Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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DSM-5 in brief

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Complaints

- The process
  - Too exclusive
  - Too secret
  - Too pharmaceutical
- The outcome
  - Validity sacrificed for reliability
  - Changes will encourage inaccurate or excessive diagnosing
  - Wrong color

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Bottom Line

- Remember, DSM-5 is *just a book*. It is primarily a psychiatric textbook that is geared for aiding research by presenting reliable diagnostic categories. It is not intended to set fair insurance company reimbursement, to define personal responsibility in court settings, or to provide a sociological commentary on the state of America's mental health.
- Poorly trained or overworked clinicians, especially in concert with self-obsessed unhappy patients, will over-diagnose and over-treat, no matter how carefully guidelines are written.

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A Few Tips on Making a Diagnosis

(Frances 2013)

- Don't just diagnose symptoms: make sure that they cluster together in a characteristic way. And make sure the symptoms cause serious and persistent problems.
- Weigh the pluses and minuses of giving a diagnosis.
- Don't use "other specified" unless you need to, but use it when you need to.
- Children, teens and older adults are especially hard to diagnose.

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Overview

- There are three sections:
  - I) Introduction and instructions
  - II) The Disorders
  - III) Conditions requiring further research, cultural formulations, dimensional scales, other stuff

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Organization

- The organization is different in order to correspond better to ICD and to reflect a developmental perspective. ICD-9 and ICD-10 codes are given. The best system coordination is to be with ICD-11.
- Specifically, organization reflects
  - Developmental, both in the book and in each category of disorder
  - Clustering of disorders into internalizing (anxiety, depression, somatic symptoms) and externalizing (impulsive, disruptive, substance related.) Research indicates that each of these two clusters reflect genetic and environmental risk factors.

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Overview

- Various diagnoses have been merged or renamed.
- There is an assumption that everyone's mental status falls on a spectrum that stretches from typical to pathological. Therefore most disorders will have a dimensional scale. Some scales cut across diagnoses.
  - Anxious distress specifier for all mood disorders
  - Panic attack for other than anxiety disorders
  - Mixed features for all mood disorders

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A Review of Systems in Section III

- Section III contains an optional Cross-Cutting Symptom Measure, looking at these domains:
  - Depression
  - Anger
  - Mania
  - Anxiety
  - Somatic symptoms
  - Suicidal Ideation
  - Psychosis

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Cross-Cutting Assessments

- Assessment Cont.
  - Sleep problems
  - Memory
  - Repetitive thoughts and behaviors
  - Dissociation
  - Personality functioning
  - Substance use

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The Axial System

- Disorders are no longer clustered as major mental illnesses, personality disorders, and medical problems related to mental illness (Axis I, II, III, IV, V)
- Axis I, II, III disorders are simply listed as independent diagnoses.
- Axis IV (psychosocial, environmental problems) will be listed as ICD-9 V codes.
- Axis V (GAF) will no longer be used since there are severity scales for each diagnosis.

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WHO Disability Schedule

- A self-administered WHODAS is provided in Section III in order to capture the degree of disability. Instructions for using this measure are given. DSM-5 does not yet endorse this scale because it has not been validated sufficiently, but there is hope that it will be useful.

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Instead of NOS…

- We are asked to
  - Indicate the disorder as mild on a severity scale
  - Use the classification "Other Specified" and explain what is it that keeps the individual from meeting standard criteria (short episodes, insufficient symptoms, etc)
  - Use the classification "Unspecified" if the clinician chooses not to specify the reason that the diagnosis cannot be made, e.g. there may be insufficient information. No reason need be given.

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Neurodevelopmental Disorders Specifics

- Intellectual Disability
  - (Intellectual Development Disorder) ICD 11
    - While generally reflecting an IQ<70, any descriptors of mild, moderate, severe or profound are based on ability to function, rather than on IQ scores. IQ scores become fairly meaningless below 70.
    - Severity levels are described in an extensive table in the chapter.
  - Global Developmental Delay

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Neurodevelopmental Disorders Specifics

- Communication Disorders
  - Language Disorder (expressive and mixed)
  - **Speech Sound Disorder** (phonological disorder)
  - Childhood-Onset Fluency Disorder (stuttering)
  - **Social (Pragmatic) Communication Disorder**: captures young people with autism-like communication problems, but lack repetitive behaviors. These children were diagnosed with PDD–NOS in DSM-IV.

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Neurodevelopmental Disorders Specifics

- **Autism Spectrum Disorder**: This category will include Asperger's, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder NOS. (Rett's disorder is dropped.) This is done because the reliability and validity of these 3 disorders is very poor. There is no evidence to support their continued separation.

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What About Asperger's Disorder?

- DSM-IV Asperger's Disorder
  - 1) Impairment in social interaction (2 of the following): nonverbal behaviors, no peer relationships, lack of shared activities, lack of social reciprocity
  - 2) repetitive activities of behavior (1 of the following): pattern of activity, rituals, motor mannerisms, fixation on parts of objects
  - 3) no delay in language
  - 4) no cognitive delay

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Neurodevelopmental Disorders Specifics

- **Autism spectrum disorders** (symptoms present in early childhood, 3 levels of severity)
  - Deficits in communication and interaction including these 3:
    - reciprocity
    - nonverbal interaction
    - having relationships
  - Repetitive and/or restrictive behaviors
  - Expanded list of specifiers (e.g. intellectual, language impairment, catatonia)

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The Controversy

- Some individuals with Asperger's do not want to be in the same category as people with autism.
- Some individuals fear that Asperger's will not meet the criteria for ASD, and they will lose benefits.
- Mental health workers believe that Asperger's is a qualitatively different illness than autism. The criteria do not capture this.

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DSM-5

- Schizophrenia Spectrum and Other Psychotic Disorders Highlights
  - Schizophrenia
  - Schizoaffective Disorder (moves to a longitudinal perspective from cross-sectional)
  - Schizophreniform Disorder
  - Delusional Disorder
  - Brief Psychotic Disorder
  - Catatonia Features Specifier

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Schizophrenia Spectrum Specifics

- The 5 subtypes of schizophrenia are dropped because they are not useful for clinical or research purposes:
  - Paranoid
  - Disorganized
  - Catatonic
  - Undifferentiated
  - Residual

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Depressive Disorders Specifics

- **Disruptive Mood Dysregulation Disorder**
  - This diagnosis is created in an effort to diagnose children with extreme temper dysregulation and rage attacks who do not show classic mania or an episodic course. These children have recently been diagnosed with bipolar disorder, NOS.

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The "Narrow" Definition

- A young person meeting the classic criteria would be said to fit the "narrow phenotype." They would be likely to be genetically related to another person with bipolar disorder. They will most likely continue to have bipolar disorder symptoms as an adult.
- There is little controversy about this group among clinicians.

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The "Broad" Definition

- These are children who are described by parents as having "mood swings," who have explosive outbursts of extreme intensity and duration. Parents have to "walk on eggshells."
- They are not particularly at risk for developing becoming bipolar adults. They are more likely to have problems with depression and anxiety as adults.
- Their parents are less likely to have psychopathology than parents with bipolar children.

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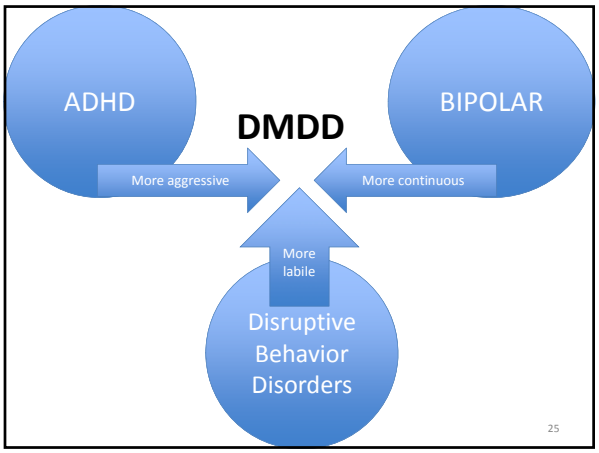

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Disruptive Mood Dysregulation Disorder

- Severe recurrent temper outbursts 3+ times/week
- General mood is irritable and angry
- Present for 12 or more months
- Between 6 and 18, onset before 10
- Not better explained by another disorder (autism, PTSD)
- Cannot be comorbid with ODD, intermittent explosive disorder, or bipolar disorder

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Diagnosing DMDD

- In field trials this disorder had poor inter-rater reliability. The primary problem was apparently difficulty differentiating oppositional defiant disorder from DMDD. There were also problems with duration – often these periods of rage attacks are time-limited. Commentators emphasize the importance of the frequency, persistence and duration criteria.

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	Bipolar mania	ADHD	Dis. Mood Dysreg Disord	Disruptive Behavior Disorders
Episodic	X			
Euphoria, grandiosity, hypersexuality, delusions hallucinations	X			
Mood lability	X		X	
Insomnia	X	+/-	+/-	
Pressured Speech	X	X	X	
Intrusiveness	X	X	X	+/-
Irritability	X	X	X	Headstrong
Rage attacks	X		X	X

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And Trauma!

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Depressive Disorders Specifics

- **Persistent Depressive Disorder** (2+ years)
  - While there is often comorbidity with personality problems, current research indicates that chronic depression is best regarded as an affective disorder.
  - There is little evidence from symptoms, demographics, treatment response, or family history that justifies a distinction between dysthymia and other forms of chronic depression.
  - Comorbid personality disorders should be addressed with psychotherapy.

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Depressive Disorders Specifics

- **Premenstrual Dysphoric Disorder**
  - This diagnosis has been moved forward from the appendix of DSM-IV. While some people have been concerned that PMDD pathologizes the normal reproductive functioning of women, the workgroup points out that the condition occurs in a minority of women (2%) and can cause significant impairment.
  - Treatment is often with time-limited serotonin antidepressants or ovulation-inhibiting hormones.

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Major Depressive Episode: The Bereavement Exclusion

- The "bereavement exclusion" (i.e. if you are grieving the loss of a loved one, you cannot be diagnosed with depression) will be dropped. People who have symptoms of a depressive episode respond to treatment whether they are grieving or not.

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When to Treat: Grief vs. Depression

- Grief
  - Yearning, disbelief, preoccupation
  - Sadness is not pervasive but comes in waves
  - Self-esteem is preserved
  - Retained ability to experience positive emotions
- Depression
  - Apathy, psychomotor retardation
  - Sadness is pervasive and constant
  - Pervasive guilt, worthlessness, and self-criticism
  - Suicidality

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Cultural Sensitivity

- Grieving is a high risk condition for being misdiagnosed due to cultural differences in client and treater.

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Obsessive-Compulsive and Related Disorders Specifics

- **Hoarding Disorder**
  - Difficulty discarding or parting with possessions regardless of the value
  - The symptoms result in the accumulation of a large number of possessions that fill up and clutter active living areas of the home so that intended use is no longer possible
  - The symptoms cause distress or impairment
  - Specifiers: with excessive acquisition, insight

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Is PTSD an Anxiety Disorder?

- Careful study of clinical, biochemical, and fMRI data has lead investigators to conclude that PTSD is not a fear and anxiety-based disorder. PTSD is one of a wide array of disorders that arise in response to traumatic events. The disorders are characterized by symptoms of avoidance, and negative alterations of mood, not fear.

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Negative Alterations in Mood or Cognition

- Several of the following:
  - Inability to remember important aspects of the trauma
  - negative expectations of the self, others, or the world
  - persistent distorted blame of the self
  - pervasive negative emotional state
  - diminished interest in significant activities
  - feeling detachment from others
  - inability to experience positive emotions

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DSM-5 Trauma and Stressor-Related Disorders

- **Reactive Attachment Disorder of Infancy**
- **Disinhibited Social Engagement Disorder**
- Posttraumatic Stress Disorder
- Acute Stress Disorder (50% go on to PTSD)
- Adjustment Disorder (moved from its own category in DSM-IV, considered a stress response syndrome following trauma)
  - Specify mood, anxiety, disturbance of conduct, etc.

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DSM-5 Trauma and Stressor-Related Disorders Specifics

- Posttraumatic Stress Disorder
  - Trauma does not include witnessing events on TV or other electronic media. Examples will be included in the text.
  - PTSD no longer requires that an individual have a subjective experience of fear or horror, since that has not been useful in determining who develops PTSD. Well-trained emergency workers, for instance, often do not show emotions during the crisis, but may develop PTSD.

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DSM-5 PTSD Highlights

- The 3 symptom clusters of DSM-IV
  - re-experiencing
  - avoidance and numbing
  - arousal
- become 4 symptom clusters in DSM-5
  - re-experiencing
  - avoidance
  - negative alterations in mood and cognition
  - arousal: now includes the “fight” as well as “flight”
- No distinction between acute and chronic, symptoms > 1 month

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DSM-5 PTSD

- Two subtypes of PTSD: PTSD in Preschool Children (6 and younger) with a lower symptom threshold, and a Dissociative specifier of PTSD (14% - more likely male, childhood onset, more symptomatic, increase suicide, more anxiety).
- Some military leaders believe that the name should be changed to posttraumatic stress injury.

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Disruptive, Impulse Control, and Conduct Disorders

- Oppositional Defiant Disorder
  - Symptoms now in 3 types: angry/irritable, argumentative/defiant, vindictiveness
  - May co-occur with conduct disorder
  - Severity scale
- Intermittent Explosive Disorder
  - Now must be older than 6, no longer requires physical aggression, may also have ADHD, conduct disorder, ODD, ASD
- Conduct Disorder
  - childhood or adolescent onset specifier
  - **Limited Prosocial** specifier (Callous and Unemotional)
- Kleptomania
- Pyromania

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Disruptive, Impulse Control, and Conduct Disorder Specifics

- **Limited Prosocial Specifier**
  - 2 or more:
    - Lack of remorse or guilt
    - Callous – lack of empathy
    - Unconcerned about performance
    - Shallow or deficient affect

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DSM-IV

- Substance Related Disorders
  - Alcohol, Amphetamine, Caffeine, Cannabis, Cocaine, Hallucinogen, Inhalant, Nicotine, Opioid, Phencyclidine, Sedative Hypnotic, Anxiolytic, Polysubstance, Other Related Disorder
  - Each substance has a
    - Use Disorder (Dependence or Abuse)
    - Induced Disorder (Intoxication, Withdrawal, Dementia, Sleep, Psychosis, etc..)

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DSM-5 Alcohol Use Disorder

- Maladaptive pattern of use leading to impairment and/or distress manifested by 2 or more:
  - Recurrent use resulting in failure to fulfill role
  - Physically hazardous (legal issues dropped)
  - Continued use despite consequences
  - Tolerance
  - Withdrawal
  - Increasing use
  - Persistent desire to cut down use
  - Great deal of time spent getting the substance, or to recover from effects
  - Activities are given up
  - **Craving**

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Substance Related and Addictive Disorders Specifics

- DSM-5 combines abuse and dependence into a single disorder graded by severity. The disorder requires 2 criteria, with 2-3 mild, 4-5 moderate, and 6+ criteria indicating severe. Specifiers for physiologic dependence and course remain.
- The task force argues that reliability and validity of the "abuse" diagnosis is poor, the criteria distinguishing abuse and dependence arbitrary, assumptions regarding abuse simply being a prodrome to dependence are incorrect, etc.
- See Hasin et al. *Am J Psych*, Aug 2013.

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DSM-5 Substance Use and Addictive Disorders

- Stimulant-Related: use, intoxication, withdrawal
- Tobacco-Related (was nicotine): use, withdrawal
- **Gambling Disorder** (was Pathological Gambling in the impulse control section)
  - Specify episodic, persistent, remission, severity

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Cultural Formulation

- DSM-5 not only contains an update of the DSM-IV Outline for Cultural Formulation, but also the Cultural Formulation Interview.
- The following categories are assessed:
  - Cultural identity of the individual
  - Cultural conceptualizations of distress
  - Psychosocial stressors and cultural features of vulnerability and resilience
  - Cultural features of the relationship between the individual and the clinician
  - Overall cultural assessment

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Cultural Formulation Interview

- 16 questions, semi-structured interview
- The CFI is formatted with a left-hand column with instructions for administering the CFI and explanation of the goals for each interview domain. The right-hand column illustrates how to explore that particular domain. (See the text, 8 pages.)
- There are supplementary modules available online: http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Cultural

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