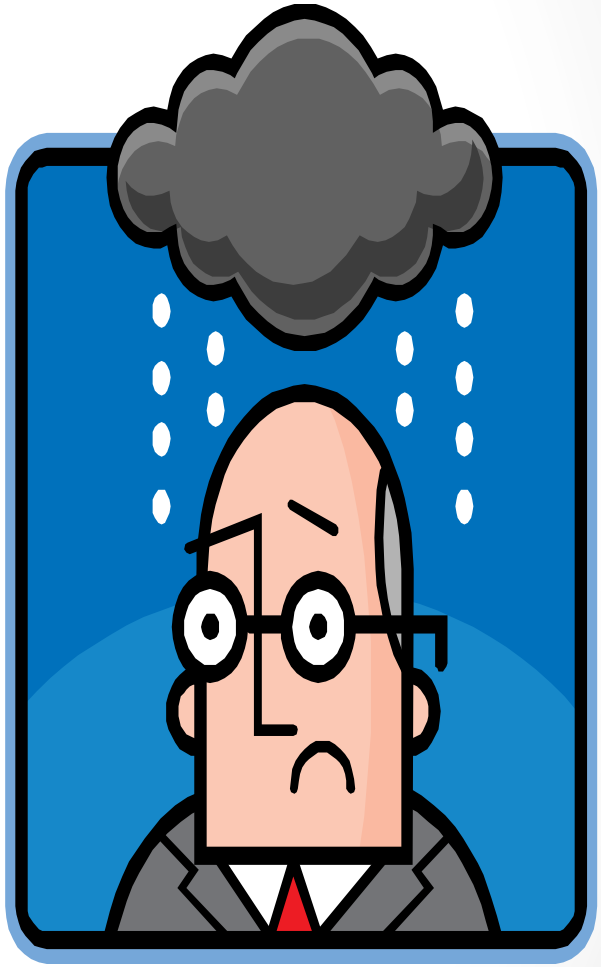
  Persistent depressive disorder

  "This disorder is a consolidation of Chronic major depression and dysthymia" p 168 DSM-5

- Eliminated the bereavement exclusion in major depression
  - There are two camps about this:
    - one camp fears there will be over diagnosing of normal grief
    - the other camp is more concerned about missing true cases of major depression because the trigger for a mood episode involved loss

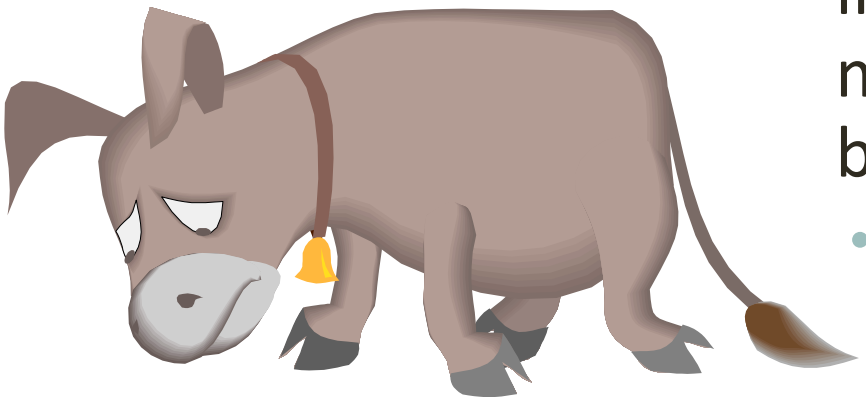
Major Depression p 160 DSM-5

- In the DSM-IV-TR it was a 2 step process to diagnose; now the depressive episode criteria are combined with the disorder criteria
- Numbers remain the same
- New specifier
  - "with anxious distress"



296.99 Disruptive Mood Dysregulation Disorder

- Diagnosed between 6 and 18 years of age with onset before 10
- The idea was to address over diagnosing of Bipolar I in children and adolescents



- There is research that supports children outgrow these behaviors
- However they are purported to be more severe than ODD or CD
- Personally I am interested in the medications that will be used for DMDD
  - P 156

From the National Institute of Health website: http://www.nimh.nih.gov/health/publications/bipolar-disorder/index.shtml

- **Antidepressant medications** are sometimes used to treat symptoms of depression in bipolar disorder. People with bipolar disorder who take antidepressants often take a mood stabilizer too. ***Doctors usually require this because taking only an antidepressant can increase a person's risk of switching to mania or hypomania, or of developing rapid cycling symptoms.***[29] To prevent this switch, doctors who prescribe antidepressants for treating bipolar disorder also usually require the person to take a mood-stabilizing medication at the same time.
- Recently, a large-scale, NIMH-funded study showed that for many people, ***adding an antidepressant to a mood stabilizer is no more effective in treating the depression than using only a mood stabilizer.***[30]

625.4 Premenstrual Dysphoric Disorder p 171

- Concern about over pathologizing normal menses, but the disorder is targeted to a minority of women who experience more dysfunction and distress than most

300.4 (F34.1) Persistent depressive disorder

- Symptoms present for 2 years; 1 year for children and adolescents
- MDD criteria may also be met for 2 years
  - 4 additional specifiers clarify the person's presentation page 189

Anxiety disorders

both ***big*** changes and ***no*** changes

- Separation anxiety disorder in this chapter
  - Can be used with adults too
- Selective mutism is in this chapter
- Panic attack as a specifier p 214
- Panic disorder WITH AGORAPHOBIA eliminated

- Moved:
  - OCD
  - PTSD
  - ASD

To clarify:

- In the DSM-IV-TR=
- Panic disorder with agoraphobia
- Panic disorder without agoraphobia
- Agoraphobia without history of panic attacks
  - Generalized anxiety
  - Social anxiety
  - Specific phobia

- In the DSM-5=
- Panic Disorder
- Agoraphobia
- Generalized anxiety
- Social anxiety
- Specific phobia
  - Can all have the panic attack specifier added; no need for it in panic disorder p 214

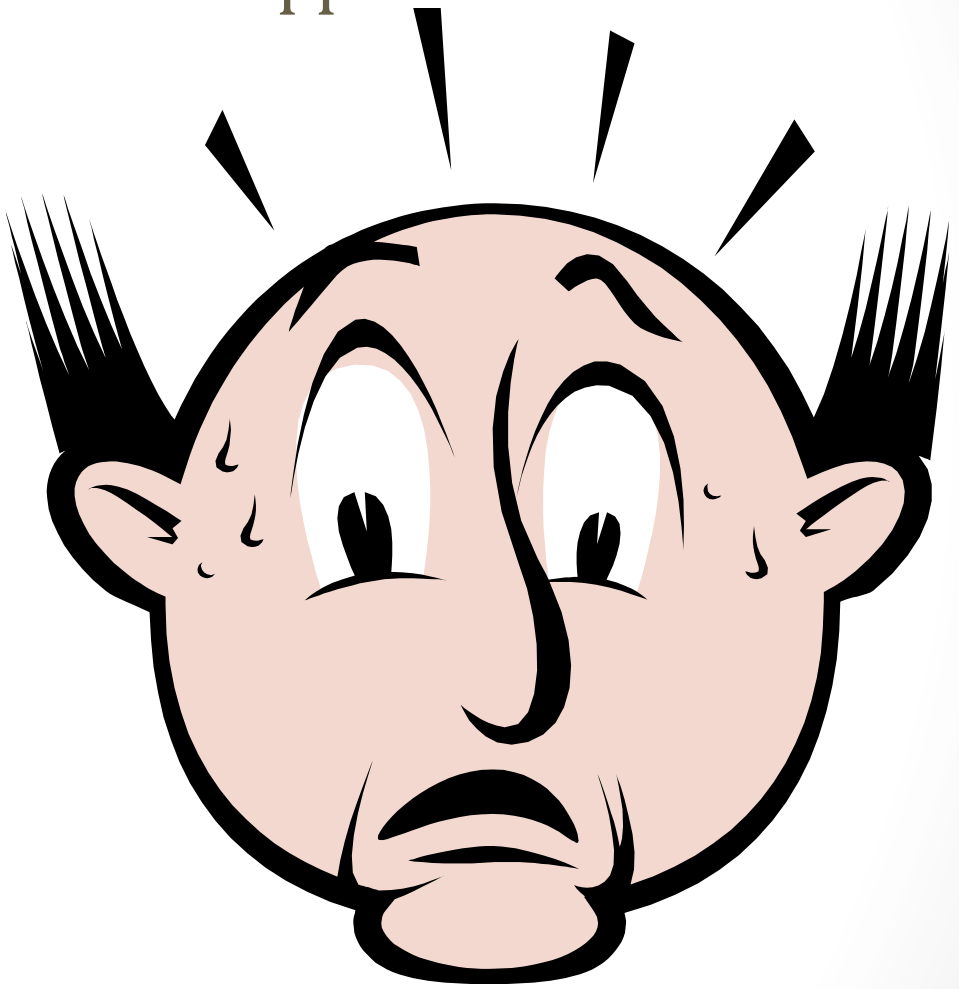
Panic attack specifier p 215

- In the text description (NOT the criteria set) DSM-IV terminology for describing different types of panic attacks:
  - situationally bound/cued
  - situationally predisposed
  - unexpected/uncued is

- DSM-5 terminology is clarified as:
  - Unexpected
  - expected panic attacks

Obsessive-Compulsive and related disorders pp 236-264

- OCD has new specifiers;
  - "with absent insight /delusional beliefs"
  - Tic-related
- New diagnosis: **Hoarding**
- Trichotillomania
- Excoriation
- Body-dysmorphic



300.3 (F42) Hoarding Disorder p. 247

A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.

B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.

C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).

E. The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome).

F. The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder).

Hoarding Disorder, Continued

Specify if: p 247

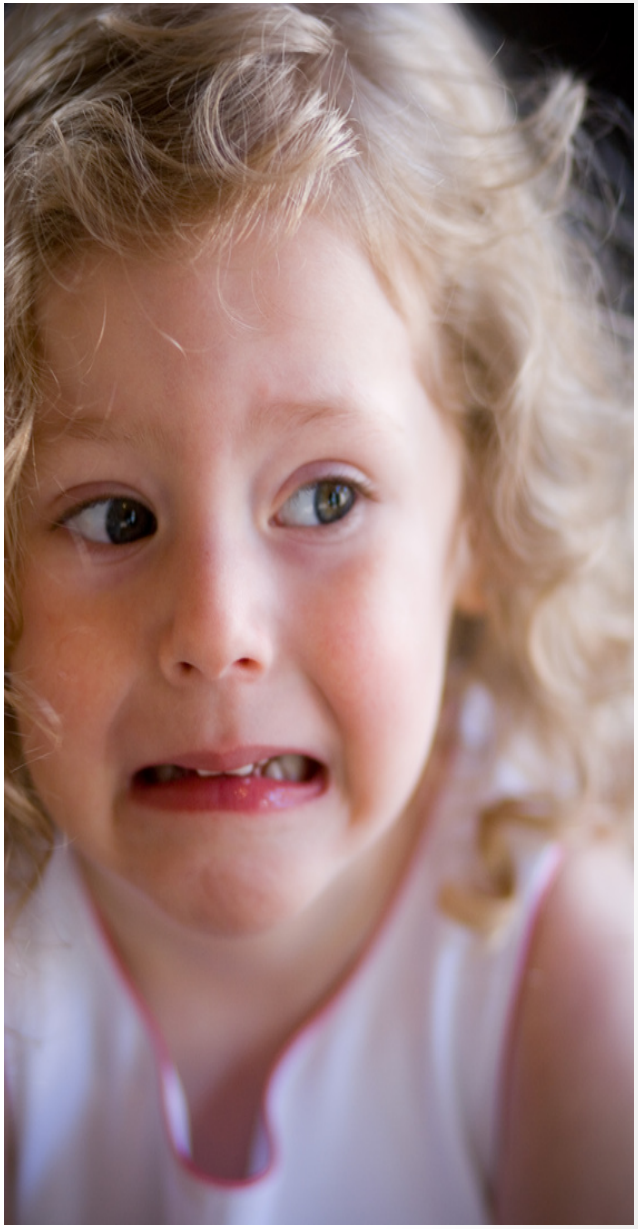
With excessive acquisition: If difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space.

Specify if:

With good or fair insight: The individual recognizes that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic.

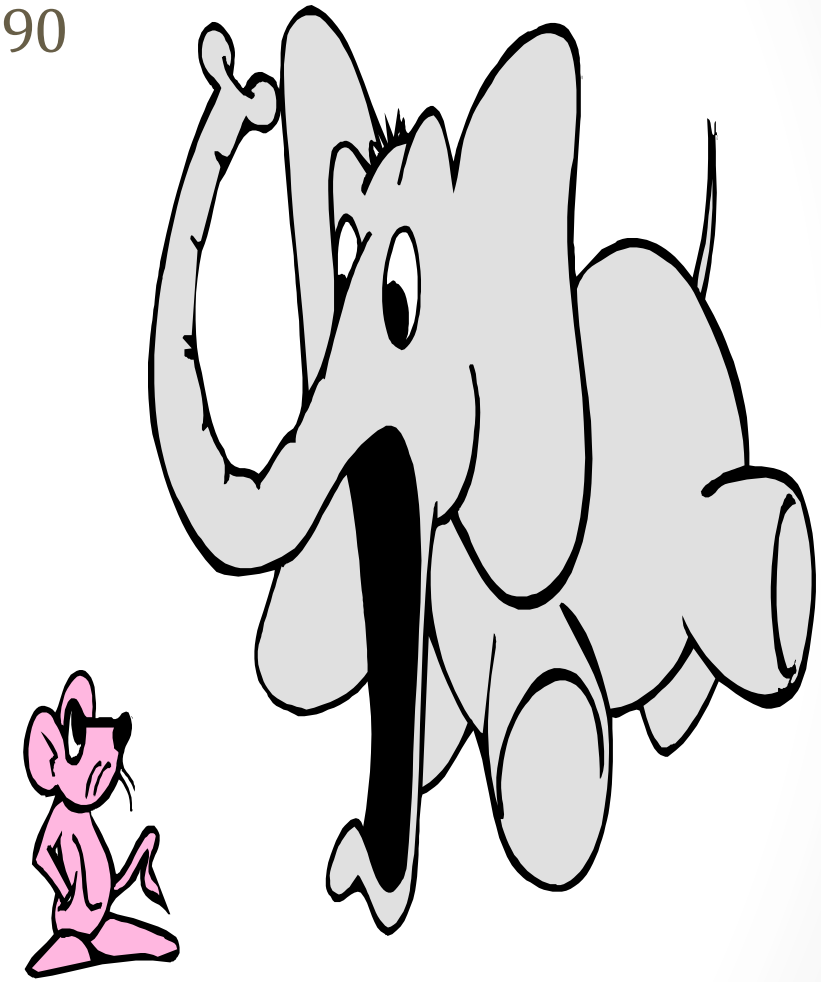
With poor insight: The individual is mostly convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

With absent insight/delusional beliefs: The individual is completely convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.



Trauma and stressor-related disorders pp 265-290

- Reactive attachment (now split into 2)
- Disinhibited social engagement disorder
- PTSD
- ASD
- Adjustment disorders



313.89 (F94.1) Reactive Attachment Disorder p 265

A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:

The child rarely or minimally seeks comfort when distressed.

The child rarely or minimally responds to comfort when distressed.

B. A persistent social and emotional disturbance characterized by at least two of the following:

Minimal social and emotional responsiveness to others.

Limited positive affect.

Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following: (DSM-IV-TR "pathogenic care")

1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.

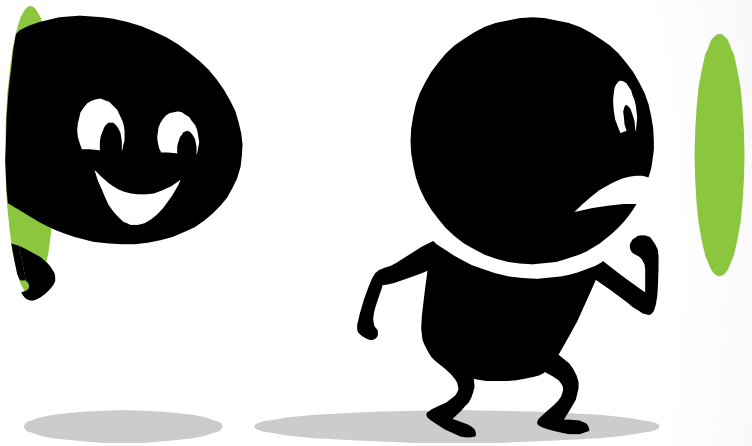
2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).

3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

Reactive Attachment Disorder

continued

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).
E. The criteria are not met for autism spectrum disorder.
F. The disturbance is evident before age 5 years.
G. The child has a developmental age of at least 9 months.



Persistent: The disorder has been present for more than 12 months.
Specify current **severity**: Reactive attachment disorder is specified as **severe** when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

313.89 (F94.2) Disinhibited social engagement disorder p 268

A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:

1. Reduced or absent reticence in approaching and interacting with unfamiliar adults.
2. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
4. Willingness to go off with an unfamiliar adult with minimal or no hesitation.

B. The behaviors in Criterion A are not limited to impulsivity (as in attention deficit/ hyperactivity disorder) but include socially disinhibited behavior.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:

1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

E. The child has a developmental age of at least 9 months.

Trauma disorders

- PTSD and ASD are both display some new wording and clarifications
- PTSD has an additional set of criterion and clarification specifically for children 6 years and younger p 272-274

309.81 PTSD p 271

- The terms "helplessness, horror, intense fear" have been removed in response to military and professional responders who did not meet that criteria
- 5 symptom lists delineate the distress
- ***With dissociative symptoms*** specifier
  - Depersonalization
  - Derealization

308.3 Acute Stress Disorder p 280

- Trauma experience criteria matches PTSD
- The 5 lists in PTSD are collapsed into one list; the person must meet 9 total criteria out of 14
- Symptoms may begin immediately after the trauma, but must persist for a minimum of 3 days

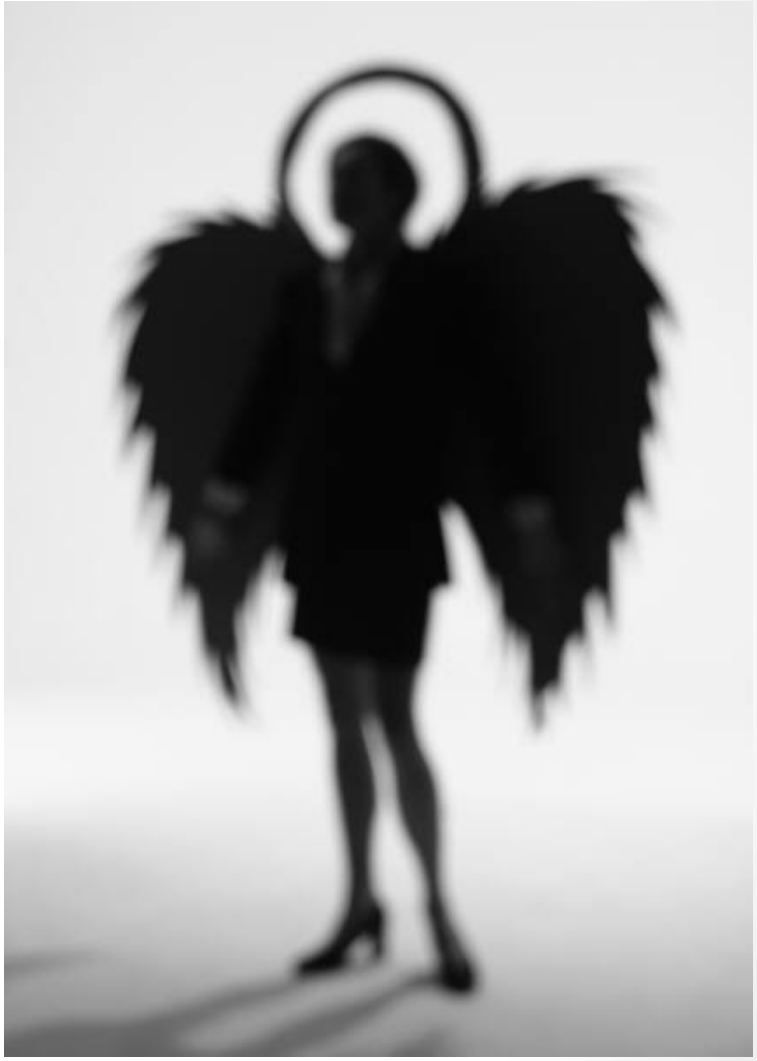
Adjustment disorders p 286-287

- Small changes to the criteria set
- Rule out "normal bereavement"
- No adjustment after 6 months (an anomaly of the DSM-IV-TR)
  - Spoke too soon, March 2014 update puts it back in!

Dissociative identity disorder

300.14 (F 44.81) P. 292

- Several minor changes in the criteria wording
- "May be described as possession in some cultures"
- "May be observed by others"
- "Not a normal part of cultural or religious practices"
  - There is also a coding note to rule out imaginary playmates and fantasy play in children



Somatic symptom and related disorders

- Formerly "somatoform disorders" now also includes factitious disorders
- In addition to ***"experiencing multiple physically unexplained symptoms"***, people can meet the criteria for diagnosis when they are ***"overly concerned about actual medically explainable symptoms"***

- 300.82 Somatic symptom disorder (p 311)
- 300.7 Illness anxiety disorder (p 315)
- 300.11 Conversion disorder (p 318)
- 316 Psychological factors affecting other medical conditions (p 322)
- 300.19 Factitious disorder (p 324)
- Other somatic symptom disorder (p 327)
- Unspecified somatic symptom disorder (p 327)

Feeding and eating disorders

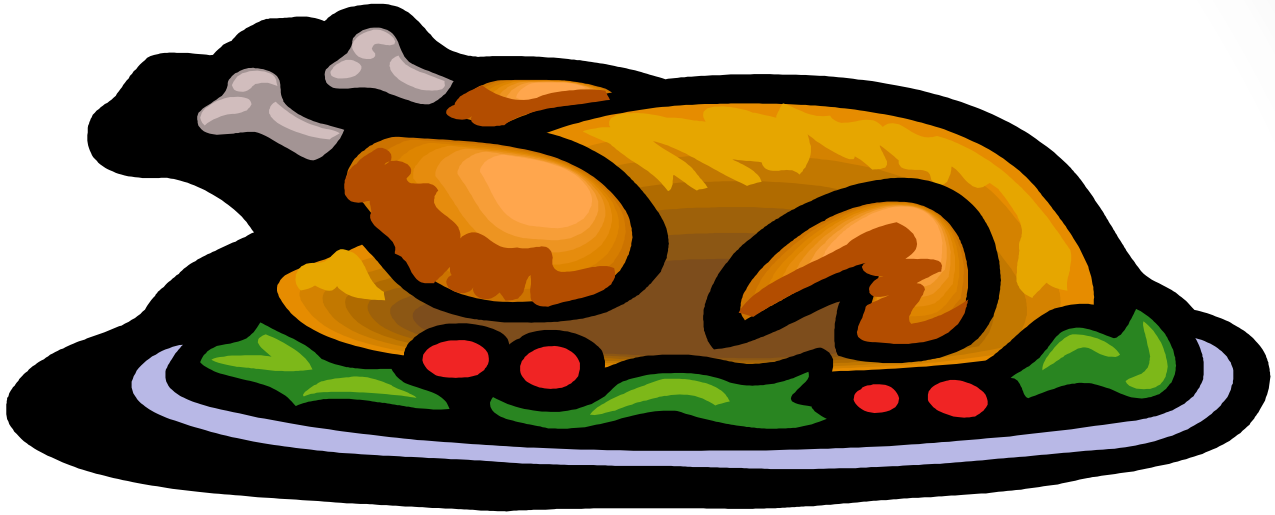
- 307.52 Pica moved to this chapter (p 329)
- 307.53 Rumination disorder (p 332)
- 307.59 Avoidant/ restrictive food intake disorder (p 334) replaces feeding disorder of infancy or early childhood

307.1Anorexia Nervosa p 338

- No longer requires amenorrhea or percentage of ideal weight: now based on BMI
- Specifiers are the same:
  - F50.01 Restricting type
  - F50.02 Binge-eating/ purging type
- 2 remission specifiers (new)
  - Partial & full
- 4 severity choices

307.51 (F50.2) Bulimia Nervosa

- Changed frequency to once per week (from twice per week)
- p 345
  - 4 severity choices
  - 2 remission specifiers



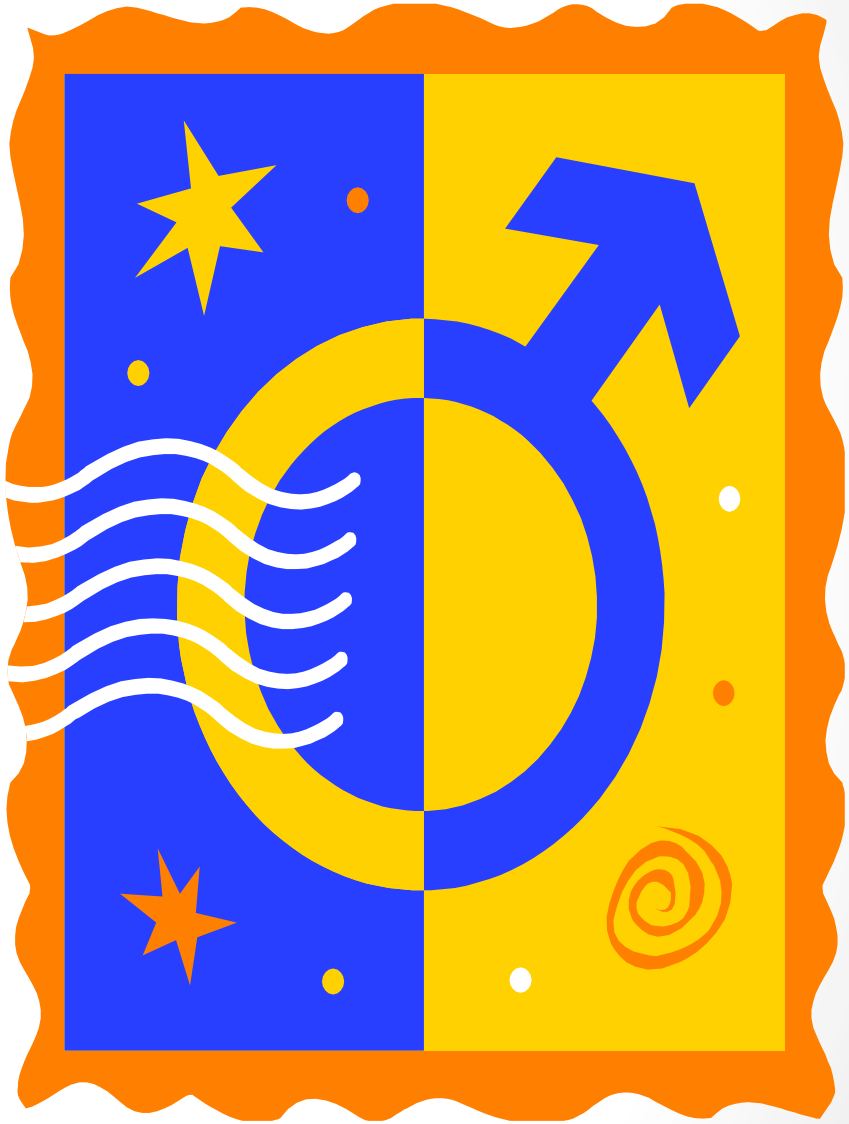
- 307.51 (F50.8) Binge-eating disorder (p 350)
- is new and very controversial
  - Has to occur once a week for 3 months
  - Not associated with purging; not anorexia or bulimia
    - 4 severity specifiers
    - 2 remission specifiers

Sleep-Wake Disorders

- Biological validators now are embedded in classification of some disorders , which reflects advances in the field
- 307.42 Insomnia disorder (p 362) *March 2014 update
- 307.44 Hypersomnolence disorder(p 368) *March 2014 update
- Narcolepsy = 5 types (p 372)
- 327.23 Obstructive sleep apnea (p 378)
- Central sleep apnea = 3 types (p 383)
- Sleep-related hypoventilation = 3 types(p 387)
- Circadian rhythm sleep-wake disorders =6 types (p 393)
- Non REM sleep arousal disorders = 2 types (p 399)
- 307.47 Nightmare disorder (p 404)
- 327.42 REM sleep behavior disorder (p 407)
- 333.94 Restless legs syndrome
- Substance/medication induced sleep disorder = 9 types (p 414)

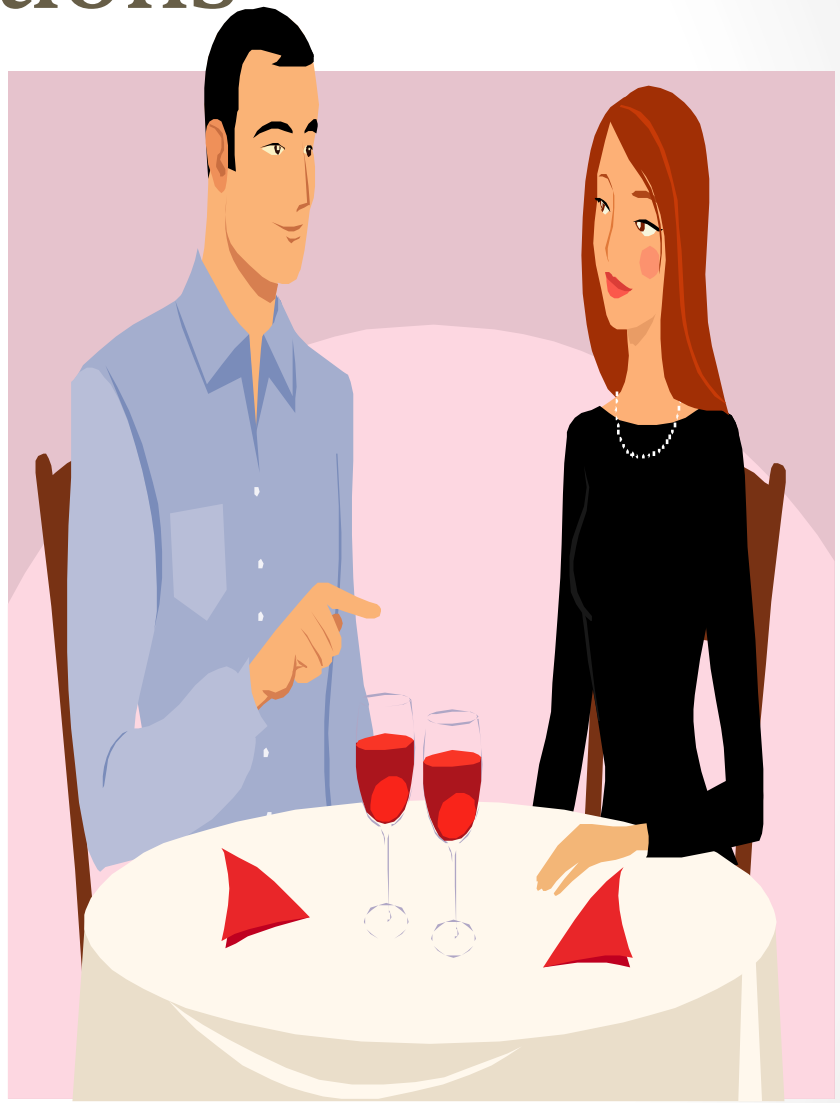
Sexual disorders divided into 3 chapters

- Sexual dysfunctions
  - Pp 423-450
- Gender dysphoria
  - Pp 451-457
- Paraphilic disorders
  - Pp 685-706

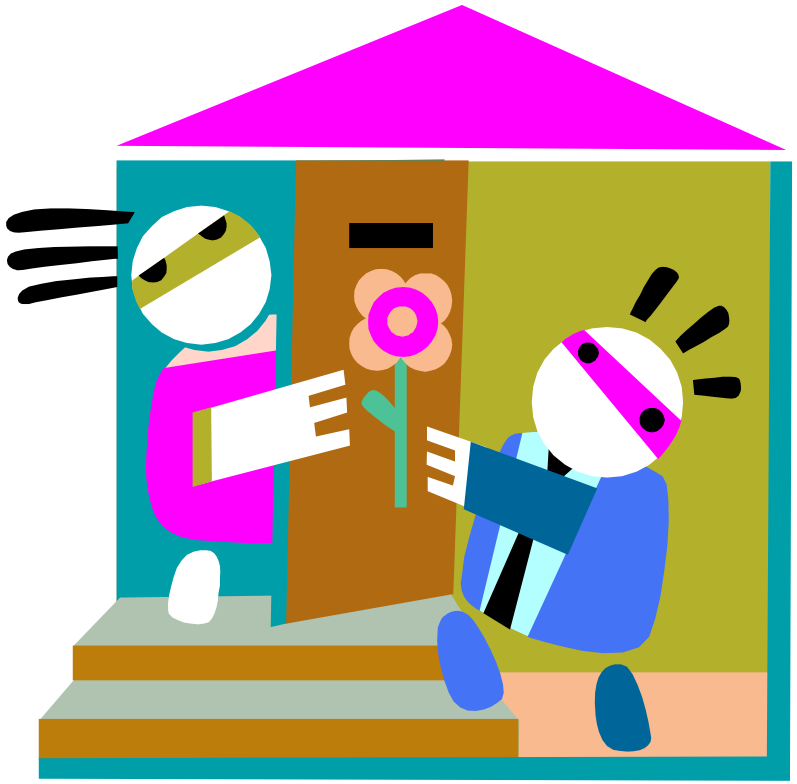


Sexual Dysfunctions

- New diagnoses
  - Delayed ejaculation (p424)
  - Male hypoactive sexual desire (p 440)
- Vaginismus is now named: genito-pelvic pain penetration disorder (p 437)



Sexual Dysfunctions (continued)



- All the sexual dysfunctions require only 2 specifiers:
  - Lifelong vs. acquired
  - Generalized vs. situational
  - DSM-IV-TR also required "Psychological vs. Combined"
- Also code the severity

302.85 (F64.1) Gender Dysphoria P 452

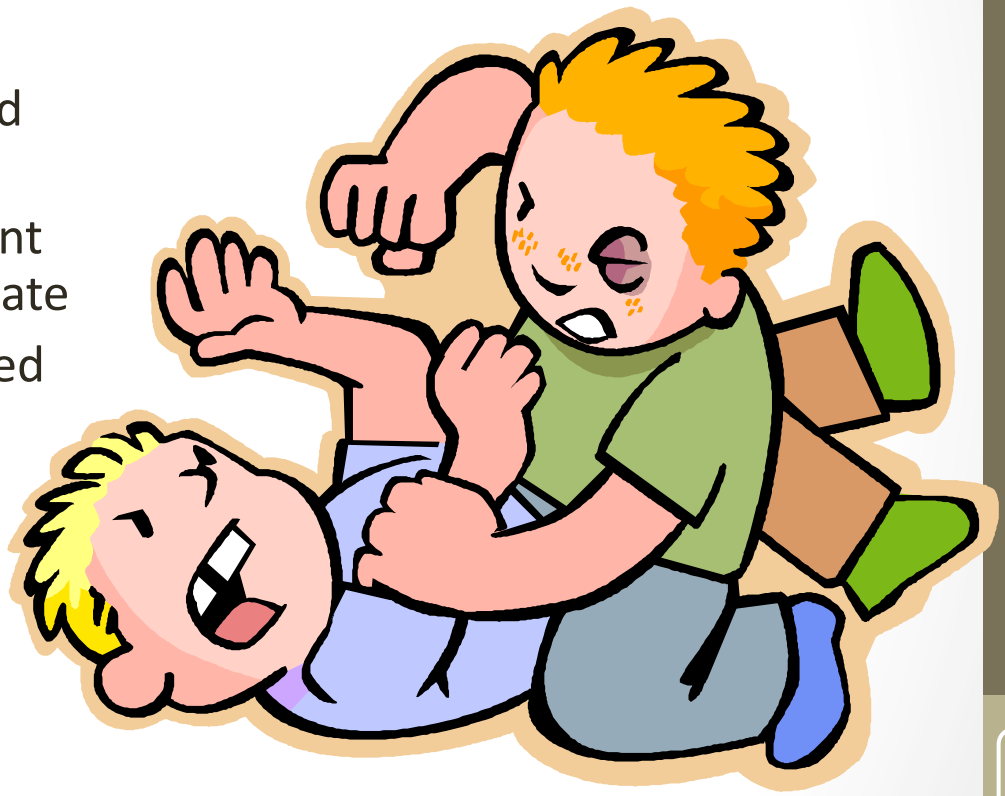
- To de-stigmatize this condition it is now not called a *"disorder"*
- 302.6 (F64.2) Separate criteria set for children
- Two specifiers
  - *With a disorder of sex development*
  - *Post transition*

Disruptive, impulse-control and conduct disorders p 461-480

- 313.81 (F91.3) Oppositional Defiant Disorder p 462
  - Much more descriptive criteria set
  - 4 symptoms from a total of 8, with the additional clarification "***exhibited during interaction with at least one individual who is not a sibling***"

Conduct disorder p 469

- Number continues to depend on the age of onset;
  - 312.81 (F91.1) Childhood onset
  - 312.82 (F91.2) Adolescent onset *March 2014 update
  - 312.89 (F91.9)Unspecified onset
- 4 new specifiers to describe prosocial emotions (lack of)
- Also specify severity



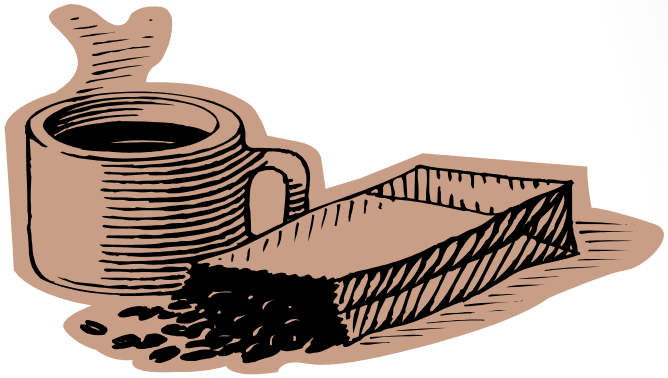
- 312.34 (F63.81) Intermittent explosive disorder
- No longer requires assaultive behavior or destruction of property
  - p 466

- Unchanged:
  - 312.33 (F63.1) Pyromania
    - p 476
- 312.32 (F63.2)
  *March 2014 update
  - Kleptomania
    - p 478

Substance use disorders p 481-589

- No more ***abuse*** and ***dependence*** (although the numbers survived!)
  - mild="abuse" (305.00)
  - moderate and severe= "dependence" (303.90)
- Each class of substance has the diagnostic criteria listed in that section, and the criteria sets are more individualized to problems in use of that specific substance

- General organization of the substance use disorders:
  - ***Alcohol*** use disorder
  - ***Alcohol*** intoxication
  - ***Alcohol*** withdrawal
  - Other ***alcohol-induced*** disorder
  - Unspecified ***alcohol-related*** disorder



- ***PCP*** is listed with ***hallucinogens***; all have no withdrawal diagnosis, but addition of: ***hallucinogen persisting perception disorder*** p 531
- ***Inhalants*** also have no withdrawal diagnosis
- Methamphetamine, amphetamines and cocaine are combined as ***stimulants***
- One can be diagnosed with ***caffeine intoxication*** (but not use) and ***tobacco use & withdrawal*** but not intoxication
- Other (or unknown) substance-related disorders p 577

312.31 (F63.0)
Gambling disorder p 585

- The first behavioral addiction to be included
  - Episodic vs. persistent
  - Remission specifier
  - Severity specifier

Internet gaming is under consideration in the "further study" section

312.31 (F63.0) Gambling Disorder p 585-586

A. Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

1.Needs to gamble with increasing amounts of money in order to achieve the desired excitement.

2. Is restless or irritable when attempting to cut down or stop gambling.

3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.

4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).

5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).

6. After losing money gambling, often returns another day to get even ("chasing" one's losses).

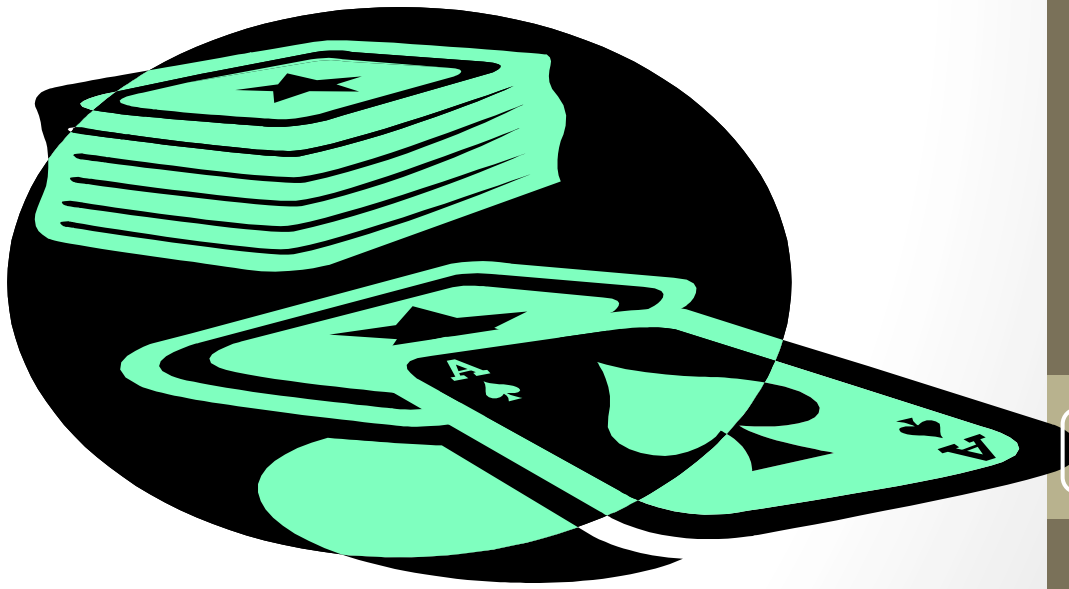
7. Lies to conceal the extent of involvement with gambling.

8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.

9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

B. The gambling behavior is not better explained by a manic episode.

Specify if:
Episodic: Meeting diagnostic criteria at more than one time point, with symptoms subsiding between periods of gambling disorder for at least several months.
Persistent: Experiencing continuous symptoms, to meet diagnostic criteria for multiple years.
Specify if: **In early remission:** After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met for at least 3 months but for less than 12 months.
In sustained remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met during a period of 12 months or longer.
Specify current severity:
Mild: 4–5 criteria met.
Moderate: 6–7 criteria met.
Severe: 8–9 criteria met.



Neurocognitive disorders

p 591-643

- Tons of changes in this chapter
  - criteria are conceptualized differently
  - Many more adults will now meet diagnostic standards
- Each of the (formerly known as) *dementias* are classified as "mild or major neurocognitive disorder"
  - also classified as "Possible or Probable"

Neurocognitive disorders

- A new table for neurocognitive domains pp 593-595
  - **Complex attention** (new)
  - **Executive function** (same)
  - **Learning and memory** (new phrasing)
  - **Language** (replaces aphasia)
  - **Perceptual-motor** (replaces apraxia)
  - **Social cognition** (new)

The disorders formerly known as dementias (and it is correct to still use dementia)

- The process of diagnosis as well as the criteria are now different
- Refer to the table of neurocognitive domains on pp 593-595 for criterion A

I. First use the diagnostic criteria to ascertain **major** or **mild** neurocognitive disorder

Major Neurocognitive Disorder pp 602-605

A. Evidence of *significant cognitive decline* from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The *cognitive deficits interfere with* independence in everyday activities (i.e., at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications).

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).

I. First use the diagnostic criteria to ascertain **major** or **mild** neurocognitive disorder

Mild Neurocognitive Disorder pp 605-606

A. Evidence of *modest cognitive decline* from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a mild decline in cognitive function; and
2. A modest impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive *deficits do not interfere* with capacity for independence in everyday activities (i.e., complex instrumental activities of daily living such as paying bills or managing medications are preserved, but greater effort, compensatory strategies, or accommodation may be required).

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).

II. Then refer to the diagnostic criteria for the probable etiology

Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease p 611

A. The criteria are met for major or mild neurocognitive disorder.

B. There is insidious onset and gradual progression of impairment in one or more cognitive domains (for major neurocognitive disorder, at least two domains must be impaired).

C. Criteria are met for either *probable* or *possible* Alzheimer's disease as follows:

For major neurocognitive disorder:

Probable Alzheimer's disease is diagnosed if either of the following is present; otherwise, **possible Alzheimer's disease** should be diagnosed.

1. Evidence of a causative Alzheimer's disease genetic mutation from family history or genetic testing.
2. All three of the following are present:
    a. Clear evidence of decline in memory and learning and at least one other cognitive domain (based on detailed history or serial neuropsychological testing).
    b. Steadily progressive, gradual decline in cognition, without extended plateaus.
    c. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline).

Alzheimer's continued p 611

For mild neurocognitive disorder:

Probable Alzheimer's disease is diagnosed if there is *evidence of a causative Alzheimer's disease genetic mutation* from either genetic testing or family history.

Possible Alzheimer's disease is diagnosed if *there is no evidence of a causative Alzheimer's disease genetic mutation* from either genetic testing or family history, and all three of the following are present:

1. Clear evidence of decline in memory and learning.
2. Steadily progressive, gradual decline in cognition, without extended plateaus.
3. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological or systemic disease or condition likely contributing to cognitive decline).

D. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

III. Lastly ascertain numbering via the coding notes : Alzheimer's page 611

Coding note: For ***major*** neurocognitive disorder due to ***probable*** Alzheimer's disease, with behavioral disturbance, code first 331.0 (G30.9) Alzheimer's disease, followed by 294.11 (F02.81). For ***major*** neurocognitive disorder due to ***probable*** Alzheimer's disease, without behavioral disturbance, code first 331.0 (G30.9) Alzheimer's disease, followed by 294.10 (F02.80).

For ***major*** neurocognitive disorder due to ***possible*** Alzheimer's disease, with behavioral disturbance, code first 331.0 (G30.9) Alzheimer's disease, followed by 294.11 (F02.81). For ***major*** neurocognitive disorder due to ***possible*** Alzheimer's disease, without behavioral disturbance, code first 331.0 (G30.9) Alzheimer's disease, followed by 294.10 (F02.80).

For ***mild*** neurocognitive disorder due to Alzheimer's disease, code 331.83 (G31.84). (Note: Do not use the additional code for Alzheimer's disease. Behavioral disturbance cannot be coded but should still be indicated in writing.) *March 2014

- 331.0 (G30.9) Alzheimer's disease, 294.11(F02.81) ***probable*** **Major** neurocognitive disorder due to Alzheimer's disease, with behavioral disturbance

- 331.9 (G31.9) Alzheimer's disease 294.11(F02.81) ***possible*** **Major** neurocognitive disorder due to Alzheimer's disease, with behavioral disturbance

- 331.83 (G31.84) **Mild** neurocognitive disorder due to Alzheimer's disease, with behavioral disturbance

Each cause of NCD (dementia) has a separate criteria set

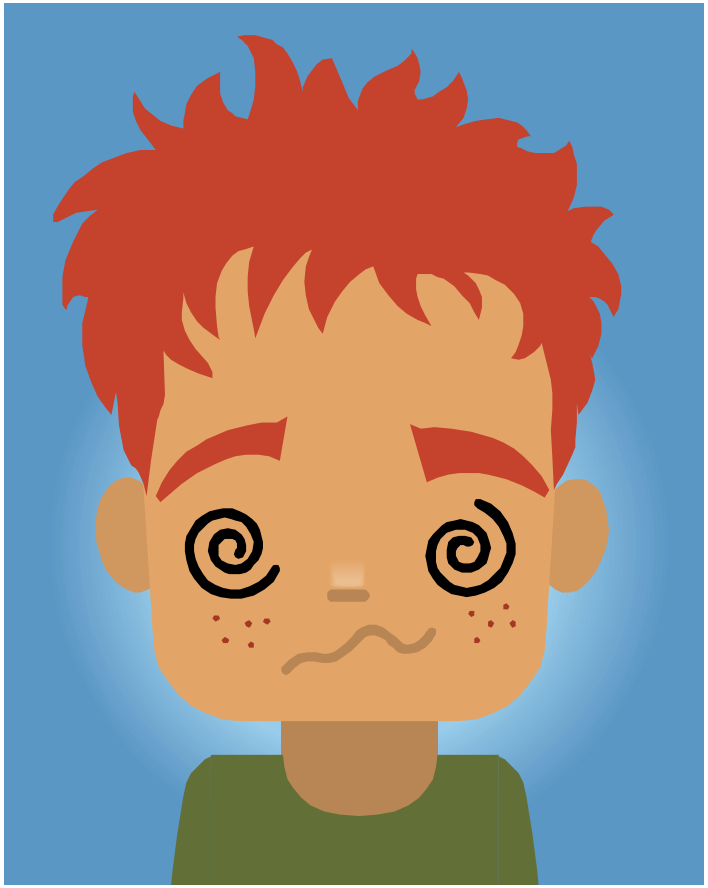
- 042 HIV infection 294.11 major neurocognitive disorder due to HIV infection, with behavioral disturbance
  - P 632

Delirium p 596

- Now the first criteria conceptualizes this disorder as a "*disturbance in attention*"
- 4 basic types of delirium with numerous numbering choices

- 2 specifiers: (new)
  - Acute or persistent
  - Hyperactive, hypoactive or mixed level of activity

Expected to change but DID NOT: Personality disorders pp 645-684



- This was a hotly debated set of changes
- Although these disorders remain **exactly** the same (for now), an entire chapter in the DSM-5 outlines the proposed "personality trait approach"

Alternative model pp. 761-781

- It is likely that the next DSM change will include some kind of a change in diagnosing personality disorders

- It could look much like this proposed system

The proposal involves assessing personality *functioning* and pathological personality *traits*

- Still includes a "general criteria" step p 761
- Reduces the total number of subtypes to 6 (from 10)
  - Antisocial
  - Avoidant
  - Borderline
  - Narcissistic
  - Obsessive- Compulsive
  - Schizotypal

Paraphilic disorders p 685-705

- This chapter remains controversial: many of these disorders are covered by criminal statutes; others are seen as life choices (if the practices are with consenting adults)

V-Codes
pp 715-727

- The V-codes chapter has exploded!

V-Codes pp 715-727 continued

- Relational problems (8)
- Abuse and neglect (79)
- Educational and occupational problems (3)
- Housing & economic problems (4)
- Other problems related to the social environment (6)
- Problems related to crime or interaction with the legal system (5)
- Other health service encounters for counseling and medical advice (2)
- Problems related to psychosocial, personal & environmental circumstances (8)
- Other circumstances of personal history (14)

In Summary

- The overall process of diagnosing remains the same with criteria sets
- Research is still needed in most areas
- Some claim that the changes in the DSM-5 are a transition to greater similarity to medical diagnosing
- Some disorders may be **less** clear; Neurocognitive

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