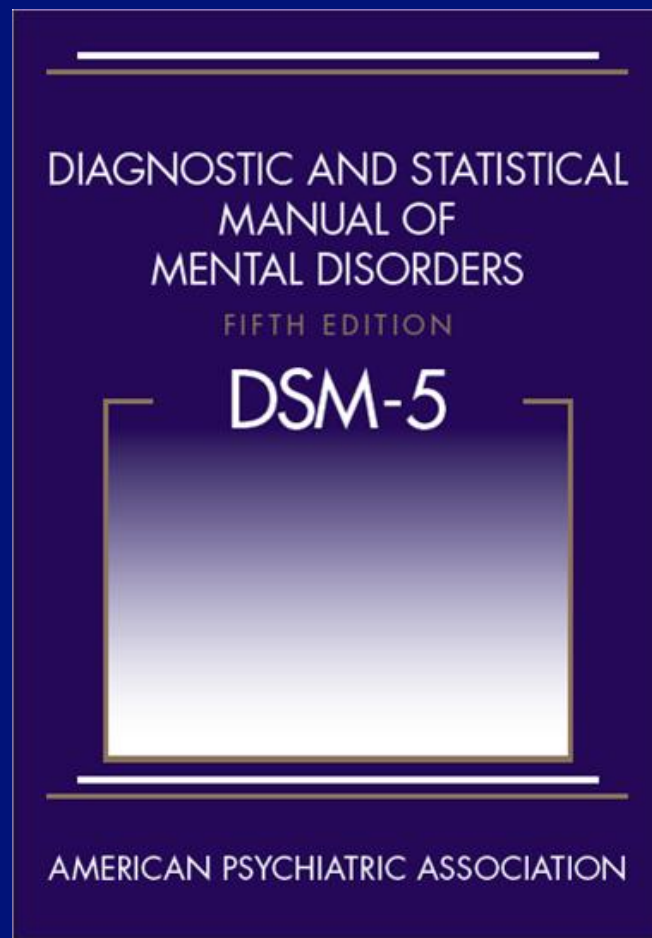


DSM-5: Classification, Criteria, and Use



Purpose

This course is for clinicians who are already familiar with DSM-IV-TR, its content, and its use. This presentation is solely to facilitate transition from DSM-IV-TR to DSM-5 and is not intended to be a basic course on DSM-5.

DSM-5 Revisions: Brief History and Conceptual Approaches

DSM History

- ◆ DSM I: 1952 influenced by Menninger's WW II classification scheme called Medical 203 for the Army. ICD 6 had just been published. 106 mental disorders
- ◆ DSM II: 1968 still with psychodynamic influence

DSM History

- ◆ DSM II Seventh Printing: 1974
Removed Homosexuality as a disease (though retained sexual orientation disturbance)
- ◆ DSM III: 1980 Influenced by RDC used at Wash U and NYSPI, the Multiaxial system appeared

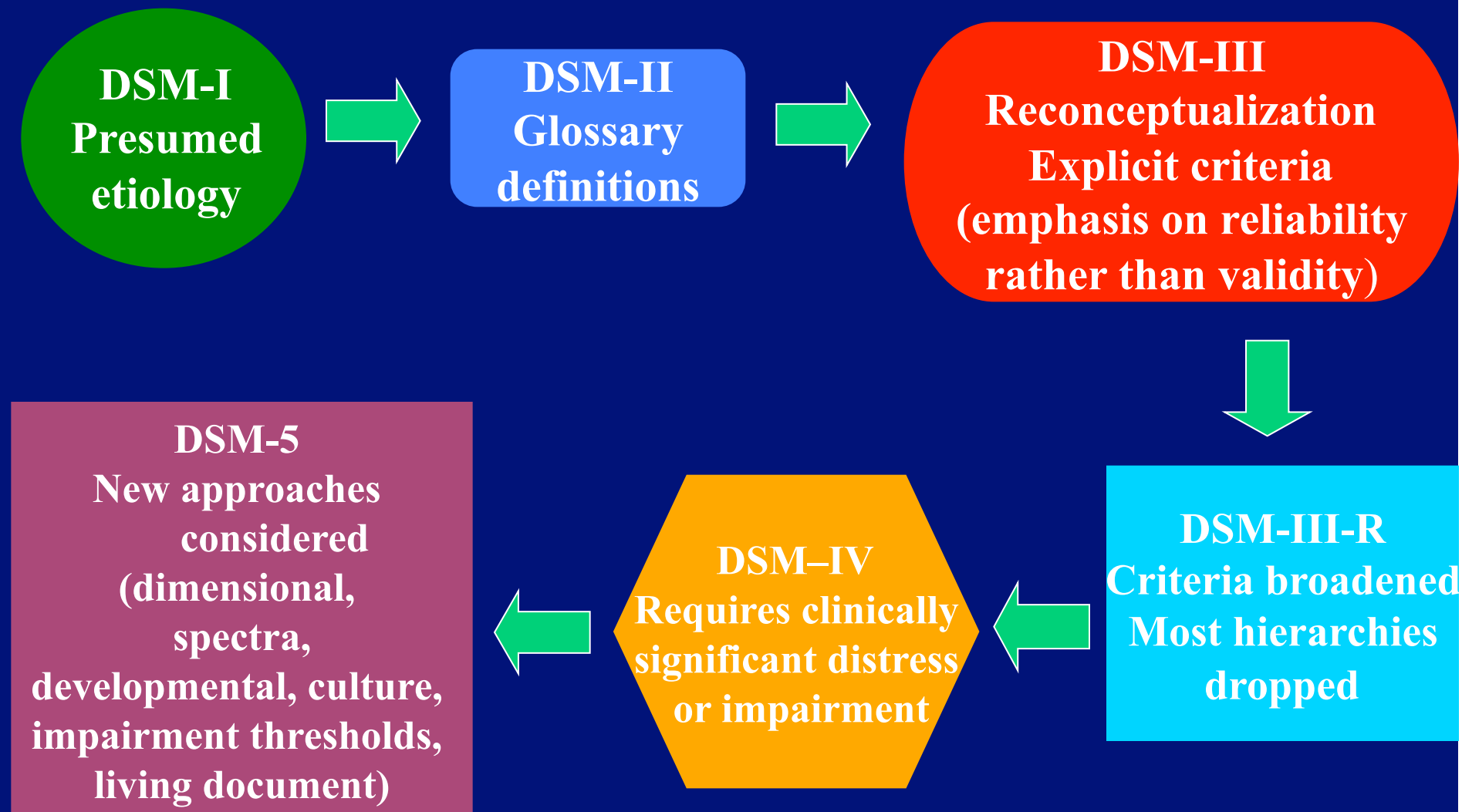
DSM History

- ◆ DSM III R: 1987 Reorganized categories and introduced PMDD and Ego Dystonic Homosexuality
- ◆ DSM IV: 1994 and DSM IV TR 2000 Asperger Disorder makes the grade!
- ◆ DSM 5: no more roman numerals...

Impact of DSM-III on International Collaboration

- ADAMHA-WHO Collaboration (1980-94)
 - 14 international Task Forces examined approaches of national “schools” of psychiatry
 - Copenhagen Conference, April 1982: 150 participants from 47 countries
 - Resulted in joint WHO/ADAMHA/APA effort to develop DSM-IV and ICD-10; CIDI, SCAN, and IPDE. ICF was next phase

Conceptual Development of DSM



Commentary

The Conceptual Development of DSM-V

Am J Psychiatry 166:6, June 2009

- ◆ **DSM-III-R:** Hierarchical arrangement partially abandoned, but...
- ◆ **DSM-IV:** Strict separation between disorders continues
- ◆ **DSM-5:** ??



Perceived Shortcomings in DSM-IV

- ◆ High rates of comorbidity
- ◆ High use of –NOS category
- ◆ Treatment non-specificity
- ◆ Inability to find a laboratory markers/ tests
- ◆ DSM is starting to hinder research progress

New Developments

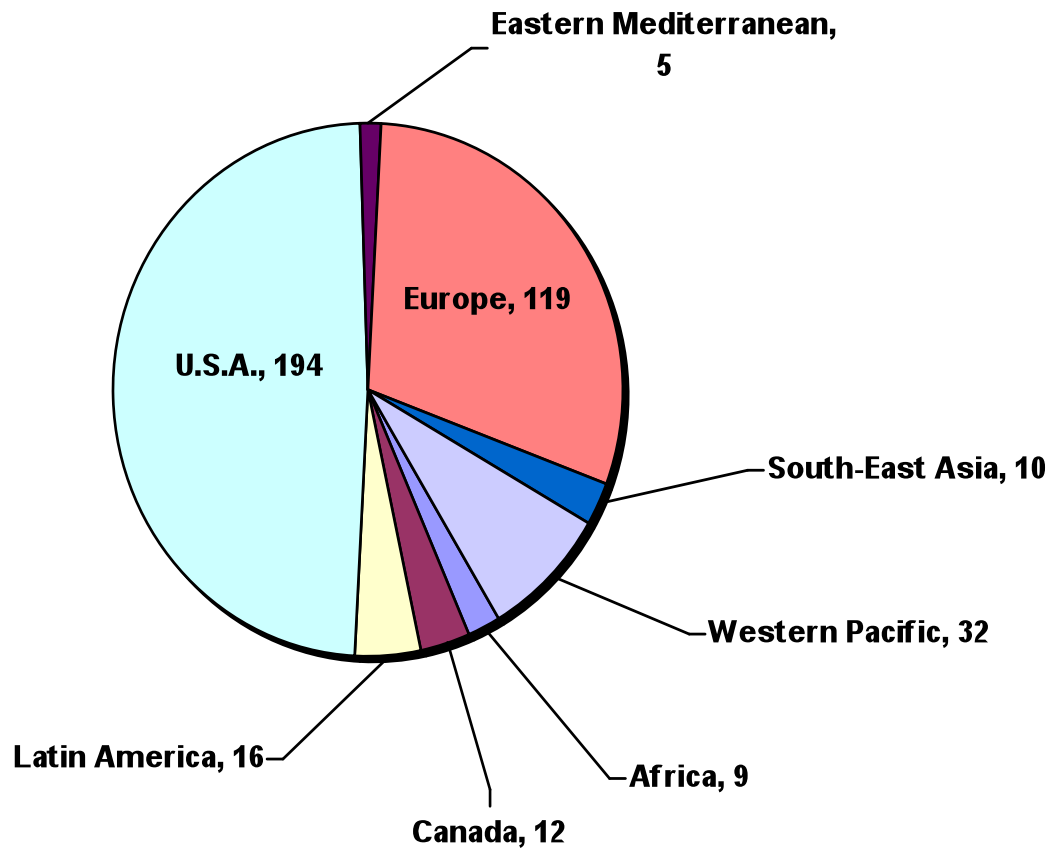
- ◆ Pressures to improve “validity”
- ◆ Move toward an “etiologically based” classification
- ◆ Are there data in these areas that can be helpful in developing/changing/refining diagnoses?
 - ◆ Cognitive or behavioral science
 - ◆ Family studies and molecular genetics
 - ◆ Neuroscience—NIMH RDoC Program
 - ◆ Functional and structural imaging

Requires a Shift
Neo-Kraepelinian to ??

Strategies for Improving DSM

- ◆ Incorporate **research** into the revision and evolution of the classification
- ◆ Move beyond a process of clinical consensus and build diagnoses on a foundation of **empirical** findings from scientific disciplines
- ◆ Seek multidisciplinary, international scientific participation in the task of planning the DSM-5 revision

APA/WHO/NIH Diagnosis Research Planning Conferences: Participant Distribution



- 397 Participants
- 39 Countries
- 16 Developing Nations
- 51% Non-US Participants
- 10% Developing Nation Participants

Africa

Kenya, 2
Nigeria, 3
South Africa, 4

Latin America

Argentina, 2
Brazil, 4
Chile, 3
Mexico, 5
Puerto Rico, 2

Eastern Mediterranean

Bahrain, 1
Israel, 3
Lebanon, 1

Europe

Belarus, 1
Belgium, 2
Denmark, 4
Estonia, 1
France, 3
Germany, 11

Europe (Cont)

Greece, 1
Hungary, 1
Italy, 5
Luxembourg, 1
Netherlands, 12
Norway, 2
Russia, 4
Spain, 5
Sweden, 4
Switzerland, 21
UK, 41

South-East Asia

India, 5
Pakistan, 2
Sri Lanka, 1
Thailand, 2

Western Pacific

Australia, 9
China, 9
Japan, 8
Korea, 3
New Zealand, 3

DSM-5 Conference Output

- ◆ 13 Conferences (2003-08)
- ◆ 10 monographs published
 - Dimensional Models of Personality Disorders
 - Diagnostic Issues in Substance Use Disorders
 - Diagnostic Issues in Dementia
 - Dimensional Approaches in Diagnostic Classification
 - Stress-Induced and Fear Circuitry Disorders
 - Somatic Presentations of Mental Disorders
 - Deconstructing Psychosis
 - Depression and GAD
 - Obsessive-Compulsive Behavior Spectrum Disorders
 - Public Health Aspects of Psychiatric Diagnosis
- ◆ More than 200 journal articles published

Dimensional Approaches in
**DIAGNOSTIC
CLASSIFICATION**

Refining the Research Agenda for DSM-V

Edited by

John E. Helzer, M.D.
Helena Chmura Kraemer, Ph.D.
Robert F. Krueger, Ph.D.
Hans-Ulrich Wittchen, Ph.D.
Paul J. Sirovatka, M.S.
Darrel A. Regier, M.D., M.P.H.

Diagnostic Issues in
**DEPRESSION^{and}
GENERALIZED
ANXIETY DISORDER**

Refining the Research Agenda for DSM-V

Edited by

David Goldberg, D.M., F.R.C.P.
Kenneth S. Kendler, M.D., Ph.D.
Paul J. Sirovatka, M.S.
Darrel A. Regier, M.D., M.P.H.

**STRESS-INDUCED
and FEAR CIRCUITRY
DISORDERS**

Refining the Research Agenda for DSM-V

Edited by

Gavin Andrews, M.D.
Dennis S. Charney, M.D.
Paul J. Sirovatka, M.S.
Darrel A. Regier, M.D., M.P.H.

DSM-5 Development

DSM-5 Task Force

(appointed 2006-2007)

- ◆ Work group chairs
- ◆ Health professionals from stakeholder groups

DSM-5 Work Groups

(appointed 2007-2008)

- ◆ Members work in specific diagnostic areas (e.g., Mood Disorders, Anxiety Disorder, etc.)
- ◆ Advisors for work groups

For more information, visit www.dsm5.org

DSM-5 Work Groups and Chairs

- ◆ ADHD & Disruptive Behavior Disorders (David Shaffer, M.D.)
- ◆ Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders (Katharine Phillips, M.D.)
- ◆ Disorders in Childhood and Adolescence (Daniel Pine, M.D.)
- ◆ Eating Disorders (Timothy Walsh, M.D.)
- ◆ Mood Disorders (Jan Fawcett, M.D.)
- ◆ Neurocognitive Disorders (Dan Blazer, M.D.; Ron Petersen, M.D. [Co-Chair]; Dilip Jeste, M.D. [Chair Emeritus])
- ◆ Neurodevelopmental Disorders (Susan Swedo, M.D.)
- ◆ Personality and Personality Disorders (Andrew Skodol, M.D.)
- ◆ Psychotic Disorders (William Carpenter, M.D.)
- ◆ Sexual and Gender Identity Disorders (Kenneth Zucker, Ph.D.)
- ◆ Sleep-Wake Disorders (Charles Reynolds, M.D.)
- ◆ Somatic Distress Disorders (Joel Dimsdale, M.D.)
- ◆ Substance-Related Disorders (Charles O' Brien, M.D., Ph.D.)

Cross-Cutting Study Groups and Chairs

- ◆ Diagnostic Spectra (Steven Hyman, M.D.)
- ◆ Life Span Developmental Approach Study Group (Susan K. Schultz, M.D.)
- ◆ Gender and Cross-Cultural Study Group (Kimberly Yonkers, M.D.)
- ◆ Psychiatric/General Medical Interface Study Group (Lawson Wulsin, M.D.)
- ◆ Impairment and Disability Assessment (Jane S. Paulsen, Ph.D.)
- ◆ Diagnostic Assessment Instruments (Jack D. Burke, Jr., M.D., M.P.H.)

Definition of a Mental Disorder

DSM-5:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

Definition of a Mental Disorder

- ◆ The diagnosis of a mental disorder should have clinical utility: it should help clinicians to determine prognosis, treatment plans, and potential treatment outcomes for their patients. However, the diagnosis of a mental disorder is not equivalent to a need for treatment.

Definition of a Mental Disorder

- ◆ Approaches to validating diagnostic criteria for discrete categorical mental disorders have included the following types of evidence:
 - **antecedent validators** (similar genetic markers, family traits, temperament, and environmental exposure);
 - **concurrent validators** (similar neural substrates, biomarkers, emotional and cognitive processing, and symptom similarity);
 - and **predictive validators** (similar clinical course and treatment response).

Definition of a Mental Disorder

- ◆ Available evidence shows that these validators cross existing diagnostic boundaries but tend to congregate more frequently within and across adjacent DSM-5 chapter groups.
- ◆ Until incontrovertible etiological or pathophysiological mechanisms are identified to fully validate specific disorders or disorder spectra, the most important standard for the DSM-5 disorder criteria will be their clinical utility.

DSM-5 Classification Structure

DSM-5 Structure

- ◆ Section I: DSM-5 Basics
- ◆ Section II: Essential Elements: Diagnostic Criteria and Codes
- ◆ Section III: Emerging Measures and Models
- ◆ Appendix
- ◆ Index

CATEGORIES vs DIMENSIONS

“According the architects of DSM-5, the introduction of dimensions is their most importance advance” --Abraham Nussbaum, MD quoting Darrel Regier (Int J Methods Psychiatr Res, 2007)

◆ WHY DIMENSIONS? * (per Nussbaum, A. . 2013)

Prior versions of DSM could not always distinguish normality from pathology and one mental disorder from another.

By introducing dimensions we can:

1. Acknowledge psychiatric symptoms that are not part of diagnostic criteria of patient's primary psychiatric disorder (e.g. panic attacks in pt with MDD)
2. measure the magnitude of a symptom (whether part of the primary disorder or not)
3. track progress of treatment
4. screen for mental disorders in particular patient populations (e.g. anxiety among adolescent patients)

Section I

- ◆ Brief DSM-5 developmental history
- ◆ Guidance on use of the manual
- ◆ Definition of a mental disorder
- ◆ Cautionary forensic statement
- ◆ Brief DSM-5 classification summary

Section II:

Chapter Structure

- A. Neurodevelopmental Disorders
- B. Schizophrenia Spectrum and Other Psychotic Disorders
- C. Bipolar and Related Disorders
- D. Depressive Disorders
- E. Anxiety Disorders
- F. Obsessive-Compulsive and Related Disorders
- G. Trauma- and Stressor-Related Disorders
- H. Dissociative Disorders

Section II: Chapter Structure

J. Somatic Symptom and Related Disorders

K. Feeding and Eating Disorders

L. Elimination Disorders

M. Sleep-Wake Disorders

N. Sexual Dysfunctions

P. Gender Dysphoria

Section II: Chapter Structure

Q. Disruptive, Impulse-Control, and Conduct Disorders

R. Substance-Related and Addictive Disorders

S. Neurocognitive Disorders

T. Personality Disorders

U. Paraphilic Disorders

V. Other Disorders

Medication-Induced Movement Disorders and Other
Adverse Effects of Medication

Other Conditions That May Be a Focus of Clinical
Attention

Section III: Purpose

- ◆ Section III serves as a designated location, separate from diagnostic criteria, text, and clinical codes, for items that appear to have initial support in terms of clinical use but require further research before being officially recommended as part of the main body of the manual
 - This separation clearly conveys to readers that the content may be clinically useful and warrants review, but is not a part of an official diagnosis of a mental disorder and cannot be used as such

Section III: Content

- ◆ Section III: Emerging Measures and Models
 - Assessment Measures
 - Cultural Formulation
 - Alternative DSM-5 Model for Personality Disorders
 - Conditions for Further Study

Section III: Content

- ◆ Section III, Conditions for Further Study
 - Attenuated Psychosis Syndrome
 - Depressive Episodes With Short Duration Hypomania
 - Persistent Complex Bereavement Disorder
 - Caffeine Use Disorder
 - Internet Gaming Disorder
 - Neurobehavioral Disorder Due to Prenatal Alcohol Exposure
 - Suicidal Behavior Disorder
 - Non-suicidal Self-Injury

Optional Section III Measures Recommended for Further Study and Evaluation

Optional Measurements in DSM-5

- ◆ Assess patient characteristics not necessarily included in diagnostic criteria **but of high relevance to prognosis, treatment planning and outcome** for most patients
- ◆ In DSM-5, these include:
 - Level 1 and Level 2 **Cross-Cutting Symptom** assessments
 - Diagnosis-specific **Severity** ratings
 - **Disability** assessment
- ◆ May be patient, informant, or clinician completed, depending on the measure

Level 1 Cross-Cutting Symptom Measure

- ◆ Referred to as “cross-cutting” because it calls attention to symptoms relevant to most, if not all, psychiatric disorders (e.g., mood, anxiety, sleep disturbance, substance use, suicide)
 - Self-administered by patient
 - 13 symptom domains for adults
 - 12 symptoms domains for children 11+, parents of children 6+
 - Brief—1-3 questions per symptom domain
 - Screen for important symptoms, not for specific diagnoses (i.e., “cross-cutting”)

Patient-Rated Level 1 Cross-Cutting Measure

Note: The following questions inquire about how you have been feeling over the past two weeks.

	None	Slight	Mild	Moderate	Severe
During the <u>past 2 weeks</u> , how much have you been bothered by the following problems:	Not at all	Rare, less than a day or two	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3	4
2. Feeling down, depressed, or hopeless?	0	1	2	3	4
3. Feeling irritated, grouchy, angry?	0	1	2	3	4
4. Sleeping less but still having a lot of energy?	0	1	2	3	4
5. Starting lots of projects or doing more risky things?	0	1	2	3	4
6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
7. Feeling panic or being frightened?	0	1	2	3	4
8. Avoiding situations that make you anxious?	0	1	2	3	4
9. Having unexplained aches and pains (e.g. head, back, joints, abdomen, legs)?	0	1	2	3	4
10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4

Online Assessment Measures

Level 1 Cross-Cutting Symptom Measures

[DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult](#) (also available in print book)

[DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17](#) (also available in print book)

[DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17](#)

Level 2 Cross-Cutting Symptom Measures

For Adults

[LEVEL 2—Depression—Adult](#) (PROMIS Emotional Distress— Depression—Short Form)

[LEVEL 2—Anger—Adult](#) (PROMIS Emotional Distress-Anger-Short Form)

[LEVEL 2—Mania—Adult](#) (Altman Self-Rating Mania Scale [ASRM])

[LEVEL 2—Anxiety—Adult](#) (PROMIS Emotional Distress—Anxiety— Short Form)

[LEVEL 2—Somatic Symptom—Adult](#) (Patient Health Questionnaire 15 Somatic Symptom Severity Scale [PHQ-15])

[LEVEL 2—Sleep Disturbance—Adult](#) (PROMIS—Sleep Disturbance—Short Form)

[LEVEL 2—Repetitive Thoughts and Behaviors—Adult](#) (Adapted from the Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale [Part B])

[LEVEL 2—Substance Use—Adult](#) (*Adapted from the NIDA-Modified ASSIST*)

For Parents of Children Ages 6–17 (Same as adult but also inattention and irritability measures)

Patient-Rated Level 1 Cross-Cutting Measure

Note: The following questions inquire about how you have been feeling over the past two weeks.

During the <u>past 2 weeks</u> , how much have you been bothered by the following problems:	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
11. Having thoughts of actually hurting yourself?	0	1	2	3	4
12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
13. Feeling that someone could hear your thoughts or that you could hear what another person was thinking?	0	1	2	3	4
14. Having problems with sleep that affected your sleep quality over all?	0	1	2	3	4
15. Having problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
16. Having unpleasant thoughts, images, or urges that repeatedly enter your mind?	0	1	2	3	4
17. Feeling driven to perform certain acts over and over again?	0	1	2	3	4
18. Not knowing who you really are or what you want out of life?	0	1	2	3	4
19. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4
20. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
21. Smoking any cigarettes, a cigar, or pipe or using snuff or chewing tobacco?	0	1	2	3	4
22. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4

Level 2 Cross-Cutting Measure

- ◆ Completed when the corresponding Level 1 item is endorsed at the level of “mild” or greater (for most but not all items, i.e., psychosis and inattention)
 - Gives a more detailed assessment of the symptom domain
 - Largely based on pre-existing, well-validated measures, including the SNAP-IV (inattention); NIDA-modified ASSIST (substance use); and PROMIS[®] forms (anger, sleep disturbance, emotional distress)

Example of a Level 2 Cross-cutting Assessment: Sleep

Please respond to each item by choosing one option per question.					
In the past SEVEN (7) DAYS....	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was restless.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was satisfied with my sleep.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
My sleep was refreshing.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
I had difficulty falling asleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
In the past SEVEN (7) DAYS....	Never	Rarely	Sometimes	Often	Always
I had trouble staying asleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I had trouble sleeping.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I got enough sleep.	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
In the past SEVEN (7) DAYS...	Very Poor	Poor	Fair	Good	Very good
My sleep quality was...	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

Diagnosis-Specific Severity Measures

- ◆ For documenting the severity of a specific disorder using, for example, the frequency and intensity of its component symptoms
- ◆ Can be administered to individuals with:
 - A diagnosis meeting full criteria
 - An “other specified” diagnosis, esp. a clinically significant syndrome that does not meet diagnostic threshold
- ◆ Some clinician-rated, some patient-rated

◆ Disorder-Specific Severity Measures

For Adults

Severity Measure for Depression—Adult (Patient Health Questionnaire [PHQ-9])

Severity Measure for Separation Anxiety Disorder—Adult

Severity Measure for Specific Phobia—Adult

Severity Measure for Social Anxiety Disorder (Social Phobia)—Adult

Severity Measure for Panic Disorder—Adult

Severity Measure for Agoraphobia—Adult

Severity Measure for Generalized Anxiety Disorder—Adult

Severity of Posttraumatic Stress Symptoms—Adult (National Stressful Events Survey PTSD Short Scale [NSESS])

Severity of Acute Stress Symptoms—Adult (National Stressful Events Survey Acute Stress Disorder Short Scale [NSESS])

Severity of Dissociative Symptoms—Adult (Brief Dissociative Experiences Scale [DES-B])

Diagnosis-Specific Severity Assessment: Symptom Domains for Schizophrenia

- ◆ Hallucinations
- ◆ Delusions
- ◆ Disorganized Speech
- ◆ Abnormal Psychomotor Beh
- ◆ Negative Symptoms
(Restricted Emotional
Expression or Avolition)
- ◆ Impaired Cognition
- ◆ Depression
- ◆ Mania

0 = Not Present

1 = Equivocal

2 = Present, but mild

3 = Present and
moderate

4 = Present and
severe

Appendix: Content

- ◆ Separate from Section III will be an Appendix, which will include
 - Highlights of Changes From DSM-IV to DSM-5
 - Glossary of Technical Terms
 - Glossary of Cultural Concepts of Distress
 - Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)
 - Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)
 - Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM)
 - DSM-5 Advisors and Other Contributors

Changes in Specific DSM Disorder Numbers; Combination of New, Eliminated, and Combined Disorders (net difference = -15)

	DSM-IV	DSM-5
Specific Mental Disorders*	172	157

◆*NOS (DSM-IV) and Other Specified/Unspecified (DSM-5) conditions are counted separately.

New and Eliminated Disorders in DSM-5

(net difference = +13)

New Disorders

1. **Social (Pragmatic) Communication Disorder**
2. **Disruptive Mood Dysregulation Disorder**
3. **Premenstrual Dysphoric Disorder** (DSM-IV appendix)
4. **Hoarding Disorder**
5. **Excoriation (Skin-Picking) Disorder**
6. **Disinhibited Social Engagement Disorder** (split from Reactive Attachment Disorder)
7. **Binge Eating Disorder** (DSM-IV appendix)
8. **Central Sleep Apnea** (split from Breathing-Related Sleep Disorder)
9. **Sleep-Related Hypoventilation** (split from Breathing-Related Sleep Disorder)
10. **Rapid Eye Movement Sleep Behavior Disorder** (Parasomnia NOS)
11. **Restless Legs Syndrome** (Dyssomnia NOS)
12. **Caffeine Withdrawal** (DSM-IV Appendix)
13. **Cannabis Withdrawal**
14. **Major Neurocognitive Disorder with Lewy Body Disease** (Dementia Due to Other Medical Conditions)
15. **Mild Neurocognitive Disorder** (DSM-IV Appendix)

Eliminated Disorders

1. **Sexual Aversion Disorder**
2. **Polysubstance-Related Disorder**

Combined Specific Disorders in DSM-5

(net difference = -28)

1. **Language Disorder** (Expressive Language Disorder & Mixed Receptive Expressive Language Disorder)
2. **Autism Spectrum Disorder** (Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder, & Rett's disorder—PDD-NOS is in the NOS count)
3. **Specific Learning Disorder** (Reading Disorder, Math Disorder, & Disorder of Written Expression)
4. **Delusional Disorder** (Shared Psychotic Disorder & Delusional Disorder)
5. **Panic Disorder** (Panic Disorder Without Agoraphobia & Panic Disorder With Agoraphobia)
6. **Dissociative Amnesia** (Dissociative Fugue & Dissociative Amnesia)
7. **Somatic Symptom Disorder** (Somatization Disorder, Undifferentiated Somatoform Disorder, & Pain Disorder)
8. **Insomnia Disorder** (Primary Insomnia & Insomnia Related to Another Mental Disorder)
9. **Hypersomnolence Disorder** (Primary Hypersomnia & Hypersomnia Related to Another Mental Disorder)
10. **Non-Rapid Eye Movement Sleep Arousal Disorders** (Sleepwalking Disorder & Sleep Terror Disorder)

Combined Specific Disorders in DSM-5 (Continued)

(net difference = -28)

11. **Genito-Pelvic Pain/Penetration Disorder** (Vaginismus & Dyspareunia)
12. **Alcohol Use Disorder** (Alcohol Abuse and Alcohol Dependence)
13. **Cannabis Use Disorder** (Cannabis Abuse and Cannabis Dependence)
14. **Phencyclidine Use Disorder** (Phencyclidine Abuse and Phencyclidine Dependence)
15. **Other Hallucinogen Use Disorder** (Hallucinogen Abuse and Hallucinogen Dependence)
16. **Inhalant Use Disorder** (Inhalant Abuse and Inhalant Dependence)
17. **Opioid Use Disorder** (Opioid Abuse and Opioid Dependence)
18. **Sedative, Hypnotic, or Anxiolytic Use Disorder** (Sedative, Hypnotic, or Anxiolytic Abuse and Sedative, Hypnotic, or Anxiolytic Dependence)
19. **Stimulant Use Disorder** (Amphetamine Abuse; Amphetamine Dependence; Cocaine Abuse; Cocaine Dependence)
20. **Stimulant Intoxication** (Amphetamine Intoxication and Cocaine Intoxication)
21. **Stimulant Withdrawal** (Amphetamine Withdrawal and Cocaine Withdrawal)
22. **Substance/Medication-Induced Disorders** (aggregate of Mood (+1), Anxiety (+1), and Neurocognitive (-3))

Changes from NOS to Other Specified/Unspecified (net difference = +24)

	DSM-IV	DSM-5
NOS (DSM-IV) and Other Specified/Unspecified (DSM-5)	41	65

Other Specified and Unspecified Disorders in DSM-5 replaced the Not Otherwise Specified (NOS) conditions in DSM-IV to maintain greater concordance with the official International Classification of Diseases (ICD) coding system. This statistical accounting change does not signify any new specific mental disorders.

Multiaxial Structure

- ◆ The Multiaxial diagnosis is no longer used
- ◆ In place of Axis I to V, the diagnoses are listed with psychiatric and medical combined.
- ◆ The convention has been to list the primary diagnosis for the visit first.

Multiaxial Structure

- ◆ Former Axis II is placed on this list in no special order
- ◆ Some felt Axis II disorders were seen as less significant and could never be “Primary”
- ◆ Though Axis III is gone, It is important to list medical diagnoses

Highlights of Specific Disorder Revisions and Rationales

Autism Spectrum Disorder (ASD)

(Neurodevelopmental Disorders)

- ◆ ASD replaces DSM-IV's autistic disorder, Asperger's disorder, childhood disintegration disorder, and pervasive developmental disorder not otherwise specified
 - Rationale: Clinicians had been applying the DSM-IV criteria for these disorders inconsistently and incorrectly; subsequently, reliability data to support their continued separation was very poor.
 - Specifiers can be used to describe variants of ASD (e.g., the former diagnosis of Asperger's can now be diagnosed as autism spectrum disorder, without intellectual impairment and without structural language impairment).

Coding ASD examples

- ◆ Autism Spectrum Disorder associated with Rett Syndrome, Level 2
Communication Supports, Level 3
Behavior supports, With Intellectual Impairment, With Language Impairment (Phrase speech) OR:
- ◆ Autism Spectrum Disorder Level 1
behavior supports without intellectual or language impairments

Intellectual Disability (Intellectual Developmental Disorder)

- ◆ Mental retardation was renamed intellectual disability (intellectual developmental disorder)
 - Rationale: The term *intellectual disability* reflects the wording adopted into U.S. law in 2010 (Rosa's Law), in use in professional journals, and endorsed by certain patient advocacy groups. The term *intellectual developmental disorder* is consistent with language proposed for ICD-11.
- ◆ Greater emphasis on adaptive functioning deficits rather than IQ scores alone
 - Rationale: Standardized IQ test scores were over-emphasized as the determining factor of abilities in DSM-IV. Consideration of functioning provides a more comprehensive assessment of the individual.

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 socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
- C. Onset of intellectual and adaptive deficits during the developmental period.

Specific Learning Disorder

- ◆ Now presented as a single disorder with coded specifiers for specific deficits in reading, writing, and mathematics
 - **Rationale:** There was widespread concern among clinicians and researchers that clinical reality did not support DSM-IV's three independent learning disorders. This is particularly important given that most children with specific learning disorder manifest deficits in more than one area.
 - By reclassifying these as a single disorder, separate specifiers can be used to code the level of deficits present in each of the three areas for any person.

Attention-Deficit/Hyperactivity Disorder

- ◆ Age of onset was raised from 7 years to 12 years
 - ◆ Rationale: Numerous large-scale studies indicate that, in many cases, onset is not identified until after age 7 years, when challenged by school requirements. Recall of onset is more accurate at 12 years.
- ◆ The symptom threshold for adults age 17 years and older was reduced to five
 - Rationale: The reduction in symptom threshold was for adults only and was made based on longitudinal studies showing that patients tend to have fewer symptoms in adulthood than in childhood. This should result in a minimal increase in the prevalence of adult ADHD.

Schizophrenia

(Schizophrenia Spectrum and Other Psychotic Disorders)

- ◆ Elimination of special treatment of bizarre delusions and “special” hallucinations in Criterion A (characteristic symptoms)
 - **Rationale:** This was removed due to the poor reliability in distinguishing bizarre from non-bizarre delusions.
- ◆ At least one of two required symptoms to meet Criterion A must be delusions, hallucinations, or disorganized speech
 - **Rationale:** This will improve reliability and prevent individuals with only negative symptoms and catatonia from being diagnosed with schizophrenia.

Schizophrenia (cont' d)

◆ Deletion of specific subtypes

- Rationale: DSM-IV's subtypes were shown to have very poor reliability and validity. They also failed to differentiate from one another based on treatment response and course.

Schizoaffective Disorder

- ◆ Now based on the lifetime (rather than episodic) duration of illness in which the mood and psychotic symptoms described in Criterion A occur
 - **Rationale:** The criteria in DSM-IV have demonstrated poor reliability and clinical utility, in part because the language in DSM-IV regarding the duration of illness is ambiguous. This revision is consistent with the language in schizophrenia and in mood episodes, which explicitly describe a longitudinal rather than episodic course. Similarly applying a longitudinal course to schizoaffective disorder will aid in its differential diagnosis from these related disorders.

Catatonia

- ◆ Now exists as a specifier for neurodevelopmental, psychotic, mood and other mental disorders; as well as for other medical disorders (catatonia due to another medical condition)
 - Rationale: As represented in DSM-IV, catatonia was under-recognized, particularly in psychiatric disorders other than schizophrenia and psychotic mood disorders and in other medical disorders. It was also apparent that inclusion of catatonia as a specific condition that can apply more broadly across the manual may help address gaps in the treatment of catatonia.

Mania and Hypomania

(Bipolar and Related Disorders)

- ◆ Inclusion of increased energy/activity as a Criterion A symptom of mania and hypomania
 - Rationale: This will make explicit the requirement of increased energy/activity in order to diagnose bipolar I or II disorder (which is not required under DSM-IV) and will improve the specificity of the diagnosis.

Mania and Hypomania

- ◆ “Mixed episode” is replaced with a “with mixed features” specifier for manic, hypomanic, and major depressive episodes
 - Rationale: DSM-IV criteria excluded from diagnosis the sizeable population of individuals with subthreshold mixed states who did not meet full criteria for major depression *and* mania, and thus were less likely to receive treatment.

Mania and Hypomania

- ◆ “With anxious distress” also added as a specifier for bipolar (and depressive) disorders
 - Rationale: The co-occurrence of anxiety with depression is one of the most commonly seen comorbidities in clinical populations. Addition of this specifier will allow clinicians to indicate the presence of anxiety symptoms that are not reflected in the core criteria for depression and mania but nonetheless may be meaningful for treatment planning.

Bereavement Exclusion (Depressive Disorders)

- ◆ Eliminated from major depressive episode (MDE)
 - Rationale: In some individuals, major loss – including but not limited to loss of a loved one – can lead to MDE or exacerbate pre-existing depression. Individuals experiencing both conditions can benefit from treatment but are excluded from diagnosis under DSM-IV. Further, the 2-month timeframe required by DSM-IV suggests an arbitrary time course to bereavement that is inaccurate. Lifting the exclusion alleviates both of these problems.

Disruptive Mood Dysregulation Disorder (DMDD)

- ◆ Newly added to DSM-5
 - Rationale: This addresses the disturbing increase in pediatric bipolar diagnoses over the past two decades, which is due in large part to the incorrect characterization of non-episodic irritability as a hallmark symptom of mania. DMDD provides a diagnosis for children with extreme behavioral dyscontrol but persistent, rather than episodic, irritability and reduces the likelihood of such children being inappropriately prescribed antipsychotic medication. These criteria do not allow a dual diagnosis with oppositional-defiant disorder (ODD) or intermittent explosive disorder (IED), but it can be diagnosed with conduct disorder (CD). Children who meet criteria for DMDD and ODD would be diagnosed with DMDD only.

DMDD

- ◆ At least age 6
- ◆ Onset by age 10
- ◆ 1 year of symptoms
- ◆ 3 temper outbursts per week
- ◆ Mood between temper outbursts is angry/irritable most of the time

Anxiety Disorders

- ◆ Separation of DSM-IV Anxiety Disorders chapter into four distinct chapters
 - Rationale: Data from neuroscience, neuroimaging, and genetic studies suggest differences in the heritability, risk, course, and treatment response among fear-based anxiety disorders (e.g., phobias); disorders of obsessions or compulsions (e.g., OCD); trauma-related anxiety disorders (e.g., PTSD); and dissociative disorders. Thus, four anxiety-related classifications are present in DSM-5, instead of two chapters in DSM-IV.

Panic Attacks Specifier

- ◆ Now a specifier for any mental disorder
 - Rationale: Panic attacks can predict the onset severity and course of mental disorders, including anxiety disorders, bipolar disorder, depression, psychosis, substance use disorders, and personality disorders.

Hoarding Disorder

(Obsessive-Compulsive and Related Disorders)

- ◆ Newly added to DSM-5
 - Rationale: Clinically significant hoarding is prevalent and can have direct and indirect consequences on the health and safety of patients as well as that of others (e.g., dependents, neighbors). Inclusion will increase the chances of these individuals receiving treatment.

Body Dysmorphic Disorder (BDD)

- ◆ Now classified as an OCD-related disorder rather than as a somatic disorder
 - Rationale: This reflects the fact that repetitive behaviors (e.g., mirror checking) are a key characteristic of this disorder and are prominent targets of intervention (e.g., response prevention).

BDD and OCD

- ◆ Both now include expanded specifiers to indicate the degree of insight present (i.e., “good or fair”; “poor”; “absent/delusional”)
 - Rationale: This allows for indication of delusional variants of OCD and BDD while permitting them to remain classified here rather than with the psychotic disorders; this reduces the risk of misdiagnosis as a psychotic disorder and subsequent treatment with antipsychotics.

Posttraumatic Stress Disorder

(Trauma- and Stress-Related Disorders)

- ◆ The stressor criterion (Criterion A) is more explicit (e.g., elimination of “non-violent death of a loved one” as a trigger) and subjective reaction (Criterion A2) is eliminated
 - Rationales: Direct and indirect exposure to trauma are still reflected in the criteria, but a review of the literature indicated more restrictive wording was needed. Criterion A2 is not well-supported by the data and rarely endorsed by military and other professionals who otherwise would meet full criteria for PTSD.

Posttraumatic Stress Disorder (cont' d)

- ◆ Expansion to four symptom clusters (intrusion symptoms; avoidance symptoms; negative alterations in mood and cognition; alterations in arousal and reactivity), with the avoidance/numbing cluster divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood
 - **Rationale:** Confirmatory factor analyses suggest PTSD is best conceptualized by four factors rather than three. Further, active avoidance and emotional numbing have been shown to be distinct; thus they have been separated here (with numbing expanded to include negative mood and cognitive symptoms).

Posttraumatic Stress Disorder (cont' d)

- ◆ Separate criteria are now available for PTSD occurring in preschool-age children (i.e., 6 years and younger)
 - Rationale: DSM-IV criteria for PTSD were not developmentally sensitive to very young children. For instance, young children are limited in their capacity to describe cognitions and internal experiences. Numerous studies indicate that children exposed to trauma can exhibit significant anxiety and other forms of distress that warrant treatment but, due to the inadequacy of the adult criteria, do not meet threshold for PTSD in DSM-IV.

RAD and DSED

- ◆ DSM-IV' s reactive attachment disorder (RAD) subtypes are now two distinct disorders: RAD and disinhibited social engagement disorder (DSED)
 - Rationale: These appear to be two distinct conditions that are characterized by different attachment behaviors. RAD is more similar to ADHD and disruptive behavior disorders and reflects poorly formed or absent attachments to others. DSED is more similar to depression and other internalizing disorders but occurs in children with both insecure and more secure attachments.

Dissociative Identity Disorder

(Dissociative Disorders)

- ◆ Additional text to support Criterion D (exclusion based on cultural or religious practices)
 - Rationale: This acknowledges that possession states are commonly recognized in cultures around the world and do not necessarily indicate presence of DID or any other mental disorder. In contrast, possession-form DID is recurrent and unwanted, leads to distress or impairment, and is not part of a broadly accepted cultural or religious practice.

Somatic Symptom and Related Disorders

- ◆ The central focus of medically unexplained symptoms has been de-emphasized throughout the chapter, and instead emphasis is placed on disproportionate thoughts, feelings, and behaviors that accompany symptoms
 - **Rationale:** The reliability of medically unexplained symptoms is low. Further, presence of medically explained symptoms *does not* rule out the possibility of a somatic symptom or related disorder being present.

Somatic Symptom Disorder (SSD)

- ◆ Replaces somatoform disorder, undifferentiated somatoform disorder, hypochondriasis, and the pain disorders
 - Rationale: DSM-IV's somatoform disorders have been shown to be rarely used in most clinics and across numerous countries, due in part to criteria and terminology that are confusing, unreliable, and not valid.
 - SSD is projected to cover the majority of patients previously diagnosed with its subsumed DSM-IV disorders, with illness anxiety disorder (new to DSM-5) likely covering the remainder.

Binge Eating Disorder (BED)

(Feeding and Eating Disorders)

- ◆ Elevated to the main body of the manual from DSM-IV's Appendix
 - Rationale: BED is highly recognized in the clinical literature as a valid and clinically useful diagnosis. Further, a significant proportion of cases of DSM-IV's eating disorder not otherwise specified (EDNOS) would meet criteria for BED; therefore, this should reduce use of the unspecified eating and feeding disorder designation in DSM-5.

Anorexia Nervosa (AN)

- ◆ Diagnosis no longer requires amenorrhea
 - Rationale: This requirement was already excluded for males, premenarcheal and postmenopausal females, and women using birth control pills. Data indicate females who menstruate but otherwise meet criteria for AN are clinically similar to non-menstruating females with AN.

Avoidant/Restrictive Food Intake Disorder (ARFID)

- ◆ Feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder
 - Rationale: The new name will facilitate more accurate diagnosis in children presenting to pediatric clinics with significantly restricted eating patterns or nutritional problems, thus also likely reducing the use of the unspecified eating or feeding disorder diagnosis in DSM-5 (formerly EDNOS in DSM-IV).

Sleep-Wake Disorders

- ◆ Primary insomnia renamed insomnia disorder
 - Rationale: This name change better reflects the bidirectional relationships between insomnia and concurrent medical disorders, rather than implying a causal relationship.
- ◆ Rapid eye movement sleep behavior disorder and restless legs syndrome both elevated to the main body of the manual
 - Rationale: Both of these disorders have ample data on clinical utility, polysomnography features, and treatment response to warrant promotion.

Circadian Rhythm Sleep Disorders

- ◆ Subtypes expanded to include advanced sleep phase syndrome, irregular sleep-wake type, and non-24-hour type
 - Rationale: Inclusion of these subtypes was based on the presence of biomarkers, familial heritability, and public health need (e.g., significant impairment that can occur from chronic sleep deprivation; association with other psychiatric disorders).

Breathing-Related Sleep Disorders

- ◆ Specific diagnostic criteria are now provided for Obstructive Sleep Apnea Hypopnea, Central Sleep Apnea, and Sleep Related Hypoventilation
 - Rationale: As consistent with the *International Classification of Sleep Disorders*, this change is supported by literature suggesting differences in each disorder's physiological and anatomical pathogenesis and comorbidities.

Sexual Dysfunctions

- ◆ Vaginismus and dyspareunia are merged into genito-pelvic pain/penetration disorder
 - Rationale: These two DSM-IV disorders were highly comorbid and difficult to differentiate, resulting in poor clinical utility and reliability. Data suggest they likely represent overlapping features of a single condition.
- ◆ To indicate the presence and degree of medical and nonmedical correlates, select associated features were added to text (e.g., partner factors, cultural or religious factors)

Gender Dysphoria

- ◆ Newly added as a separate diagnostic class in DSM-5
 - Rationale: This new diagnostic class reflects a change in the conceptualization of gender identity disorder's (GID) defining features by emphasizing the phenomenon of “gender incongruence” rather than cross-gender identification, as in DSM-IV.
 - The name change responds to concerns from consumers and advocates that the term *gender identity disorder* was stigmatizing. The revised term is already familiar to clinicians working with these populations and better reflects the emotional component of the diagnostic criteria.

Gender Dysphoria

- ◆ Criteria now include two separate sets for children and for adults/adolescents
 - Rationale: Slight changes in the wording of criteria for children were necessary given developmental considerations. For example, some children might not verbalize the desire to be of another gender due to fear of social reprimand or if living in a household where such verbalizations lead to punishment.

Conduct Disorder (CD)

(Disruptive, Impulse-Control, and Conduct Disorders)

- ◆ Addition of a conduct disorder specifier called “with limited prosocial emotions”
 - Rationale: Data have identified a subgroup of children with CD that display a lack of guilt and empathy, lack of concern over performance in important activities, and shallow affect. Compared to other children with CD, this subgroup appears to have more severe symptoms, a more stable course, and greater levels of aggression. Addition of this specifier will inform the development of specialized treatments separate from those used with other CD populations.

Intermittent Explosive Disorder (IED)

- ◆ Provides more specific criteria to define types of outbursts and the frequency needed to meet threshold. Further, diagnosis is now limited to children at least 6 years of age.
 - Rationale: More explicit criteria was needed to better differentiate IED from similar disorders of DMDD and CD, which also involve outbursts of aggressive or negative behavior. The addition of the age limit to children at least 6 years reflects the lack of research on IED in very young populations.

Substance Use Disorder (SUD) (Substance-Related and Addictive Disorders)

- ◆ Consolidate substance abuse with substance dependence into a single disorder called substance use disorder
 - Rationale: *Dependence* is a misunderstood term that has negative connotations when in fact it refers to normal patterns of withdrawal that can occur from the proper use of medications.

Substance Use Disorder (cont' d)

- Rationale continued: Further, studies from clinical and general populations indicate DSM-IV substance abuse and dependence criteria represent a singular phenomenon but encompassing different levels of severity. Mild SUD (2-3/11 criteria) will be coded with the DSM-IV substance abuse code to reflect the intent but not reality of considering substance abuse less severe than substance dependence. Moderate (4-5/11 criteria) and severe (6+/11 criteria) SUD will be coded with DSM-IV substance dependence codes.

Substance Use Disorder (cont' d)

- ◆ Removal of one of the DSM-IV abuse criteria (legal consequences), and addition of a new criterion for SUD diagnosis (craving or strong desire or urge to use the substance)
 - Rationales: The legal criterion had poor clinical utility and its relevance to patients varied based on local laws and enforcement of those laws. Addition of craving as a symptom is highly validated, based on clinical trials and brain imaging data, and may hold potential as a future biomarker for the diagnosis of SUD.

Neurocognitive Disorders (NCD)

- ◆ Use of the term *major neurocognitive disorder* rather than *dementia*
 - Rationale: The term *dementia* is usually associated with neurodegenerative conditions occurring in older populations, as in Alzheimer's disease and Lewy Body dementia. However, DSM-5's major NCD refers to a broad range of possible etiologies that can occur even in young adults, such as major NCD due to traumatic brain injury or HIV infection.

Mild NCD

◆ Newly added to DSM-5

- **Rationale:** Patients with mild NCD are frequently seen in clinics and in research settings, and there is widespread consensus throughout the field that these populations can benefit from diagnosis and treatment. The clinical utility of such a diagnosis also is highly supported in the literature.

NCD Subtypes

- ◆ Elevation of DSM-IV etiological subtypes (e.g., frontotemporal dementia, dementia with Lewy Bodies) to separate, independent disorders
 - Rationale: Separate criteria for 10 etiologies were developed based on clinical need and to reflect the best clinical practices endorsed by neurologists, neuropsychiatrists, and others who routinely work with these patients. Etiological criteria provide clarity for clinicians, more accurate diagnoses for patients, and support for researchers in uncovering potential biomarkers that may inform diagnosis in the future.

Personality Disorders (PD)

- ◆ All 10 DSM-IV PDs remain intact in Section II. However, Section III contains an alternate, trait-based approach to assessing personality and PDs that includes specific PD types (e.g., borderline, antisocial) but allows for the rating of traits and facets, facilitating diagnosis in individuals who meet core criteria for a PD but do not otherwise meet a specific PD type.
 - Rationale: A hybrid model with both dimensional and categorical approaches is included in Section III. This model calls for evaluation of impairments in personality functioning and characterizes five broad areas of pathological personality traits. It identifies six PD types, each defined by both impairments in personality functioning and a pattern of impairments in personality traits. We will evaluate the strengths and weaknesses of the model, leading to greater understanding of the causes and treatments of PDs.

Paraphilic Disorders

- ◆ Chapter title and content emphasize paraphilic disorders rather than paraphilias
 - Rationale: Paraphilias that do not involve non-consenting victims (e.g., transvestism) are not necessarily indicative of a mental disorder. To have a paraphilic disorder requires distress, impairment, or abuse of a non-consenting victim.

Paraphilic Disorders

- ◆ “In a controlled environment” and “in remission” specifiers added to all paraphilic disorders
 - **Rationale:** These new specifiers reflect important aspects of clinical status that may impact symptom presentation. For instance, opportunities to engage in paraphilic disorder behaviors may be limited if the individual is in an institutional setting or other controlled environment.

Use of DSM-5

Structure of Disorder Chapters

- ◆ Criteria
- ◆ Subtypes and/or specifiers
- ◆ Severity
 - Codes and recording procedures
- ◆ Explanatory text (new or expanded)
 - Diagnostic and associated features; prevalence; development and course; risk and prognosis; culture- and gender-related factors; diagnostic markers; functional consequences; differential diagnosis; comorbidity

Cautionary Statement for Forensic Use

However, the use of DSM-5 should be informed by an awareness of the risks and limitations of its use in forensic settings. In most situations, the clinical diagnosis of a DSM-5 mental disorder such as intellectual disability (intellectual developmental disorder), schizophrenia, major neurocognitive disorder, gambling disorder, or pedophilic disorder does not imply that an individual with such a condition meets **legal criteria** for the presence of a mental disorder or a specified **legal standard** (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is -usually required beyond that contained in the DSM-5 diagnosis.

Forensic Review of DSM-5

- ◆ APA's Council on Psychiatry and Law assigned 2 reviewers to each work group
- ◆ Extensive review of criteria and text, with feedback distributed to work groups for consideration for further revisions
- ◆ Important implications for competency hearings, rendering decisions about mental state (e.g., not guilty by reason of insanity, capital punishment), civil commitments, and more

Pedophilic Disorder

- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).
- B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
- C. The individual is at least age 16 years and at least 5 years older than the child or children in Criterion A.

New DSM-5 Diagnoses Code Issues

- ◆ Dual coding provided to account for lag between DSM-5's publication and official implementation of ICD-10-CM codes (October 1, 2014)
- ◆ Codes accompany each criteria set
 - Some codes are used for multiple disorders
- ◆ In select places, unique codes are given for subtypes, specifiers, and severity
- ◆ For neurocognitive and substance/medication-induced disorders, coding depends on further specification

New DSM-5 Diagnoses Code Issues

DSM-5 Disorder	ICD-9-CM Code	ICD-9-CM Title	ICD-10-CM Code	ICD-10-CM Title
Social (Pragmatic) Communication Disorder	315.39	Other developmental speech or language disorder	F80.89	Other developmental disorders of speech and language
Disruptive Mood Dysregulation Disorder	296.99	Other Specified Episodic Mood Disorder	F34.8	Other Persistent Mood [Affective] Disorder
Premenstrual Dysphoric Disorder (from DSM-IV appendix)	625.4	Premenstrual tension syndromes	N94.3	Premenstrual tension syndrome

New DSM-5 Diagnoses Code Issues

DSM-5 Disorder	ICD-9-CM Code	ICD-9-CM Title	ICD-10-CM Code	ICD-10-CM Title
Hoarding Disorder	300.3	Obsessive Compulsive Disorders	F42	Obsessive Compulsive Disorder
Excoriation (Skin Picking) Disorder	698.4	dermatitis factitia [artefacta]	L98.1	factitial dermatitis
Binge Eating Disorder (from DSM-IV Appendix)	307.51	bulimia nervosa	F50.2	bulimia nervosa
Substance Use Disorders	Coding will be applied based on severity: ICD codes associated with substance abuse will be used to indicate mild SUD; ICD codes associated with substance dependence will be used to indicate moderate or severe SUD			

New DSM-5 Diagnoses Code Issues

- ◆ When using these DSM-5 diagnoses, clinicians should note the name of the disorder next to the code listing, since no distinct code yet exists for these diagnoses.
- ◆ The APA is working with insurers to ensure these are recognized as distinct entities.

Important Insurance Considerations

- ◆ There may be some delay for certain insurance carriers to update their coding systems
- ◆ Similar delays may exist for removing the multiaxial format from forms and computer systems
 - Place all mental and other medical disorders on a single list—with ICD code and name of disorder
 - In place of Axis IV, use DSM-5's v/z/t codes
 - WHODAS 2.0 provided for disability rating (formerly Axis V), but no replacement for the GAF has been approved as of yet

For more information about CMS acceptance of DSM-IV and ICD-9-CM codes, visit their online FAQ at:
<https://questions.cms.gov/faq.php?id=5005&faqId=1817>

DIAGNOSTIC AND STATISTICAL
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MENTAL DISORDERS

FIFTH EDITION

DSM-5

AMERICAN PSYCHIATRIC ASSOCIATION