DSM-5 Criteria and ICD10 Codes: Classification and Use

September 24, 2015
Erick Messias, MD, PhD
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 Evolution

DSM I 1952
132 pages

DSM II 1968
119 pages

DSM III 1980
494 pages

DSM IV 1994
886 pages

Erick Messias, MD
DSM-5 Revisions: Brief History and Conceptual Approaches
ICD-8-9 and DSM-II

• 1967-1972 US-UK study: demonstrated need for common definitions (incorporated in semi-structured PSE interview) for clinicians to eliminate wide national variations in diagnosis. DSM-II had glossary in 1968

• 1972: Feighner Criteria—16 disorders, Renard Interview

• 1977 ICD-9: Glossary of symptom definitions
ICD-9 and DSM-III

• 1978  Spitzer et al. modified and expanded Feighner to create the Research Diagnostic Criteria (RDC) and SADS Interview

• 1980  DSM-III—went beyond glossary of symptoms to explicit criteria sets based on RDC
DSM-III and ICD-9 Impact on Diagnostic Instrument Development

• 1979 Robins et al. developed NIMH Diagnostic Interview Schedule (DIS) incorporated DSM-III criteria for use in ECA

• 1982 Spitzer et al. developed the Structured Clinical Interview for DSM (SCID)

• Emerged as a standardized instrument for clinical research in U.S. and abroad
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

- **DSM-I**: Presumed etiology
- **DSM-II**: Glossary definitions
- **DSM-III**: Reconceptualization
  - Explicit criteria (emphasis on reliability rather than validity)
- **DSM-IV**: Requires clinically significant distress or impairment
- **DSM-III-R**: Criteria broadened
  - Most hierarchies dropped
- **DSM-5**: New approaches considered
  - (dimensional, spectra, developmental, culture, impairment thresholds, living document)

The Conceptual Development of DSM-5

• **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

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

**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

**Latin America**
- Argentina, 2
- Brazil, 4
- Chile, 3
- Mexico, 5
- Puerto Rico, 2

**Latin America**
- Argentina, 2
- Brazil, 4
- Chile, 3
- Mexico, 5
- Puerto Rico, 2

**Eastern Mediterranean**
- Bahrain, 1
- Israel, 3
- Lebanon, 1

**Eastern Mediterranean**
- Bahrain, 1
- Israel, 3
- Lebanon, 1

**South-East Asia**
- India, 5
- Pakistan, 2
- Sri Lanka, 1
- Thailand, 2

**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

**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

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.)
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
Section 1

- 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

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)*

<table>
<thead>
<tr>
<th></th>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Mental Disorders*</td>
<td>172</td>
<td>157</td>
</tr>
</tbody>
</table>

*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. **Hypersomnia Disorder** (Primary Hypersomnia & Hypersomnia Related to Another Mental Disorder)

10. **Non-Rapid Eye Movement Sleep Arousal Disorders** (Sleepwalking Disorder & Sleep Terror Disorder)

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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)
22. Substance/Medication-Induced Disorders (aggregate of Mood (+1), Anxiety (+1), and Neurocognitive (-3))
### Changes in NOS DSM Disorder Numbers

#### Changes from NOS to Other Specified/Unspecified

*(net difference = +24)*

<table>
<thead>
<tr>
<th></th>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOS (DSM-IV and Other Specified/Unspecified (DSM-5)</td>
<td>41</td>
<td>65</td>
</tr>
</tbody>
</table>

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 Diagnosis

**Axis I.** Major Depressive Disorder, Recurrent, Moderate; Marijuana Abuse

**Axis II.** Avoidant Personality Disorder

**Axis III.** Diabetes Mellitus, Hypertension

**Axis IV.** Social, Financial, Occupation

**Axis V.** GAF 35

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**DSM-IV**

**DSM-5**

Major Depressive Disorder, Recurrent, Moderate

Marijuana Abuse

Avoidant Personality Disorder

Diabetes Mellitus

Hypertension

Social Exclusion or Rejection (V62.4)

Low Income (V60.2)

Other Problem Related to Employment (V62.29)
Highlights of Specific Disorder Revisions and Rationales
# Autism Spectrum Disorders

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Autistic Disorder</td>
<td>• F 84.0 Autism Spectrum Disorder,</td>
</tr>
<tr>
<td>• Rett’s Disorder</td>
<td>(Severity = Level 1 [requiring support]</td>
</tr>
<tr>
<td>• Childhood Disintegrative Disorder</td>
<td>to Level 3 [requiring very substantial</td>
</tr>
<tr>
<td>• Asperger’s Disorder</td>
<td>support])</td>
</tr>
<tr>
<td>• Pervasive Developmental Disorder NOS</td>
<td></td>
</tr>
</tbody>
</table>
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).
Intellectual Disability

DSM-IV

- Mild Mental Retardation
  - IQ 50-55 to 70
- Moderate Mental Retardation
  - IQ 35-40 to 50-55
- Severe Mental Retardation
  - IQ 20-25 to 35-40
- Profound Mental Retardation
  - IQ below 20-25
- Mental Retardation, Severity Unspecified
  - IQ untestable

DSM-5

- Intellectual Disability (Intellectual Developmental Disorder), specify F70 mild, F71 moderate, F72 severe, F73 profound
  - Note: No IQ cut-off levels
  - No before 18 years of age, instead during development period
- F88 Global Developmental Delay
- F79 Unspecified 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.

## Attention Deficit Hyperactivity Disorder

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Attention-Deficit/ Hyperactive Disorder</td>
<td></td>
</tr>
<tr>
<td>• Combined type</td>
<td></td>
</tr>
<tr>
<td>• Predominantly inattentive</td>
<td></td>
</tr>
<tr>
<td>• Predominantly hyperactive-impulsive type</td>
<td></td>
</tr>
<tr>
<td>• Attention-Deficit/ Hyperactive Disorder NOS</td>
<td></td>
</tr>
<tr>
<td>• Conduct Disorder</td>
<td></td>
</tr>
<tr>
<td>• Oppositional Defiant Disorder</td>
<td></td>
</tr>
<tr>
<td>• Disruptive Behavior Disorder NOS</td>
<td></td>
</tr>
<tr>
<td>• (Moved to Impulse Control ..)</td>
<td>• Attention-Deficit/ Hyperactive Disorder</td>
</tr>
<tr>
<td></td>
<td>• F90.2 Combined presentation</td>
</tr>
<tr>
<td></td>
<td>• F90.0 Predominantly inattentive presentation</td>
</tr>
<tr>
<td></td>
<td>• F90.1 Predominantly hyperactive-impulsive presentation</td>
</tr>
<tr>
<td></td>
<td>• F90.8 Other Specified Attention-Deficit/ Hyperactive Disorder</td>
</tr>
<tr>
<td></td>
<td>• F90.9 Unspecified Attention-Deficit/ Hyperactive Disorder</td>
</tr>
</tbody>
</table>
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.

Specific Learning Disorders

### DSM-IV
- Reading Disorder
- Mathematics Disorder
- Disorder of Written Expression
- Learning Disorder NOS

### DSM-5
- Specific Learning Disorder
  - F81.0 With impairment in reading
  - F81.81 With impairment in written expression
  - F81.2 With impairment in Mathematics
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.

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expressive Language Disorder</td>
<td>• F80.9 Language Disorder</td>
</tr>
<tr>
<td>• Mixed Receptive-Expressive Language Disorder</td>
<td>• F80.0 Speech Sound Disorder</td>
</tr>
<tr>
<td>• Phonological Disorder</td>
<td>• F80.81 Childhood-Onset Fluency Disorder (Stuttering)</td>
</tr>
<tr>
<td>• Stuttering</td>
<td>• F80.89 Social (Pragmatic) Communication Disorder</td>
</tr>
<tr>
<td>• Communication Disorder NOS</td>
<td>• F80.9 Unspecified Communication Disorder</td>
</tr>
</tbody>
</table>
Social (Pragmatic) Communication Disorder

Diagnostic Criteria

A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following:

1. Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.

2. Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on a playground, talking differently to a child than to an adult, and avoiding use of overly formal language.

3. Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction.

4. Difficulties understanding what is not explicitly stated (e.g., making inferences) and nonliteral or ambiguous meanings of language (e.g., idioms, humor, metaphors, multiple meanings that depend on the context for interpretation).

B. The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.

C. The onset of the symptoms is in the early developmental period (but deficits may not become fully manifest until social communication demands exceed limited capacities).

D. The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains of word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability (intellectual developmental disorder), global developmental delay, or another mental disorder.
# Schizophrenia Spectrum and Other Psychotic Disorders

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Schizophrenia                                                       • F21 Schizotypal (Personality) Disorder</td>
<td></td>
</tr>
<tr>
<td>• Schizophreniform Disorder                                           • F22 Delusional Disorder</td>
<td></td>
</tr>
<tr>
<td>• Schizoaffective Disorder                                            • F23 Brief Psychotic Disorder</td>
<td></td>
</tr>
<tr>
<td>• Delusional Disorder                                                 • F20.9 Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>• Brief Psychotic Disorder                                            • F20.81 Schizophreniform Disorder</td>
<td></td>
</tr>
<tr>
<td>• <strong>Shared Psychotic Disorder</strong>                                       • Schizoaffective Disorder F25.0 (D) F25.1 (B)</td>
<td></td>
</tr>
<tr>
<td>• Psychotic Disorder Due to General Medical Condition                 • Substance/Medication-Induced Psychotics Disorder – ICD code depends on substance</td>
<td></td>
</tr>
<tr>
<td>• Substance Induced Psychotic Disorder                                • Psychotic Disorder Due to Another Medical Condition - ICD code depends on condition</td>
<td></td>
</tr>
<tr>
<td>• Psychotic Disorder NOS                                              • F06.1 Catatonia Associated With Another Mental Disorder (Catatonia Specifier)</td>
<td></td>
</tr>
<tr>
<td>• F06.1 Catatonic Disorder Associated with Another Medical Condition</td>
<td></td>
</tr>
<tr>
<td>• F06.1 Unspecified Catatonia</td>
<td></td>
</tr>
</tbody>
</table>

*Other Specified Schizophrenia Spectrum and ……*

*Unspecified Schizophrenia Spectrum and ……*
• 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 (continued)

• 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.

### Bifurcation of Mood Disorder Chapter

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mood Disorders</td>
<td>• Bipolar and Related Disorders</td>
</tr>
<tr>
<td></td>
<td>• Depressive Disorders</td>
</tr>
</tbody>
</table>
Bipolar and Related Disorders

- F31 Bipolar I Disorder
- F31 Bipolar II Disorder
- F34.0 Cyclothymic Disorder
- Substance/Medication Induced Bipolar and Related Disorders
- Bipolar and Related Disorders Due to Another Medical Condition
- F31.89 Other Specified Bipolar and Related Disorders
- F31.9 Unspecified Bipolar and Related Disorders

Depressive Disorders

- F34.8 Disruptive Mood Dysregulation Disorder (New)
- F32/33 Major Depressive Disorder
- F34.1 Persistent Depressive Disorder (Dysthymia)
- N94.3 Premenstrual Dysphoric Disorder (New)
- Substance/Medication Induced Depressive Disorder
- F06 Depressive Disorder Due to Another Medical Condition
- F32.8 Other Specified Depressive Disorder
- F32.9 Unspecified Depressive Disorder
Premenstrual Dysphoric Disorder

Diagnostic Criteria

A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses.

B. One (or more) of the following symptoms must be present:
1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).
2. Marked irritability or anger or increased interpersonal conflicts.
3. Marked depressed mood, feelings of hopelessness, or self-deprecatory thoughts.
4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.

C. One (or more) of the following symptoms must additionally be present, to reach a total of five symptoms when combined with symptoms from Criterion B above.
1. Decreased interest in usual activities (e.g., work, school, friends, hobbies).
2. Subjective difficulty in concentration.
3. Lethargy, easy fatigability, or marked lack of energy.
4. Marked change in appetite; overeating; or specific food cravings.
5. Hypersomnia or insomnia.
6. A sense of being overwhelmed or out of control.
7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of “bloating,” or weight gain.

Note: The symptoms in Criteria A–C must have been met for most menstrual cycles that occurred in the preceding year.

D. The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).

E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders).

F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (Note: The diagnosis may be made provisionally prior to this confirmation.)

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).
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.
• “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.
“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.
• 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.
Disruptive Mood Dysregulation Disorder (DMDD)

**Diagnostic Criteria**

A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.

B. The temper outbursts are inconsistent with developmental level.

C. The temper outbursts occur, on average, three or more times per week.

D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).

E. Criteria A–D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A–D.

F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.

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

H. By history or observation, the age at onset of Criteria A–E is before 10 years.

I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

   **Note:** Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).

   **Note:** This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet 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.

K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.
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.

# Anxiety Disorders

**DSM-IV**

- Panic Disorder *Without Agoraphobia* and Panic Disorder *With Agoraphobia*
- Agoraphobia *Without History of Panic Disorder*
- Specific Phobia
- Social Phobia
- Obsessive Compulsive Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Generalized Anxiety Disorder
- Anxiety Disorder Due to GMC
- Substance Induced Anxiety Disorder
- Anxiety Disorder NOS

**DSM-5**

- F93.0 Separation Anxiety Disorder
- F94.0 Selective Mutism
- F40 Specific Phobia
- F40.10 Social Anxiety Disorder
- F41.0 Panic Disorder
- F40.00 Agoraphobia
- F41.1 Generalized Anxiety Disorder
- Substance/Medication Induced Anxiety Disorder
- F06.4 Anxiety Disorder Due to Another Medical Condition
- F41.8 Other Specified Anxiety Disorder
- F41.9 Unspecified Anxiety Disorder
• 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.
DSM-5 Obsessive-Compulsive and Related Disorders

- F42 Obsessive-Compulsive Disorder
- F45.22 Body Dysmorphic Disorder (from DSM-IV Somatoform Disorders)
- F42 Hoarding Disorder (New)
- F63.2 Trichotillomania (from DSM-IV Impulse Control Disorders)
- L98.1 Excoriation (Skin Picking) Disorder (New)
- Substance/Medication Induced Obsessive-Compulsive and Related Disorders
- F06.8 Obsessive-Compulsive and Related Disorders Due to Another Medical Condition
- F42 Other Specified Obsessive-Compulsive and Related Disorder
- F42 Unspecified Obsessive-Compulsive and Related Disorder

Excoriation (Skin-Picking) Disorder

Diagnostic Criteria

A. Recurrent skin picking resulting in skin lesions.
B. Repeated attempts to decrease or stop skin picking.
C. The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).
E. The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm oneself in nonsuicidal self-injury).

698.4 (L98.1)
• 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.
Hoarding Disorder

Diagnostic Criteria

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 undelugered, 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).

Specify if:

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.

300.3 (F42)
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).
• 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.
DSM-5 Trauma- and Stressor-Related Disorders

- F94.1 Reactive Attachment Disorder (from DSM-IV Other Disorders of Infancy, …)
- F94.2 Disinhibited Social Engagement Disorder (New)
- F43.10 Posttraumatic Stress Disorder
- F43.0 Acute Stress Disorder
- F43.2 Adjustment Disorders (from DSM-IV Adjustment Disorders)
- F43.8 Other Specified Trauma- and Stressor Related Disorder
- F43.9 Unspecified Trauma- and Stressor Related Disorder
• 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.
Disinhibited Social Engagement Disorder

**Diagnostic Criteria**

**313.89 (F94.2)**

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.

*Specify if:*

**Persistent:** The disorder has been present for more than 12 months.

*Specify current severity:*

Disinhibited social engagement disorder is specified as **severe** when the child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.
Disinhibited Social Engagement Disorder vs Reactive Attachment Disorder

DSED

Diagnostic Criteria

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

RAD

Diagnostic Criteria

A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
   1. The child rarely or minimally seeks comfort when distressed.
   2. 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:
   1. Minimal social and emotional responsiveness to others.
   2. Limited positive affect.
   3. 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:
   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 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.
Specify if:
   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.
• 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 (continued)

- 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 (continued)

• 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.
## Dissociative Disorders

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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.

Dissociative Amnesia

• Now includes a dissociative fugue specifier, which was previously an independent disorder

• Rationale: This revision was implemented due to a lack of clinical and epidemiological data supporting dissociative fugue as an independent disorder and due to the low validity of DSM-IV dissociative fugue criteria.
# Somatic Symptoms and Related Disorders

## DSM-IV
- Somatization Disorder
- Undifferentiated Somatoform Disorder
- Conversion Disorder
- Pain Disorder
- Hypochondriasis
- Body Dysmorphic Disorder
- Somatoform Disorder NOS

## DSM-5
- F45.1 Somatic Symptom Disorder
- F45.21 Illness Anxiety Disorder (New)
- F44 Conversion Disorder (Functional Neurological Symptom Disorder)
- F54 Psychological Factors Affecting Other Medical Conditions
- F68.10 Factitious Disorder
  - Factitious Disorder Imposed on Self
  - Factitious Disorder Imposed on Another
- F45.8 Other Specified Somatic Symptom and Related Behaviors
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.
Feeding and Eating Disorders

**DSM-IV**

- Anorexia Nervosa
- Bulimia Nervosa
- Eating Disorder NOS

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**DSM-IV Feeding and Eating Disorders of Infancy or Early Childhood**

- Pica
- Rumination Disorder
- Feeding Disorder of Infancy or Early Childhood

**DSM-5**

- F50 or F98.3 Pica
- F98.21 Rumination Disorder
- F50.8 Avoidant/Restrictive Food Intake Disorder
- F50.02 or 01 Anorexia Nervosa
- F50.2 Bulimia Nervosa
- F50.8 Binge-Eating Disorder
- F50.8 Other Specified Feeding or Eating Disorder
- F50.9 Unspecified Feeding or Eating Disorder
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.
Binge Eating Disorder

**Diagnostic Criteria**

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:
   1. Eating much more rapidly than normal.
   2. Eating until feeling uncomfortably full.
   3. Eating large amounts of food when not feeling physically hungry.
   4. Eating alone because of feeling embarrassed by how much one is eating.
   5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Specify if:

- **In partial remission:** After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.

- **In full remission:** After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- **Mild:** 1–3 binge-eating episodes per week.
- **Moderate:** 4–7 binge-eating episodes per week.
- **Severe:** 8–13 binge-eating episodes per week.
- **Extreme:** 14 or more binge-eating episodes per week.
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

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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).
• 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.
Central Sleep Apnea

Diagnostic Criteria

A. Evidence by polysomnography of five or more central apneas per hour of sleep.
B. The disorder is not better explained by another current sleep disorder.

Specify whether:

327.21 (G47.31) Idiopathic central sleep apnea: Characterized by repeated episodes of apneas and hypopneas during sleep caused by variability in respiratory effort but without evidence of airway obstruction.

786.04 (R06.3) Cheyne-Stokes breathing: A pattern of periodic crescendo-decrescendo variation in tidal volume that results in central apneas and hypopneas at a frequency of at least five events per hour, accompanied by frequent arousal.

780.57 (G47.37) Central sleep apnea comorbid with opioid use: The pathogenesis of this subtype is attributed to the effects of opioids on the respiratory rhythm generators in the medulla as well as the differential effects on hypoxic versus hypercapnic respiratory drive.

Coding note (for 780.57 [G47.37] code only): When an opioid use disorder is present, first code the opioid use disorder: 305.50 (F11.10) mild opioid use disorder or 304.00 (F11.20) moderate or severe opioid use disorder; then code 780.57 (G47.37) central sleep apnea comorbid with opioid use. When an opioid use disorder is not present (e.g., after a one-time heavy use of the substance), code only 780.57 (G47.37) central sleep apnea comorbid with opioid use.

Note: See the section "Diagnostic Features" in text.

Specify current severity:

Severity of central sleep apnea is graded according to the frequency of the breathing disturbances as well as the extent of associated oxygen desaturation and sleep fragmentation that occur as a consequence of repetitive respiratory disturbances.
Sleep-Related Hypoventilation

Diagnostic Criteria

A. Polysomnography demonstrates episodes of decreased respiration associated with elevated CO₂ levels. (Note: In the absence of objective measurement of CO₂, persistent low levels of hemoglobin oxygen saturation unassociated with apneic/hypopneic events may indicate hypoventilation.)

B. The disturbance is not better explained by another current sleep disorder.

Specify whether:

327.24 (G47.34) Idiopathic hypoventilation: This subtype is not attributable to any readily identified condition.

327.25 (G47.35) Congenital central alveolar hypoventilation: This subtype is a rare congenital disorder in which the individual typically presents in the perinatal period with shallow breathing, or cyanosis and apnea during sleep.

327.26 (G47.36) Comorbid sleep-related hypoventilation: This subtype occurs as a consequence of a medical condition, such as a pulmonary disorder (e.g., interstitial lung disease, chronic obstructive pulmonary disease) or a neuromuscular or chest wall disorder (e.g., muscular dystrophies, postpolio syndrome, cervical spinal cord injury, kyphoscoliosis), or medications (e.g., benzodiazepines, opiates). It also occurs with obesity (obesity hypoventilation disorder), where it reflects a combination of increased work of breathing due to reduced chest wall compliance and ventilation-perfusion mismatch and variably reduced ventilatory drive. Such individuals usually are characterized by body mass index of greater than 30 and hypercapnia during wakefulness (with a pCO₂ of greater than 45), without other evidence of hypoventilation.

Specify current severity:

Severity is graded according to the degree of hypoxemia and hypercarbia present during sleep and evidence of end organ impairment due to these abnormalities (e.g., right-sided heart failure). The presence of blood gas abnormalities during wakefulness is an indicator of greater severity.
Rapid Eye Movement Sleep Behavior Disorder

**Diagnostic Criteria**

327.42 (G47.52)

A. Repeated episodes of arousal during sleep associated with vocalization and/or complex motor behaviors.

B. These behaviors arise during rapid eye movement (REM) sleep and therefore usually occur more than 90 minutes after sleep onset, are more frequent during the later portions of the sleep period, and uncommonly occur during daytime naps.

C. Upon awakening from these episodes, the individual is completely awake, alert, and not confused or disoriented.

D. Either of the following:
   1. REM sleep without atonia on polysomnographic recording.
   2. A history suggestive of REM sleep behavior disorder and an established synucleinopathy diagnosis (e.g., Parkinson’s disease, multiple system atrophy).

E. The behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (which may include injury to self or the bed partner).

F. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

G. Coexisting mental and medical disorders do not explain the episodes.
Restless Legs Syndrome

<table>
<thead>
<tr>
<th>Diagnostic Criteria</th>
<th>333.94 (G25.81)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. An urge to move the legs, usually accompanied by or in response to uncomfortable and unpleasant sensations in the legs, characterized by all of the following:</td>
<td></td>
</tr>
<tr>
<td>1. The urge to move the legs begins or worsens during periods of rest or inactivity.</td>
<td></td>
</tr>
<tr>
<td>2. The urge to move the legs is partially or totally relieved by movement.</td>
<td></td>
</tr>
<tr>
<td>3. The urge to move the legs is worse in the evening or at night than during the day, or occurs only in the evening or at night.</td>
<td></td>
</tr>
<tr>
<td>B. The symptoms in Criterion A occur at least three times per week and have persisted for at least 3 months.</td>
<td></td>
</tr>
<tr>
<td>C. The symptoms in Criterion A are accompanied by significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.</td>
<td></td>
</tr>
<tr>
<td>D. The symptoms in Criterion A are not attributable to another mental disorder or medical condition (e.g., arthritis, leg edema, peripheral ischemia, leg cramps) and are not better explained by a behavioral condition (e.g., positional discomfort, habitual foot tapping).</td>
<td></td>
</tr>
<tr>
<td>E. The symptoms are not attributable to the physiological effects of a drug of abuse or medication (e.g., akathisia).</td>
<td></td>
</tr>
</tbody>
</table>
### DSM-IV

Sexual Dysfunctions
- Sexual Desire Disorders
  - Hypoactive Sexual Desire Disorder
  - Sexual Aversion Disorder
- Sexual Arousal Disorders
- Orgasmic Disorders
- Sexual Pain Disorders (Not due to GMC)
  - Dyspareunia
  - Vaginismus

Sexual Dysfunction Due to GMC
- Female Hypoactive Disorder Due to {GMC}
- Male Hypoactive Disorder Due to {GMC}
- ..........

### DSM-5

- F52.32 Delayed Ejaculation
- F52.21 Erectile Disorder
- F52.31 Female Orgasmic Disorder
- F52.22 Female Sexual Interest/Arousal Disorder
- F52.6 Genito-Pelvic Pain/Penetration Disorder
- F52.0 Male Hypoactive Sexual Desire Disorder
- F52.4 Premature Ejaculation
- Substance/Medication Induced Sexual Dysfunction
- F52.8 Other Specified Sexual Dysfunction
- F52 Unspecified Sexual Dysfunction
# Paraphilic Disorders

## DSM-IV

**Paraphilias**
- Exhibitionism
- Fetishism
- Frotteurism
- Pedophilia
- Sexual Masochism
- Sexual Sadism
- Transvestic Fetishism
- Voyeurism
- Paraphilia NOS

**Gender Identity Disorders**
- Gender Identity Disorder – in children, in adolescence/adults
- Gender Identity Disorder NOS
- Sexual Disorder NOS

## DSM-5

- F65.3 Voyeuristic Disorder
- F65.2 Exhibitionistic Disorder
- F65.81 Frotteuristic Disorder
- F65.51 Sexual Masochism Disorder
- F65.52 Sexual Sadism Disorder
- F65.4 Pedophilic Disorder
- F65.0 Fetishistic Disorder
- F65.1 Transvestic Disorder
- F65.89 Other Specified Paraphilic DO
- F65.9 Unspecified Paraphilic Disorder

**DSM-5 – Gender Dysphoria**
- Gender Dysphoria; F64.2 in children; F64.1 In adolescence or adults
- F64.8 Other Specified Gender Dysphoria
- F64.9 Unspecified Gender Dysphoria
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.
• 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.
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.

“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.
### DSM-IV
- Intermittent Explosive Disorder
- Kleptomania
- Pyromania
- Pathological Gambling
- Trichotillomania
- Impulse-Control Disorder NOS

### DSM-5
- F91.3 Oppositional Defiant Disorder
- F63.81 Intermittent Explosive Disorder
- F91.1/2/9 Conduct Disorder
- F60.2 Antisocial Personality Disorder
- F63.1 Pyromania
- F63.3 Kleptomania
- F91.8 Other Specified Disruptive, Impulse Control, and Conduct Disorders
- F91.9 Unspecified Disruptive, Impulse Control, and Conduct Disorders
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-Related and Addictive Disorders

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>{Substance} Use Disorders</strong></td>
<td><strong>{Substance}-Related Disorders</strong></td>
</tr>
<tr>
<td><strong>{Substance} Abuse</strong></td>
<td><strong>{Substance} Use Disorder</strong></td>
</tr>
<tr>
<td><strong>{Substance} Dependence</strong></td>
<td><strong>Mild, Moderate, Severe</strong></td>
</tr>
<tr>
<td><strong>{Substance}-Induced Disorders</strong></td>
<td><strong>{Substance} Intoxication</strong></td>
</tr>
<tr>
<td><strong>{Substance} Intoxication</strong></td>
<td><strong>With use disorder, mild</strong></td>
</tr>
<tr>
<td><strong>{Substance} Withdrawal</strong></td>
<td><strong>With use disorder, moderate to severe</strong></td>
</tr>
<tr>
<td><strong>{Substance}-Induced {Condition} Disorder</strong></td>
<td><strong>Without use disorder</strong></td>
</tr>
<tr>
<td><strong>{Substance}-Related Disorder NOS</strong></td>
<td><strong>{Substance} Withdrawal</strong></td>
</tr>
<tr>
<td><strong>Polysubstance Dependence</strong></td>
<td><strong>Other {Substance}-Induced Disorders</strong></td>
</tr>
<tr>
<td><strong>Unspecified {Substance}-Related Disorders</strong></td>
<td><strong>Unspecified {Substance}-Related Disorders</strong></td>
</tr>
<tr>
<td>DSM-IV</td>
<td>DSM-5</td>
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<tr>
<td></td>
<td>• Non-Substance-Related Disorders</td>
</tr>
<tr>
<td></td>
<td>• F63.0 Gambling Disorder</td>
</tr>
</tbody>
</table>
• 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.
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 (continued)

- 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.
Caffeine Withdrawal

Diagnostic Criteria

292.0 (F15.93)

A. Prolonged daily use of caffeine.

B. Abrupt cessation of or reduction in caffeine use, followed within 24 hours by three (or more) of the following signs or symptoms:
   1. Headache.
   2. Marked fatigue or drowsiness.
   3. Dysphoric mood, depressed mood, or irritability.
   4. Difficulty concentrating.
   5. Flu-like symptoms (nausea, vomiting, or muscle pain/stiffness).

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The signs or symptoms are not associated with the physiological effects of another medical condition (e.g., migraine, viral illness) and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.
Cannabis Withdrawal

**Diagnostic Criteria**

292.0 (F12.288)

A. Cessation of cannabis use that has been heavy and prolonged (i.e., usually daily or almost daily use over a period of at least a few months).

B. Three (or more) of the following signs and symptoms develop within approximately 1 week after Criterion A:
   1. Irritability, anger, or aggression.
   2. Nervousness or anxiety.
   3. Sleep difficulty (e.g., insomnia, disturbing dreams).
   4. Decreased appetite or weight loss.
   5. Restlessness.
   6. Depressed mood.
   7. At least one of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache.

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

**Coding note:** The ICD-9-CM code is 292.0. The ICD-10-CM code for cannabis withdrawal is F12.288. Note that the ICD-10-CM code indicates the comorbid presence of a moderate or severe cannabis use disorder, reflecting the fact that cannabis withdrawal can only occur in the presence of a moderate or severe cannabis use disorder. It is not permissible to code a comorbid mild cannabis use disorder with cannabis withdrawal.
# Neurocognitive Disorders

## DSM-IV

- **Delirium**
- **Dementia**
  - Dementia of Alzheimer’s Type, with early or late onset
  - Vascular Dementia
  - Dementia Due to {HIV Disease, Head Trauma, Parkinson’s Disease, Pick’s Disease, Creutzfeldt-Jakob Disease, GMC, Substance, Multiple Etiologies}
  - Dementia NOS
- **Amnestic Disorders**
  - Amnestic Disorder Due to {GMC}
  - Substance Induced Amnestic Disorder
- **Cognitive Disorders**
  - Cognitive Disorder NOS

## DSM-5

- **Delirium**
- **G31.9 Major or G31.84 Mild Neurocognitive Disorder Due to Alzheimer’s Disease**
- **G31.9 Major or G31.84 Mild Frontotemporal Neurocognitive Disorder**
- **G31.9 Major or G31.84 Mild Neurocognitive Disorder With Lewy Bodies**
- **G31.9 Major or G31.84 Mild Vascular Neurocognitive Disorder**
- **G31.9 Major or G31.84 Mild Neurocognitive Disorder Due to {Traumatic Brain Injury, HIV Infection, Prion Disease, Parkinson’s Disease, Huntington’s Disease, Another Medical Condition, Substance, Multiple Etiologies}**
- **R41.9 Unspecified Neurocognitive Disorder**
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.
• 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.

Major or Mild Neurocognitive Disorder with Lewy Bodies

Diagnostic Criteria

A. The criteria are met for major or mild neurocognitive disorder.
B. The disorder has an insidious onset and gradual progression.
C. The disorder meets a combination of core diagnostic features and suggestive diagnostic features for either probable or possible neurocognitive disorder with Lewy bodies.

For probable major or mild neurocognitive disorder with Lewy bodies, the individual has two core features, or one suggestive feature with one or more core features. For possible major or mild neurocognitive disorder with Lewy bodies, the individual has only one core feature, or one or more suggestive features.

1. Core diagnostic features:
   a. Fluctuating cognition with pronounced variations in attention and alertness.
   b. Recurrent visual hallucinations that are well formed and detailed.
   c. Spontaneous features of parkinsonism, with onset subsequent to the development of cognitive decline.

2. Suggestive diagnostic features:
   a. Meets criteria for rapid eye movement sleep behavior disorder.
   b. Severe neuroleptic sensitivity.

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.

Coding note: For probable major neurocognitive disorder with Lewy bodies, with behavioral disturbance, code first 331.82 (G31.83) Lewy body disease, followed by 294.11 (F02.81) probable major neurocognitive disorder with Lewy bodies, with behavioral disturbance. For probable major neurocognitive disorder with Lewy bodies, without behavioral disturbance, code first 331.82 (G31.83) Lewy body disease, followed by 294.10 (F02.80) probable major neurocognitive disorder with Lewy bodies, without behavioral disturbance. For possible major neurocognitive disorder with Lewy bodies, code 331.9 (G31.9) possible major neurocognitive disorder with Lewy bodies. (Note: Do not use the additional code for Lewy body disease. Behavioral disturbance cannot be coded but should still be indicated in writing.) For mild neurocognitive disorder with Lewy bodies, code 331.83 (G31.84). (Note: Do not use the additional code for Lewy body disease. Behavioral disturbance cannot be coded but should still be indicated in writing.)
Mild Neurocognitive Disorder

Diagnostic Criteria

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).

Specify whether due to:

- Alzheimer’s disease
- Frontotemporal lobar degeneration
Mild Vs Major Neurocognitive Disorder

**Diagnostic Criteria**

A. Evidence of 

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a 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 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).

Specify whether due to:

- Alzheimer’s disease
- Frontotemporal lobar degeneration
- Lewy body disease

---

**Diagnostic Criteria**

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).

Specify whether due to:

- Alzheimer’s disease
- Frontotemporal lobar degeneration
- Lewy body disease
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.

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-Related Level 1 Cross-Cutting Measure

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

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

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

<table>
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<tr>
<th>During the past 2 weeks, how much have you been bothered by the following problems:</th>
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<th>Slight Rare, less than a day or two</th>
<th>Mild Several days</th>
<th>Moderate More than half the days</th>
<th>Severe Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Having thoughts of actually hurting yourself?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Hearing things other people couldn’t hear, such as voices even when no one was around?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Feeling that someone could hear your thoughts or that you could hear what another person was thinking?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. Having problems with sleep that affected your sleep quality over all?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. Having problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. Having unpleasant thoughts, images, or urges that repeatedly enter your mind?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. Feeling driven to perform certain acts over and over again?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. Not knowing who you really are or what you want out of life?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. Not feeling close to other people or enjoying your relationships with them?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. Drinking at least 4 drinks of any kind of alcohol in a single day?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. Smoking any cigarettes, a cigar, or pipe or using snuff or chewing tobacco?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>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)]?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>In the past SEVEN (7) DAYS....</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>My sleep was restless.</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>I was satisfied with my sleep.</td>
<td>☐ 5</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
<td>☐ 1</td>
</tr>
<tr>
<td>My sleep was refreshing.</td>
<td>☐ 5</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
<td>☐ 1</td>
</tr>
<tr>
<td>I had difficulty falling asleep.</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the past SEVEN (7) DAYS....</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I had trouble staying asleep.</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>I had trouble sleeping.</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>I got enough sleep.</td>
<td>☐ 5</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
<td>☐ 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the past SEVEN (7) DAYS.....</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>My sleep quality was...</td>
<td>☐ 5</td>
<td>☐ 4</td>
<td>☐ 3</td>
<td>☐ 2</td>
<td>☐ 1</td>
</tr>
</tbody>
</table>
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
### Diagnosis-Specific Severity Assessment: Symptom Domains for Schizophrenia

<table>
<thead>
<tr>
<th>Symptom Domain</th>
<th>Severity Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallucinations</td>
<td>0 = Not Present, 1 = Equivocal, 2 = Present, but mild, 3 = Present and moderate, 4 = Present and severe</td>
</tr>
<tr>
<td>Delusions</td>
<td></td>
</tr>
<tr>
<td>Disorganized Speech</td>
<td></td>
</tr>
<tr>
<td>Abnormal Psychomotor Beh</td>
<td></td>
</tr>
<tr>
<td>Negative Symptoms</td>
<td></td>
</tr>
<tr>
<td>(Restricted Emotional Expression or Avolition)</td>
<td></td>
</tr>
<tr>
<td>Impaired Cognition</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Mania</td>
<td></td>
</tr>
</tbody>
</table>

• WHODAS 2.0 is the recommended, but not required, assessment for disability
• Corresponds to disability domains of ICF
• Developed for use in all clinical and general population groups
• Tested world-wide and in DSM-5 Field Trials
• 36 questions, self-administered with clinician review
• For Adult Patients
  • Child version developed by DSM-5, not yet approved by WHO
WHODAS Domains

- Understanding and communicating
- Getting around
- Self Care
- Getting along with people
- Life activities
  - household
  - work or school
- Participation in Society
Accessing the Measures

• Print:
  • Level 1 X-C Adult and Parent
  • Psychosis Severity
  • Adult Disability

• Online:
  • All Level 1 and Level 2 X-C
  • All Disorder Severity
  • Adult Disability

• www.psychiatry.org/dsm5
Use of DSM-5
Use of DSM-5

• Case formulation
• Definition of a mental disorder
• Clinical significance criterion
• Section II
  • Structure of disorder chapters
  • ICD-9-CM and ICD-10-CM coding
• Making a diagnosis

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).
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.
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
Making a Diagnosis

- Administer cross-cutting assessments (suggested)
- Administer WHODAS 2.0 (suggested, not required)
- Conduct clinical interview (informed in part by assessment scores)
- Determine whether or not diagnostic threshold is met
- Consider subtypes and/or specifiers
Making a Diagnosis

• Consider contextual information, disorder text (e.g., course, differential), distress, clinician judgment

• Diagnosis is given
  • Administer severity assessments (suggested)

• Apply codes and follow instructions as per coding and recording procedures

• Develop treatment plan and outcome monitoring approach
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.

• 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
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.

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
<table>
<thead>
<tr>
<th>DSM-5 Disorder</th>
<th>ICD-9-CM Code</th>
<th>ICD-9-CM Title</th>
<th>ICD-10-CM Code</th>
<th>ICD-10-CM Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social (Pragmatic) Communication Disorder</td>
<td>315.39</td>
<td>Other developmental speech or language disorder</td>
<td>F80.89</td>
<td>Other developmental disorders of speech and language</td>
</tr>
<tr>
<td>Disruptive Mood Dysregulation Disorder</td>
<td>296.99</td>
<td>Other Specified Episodic Mood Disorder</td>
<td>F34.8</td>
<td>Other Persistent Mood [Affective] Disorder</td>
</tr>
<tr>
<td>Premenstrual Dysphoric Disorder (from DSM-IV appendix)</td>
<td>625.4</td>
<td>Premenstrual tension syndromes</td>
<td>N94.3</td>
<td>Premenstrual tension syndrome</td>
</tr>
</tbody>
</table>
## New DSM-5 Diagnoses Code Issues

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

- Lowering diagnostic threshold
- Bereavement exclusion
- Creation of “new” diseases
  - DMDD, Binge Eating, Mild Neurocognitive do
- Opening the door to behavioral addiction
  - Gambling, internet
- Main spokesperson today: Allen Frances, MD
Problems in Classifying Mental Disorders

• There is NO SINGLE objective diagnostic test for a mental illness

• Mental disorders are diagnosed on the basis of self-reported symptoms or observed behaviors
• **Construct validity and reliability** – of DSMs diagnostic categories and criteria. Although DSM states that it is based on an empirical foundation, critics state it is overstated.

• In my opinion, DSM has pretty good reliability but the validity of the diagnosis is questionable. For example, based on DSM, most clinicians can fairly consistently (reliable) agree on a diagnosis of schizophrenia but not really understand what schizophrenia truly means.

• Reliability of some categories questionable: Personality disorders
• **Reliability (Precision)** – repeatability (reproducibility) of a test/screen
  
  • A reliable test gives consistent results when the test is performed more than once on the same individual under the same conditions

• **Validity (Accuracy)** - ability of the test/screen to distinguish between who has a disease and who does not – the truth
Reliability and Validity

• A valid test with poor reliability is not good

• A reliable test that is not valid is not good

• Ideally, want to have both valid and reliable test
Validity of DSM

• Because DSM disorders are based largely on a constellation of symptoms and not underlying etiopathology, validity is questionable

• This is similar to Congestive Heart Failure which is a syndrome based on different etiological factors (right sided failure due to chr. bronchitis-emphysema, lt. sided failure due to CAD/MI, HTN, etc.). Treatment is directed to underlying etiology

• Similarly, Schizophrenia could represent the final common manifestation of multiple different etiological pathways (but we do not know what they are yet). This may explain why its presentation is so heterogeneous – and why our treatment does not seem to work for some and work for others.
Criticisms of DSM

- Symptomatological bias – based mainly on symptoms of mental disorders. No attempt to explain underlying etiopathology or relationships of the symptoms or mental disorders. This is really of necessity because of a lack of understanding. Much work needs to be done!

- Too easy to approach dx as a checklist. Like a Chinese menu. Very categorical – severity of each symptom not measured. Categorical vs dimensional
Reductionist Bias – supposedly unjustified categorical distinctions between disorders and normal and abnormal. Symptom based approach does not take into account whether the disorder is internal or an (mal)adaptive psychological response to adverse life experiences. For example, endogenous depression vs exogenous depression (DSM does not recognize this difference)
In Defense of DSM

• The developers of DSM have very clearly stated that the diagnostic categories listed are simply prototypes. They are to be used in conjunction with good clinical judgment. They are guidelines. Unfortunately, too many stakeholders use it like the Bible of Psychiatry which it is not.

• Greatly facilitated communication among stakeholders and fostered research to develop new treatments.

• DSM has limitations but still a very useful tool that has advanced the mental health field

• DSM is a WORK in PROGRESS – we will get it right, eventually - by Version 20? 😊 😊
Thank you