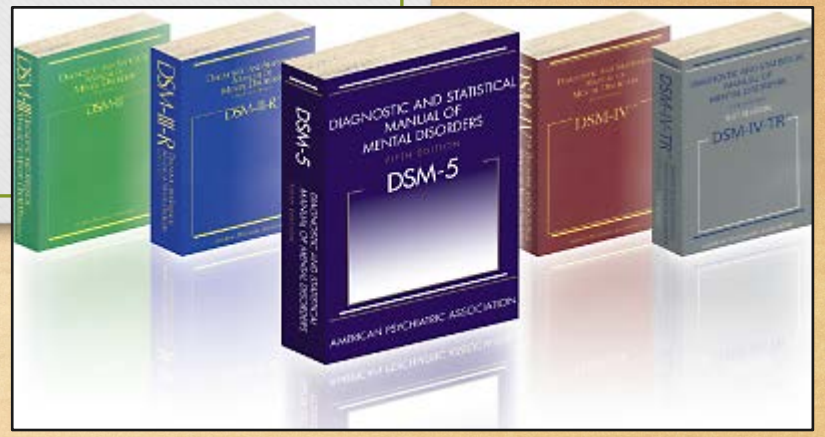
DSM 5 Changes

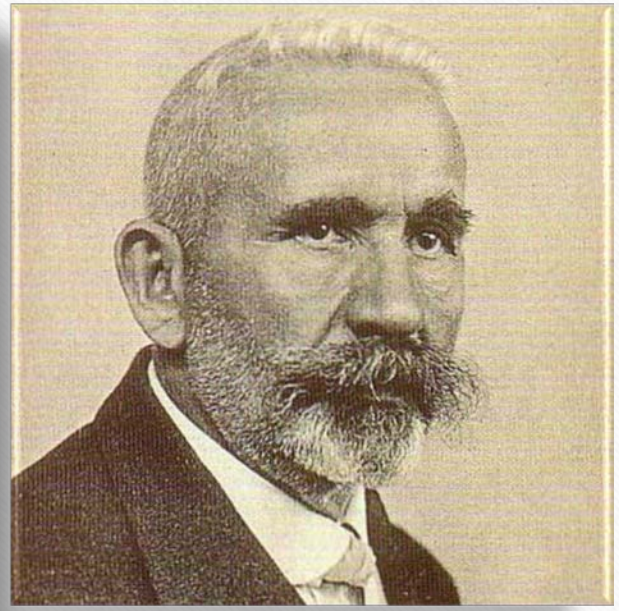
Child and Adolescent Psychiatry

Dr Kristy Fenton



Classification History

Dementia Praecox



Manic Depression

Emile Krapelin (1856-1926)

- Patient histories
- Separation of dementia praecox and manic depression
- Described patterns and course of disorders

Pre DSM

Before American Civil War (1861-1865)

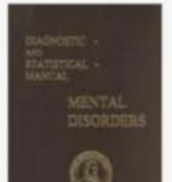
- Idiocy
- Insanity
- Drapetomania

Post Civil War

- Mania
- Melancholia
- Monomania
- Paresis
- Dementia
- Dipsomania
- Epilepsy

DSM-I (1952)

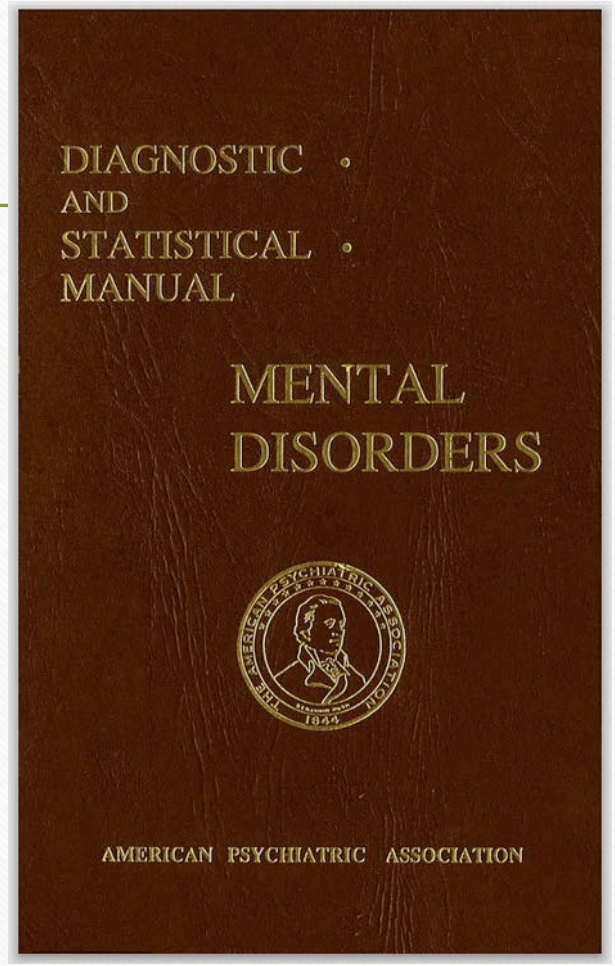
- **DSM I- 106 diagnoses in 3 areas:**
  - organic brain syndromes
  - functional disorders
  - mental deficiency.
  - Only one childhood diagnosis, Adjustment Reaction of Childhood/Adolescence.



DSM I
Diagnostic and Statistical Manual Mental Disorders
Limited edition
Published **April 1952** by American Psychiatric Association.
Written in English.

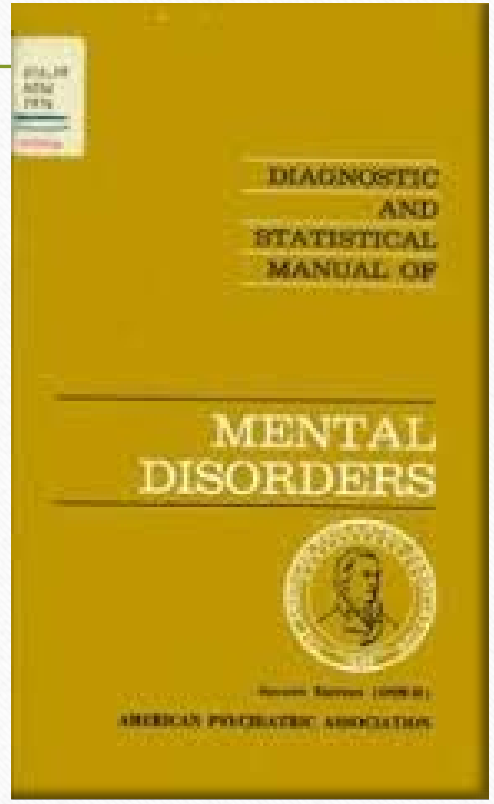
DSM 1 (1952)

- 106 diagnoses in 3 areas:
  - Organic brain syndromes
  - Functional disorders
  - Mental deficiency
  - **Adjustment reaction of childhood / adolescence**



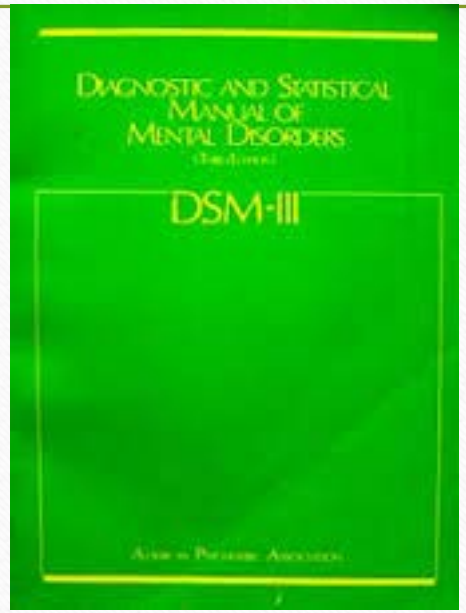
DSM-II (1968, revised 1974)

- 185 diagnoses in 11 categories
- Additon of 'Behavior Disorders of Childhood – Adolescence'
- Hyperkinetic Reaction
- Withdrawing Reaction
- Overanxious Reaction
- Runaway Reaction
- Unsocialised Aggressive Reaction
- Group Delinquent Reaction



DSM III (1980)
(ICD-9 1979)

- 265 diagnosis
  - Multi Axial system
  - Based on scientific evidence
  - Structured interview
  - Descriptive approach
  - Operationalised diagnostic critera
- DSM –III-R (1987) – 297 diagnosis



DSM-IV 1994
(ICD 10)

- DSM-IV - 365 diagnoses

- 2000 DSM-IV-TR - 365 diagnoses

- Development of DSM-5 , more than a decade in process, has been the object of immense public and professional interest

- Process began in 1999

- APA collaborated on the DSM-5 together with;
  - NIMH
  - WHO (to harmonise with ICD-11)
  - National Institute on Drug Abuse
  - National Institute on Alcohol Abuse and Alcoholism

DSM-5 task force

- DSM-5 task force was formed in 2007
- Composed of world-renowned leaders in psychiatric research, dx, and treatment
- Had 13 work groups
- 160 members
- 97 psychiatrists, 47 psychologists, paediatricians neurologists, epidemiologists, social work, paediatric nursing, speech therapy and consumer groups
- More than 300 outside advisors
- Public input through the DSM-5 website

Main highlights

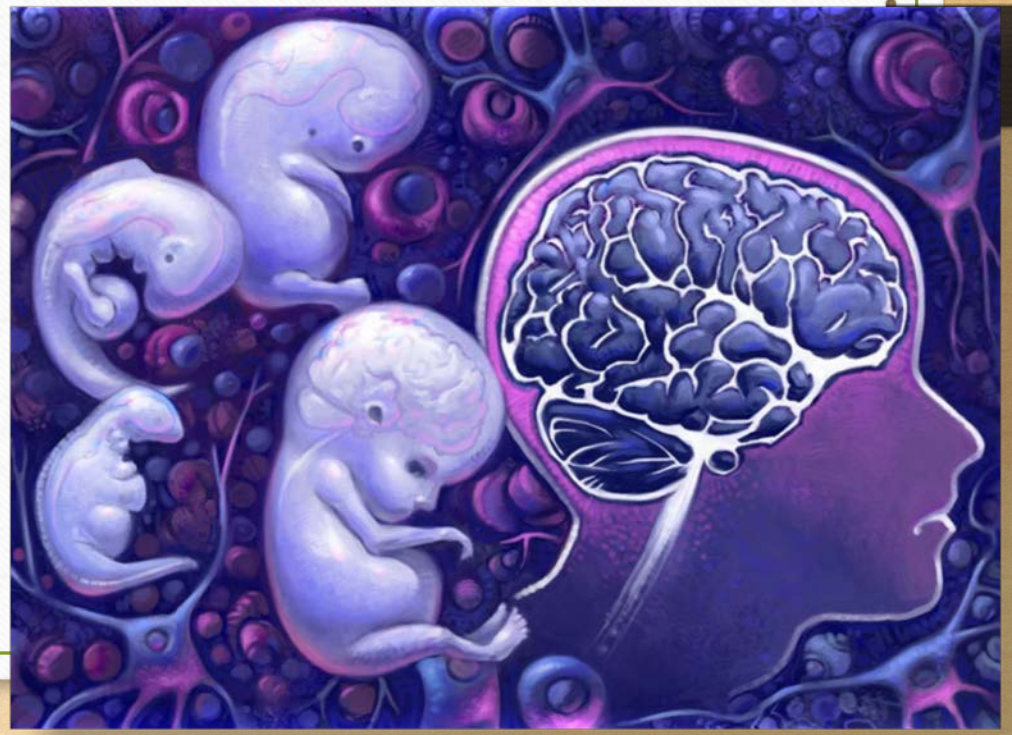
- Change from roman numerals
- Removing the multiaxial system
  - Axis I – all psychological diagnostic categories except mental retardation and personality disorder
  - Axis ii – personality disorders and mental retardation
  - Axis iii – General medical conditions; acute medical conditions and physical disorders
  - Axis iv – psychosocial and environmental factors contributing to the disorder
  - Axis v – global assessment of functioning or children's global assessment Scale for children and teens under the age of 18
- Categorical diagnoses in section 2
  - Dimensional approach – rate disorders along a continuum
  - Largely eliminate the need for "not otherwise specified (NOS)" conditions
  - Now termed "not elsewhere defined (NED)"
- Revised chapter order – child and adolescent chapter removed
- Some diagnostic criteria have been added or revised
- New chapters added
- New disorders added
  - Autism spectrum disorder
  - Binge eating disorder
  - Disruptive mood dysregulation disorder (DMDD)
  - Excoriation (skin picking disorder)
  - Hoarding disorder
  - Gender dysphoria disorder
- Number of categories has been reduced 172 to 157
- Those 'disorders' requiring further investigation are included in section 3 (appendix)
- Bipolar disorders have their own chapter
- Personality disorders have a chapter (instead of axis II)

Areas of interest?

- Neurodevelopmental disorders
- Binge eating disorder
- Depressive disorders
  - Disruptive mood dysregulation disorder (DMDD)
    - Olga will discuss this at the end
- Hoarding, skin picking and rethinking ocd
- Personality disorders
- Oppositional defiant/conduct disorders
- Mixed mood specifier
- Section 3 disorders

Neurodevelopmental disorders

- Intellectual disability (intellectual developmental disorder)
- Communication disorders
- Autism spectrum disorders
- Attention deficit / hyperactivity disorder
- Motor disorders



Intellectual disability (Intellectual disability disorder)

- Change of name from 'mental retardation'
- Due to call for destigmatisation / rosa's law
- The term *intellectual developmental disorder* was placed in parentheses to reflect the World Health Organisation's classification system, which lists "disorders" in the International Classification of Diseases (ICD; ICD-11 to be released in 2015) and bases all "disabilities" on the International Classification of Functioning, Disability, and Health (ICF). as the ICD-11 will not be adopted for several years, *intellectual disability* was chosen as the current preferred term with the bridge term for the future in parentheses.

- Diagnostic criteria emphasises the need for:
  - Cognitive capacity (IQ)
  - Adaptive functioning
- Severity is indicated by level of adaptive functioning rather than IQ score

Autism spectrum disorder

- Autism spectrum disorder is a new DSM–5 name that reflects the scientific consensus that for previously separate disorders are actually single condition with different levels of Symptom severity into core domains
- ASD now encompasses the previous DSM-IV:
  - Autistic disorder (autism)
  - Asperger's disorder
  - Childhood disintegrated disorder
  - Pervasive developmental disorder not otherwise specified
- ASD is characterised by presence of both:
  - Deficits in social communication and social interaction and
  - Restricted repetitive behaviours, interests, and activities (RRB's)

Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRB's are present

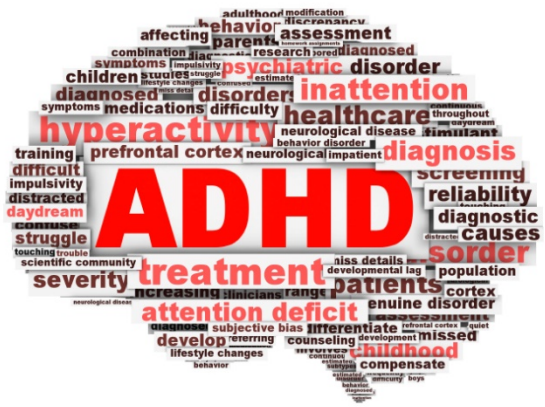
Autism spectrum disorder – the implications

- Among the most controversial of the DSM-5 revisions
- Change made owing to DSM-5 taskforce's dimensional approach to categorise psychopathology
- Concern that a large percentage of persons formerly diagnosed with an ASD would fall outside the new diagnostic criteria, and may be ineligible for certain services
- However, it was also felt patients will be diagnosed more consistently across a single spectrum, with indicators of different severity of symptoms
- Concerns that the revised criteria could result in a very heterogeneous clinical presentation, with mild PDD – NOS on the one end and severe autism on the other
- On the other hand, clinicians can diagnose across a related spectrum of symptoms and behaviours, recognising overlapping features and focus on the severity of symptoms, which will help guide treatment approaches more directly

Communication disorders

- The DSM-5 communication disorders include:
  - language disorder (combines DSM – IV expressive and mixed receptive and expressive language disorders)
  - Speech sound disorder (a new name for fun more logical disorder)
  - Childhood onset fluency disorder (stuttering)
  - Social (pragmatic) communication disorder, a new condition for persistent difficulties in the social uses the verbal and non-verbal communication

- **Because social communication deficits are one component of autism spectrum disorder (ASD), it is important to note that social (pragmatic) communication disorder cannot be diagnosed in the presence of restricted repetitive behaviours, interests, and activities (the other component of ASD)**

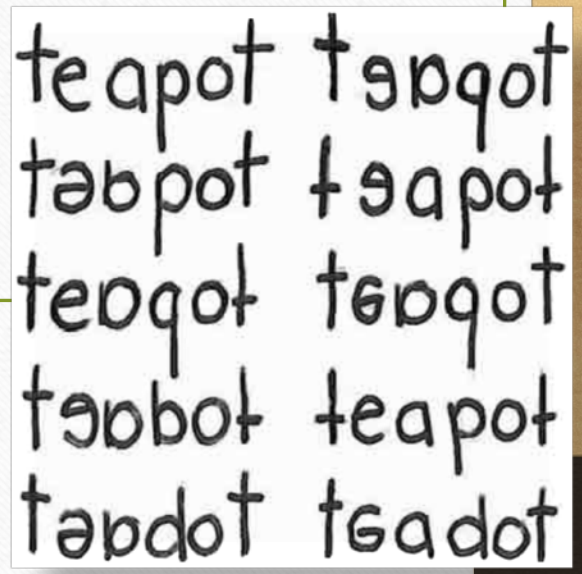


Attention deficit/hyperactivity disorder

The diagnostic criteria for ADHD in DSM-5, similar to those in dSM-IV. The same 18 symptoms are used as in DSM-IV, and continue to be divided into 2 symptom domains (inattention and hyperactivity/impulsivity), of which at least 6 symptoms (5 in those over 17) in one or both domains are required for diagnosis

- However, several changes have been made in DSM-5:
  - The cross situational requirement has been strengthened to "several" symptoms in each setting (eg. Home, work, school)
  - The onset criterion has been changed from "symptoms that caused impairment were present before age 7" to "several inattentive or hyperactive/impulsive symptoms were present prior to the age 12"
  - Subtypes have been replaced with presentation specifiers that Map directly onto the prior subtypes eg. Combined, predominantly inattentive or predominantly hyperactive/impulsive
  - Comorbidity with autism spectrum disorder is now allowed

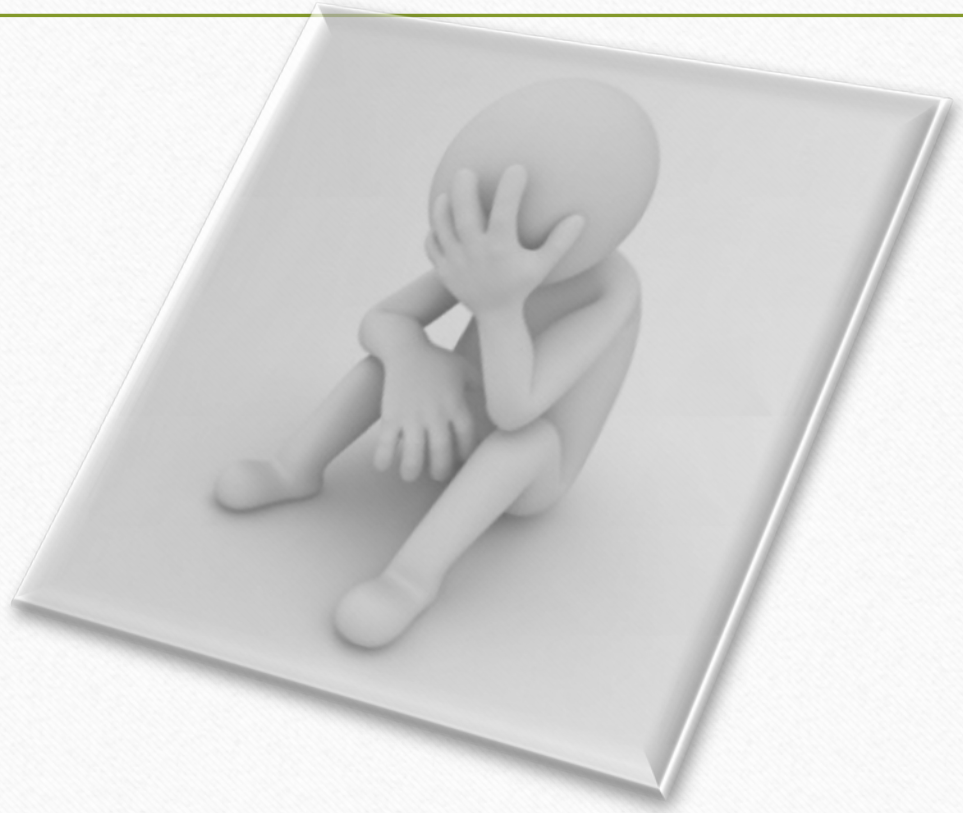
Specific learning disorder



- Specific learning disorder combines the DSM-IV diagnosis of
  - Reading disorder
  - Mathematics disorder
  - Disorder of written expression
  - Learning disorder (not otherwise specified)
- Because learning deficits in the areas of reading, written expression, and mathematics commonly occur together, coded specifiers for the deficit sites in each area are included e.g. stop specific learning disorder with impairment in reading
- Impairment broken down into mild moderate and severe

Depressive disorders

- Separate chapter form bipolar disorders
- Several new depressive disorders
  - Disruptive mood this regulation disorder - OLGA
  - Premenstrual dysphoric disorder
  - Dysthymia in DSM-iV now falls under the category of persistent depressive disorder



BIPOLAR: Mixed-mood specifier

- In DSM-5, the new specifier "with mixed features" can be applied to bipolar i disorder, bipolar 2 disorder, bipolar disorder NED
- The change was made to reflect the clinical phenomenon of "mixed" mood states that do not meet full criteria for a mixed episode
- the predominant mood can either be depression, mania, hypomania
- The secondary mood can be "subclinical" in that some aspects of the secondary mood diagnosis would be present but not sufficiently so to make a formal diagnosis
- Patients who meet full criteria for both depression and mania together will be labelled as having a manic episode with mixed features
- To be diagnosed with the "with mixed features" specifier, a person has to meet the full criteria for one mood (depression, mania or hypomania) and have 3 or more symptoms of the other mood pole.
- Symptoms that are common to both mood poles (mania/hypomania and depression) are not included in the possible criteria from mixed mood. These include distractibility, irritability, insomnia, and indecisiveness

Mixed-Mood specifier

- For the patient with predominant mania or hypomania, at least 4 of the following depressive symptoms must be present nearly every day during the most recent week of a manic episode or during the most recent 4 days of a hypomanic episode:
  - Depressed mood
  - Diminished interest or pleasure
  - Slowed physical and emotional reaction
  - Fatigue or loss of energy
  - Recurrent thoughts of death
- For someone with predominant depression, at least 3 of the following symptoms must be present nearly every day during the most recent 2 weeks of the major depressive episode:
  - Elevated mood
  - Inflated self-esteem
  - Decreased need to sleep
  - Increasing energy or goal directed activity

Mixed mood specifier – the implications

- The specifier will allow clinicians to more accurately diagnose patients who may be suffering from concurrent symptoms of depression and mania/hypomania
- better tailor treatment to their behaviours. This is especially important since many patients with mixed features, depending on their predominant symptoms, demonstrate poor response to lithium or become less stable when taking antidepressants.
- Additionally, more accurately identifying these concurrent behaviours may allow clinicians to recognise people with a unipolar disorder at increased risk of progression to bipolar disorder.

Disruptive, impulse control, and conduct disorders

- Brings together disorders previously in "disorders usually first diagnosed in infancy, childhood, or adolescents" and the chapter "impulse control disorders not otherwise specified"
- ~~Oppositional defiant disorder:~~
  - Firstly, are now grouped into 3 types:
    - angry/irritable mood
    - argumentative/defiant behaviour
    - vindictiveness
    - This change highlights that the disorder reflects both emotional and behavioural symptomatology
  - Secondly, the exclusion criteria for conduct disorder has been removed
  - Thirdly, guidance note regarding the frequency of behaviours has been added (more than once a week), as it is recognised that symptoms of ODD occur commonly normal developing children and adolescents
  - Fourthly, a severity rating is when added to the criteria to indicate the degree of pervasiveness of symptoms across settings as an important indicator of severity

binge eating disorder

THE CHANGE : graduated from appendix b (further study) to section 2

Implications:

- DSM-IV
  - ~~AnorexiA NERVOSA~~
  - BULIMIA NERVOSA
  - EATING DISORDER nos
- binge eating disorder HAS DISTINCT CLINICAL PROFILE FROM OTHER EATING DISORDERS BUT THERE IS SOME OVERLAP
  - Like bulimia, recurrent episodes of binge eating, without compensatory behaviours
- Inclusion implies need for recognition of psychiatric underpinnings of certain types of obesity

Criticisms:

1. may show considerable symptom overlap with non pathologic problematic eating
2. May be a manifestation of other illnesses
3. No suggestion of causation in the manual

Hoarding, skin picking, and rethinking OCD

- New chapter grouping obsessive-compulsive disorder (OCD) and related disorders, including:
  - Body dysmorphic disorder
  - Conditions formally found in the "impulse control disorder (ICD) not elsewhere classified"
  - Trichotillomania
- two new diagnosis are included in this chapter:
  - Excoriation (skin picking) disorder – repetitive and compulsive picking of skin resulting in tissue damage
  - Hoarding disorder – persistent difficulty discarding with possessions regardless of their value

OCD chapter: The implications

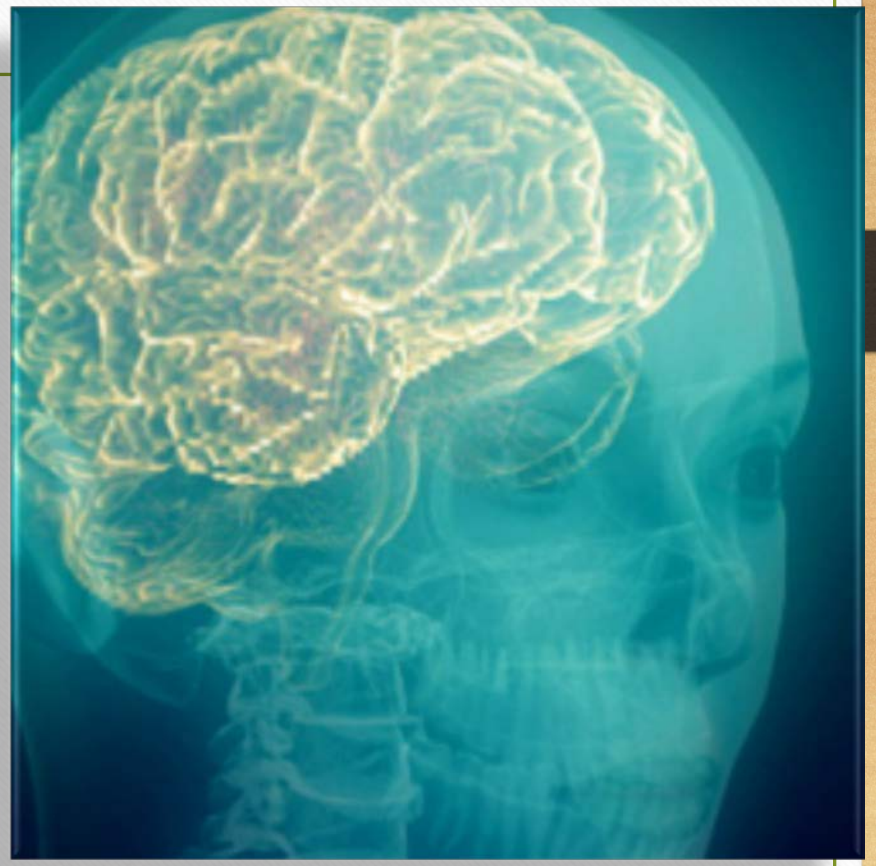
- Distinguishing between OCD and previous ICD disorders can be difficult due to symptom overlap
- Skin picking and other impulsive behaviours are sometimes seen in a OCD/anxiety, therefore adding a new excoriation disorder risks stigmatising patients with no psychiatric diagnoses
- However a large body of research suggest that ICD is distinct from OCD, both neurobiologically and clinically
- Treatment effects also tend to differ
- The addition of hoarding disorder is supported by research suggesting that although OCD and hoarding can co-occurrence, they are also neurobiologically and clinically distinct and may respond differently to therapy

Personality disorders

- Initial proposals:
  - 6 personality disorder diagnosis of instead of the 10 in the DSM-IV
  - To move from categorical to a trait-based, dimensional classification system
  - This proposal was ultimately voted down; however the dimensional-categorical model is included in section 3 for further research
- Interestingly, in the field trials, only borderline personality disorder had good inter-rater reliability. In contrast, obsessive-compulsive personality disorder and antisocial personality disorder where in the questionable reliability range
- The fact that borderline personality disorder had such good inter-rater reliability, whereas the other person disorders did not, may support views that it could belong in the bipolar disorder spectrum rather than being classified as a personality disorder.

Section 3 disorders

- Contains a number of conditions requiring ~~further research before consideration~~ as official diagnosis:
  - Trait-based personality disorder classification system
  - "attenuated psychosis syndrome"
    - Concern that including this condition in section 2 would over medicalise often non-specific phenomena that have a transition to psychosis in only 20 to 30% of individuals over a period of 1 to 3 years

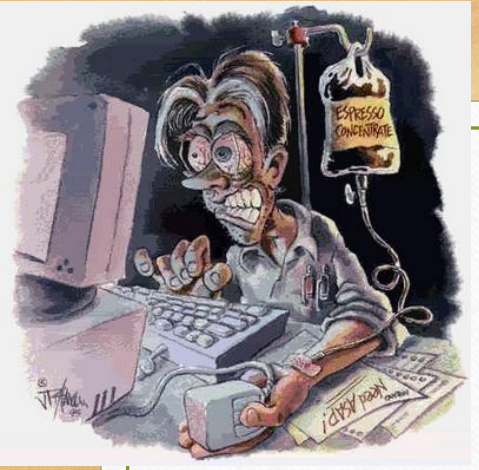


Section 3 disorders – non-suicidal self injury (NSSI)

- Non-suicidal self injury – previously considered a symptom of borderline personality disorder, is recognised as a distinct condition in the new manual
  - Research suggests that NSSI can occur independent of BPD, such as in patients with depression or even in those with no other diagnosable psychopathology
  - Criteria for NSSI require 5 or more days of intentional self-inflicted damage to the surface of the body without suicidal intent within the past year

NSSI

- Patients also must engage in the self injurious behaviour with at least one of the following expectations
  - To seek relief from a negative feeling/cognitive state
  - To resolve an interpersonal difficulty
  - To induce a positive state
- The behaviour must also be associated with one of the following criteria:
  - Interpersonal difficulty / negative feelings and thoughts e.g. depression, anxiety
  - Premeditation
  - Ruminating on (non-suicidal) self injury
  - Socially sanctioned behaviours, like body piercing or Tatooing, do not qualify for the diagnosis, nor do scab picking or nailbiting.



Section 3 disorders – Internet gaming disorder

- Distinct from Internet gambling disorder – this is categorised as the only non-substance related addictive disorder
- To qualify for Internet gaming disorder, patients must meet at least 5 of the 9 following criteria within the past year:
  1. Preoccupation with games
  2. Psychological withdrawal symptoms (e.g., anxiety, irritability)
  3. Tolerance (the need to spend an increasing amount of time playing games)
  4. Unsuccessful attempts to control limits game participation
  5. Loss of interest in previous hobbies
  6. Continued use despite knowledge of problem
  7. Deceiving family members and/or therapists
  8. Use of Internet games to escape the negative moods
  9. Has jeopardised lost a relationship, job, or educational opportunity

Other changes not covered in this talk

- Schizophrenia – subtypes eliminated
- Schizoaffective disorder – a major mood episode must be present for the majority of the disorders total duration after criterion a has been met
- Delusional disorder – no longer a requirement for the delusions to be non-bizarre
- Substance use disorder
- Bereavement exclusion has been removed – in DSM-iv there was an exclusion criteria for major depressive disorder that was applied to depressive symptoms lasting less than 2 months following the death of a loved one
- Changes and criteria for agoraphobia, specific phobia and social anxiety disorder – deletion of the requirement that individuals over age 18 years recognise that there are societies excessive or unreasonable. The duration criteria for specific phobia "typically lasting for 6 months or more" now applies to all ages
- Separation anxiety disorder and selective mutism are now classified as an anxiety disorder
- Trauma and stress related disorders – of note reactive attachment disorder. In DSM for a diagnosis of reactive attachment disorder had 2 subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. In DSM 5 the subtypes are defined as distinct disorders: reactive attachment disorder and disinhibited social engagement disorder
- Somatic symptoms and related disorders
- Dementia classified as neurocognitive disorder – new disorder of mild NCD
- Feeding / eating disorders not discussed – the requirement amenorrhoea in anorexia nervosa has been eliminated
- Sleep wake disorders
- Sexual dysfunctions
- Gender dysphoria – new diagnostic class
- And many more……..

Links