Update on DSM 5
**DSM 5**

- 14 years
- 1500 expert reviewers
- Plethora committees, work groups, meetings
- Revisions galore
- Field testing completed
- 25 million dollars
- Now ready for release in May 2013
Diagnostic Statistical Manual

- DSM began WWII, first edition published 1952
- 132 pages
- Since then there has been 4 revisions
- Currently DSM IV TR (text revision) 943 pages
- Next revision released DSM V May 2013
Anxiety Disorder

- DaCosta’s syndrome 1871
- Soldier’s heart
- Effort syndrome
- Neurocirculatory asthenia
- Anxiety neurosis 1894
- DSM 1 1952 anxiety neurosis
- DSM II 1962 anxiety neurosis
- DSM III 1980 anxiety neurosis split into PD, GAD and PTSD
- 1994 Acute Stress Disorder
BED

• Criteria include frequent overeating—at least once a week for three months—combined with lack of control, marked feelings of distress, and are associated with three or more of the following:
BED 3 of the below

Eating much more rapidly than normal.
Eating until feeling uncomfortably full.
Eating large amounts of food when not feeling physically hungry.

Eating alone because of feeling embarrassed by how much one is eating.

Feeling disgusted with oneself, depressed or very guilty afterward.
AN

DSM –IV Criterion A no longer requires

*Refusal* to maintain body weight at or above a minimally normal weight for age and height

The DSM-IV Criterion D no longer requires

*amenorrhea, or the absence of at least three menstrual cycles.*
DSM-5 criteria reduce the frequency of binge eating and compensatory behaviors to once a week from twice weekly as specified in DSM-IV.
Hoarding Disorder

Acquiring too many possessions,

Difficulty discarding or getting rid of them when they are no longer useful or needed.

Difficulty organizing possessions

When these behaviors lead to enough clutter and disorganization to affect someone’s health or safety, or they lead to significant distress, then hoarding becomes a “disorder”

http://www.ocfoundation.org/hoarding/diagnosing.aspx
"I know it's good for nothing, but I'm keeping it until it's good for something!"
Skin Picking Disorder

Dermatillomania
Neurotic excoriation
Pathologic skin picking disorder
Compulsive skin picking disorder
Psychogenic excoriation
Olfactory Reference Disorder
OCD and related disorders

• OCD
• Hair pulling Disorder
• Skin picking Disorder
• Hoarding Disorder
• Body Dysmorphic Disorder-----migration from Somatform Disorders
• Olfactory reference Disorder
CHANGES
Neurodevelopmental Disorders in DSM 5
Childhood Disintegrative

Classic autism

Asperger syndrome

P.D.D.–N.O.S.*

Proposed definition (D.S.M.–V)

Autism spectrum disorder

Social communication disorder
### Mental Retardation

#### Intellectual Disability

<table>
<thead>
<tr>
<th>IQ Score</th>
<th>Level of Mental Retardation</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-69</td>
<td>Mild Mental Retardation</td>
</tr>
<tr>
<td>36-49</td>
<td>Moderate Mental Retardation</td>
</tr>
<tr>
<td>20-34</td>
<td>Severe Mental Retardation</td>
</tr>
<tr>
<td>Below 20</td>
<td>Profound Mental Retardation</td>
</tr>
</tbody>
</table>
(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
(b) often has difficulty sustaining attention in tasks or play activities
(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish school work, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
(e) often has difficulty organizing tasks and activities
(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities
(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively
(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)
AD/HD Disorder

- Age of onset now 12 yo or younger
- Previous was 7 yo or younger
- Adults now need only 5 criteria not 6
- Removal of subtypes: hyperactive, inattentive, mixed
CHANGES in Schizophrenia and Psychotic Disorders in DSM 5
One “core” positive symptom or any two

Hallucinations
Delusions
Disorganized thinking/speech
Disorganized behavior (i.e. catatonia)
Affective blunting/Alogia/Avolition
Two symptoms but one must be a positive “core”

- Hallucinations
- Delusions
- Disorganized thinking/speech
- Disorganized behavior (i.e. catatonia)
- Affective blunting/Alogia/Avolition
**DSM IV** ok to have one delusion or hallucination if was bizarre enough, but in general need two symptoms

**DSM 5** you need two symptoms one of which is a core symptom

**DSM 5** eliminated the *subtypes* of schizophrenia
Five Subtypes of Schizophrenia (DSM IV):
Catatonic
Disorganized
Paranoid
Residual
Undifferentiated

NO Subtypes of Schizophrenia (DSM 5):
but use specifiers instead (i.e. Catatonia):
Duration/time unchanged
DSM IV and DSM 5
for Schizophrenia

6 months duration with one of those months with active symptoms
DSM IV TR Criteria for Schizophrenia

(1) delusions
(2) hallucinations
(3) disorganized speech (e.g., frequent derailment or incoherence)
(4) grossly disorganized or catatonic behavior
(5) Negative symptoms, i.e., affective flattening, alogia, or avolition

6 months duration with one month of active symptoms
“Some clinicians and researchers believe that many patients with schizophrenia experience unsatisfactory outcomes because we identify the illness and initiate treatment after substantial brain tissue damage has occurred. Introducing attenuated psychosis syndrome will support clinicians’ efforts to recognize mild psychotic symptoms early in their evolution and to monitor—and if necessary, intervene—during these crucial early stages. Risks include possible stigma and inappropriate use of medications and other treatments “

Rajiv Tandon, MD, Professor of Psychiatry *
University of Florida    Gainesville, FL
Commentaries/Controversies in Psychiatry/Getting ready for DSM-5: Psychotic disorders
Current Psychiatry  Vol. 11, No. 4
APS

• Attenuated Psychosis Syndrome
• DSM 5 section III/Research/Further Investigation
• Milder and Shorter
• Possibility of proceeding towards Schizophrenia, Schizophreniform, Schizoaffective Disorder
Schizoaffective Disorder

This mental disorder is diagnosed when the symptom criteria for Schizophrenia are met and during the same continuous period there is a Major Depressive, Manic or Mixed Episode. During that same period hallucinations or delusions must be present for at least 2 weeks while there are no mood symptoms.

Diagnostic criteria for 295.70 Schizoaffective Disorder (DSM IV - TR)

A. An uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia.
   Note: The Major Depressive Episode must include Criterion A1: depressed mood.

B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms.

C. Symptoms that meet criteria for a mood episode are present for a majority (>50%) of the total duration of the active and residual periods of the illness.
CHANGES in Bipolar and related Disorders in DSM 5
**Criterion A for Manic Episode  
*(DSM IV - TR)*  
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, and abnormally and persistently increased activity or energy.

**Criterion A for Hypomanic Episode  
*(DSM IV - TR)*  
A. A distinct period of persistently elevated, expansive, or irritable mood and persistently increased activity or energy.  

Specifiers

Elimination of Bipolar I *Mixed* type

Instead using the specifier of *Mixed* state in MDD and Bipolar Manic

Can also use *Catatonia* as a specifier to describes states.

MDD, Bipolar Disorder, Schizophrenia with *catatonia*

Bipolar I disorder *Depressed* type
Bipolar I disorder *Manic* type

*Anxious distress* as a specifier for both bipolar and depressive disorders
Diagnostic criteria for Major Depressive Episode

DSM 5

2 weeks and 5 symptoms below

Depressed mood or loss of interest/pleasure

Weight loss or gain
Insomnia or hypersomnia
Fatigue/loss energy
Feeling of worthlessness/Excessive guilt
Psychomotor retardation/agitation
Suicidal thoughts
Cognitive impairment memory, concentration, indecision, reading

Exclusionary Criteria for Bereavement: If grief is less than 2 months cannot Dx Major Dep Disorder, unless Pathological Bereavement/Grief is suspected.

DSM 5

Exclusionary Criteria for Bereavement: If grief is less than 2 months cannot Dx unless Pathological Bereavement/Grief is suspected.
CHANGES in Depressive Disorders in DSM 5
Mixed Anxiety/Depression - proposed for Section III, a section in DSM-5 in which conditions that require further research will be included

Major Depressive Episode - proposed removal of the bereavement exclusion and addition of a footnote to clarify for clinicians how to differentiate bereavement and other loss reactions from Major Depression

Persistent Depressive Disorder = Dysthymia
Disruptive Mood Dysregulation Disorder (DMDD)

Temper Dysregulation Disorder with Dysphoria (TDDDD)

Bipolar Disorder NOS
**Disruptive Mood Dysregulation Disorder (DMDD)**

A. The disorder is characterized by *severe recurrent temper outbursts* that are grossly out of proportion in intensity or duration to the situation.

1. The temper outbursts are manifest verbally and/or behaviorally, such as in the form of verbal rages or physical aggression towards people or property.

2. The temper outbursts are inconsistent with developmental level.
**Disruptive Mood Dysregulation Disorder (DMDD)**

B. **Frequency:**
The temper outbursts occur, on average, three or more times per week.

C. **Mood between temper outbursts:**

1. Nearly every day, most of the day, the mood between temper outbursts is persistently irritable or angry.

2. The irritable or angry mood is observable by others (e.g., parents, teachers, peers).
D. **Duration:** 12 or more months. Throughout that time, the person has not had 3 or more consecutive months when they were without the symptoms of Criteria A-C.

E. Criterion A or C is present in at least **two settings** (at home, at school, or with peers) and must be severe in at least in one setting.

F. The diagnosis should not be made for the first **time before age 6 or after age 18**.

G. The onset of Criteria A through E is **before age 10 years**.

). (Note: This diagnosis cannot co-exist with Oppositional Defiant Disorder or Bipolar Disorder, though it can co-exist with Attention Deficit/Hyperactivity Disorder, Conduct Disorder, and Substance Use Disorders. Individuals meeting criteria for both Disruptive Mood Dysregulation Disorder and Oppositional Defiant Disorder should only be given the diagnosis of Disruptive Mood Dysregulation Disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of Disruptive Mood Dysregulation Disorder should not be assigned.
CHANGES in Anxiety Disorders in DSM 5
Anxiety Disorders

• Migration of OCD into a separate category
• Migration of PTSD into a separate category
• Addition of Substance-Induced Anxiety Disorder
• Addition Anxiety Disorder Attributable to Another Medical Condition
• Addition Anxiety Disorder Not Elsewhere Classified
OCD has moved

PTSD has moved
TRAUMA and STRESS RELATED Disorders

Adjustment Disorder
Acute Stress Disorder
Post Traumatic Stress Disorder
Dissociative Disorders
PTSD in DSM 5

- Symptoms are mostly the same. The 3 clusters of DSM-IV symptoms will be divided into 4 clusters in DSM-5: intrusion symptoms, avoidance symptoms, arousal/reactivity symptoms, and negative mood and cognitions.

It is proposed that a few symptoms will be added and some revised.

- Criterion A2 (requiring fear, helplessness or horror happen right after the trauma) will be removed.
CHANGES in Dementia to Neurocognitive Disorders in DSM 5
Vascular Neurocognitive Disorder

Frontotemporal Neurocognitive Disorder

Neurocognitive Disorder due to Lewy Body Dementia

Neurocognitive Disorder due to Parkinson’s Disease

Neurocognitive Disorder due to HIV infection
Substance-Induced Neurocognitive Disorder

Neurocognitive Disorder due to Huntington’s Disease

Neurocognitive Disorder due to Prion Disease

Neurocognitive Disorder due to Another Medical Condition

Neurocognitive Disorder due to Alzheimer’s Disease

Neurocognitive Disorder Not Elsewhere Classified
CHANGES in Substance Use and Addictive Disorders in DSM 5
NO MORE *ABUSE* AND *DEPENDENCE*

CONTINUUM RATHER THAN BLACK AND WHITE PERSEPECITIVE

Use of *Specifiers*
Addition of *Pathological Gambling* added an “addiction”.

Addition of criteria for *Caffeine Use Disorder* - proposed for Section III

Addition of criteria for *Internet Use Disorder* - proposed for Section III
Somatoform Disorders

Elimination of

Hypochondriasis
Pain Disorder
Undifferentiated Somatization Disorder
Somatization Disorder

Migration of

Body Dysmorphic disorder
to OCD and related Disorders
Somatoform Disorders

Elimination of

Hypochondriasis
Pain Disorder
Undifferentiated Somatization Disorder
Somatization Disorder

SSD
What is left?

*Somatic Symptom Disorder*

Conversion Disorder
Factious Disorder
NOS replaced with NEC