MORE THAN JUST WORDS AND NUMBERS:

THE TOP 15 FUNDAMENTAL CHANGES TO THE DSM-5 & THE TRANSITION TO ICD-10

Joseph M. Roberts, Ph.D.

PPA

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DISCLAIMERS

- Much of the information found in this presentation is a direct reference (often verbatim) of DSM-IV and DSM-5 criteria found in either volume as well as the free “bluebook” of ICD-10.

- The countdown format is based on the clinical opinion of the presenter based on the magnitude and the impact of the potential changes to diagnosis and treatment.

- Selections were made based on likelihood of immediate impact in practice situations with both children and adults.
OBJECTIVES

1. Describe the most critical changes to the DSM-5 as compared to DSM IV
2. Analyze the supportive research to determine if the changes are well-validated
3. Compare DSM 5 to ICD-10 in regards to the most common psychiatric categories
4. Assess how these changes will likely impact mental health systems across levels of care
5. Critique areas of future diagnostic exploration hinted at in DSM-5
DSM-5 descriptors and coding can be used now (and APA encourages this).

That being said, the deadline of October 1, 2014 where all ICD 10 codes were to become the rule-of-the-land, has now been moved to October 2015 (the President signed this legislation that was passed by the Senate and House in April 2014).

Additionally, you can likely ignore ICD-11. Though it is slated for a 2015/2016 release, the US won’t adapt those codes for many (many) years.
# CENTRAL DIFFERENCES BETWEEN THE DSM AND ICD

<table>
<thead>
<tr>
<th>Diagnostic &amp; Statistical Manual of Mental Disorders</th>
<th>International Classification of Diseases</th>
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<tbody>
<tr>
<td>Applies to only mental disorders</td>
<td>Applies to both physical &amp; mental disorders</td>
</tr>
<tr>
<td>Produced singularly by the American Psychiatric Association (by invite only)</td>
<td>Produced by World Health Organization by a multidisciplinary, multilingual, and multicultural group</td>
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<tr>
<td>Approved by the APA</td>
<td>Approved by World Health Assembly</td>
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<td>For profit (with a current cost of $102 on Amazon.com)</td>
<td>For free (and available as a PDF at <a href="http://www.who.int/classifications/icd/en/bluebook.pdf">http://www.who.int/classifications/icd/en/bluebook.pdf</a>)</td>
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<tr>
<td>Predominately used by researchers worldwide and by US clinicians</td>
<td>Predominately used by clinicians outside of the US</td>
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<td>Concept compliant disorders (US)</td>
<td>HIPAAA compliant codes (US &amp; World)</td>
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</table>
“DSM and the ICD should be thought of as companion publications. DSM-5 contains the most up-to-date criteria for diagnosing mental disorders, along with extensive descriptive text, providing a common language for clinicians to communicate about their patients. The ICD contains the numbers used in DSM-5 and all of medicine, needed for insurance reimbursement and for monitoring morbidity and mortality statistics by national and international health agencies” (Insurance Implications of DSM-5, p.3).

But is that all there is to it?
ICD-10 has more codes and does not always align with DSM-5 (especially with new DSM-5 disorders like Binge-Eating Disorder which maps to Other Eating Disorder (F50.8) and Hoarding Disorder which maps to OCD (F42)).

DSM-5 is limited to what is contained in the ICD-10 because HIPPA follows ICD coding and so the DSM-Task Force on Insurance Implications indicated that both the NAME and the CODE number should always be recorded in the medical record to support BOTH DSM and ICD.

Insurance companies are calling this the “largest change to ever happen to healthcare” and an event that may take years “to recover” from!
Federal education laws that describe Individualized Education Programs (IEPs) and Special Education do not specify that the DSM must be used to make those determinations.

There are real concerns related to revenue disruption and technology interface during the migration.

DSM-5 is the text predominately taught in graduate programs in the US, with ICD barely being mentioned in most curricula.

Every country is permitted to alter the ICD to fit its specific needs. In the US, the Center for Disease Control is charged with that task.
CENTRAL CONCERNS OF THE DSM-5
WELCH, KLASSEN, BORISOVA, & CLOTHIER (2013)

- Concerns over the influence of the pharmaceutical industry on workgroup members.
- Concerns that the two central pillars of “paradigm change” (dimensional ratings and an etiological focus) were ultimately not effectively implemented.
- Concerns over reduced thresholds on some disorders (ADHD) and the potential addition of diagnoses that are common to the general population (binge-eating disorder).
- Concerns over the fact that the field trials did not have a second quality-control phase and had mass community therapist attrition.
- Concerns over the use of kappa as low as .2, unlike DSM III and IV that used Kappa of .4 as the absolute cutoff of diagnostic acceptability between raters.
Allen Frances, the Task Force Chair of DSM-IV, certainly thought so and posted numerous blog and articles in both popular news websites and in industry journals between 2009 and 2013.

He even wrote a book called *Saving Normal* that came out the same month as DSM-5 (May 2013).

He posited 10 of the “Worst Changes” of DSM-5 in *Psychology Today* (12/2/12), and suggested clinicians ignore them in their diagnostic decisions.
1) The addition of Disruptive Mood Dysregulation Disorder
2) Normal Grief will become MDD
3) Everyday forgetting in the elderly will be misdiagnosed as Minor Neurocognitive Disorder
4) Adult ADHD rates will likely have a fad soar-rate
5) Sporadic gluttony can now be Binge Eating Disorder
6) Changes to Autism will lower rates, but impact school services for those in need
7) Recreational and first-time substance users will be diagnostically merged with “hardcore addicts”.
8) Behavioral Addictions (i.e. gambling disorder) will open the door to everything we “like to do a lot”.
9) Potential obscuring of GAD with worries of the everyday
10) Greater misdiagnosis of PTSD in forensic settings
In a *Psychiatric Times* article (2009), Frances spouted philosophical on the struggles with integrating the two sources as well as where each “shines”.

Indicated that combining the two has always been difficult due to scheduling issues and with each group having different affections for word-choice and concepts.

Frances referenced stats that suggest that DSM IV and ICD-10 had only one diagnosis that had identical wording (transient tic disorder).

20% of diagnoses had reflected different conceptual frames or had significant wording differences.

Ideally, Frances would like to see a division of labor, with ICD being the guide for clinicians and DSM being the tome for researchers.
NOT READY FOR PRIME TIME . . .

- Suicidal Behavior Disorder & Nonsuicidal Self-injury
- Coercive paraphilia
- Pedohebephilia Disorder
- Hypersexual Disorder
- Attenuated Psychosis Disorder
- PD Dimensional Assessment
- Persistent Complex Bereavement Disorder

From Section III
Emerging Measures & Models
#15: GAMBLING DISORDER JOINS THE SUBSTANCE ABUSE SECTION

- 1) Needs to gamble with increasing amounts of money in order to achieve desired excitement.
- 2) is restless or irritable when trying to cut down gambling.
- 3) Has made repeated unsuccessful attempts to cut down gambling.
- 4) Is often preoccupied by gambling.
- 5) Often gambles when feeling distressed.
- 6) After losing money, often returns the next day to get even --“chasing” one’s losses.
- 7) Lies to conceal the extent of involvement in gambling.
- 8) Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
- 9) Relies on others to provide money to relieve desperate financial situations caused by gambling.
Although gambling disorder seems like a logical addition, the introduction of a non-substance use disorder opens the way for other non-consumable considerations (internet, shopping, etc.).

This also speaks to the dramatic changes that have occurred in the D&A community over the past decade, as it has increasingly merged with mental health treatment.

Interestingly, gambling disorder makes it debut as substance used disorder gets a major overhaul. More on that later.
In ICD-10, pathological gambling, fire-setting, and stealing are interestingly located with the personality disorders.

**Pathological Gambling (F63)** is considered a Habit and Impulse Disorder in ICD-10 as compared to a Non-Substance-Related Disorder (under the Substance Used Disorder Category) in DSM-5.

The diagnostic description is quite simple: Persistent, repeated gambling which continues and often increases despite adverse social consequences such as impoverishment, impaired family relationships, and disruptions to personal life.

Rule-outs include: normative gambling, mania-induced gambling, and gambling by sociopathic personality types.
#14: MULTIPLE PERSONALITY DISORDER CONTINUES TO FADE FROM HISTORY (DID)

- **Criterion B** from DSM IV Dissociative Identity Disorder has been **completely removed** *(At least two of these identities or personality states recurrently take control of the person’s behavior.)*

- One of the more embarrassing (and refuted) chapters in psychology is coming to its ultimate demise as dissociation is **aligned with traumatic reactions and away from MPD folklore.**

- Rates of DID have dropped substantially since the 1990s to less than 2% *(and this is likely too high).*

- Many cultural elements including direct comparison to **religious possession** are added to the diagnostic category for DID.
A) Disruption of identity by two or more distinct personality states, which may be described in some cultures as an experience of possession. This disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory motor functioning.

A) The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about environment & self.)
Other specified DID covers: Identity disturbance due to prolonged and intensive coercive persuasion through brainwashing, torture, and political imprisonment.

DSM-5 offers insight into triggers for decompensation through a developmental lens including a DID-afflicted client’s: 1) removal from a traumatizing situation; 2) children reaching the same age as they were when abused; 3) later (additive) trauma; and 4) the abuser’s death.

It is interesting that the DSM-5 states: “the dissociative disorders are placed next to, but are not part of, the trauma and stressor related disorders, reflecting the close relationship between these diagnostic classes”.

WHY IT MATTERS
Dissociative Disorders appear in several places in the ICD-10, and in some ways represent a holdover from classic hysteria definitions.

ICD-10 makes linkages between dissociative disorders and conversion symptoms and explain that “it also seems reasonable to presume that the same (or very similar) psychological mechanisms are common to both types of symptoms” (p. 18).

Multiple personality disorder still exists as code F44.81 under Other Dissociative (Conversion) Disorders in ICD-10—a code that maps on to DID in DSM-5.

But this caveat is given: “If multiple personality disorder (F44.81) does exist as something other than a culture-specific or even iatrogenic condition, then it is presumably best placed among the dissociative group”.
Not only has Separation Anxiety been expanded to include adults, other disorders such as ODD, Specific Phobia, Selective Mutism and ADHD have become more easily diagnosable in those over 18 years of age.

This shift in thinking considers developmental thresholds over chronological age.

Adult symptoms of Separation Anxiety Disorder include:

- Discomfort in travelling alone
- Increased cardiovascular symptoms
- Increased appearance of dependency and overprotection
- Over concern with partners and children
Children have a Criterion B duration requirement of 4 weeks of symptoms compared to 6 months or more for adults.

A special exclusion is made for considering resistance to change as connected to autism.

Criterion C in DSM-IV (The onset is before age 18 years) has been removed as the disorder can now apply to adults.
A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months and evidenced by 4+ of these symptoms in interaction with another individual who is not a sibling.

- **Angry/Irritable Mood**
  - Often loses temper
  - Is often touchy or easily annoyed
  - Is often angry or resentful

- **Argumentative/Defiant Behavior**
  - Often argues with authority figures/adults
  - Often defies or refuses to comply with rules
  - Often deliberately annoys others
  - Often blames others for his or her mistakes or behaviors

- **Vindictiveness**
  - Has been spiteful or vindictive at least twice in last 6 months
ODD SPECIFIERS

- **Mild (1 setting)**
- **Moderate (2 settings)**
- **Severe (3 settings)**

According to the DSM-5, it is not uncommon for one with ODD to **only** show symptoms at home.
The DSM-5 claims to be more developmentally focused and one way it shows that is through extending historically child-based disorders into adulthood.

Before one balks at diagnosing an adult with Separation Anxiety Disorder or Oppositional Defiant Disorder, consider that the alternatives are often Dependent PD and Antisocial PD for adults--even when diagnostically inaccurate.

Interestingly, family systems ideas of enmeshment have enhanced utility when considering adults with Separation Anxiety Disorder.
Although the DSM-5 has moved SAD (F93.0) to the Anxiety Disorders, it remains in ICD-10 Section for Behavioral and Emotional Disorders with onset usually occurring in childhood and adolescence with Hyperkinetic disorders (ADHD), Conduct disorders, and disorders of social functioning.

ICD-10 does not elaborate on exceptions made for adults and indicates that the diagnosis should not be used unless “it constitutes an abnormal continuation of developmentally appropriate separation anxiety”.

This language suggests that separation anxiety in relation to spouses and children is less supported here.
Gender dysphoria refers to distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.

The DSM IV described Gender Identity Disorder as requiring both a cross gender identification piece and persistent discomfort about one’s assigned sex.

Gender Dysphoria in DSM-5 has separate diagnostic criteria for children vs. adolescents and adults.

Of interest: DSM-5 makes it a point to reject social constructivist theories that deny the influence of biology on gender expression.
<table>
<thead>
<tr>
<th>Child Gender Dysphoria</th>
<th>Adult Gender Dysphoria</th>
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<tbody>
<tr>
<td>A strong desire to be of the other gender or insistence that</td>
<td>A marked incongruence between expressed gender and secondary</td>
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<tr>
<td>one is the other gender</td>
<td>sex characteristics</td>
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<tr>
<td>A strong preference of playmates of the other gender</td>
<td>A strong desire to be rid of one’s primary/secondary sex</td>
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<td></td>
<td>characteristics</td>
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<tr>
<td>A strong preference for cross-gender roles in make-believe play</td>
<td>A strong conviction that one has the typical feelings &amp;</td>
</tr>
<tr>
<td></td>
<td>reactions of the other gender</td>
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</tbody>
</table>
WHAT IT IS NOT

Gender Dysphoria

Nonconformity to gender roles

Schizophrenia

Transvestic disorder

Body Dysmorphic disorder
Proponents of the new diagnosis state that it is not a permanent condition, but a temporary state. This helps to reduce stigma often directed at transgendered individuals, and refutes the idea that simply being transgendered is, in itself, a disorder.

Opponents of the disorder are split. Some believe that GD should not be considered a mental disorder at all, and instead be more aligned with a strict bio-medical designation (as sex reassignment surgery is beyond the psychiatric field).

Others worry that a shift away from the conceptual nature of GID might reduce insurance reimbursement of such surgeries.
The current DSM-5 Adult Gender Dysphoria code currently maps to the ICD-10 code for dual-role transvestism (F64.1).

APA has petitioned that this be change to the code that corresponds to transsexualism . . . But in either case they are not conceptual equals and the ICD-10 maintains the trait-based language common to DSM IV Gender Identity Disorder.

It remains to be seen how the complex interplay between gender dysphoria, transvestism, transvestism disorder, and even the continued murky labels attributed to paraphilias will play out with the integration.
#11: TRAIT BASED PD DIAGNOSIS IS OFFERED AS AN ALTERNATIVE IN SEC III

- Though the *traditional, categorical approach* to diagnosing Personality Disorders remains intact in DSM-5, there is an additional approach offered (Section III: Emerging Measures & Models) that reflects a more trait-based approach.
- This model emerges out of research suggesting that personality disorders are both *characterized by overall functional impairment* and *trait-based pathology*.
- Because most clients that meet the standards for one personality often meet criteria for more, *other-specified personality disorder is often correct*, but it yields little additional information for clinicians in which to address treatment directions.
GENERAL CRITERIA FOR PD IN THE ALTERNATIVE MODEL

- A. Moderate or greater impairments in personality functioning
- B. One or more pathological personality traits
  - 5 Domains order the trait facets including: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism.
  - There are 25 trait facets (pg. 779) that support the redesigned disorders. Though they are too extensive to discuss in full here, some examples include:
    - Hostility, Depressivity, Emotional Lability, Grandiosity
- C. The impairments in personality functioning and trait expression are relatively inflexible and pervasive across situations
- D. The impairments in personality functioning and trait expression are relatively stable across time with onsets traceable to at least adolescence or early adulthood.
CRITERION (A) PERSONALITY FUNCTIONING

Elements

- **Self**
  - Identity
  - Self-Direction

- **Interpersonal**
  - Empathy
  - Intimacy

Impairment Severity Scale

- Level 0 = none
- Level 1 = minor
- Level 2 = moderate
- Level 3 = severe
- Level 4 = extreme
The ICD uses a rather simple descriptive approach to personality disorders that are described as a severe disturbance in the characterological constitution and behavioral tendencies with a focus on social disruptions.

Further diagnostic guidelines demand that the pattern is enduring, of long standing, and not limited to episodes of mental illness.

Some key differences between DSM-5 and ICD-10 are in the specific disorders. ICD-10 endorses the following specific personality disorders. There are some key differences that may have utility to clinicians (especially as they relate to Dissocial over Antisocial PD, Emotionally Unstable PD over Borderline PD, and Anxious PD over Avoidant PD.)
DSM-5® ICD-10 CROSSWALK
PERSONALITY DISORDERS-2

Paranoid
Schizotypal

Paranoid
Schizoid
Schizotypal

Antisocial
Borderline
Histrionic
Narcissistic

Avoidant
Dependent
OCPD

Dissocial
Emotionally
Unstable

Anxious
Dependent
Anankastic

Schizotypal
Disorder is not
with PDs, but
Schizophrenia
#10: AGORAPHOBIA REDEFINED AND PANIC SPECIFIER EXPANDED

Public Transportation

Being in enclosed spaces

Being in open spaces

Standing in line or being in a crowd

Being outside of the home alone

2 needed
<table>
<thead>
<tr>
<th>DSM IV</th>
<th>DSM-5</th>
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<tbody>
<tr>
<td>A) Anxiety about being in places or situations from which escape might be difficult or embarrassing or in where help might not be available from a predisposed panic attack.</td>
<td>A) Marked fear or anxiety about 2 or more of the five situations (listed on prior slide)</td>
</tr>
<tr>
<td>B) The situations are avoided or else endured with marked distress.</td>
<td>B) Person fears or avoids these situations because of thoughts that escape might be difficult or help might not be available.</td>
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<td></td>
<td>C) The agoraphobic situation almost always provoke fear or anxiety</td>
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</table>
FROM SUBTYPES TO SPECIFIERS

Animal
Natural-Environmental
Blood Injection-Injury
Situational
Other
PANIC ATTACK SPECIFIER

- Same symptoms as Panic Disorder (Criterion A)

Note: Unlike Panic Disorder, panic attacks can be EXPECTED or UNEXPECTED.
1) The changes help give clarity to the differences between *specific phobias* and *agoraphobia*, and it will now be its own disorder separate from the notorious profile of panic attacks.

2) Panic attacks as a specifier will have *added utility* and likely permit better diagnosis of depression and traumatic disorders than in the past.
In this case, DSM-5 has more closely followed the groundwork laid by ICD-10.

The ICD-10 Agoraphobia diagnosis demands that all of the following criteria should be fulfilled:

- (a) the psychological or autonomic symptoms must be primarily manifestations of anxiety and not secondary symptoms
- (b) the anxiety must be restricted to (or occur mainly in) at least two of the following situations: crowds, public places, travelling away from home, and travelling alone; and
- (c) avoidance of the phobic situation must be, or have been, a prominent feature.

ICD still differentiates Agoraphobia With Panic (F41.0) and Without Panic (F40.0)—But DSM-5 maps to F41.0.
#9: PREMENSTRUAL DYSPHORIC DISORDER IS ADDED FOR WOMEN

A. In the majority of menstrual cycles, at least 5 symptoms must be present in the final week before the onset of menses, improve within a few days after menses, and become minimal or absent postmenses.

<table>
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<tr>
<th>B. One or more of the following</th>
<th>C. One or more of the following</th>
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<tbody>
<tr>
<td>1) Marked affective lability</td>
<td>1) Decreased interest in usual activities</td>
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<tr>
<td>2) Marked irritability or anger</td>
<td>2) Subjective difficulty in concentration</td>
</tr>
<tr>
<td>3) Marked depressed mood or feelings of hopelessness</td>
<td>3) Lethargy and fatigue</td>
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<tr>
<td>4) Marked anxiety or tensions and or feelings of being keyed up</td>
<td>4) Marked change in appetite (overeating, special food cravings)</td>
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<td></td>
<td>5) Hypersomnia or insomnia</td>
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<td></td>
<td>6) A sense of being overwhelmed</td>
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<td>7) Physical symptoms such as breast tenderness, muscle pain, bloating.</td>
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</tbody>
</table>
Criterion A should be confirmed by daily ratings over the course of 2 menstrual cycles. Subjective memory should not be relied upon, but a provisional diagnosis can be made until data is collected.
The DSM III R had been strongly criticized for being sexist and for pathologizing normative female socialization and biological processes.

These issues came to a head while the workgroups considered adding Self-Defeating PD (SDPD) and Late Luteal Phase Dysphoric Disorder (LLPDD) to the DSM IV.

Pantony & Caplan (1991) argued that the disorder Delusional Dominating PD (DDPD) should be added to describe men that show a cluster of personality issues that emerge from a pressure to conform to a rigid masculine role.
The addition of PMDD and some changes to the perinatal specifiers need to be considered when working with females that are struggling with depression or anxiety symptoms.

With peripartum onset (as opposed to postpartum)- DSM-5 notes that as many as 50% of postpartum, MDD episodes actually begin before delivery.

The concern: the DSM has a history of marginalizing and pathologizing female experiences. If this new diagnosis is not considered with a critical eye in both form and function, normative biological processes could me wrongly labeled as dysfunction.
Try this coding dilemma on for size. PMDD currently maps to the normal physiological condition of ICD-10 premenstrual tension syndrome (N94.3). These are two very different things and APA has since petitioned that PMDD align in a more direct way with the depressive disorders going forward.

It would not be customary for ICD-10 (which addresses both physical and mental disorders) to shift a phenomenon that has historical biological roots to that of a categorical depressive disorder.

Since the condition is evidenced in the current ICD code, and the conceptual battleground is over whether it should be regarded as a depressive disorder, one wonders what the complete motive might be here...
Subtypes (paranoid, catatonic, disorganized, etc.) were removed due to poor validity and limited stability. Interestingly, in the DSM IV, there was talk of designating three types (psychotic, disorganized, and negative), but that has since lost its support.

A dimensional severity rating scale is included in Section III to address variance of symptoms.

Elimination of the DSM IV need for bizarre delusions/hallucinations or hearing 2 or more conversing voices, leading to a requirement that at least 2 of these Criteria (A) symptoms much exist: hallucinations, delusions, or disorganized speech.
FAMILY TREE

- Schizophrenia
- Brief Psychotic disorder
- Delusional Disorder
- Schizoaffective Disorder
- Schizotypal PD
- Catatonic
- Undifferentiated
- Paranoid
- Disorganized
- Residual
This easy assessment screen examines 8 symptom categories on a range from 0 (not present) to 4 (present and severe). It is recommended that this scale be incorporated into diagnostic profiles of those suffering from psychosis.

Categories include:

- I. Hallucinations
- II. Delusions
- III. Disorganized Speech
- IV. Abnormal Psychomotor Activity
- V. Negative symptoms
- VI. Impaired cognition
- VII. Depression
- VIII. Mania
Overall, small changes and cleaning house. The subtypes were historically problematic (though some are certainly annoyed with the loss of the paranoid subtype).

Perhaps the biggest change is one that was not yet mentioned: Delusional disorder no longer has the requirement that delusions be non-bizarre, and a specifier is included to denote bizarre types.

Also, Schizoaffective disorder is now conceptually considered a bridge disorder that incorporates schizophrenia, bipolar disorder and major depressive disorder.

The severity scales (if used across settings) will help to better communicate differences between those suffering with this debilitating disorder, as well as track changes over time.
Whether DSM IV or DSM 5 the subgroupings of schizophrenia have never exactly matched with those of the ICD.

ICD-10 has the following variants of schizophrenia:

- F20.0 Paranoid schizophrenia
- F20.1 Hebephrenic schizophrenia
- F20.2 Catatonic schizophrenia
- F20.3 Undifferentiated schizophrenia
- F20.4 Post-schizophrenic depression
- F20.5 Residual schizophrenia
- F20.6 Simple schizophrenia
- F20.8 Other schizophrenia
- F20.9 Schizophrenia, unspecified

More commonly known as the old Disorganized Type
Child specific additions (under 6)

- (A). Exposure events can occur through witnessing or hearing about harm to parents or caregivers
- (B). Spontaneous and intrusive memories may not necessarily appear distressing and may be experienced as play re-enactment
- (C). Children only require 1 symptom of persistent avoidance or negative alteration in consciousness as compared to adults who need 1 from the Avoidant Category (C) and 2 from the Negative Alterations in Moods and Cognitions Category (D)
- (D) In regards to Increased Arousal, unlike adults, children do not have the symptom of “Reckless or Self Destructive Behavior”
DSM IV AND DSM-5 CRITERION PATHS FOR ADULT PTSD

**DSM-5**

A. Exposure event
B. Intrusion Symptoms
C. Avoidance of Stimuli
D. Negative Alterations in Moods and Cognitions
E. Increased Arousal

**DSM-IV**

A. Exposure Event
B. Re-experiencing Symptoms
C. Avoidance of Stimuli + Numbing
D. Increased Arousal

**Numbers**

- A. Exposure event: 1+
- B. Intrusion Symptoms: 1+
- C. Avoidance of Stimuli: 1+
- D. Negative Alterations in Moods and Cognitions: 2+
- E. Increased Arousal: 2+
Criterion (A) new additions such as: Learning that trauma has occurred to a close family member/friend, and experiencing repeated or extreme exposure to aversive details of trauma

(Criterion (E) - Increased Arousal, “Reckless or self-destructive behavior” is added as a symptom.

The Criterion (A) symptom: The person’s response involved intense fear, helplessness, or horror has been cut.

Many Criterion (C) symptoms have been merged together from 7 to 2, and “sense of foreshortened future” has been cut.

“Inability to recall an important aspect of the trauma” has been moved to new Criterion (D) and attached to dissociative states.
FAMILY TREE

PTSD

Acute Stress Disorder

Adjustment Disorders

Unspec. Trauma

Other Specified Trauma

Reactive Attachment Disorder

Disinhibited Social Engagement Disorder
SPECIFIERS

With dissociative symptoms
-The individual’s symptoms meet the criteria for PTSD and include the additional experiences of:

- **Depersonalization** - persistent or recurrent feelings of being detached from one’s own mental processes (as if an outside observer) - or
- **Derealization** - persistent or recurrent experiences of unreality of surroundings (dreamlike world)

With delayed expression
- Full diagnostic criteria not achieved until 6 months after event
Behavioral *violence and recklessness* that emerges after trauma has long been recognized by clinicians, but was not endorsed as central to PTSD in DSM IV. Now it is.

The criterion of **Negative Alterations in Moods and Cognitions** both normalizes the dysphoria that occurs with trauma, as well as the issues with sensorium, memory, and consciousness—all without adding unnecessary additional disorders to the mix.

Expect to see an *increase of PTSD diagnosis in first responders* (police, paramedics, and even some types of counselors), as it is now a central feature of Criterion A.
Just as the ICD-10 has PTSD in the Subsection reserved for Reaction To Severe Stress and Adjustment Disorders, the removal of PTSD from anxiety disorders and positioned within the new Trauma and Stressor Related Disorders seems consistent with global ideas of trauma.

PTSD-American-style has potentially lowered the threshold considerably in the DSM-5 rebrand.

- **DSM-5 PTSD** arises from a direct experience, witnessing it happen to another, hearing about it happening to a close family member or friend, or first-responder trauma.

- **ICD-10 PTSD** arises as a response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g. natural or man-made disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape or other crime).
“IQ scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks” (p. 37).

Hence, the introduction of 3 mandatory specifiers—each tracked across 4 levels of functioning.
## EXAMPLE SPECIFIER: SOCIAL DOMAIN

- All specifiers are based on Adaptive Functioning (B) with indicators of mild, moderate, severe, and profound

<table>
<thead>
<tr>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
<th>PROFOUND</th>
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<tbody>
<tr>
<td>Often immature in social situations; language and interaction patterns are often more concrete and prone to misinterpretation; person may be at risk for being manipulated by others and have less awareness of risk</td>
<td>Shows marked differences in social and communicative behavior; spoken language is often less sophisticated than peers and social cues may not be accurately perceived; may have long-term friendships and romantic relationships</td>
<td>Speech is limited and may be expressed in simple words and phrases; often focused on here-and-now and on the everyday events; family is often the primary social arena and these relationships are often a source of comfort</td>
<td>Expresses needs and emotions largely through non-verbal means; tends to engage with close family members and may have co-occurring sensory &amp; physical impairments that may prevent social activities.</td>
</tr>
</tbody>
</table>
This is a law that was passed through bill S.2781, which replaces several instances of the word “mental retardation” with the newly minted, “intellectual disability”. It passed unanimously in the Senate and signed into law by President Obama on October 5, 2010 (who says political sides can’t agree on anything?!).

The law is named after a young girl with Down’s Syndrome named Rosa Marcellino who worked with her family to remove the word from health code statutes in her birth state of Maryland.
●A) **Deficits in Intellectual Functioning** such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized testing.

●A) **Significantly subaverage intelligence functioning**: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectually functioning)
FAMILY TREE: LEARNING DISORDERS

- Language Disorder
  - Social Comm Disorder
  - Speech Sound Disorder
- Disorder of Written Expression
  - Specific Learning Disorder
  - Childhood Onset Fluency Disorder
- Unspecified Comm Disorder
  - Stuttering
  - Mathematics Disorder
  - Expressive Language Disorder
  - Mixed Receptive Expressive Disorder
  - Phonological Disorder
  - Reading Disorder
  - Disorder of Written Expression NOS
These changes come from strong feedback in the LD research community that have grown suspicious of using IQ thresholds as the primary support for ID and LD due to rejection of static cutoff scores and concerns that academic achievement and practical functionality are not always congruent.

The battle over IQ continues to rage on. Though there is tremendous evidence to show IQ as an enduring and predictive trait to future success, it does not represent the entirety of an individual's functioning.

These changes may help clinicians and schools to refocus on vocational and interpersonal strengths in children and adults.
ICD-10 (F72-F79)

- Still uses the term “Mental Retardation”.
- IQ scores are more clearly delineated to each severity level (mild: IQ 50-69, moderate: IQ 35-49, severe: IQ 20-34, profound: IQ under 20)
- Describes past historical terms that have been retired from use such as (feeble-mindedness, mental subnormality, moron, and oligophrenia).
- Adaptive behavior is reflected by the addition of a 4th character:
  - F7x.0 Minimal impairment of behavior
  - F7x.1 Significant impairment of behavior requiring treatment
  - F7x.8 Other impairments of behavior
  - F7x.9 Without mentation of impairment of behavior

DSM-5 🧮 ICD-10 CROSSWALK
INTELLECTUAL DISABILITY
A) Severe, recurrent temper outbursts manifested verbally or behaviorally 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) Temper outbursts occur 2-3 times per week

D) The mood between outbursts is persistently irritable or angry most of the day, nearly every day and observable by others

E) Criteria A-D have been present for 12 months with no period lasting 3 months or more without all criteria

F) A & D are present in at least 2 settings

G) Diagnosis should not be used under 6 or older than 18

NOTE: The diagnosis cannot coexist with ODD, Intermittent Explosive Disorder, or bipolar Disorder
PROBLEMS WITH BIPOLAR DIAGNOSIS IN CHILDREN & ADOLESCENTS
REDDY & ATAMANOFF (2005)

1) Bipolar disorder is mostly identified as a disorder that emerges after adolescence and is more tied to adult diagnostic considerations.

2) Lack of understanding and focus in diagnosis courses has made BP difficult to discern in adolescents.

3) There have been inconsistent criteria throughout the last 30 years of the DSM.

4) Developmental phases overlap significantly with some of the features of BP, which makes for complicated diagnostic determinations.

5) There has not been an abundance of psychometrically sound assessment tools that properly identify BP.
OLD & NEW BIPOLAR SPECIFIERS
(SEE DEPRESSIVE DISORDERS FOR MORE INFORMATION)
Though officially a part of the Depressive Disorders, the new addition of the **Disruptive Mood Dysregulation Disorder** will influence the diagnosis of children with **ODD, ADHD & Depression** in even greater ways than differentiating between pediatric Bipolar.

The upside of this is that DMDD does not continue past 18 years of age, so this will require a re-evaluation if symptoms prevail.

The downside is that more children may be placed on **antidepressant medicine** at an earlier age before family-based interventions or psychotherapy are fully exhausted.
So, this is one of those ICD disorders that does not Map well to DSM-5. DMDD aligns with ICD-10 Other Persistent Mood Affective Disorder (F34.8).

Along with Binge-Eating Disorder, and Mild Neurocognitive Disorder, DMDD stands out as one of the more heated controversies that, to some, seems to pathologize temper tantrums in an attempt to clean-up the last decades’ over-diagnosis of pediatric bipolar disorder.
The most critical aspect of the DSM-5 change, is that Abuse and Dependence categories are no longer separated. Instead, criteria are included for the umbrella diagnosis of Substance Use Disorder (fill in substance of choice).

The word “addiction” has reduced utility in the DSM-5 and it is implied that the word has negative connotations compared to the more neutral “use disorder”.

The criterion: craving, or a strong desire or urge to use a substance, has been added—surprisingly, reminding us that it was never there in previous editions.
(A) A MALADAPTIVE PATTERN OF DRINKING, LEADING TO
CLINICALLY SIGNIFICANT IMPAIRMENT OR DISTRESS, AS
MANIFESTED BY AT LEAST . . .

<table>
<thead>
<tr>
<th>DSM IV ABUSE</th>
<th>DSM IV DEPENDENCE</th>
<th>DSM-5 USE DISORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 of the following occurring within a 12-month period:</td>
<td>3 of the following occurring any time in the same 12-month period:</td>
<td>2 of the following occurring within a 12-month period:</td>
</tr>
<tr>
<td>1) Failure of roles</td>
<td>1) Tolerance</td>
<td>1) Larger amounts needed</td>
</tr>
<tr>
<td>2) Use when hazardous</td>
<td>2) Withdrawal</td>
<td>2) Desire to cut down</td>
</tr>
<tr>
<td>3) <strong>Recurrent Alcohol-related legal issues</strong></td>
<td>3) Larger amounts needed</td>
<td>3) Time spent in pursuit</td>
</tr>
<tr>
<td>4) Use despite personal issues</td>
<td>4) Desire to cut down</td>
<td><strong>4) Craving</strong></td>
</tr>
<tr>
<td></td>
<td>5) Activities given up</td>
<td>5) Failure of roles</td>
</tr>
<tr>
<td></td>
<td>6) Time spent in pursuit</td>
<td>6) Use despite interpersonal issues</td>
</tr>
<tr>
<td></td>
<td>7) Use despite physical problem exacerbation</td>
<td>7) Activities given up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8) Use when hazardous</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9) Use despite physical problem exacerbation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10) Tolerance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11) Withdrawal</td>
</tr>
</tbody>
</table>

(A) A MALADAPTIVE PATTERN OF DRINKING, LEADING TO CLINICALLY SIGNIFICANT IMPAIRMENT OR DISTRESS, AS MANIFESTED BY AT LEAST . . .
SEVERITY SPECIFIERS

- Based on Criterion A symptoms

- **Mild Alcohol Use Disorder**
  (2-3 symptoms from Criterion A)

- **Moderate Alcohol Use Disorder**
  (4-5 symptoms from Criterion A)

- **Severe Alcohol Use Disorder**
  (6+ symptoms from Criterion A)
The collapse of divisions between abuse and dependence will alter the assessment applications of these disorders almost immediately.

The abstinence-only protocols of treatment, as well as groups such as AA, may have increased competition from harm reduction models of therapy.

Severity indicators based on the number of Criterion A endorsements adds greater logic to the level of disorder from mild to severe, but does not consider the “true weight” of different symptoms (e.g. Time spent in pursuit vs. Withdrawal)

Opponents of the change also suggest that it is very easy to achieve a diagnosis of Alcohol Use Disorder with the reduced threshold, specifically in younger people that spend considerable time in the pursuit of social events where drinking is ubiquitous (i.e. college settings).
There are an overabundance of substance use diagnoses in ICD-10.

Take Cannabis-Related Disorder: DSM-5 has 10 distinct diagnoses related to the usage disorder of this substance compared to over 40 identified by the ICD-10!

Additionally, and of greatest import to this section, ICD-10 has retained the distinction between abuse and dependence (Dependence Syndrome).

It should also be noted that the subsection of the ICD-10 is called Mental and Behavioral Disorders due to Psychoactive Substance Use, in contrasts to the DSM-5 Substance-Related and Addictive Disorders, which again seems to reduce the role of behavior.
DSM-5 removed differential categories such as Asperger’s Disorder, Childhood Disintegrative Disorder, and PDD NOS. Rett Syndrome is also not specifically classified as ASD.

Whereas DSM IVTR described Qualitative impairments in communication that were connected to delays in spoken language and language that is stereotyped, repetitive, and idiosyncratic, DSM-5 merged this criteria with Social Interaction Impairments into a new criterion (A). Problems with Language are classified as Language Disorder and are a separate diagnostic category.
FAMILY TREE

Social Comm. Disorder

Autism Spectrum Disorder

Rett Syndrome

PDD NOS

Asperger’s Disorder

Childhood Disint. Disorder
A) Persistent deficits in social communication & interactions across multiple contexts, as manifested by deficits in social-emotional reciprocity, non-verbal communicative behaviors, and in developing, maintaining, and understanding relationships (social intuition).

B. Restricted, repetitive patterns of behavior, interests, or activities.

A) Qualitative impairment in social interaction & communication, and displays restricted, repetitive and stereotyped patterns of behaviors, interests, and activities.
SPECIFIERS

- With or without intellectual impairment
- With or without accompanying language impairment
- Associated with a known medical or genetic condition or environmental factor
- Associated with another neurodevelopmental, mental, or behavioral disorder
- With catatonia
### Examples of Severity Levels

<table>
<thead>
<tr>
<th>Social Communication &amp; Restricted, repetitive behavioral patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 3</strong></td>
</tr>
<tr>
<td>Requiring very substantial support</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
</tr>
<tr>
<td>Requiring substantial support</td>
</tr>
<tr>
<td><strong>Level 1</strong></td>
</tr>
<tr>
<td>Requiring support</td>
</tr>
</tbody>
</table>

Each area should be addressed separately within the diagnostic profile:

*Requiring support for social communication and requiring very substantial support for RRBs*
DIFFERENTIAL DIAGNOSIS

ASD

Intellectual Disability or Language Disorder

Social (Pragmatic) Communication Disorder

Schizophrenia

Stereotypic Movement Disorder

Rett Syndrome
Many parents with children with Asperger’s Disorder are reluctant to accept the label of Autistic Spectrum Disorder for reasons separate from diagnostic relevance.

The addition of Social (Pragmatic) Disorder will identify a new group of clients that have long been diagnosed with Spectrum Disorders, and who will now be considered distinct... for better or worse.

Funding options and supports for children with Rett Syndrome and Social Communication Disorder may not be as readily available based on existing standards.

Severity specifiers may help to refine our understanding of ASD and better address services for those that require minimal vs. substantial support (well, it is better than the GAF at least!)
Social Pragmatic Disorder (Lack of social intuition minus RRBs) is currently coded with Other Developmental Speech or Language Disorder (F80.9), yet the APA is asking that the ICD-10 CM create a new category as the presentation is believed to be fundamentally different from ICD conceptualization and is not related to speech or language except in the most broad sense.

Not only is Asperger’s (F84.5) retained in ICD-10, but Childhood Autism (F.84.0) is differentiated from Atypical Autism (F84.1). The DSM-5 only maps to F84.0 for Autism Spectrum Disorder.

Atypical Autism is described as: a pervasive developmental disorder that differs based on age of onset or in a failure to fulfill all three diagnostic criteria (reciprocal social interactions, communication, or RRBs). This is often attributable to those with profound or severe ID.
For years, it has been acknowledged that depression and anxiety often present simultaneously as a mixed dysphoric presentation that can be less amenable to typical antidepressants.

A greater mix of anxiety and depressive symptoms are associated with higher suicide risk, longer treatment needs, and worse overall prognosis.

Neuroticism is a dominant personality trait and a well-supported risk-factor in developing MDD and GAD.

DSM workgroups have struggled in how to create linkages between these two disorders that are more like separate sides of a coin, rather than two distinct islands of symptomology.

The compromise: add an anxiety distress specifier that can be utilized within MDD and PDD (Dysthymic Disorder).
With anxious distress

- Presence of at least 2 of these during most days of MDD or Persistent Depressive Disorder
  - Feeling keyed-up or tense
  - Feeling unusually restless
  - Difficulty concentrating because of worry
  - Fear that something awful might happen
  - Feeling that the individual might lose control

Severity = 2 symptoms (mild), 3 symptoms (moderate), 4-5 symptoms (moderate-severe), and 4-5 symptoms with motor agitation (severe)
## GAD VS. ANXIETY SPECIFIERS

<table>
<thead>
<tr>
<th>GAD (3 or more)</th>
<th>Anxiety Specifier (at least 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Restlessness or feeling keyed-up or on edge</td>
<td>1) Feeling keyed-up or tense</td>
</tr>
<tr>
<td></td>
<td>2) Feeling unusually restless</td>
</tr>
<tr>
<td>2) Being easily fatigued</td>
<td></td>
</tr>
<tr>
<td>3) Difficulty concentrating or mind going blank</td>
<td>3) Difficulty concentrating because of worry</td>
</tr>
<tr>
<td>4) Irritability</td>
<td></td>
</tr>
<tr>
<td>5) Muscle tension</td>
<td></td>
</tr>
<tr>
<td>6) Sleep disturbance (difficulty falling asleep, or restless, sleep)</td>
<td>4) Fear that something awful might happen</td>
</tr>
<tr>
<td></td>
<td>5) Feeling that the individual might lose control</td>
</tr>
</tbody>
</table>
The elephant in the room with suicidal ideation is depression with the agitating factor of anxiety. Consider anxiety the fuel to carry out self-harm actions.

No combination of disorders accounts for more diagnostic confusion than depression and anxiety interactions. Everything from ADHD, Bipolar, PTSD, and Personality Disorders are misdiagnosed because of our overall lack of understanding of these two highly common phenomena.
FDA advisory committee considered data from meta-analyses with close to 100,000 participants across 372 randomized trials examining the effects of antidepressants on suicidality. Analyses across age groups showed no discernible risk; however, age-stratified comparisons showed that 18-24 year olds showed some increase, but was not clinically significant. Ultimately, the FDA placed an increase risk of suicide through antidepressant use at .01%
DSM-5 does not offer a “Bereavement Exclusion” per se for MDE and suggests that grief and MDE can occur simultaneously and can be determined through clinical review. Grief tends to present with “a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE” (p.126 DSM-5).

Moreover, if the symptoms begin within 2 months of the loss of a loved one and do not persist beyond these 2 months, they are generally considered to result from Bereavement unless they are associated with marked functional impairment or include morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (p.740, DSM IV).
SUICIDAL BEHAVIOR DISORDER

Criteria

- **A**: Within last 24 months, the individual has made a suicide attempt
- **B**: The act does not meet criteria for nonsuicidal self-injury
- **C**: The diagnosis is not applied to suicidal ideation or to preparatory acts
- **D**: The act was not initiated during a state of delirium or confusion
- **E**: The act was not undertaken solely for a political or religious objective

**Specify if:**

- Current: Not more than 12 months since past attempt
- In early remission: 12-24 months since last attempt
ICD-10 and DSM-5 are very similar in their conceptualizations of depression, but ICD-10 adds **reduced energy** into the cardinal symptoms of **depressed mood** and **loss of interest and enjoyment**.

Additionally, ICD-10 does not seem to endorse some of the atypical symptoms of DSM-5 depression (increased appetite and hypersomnia) and instead supports diminished appetite and disturbed sleep.

While DSM-5 suggests that clients can have **recurrent thoughts of death** (as well as suicidal thoughts and actions), ICD-10 elevates the threshold with self-harm or suicide action as the start point of such symptomology.

ICD-10 also adds **bleak and pessimistic views of the future** to their diagnostic profile, well-supported by Beck’s negative cognitive triad, but interestingly absent from DSM-5.
One of the biggest changes to the DSM-5, is the introduction of the **With Limited Prosocial Emotions Specifiers to CD**

- *Lack of remorse or guilt*
- *Callousness or lack of empathy*
- *Unconcerned about Performance*
- *Shallow or deficient affect*

These criteria have emerged out of the psychopathy research championed by Robert Hare and others and adds a dimension to Conduct Disorder that highlights those children that may be the most dangerous long-term.
<table>
<thead>
<tr>
<th>HARE Psychopathy Youth</th>
<th>CONDUCT DISORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Lack of remorse</td>
<td>Lack of remorse or guilt</td>
</tr>
<tr>
<td>2-Callous/Lack of empathy</td>
<td>Callous-lack of empathy</td>
</tr>
<tr>
<td>3-Parasitic Orientation</td>
<td>Unconcerned about performance</td>
</tr>
<tr>
<td>4-Failure to accept responsibility</td>
<td></td>
</tr>
<tr>
<td>5-Irresponsibility</td>
<td></td>
</tr>
<tr>
<td>6-Lacks Goals</td>
<td></td>
</tr>
<tr>
<td>7-Shallow affect</td>
<td>Shallow or deficient affect</td>
</tr>
<tr>
<td>8-Impression Management</td>
<td></td>
</tr>
<tr>
<td>9-Pathological Lying</td>
<td>Core conduct disorder-specific symptoms</td>
</tr>
<tr>
<td>10-Criminal Versatility</td>
<td></td>
</tr>
<tr>
<td>11-Violations of Conditional Release</td>
<td></td>
</tr>
<tr>
<td>12-Serious Criminal Behavior</td>
<td></td>
</tr>
<tr>
<td>13-Early behavior problems</td>
<td></td>
</tr>
<tr>
<td>14-Manipulation for personal gain</td>
<td></td>
</tr>
</tbody>
</table>
Oh boy, does it ever matter. One might wonder why psychopathy measures are appearing so distinctly in Conduct Disorder before Antisocial PD.

Clinicians need to be aware that diagnosing children with this disorder may have rather serious consequences on their life in both the short-term and long-term.

As we are notoriously poor at predicting dangerousness, some concern should arise in specifiers that demand greater systemic action while suggesting far worse treatment outcomes.
### DSM-5 ➔ ICD-10 CROSSWALK
#### ANTISOCIAL PD

<table>
<thead>
<tr>
<th>ASPD</th>
<th>Dissocial PD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Failure to conform to social norms with respect to lawful behaviors</td>
<td>-Irresponsibility &amp; disregard for social norms, rules, and obligations</td>
</tr>
<tr>
<td>2. Deceitfulness, as indicated by repeated lying, etc.</td>
<td>Incapacity to maintain enduring relationships, though having no difficulty in establishing them</td>
</tr>
<tr>
<td>3. Impulsivity or failure to plan ahead.</td>
<td></td>
</tr>
</tbody>
</table>
| 4. Irritability and aggressiveness, as indicated by repeated physical fights | -Very low tolerance to frustration and a low threshold for aggressive action  
-Persistent Irritability |
| 5. Reckless disregard for safety | Marked proneness to blame others |
| 6. Consistent irresponsibility | -Gross and persistent attitude of irresponsibility |
| 7. Lack of remorse | -Callousness  
-Incapacity for guilt and to profit from experience, especially punishment |
Although the DSM IV permitted the use of a non multi-axial format for mental health, the insurance industry helped to cement the classic 5 Axes in the minds of clinicians.

GAF scores have been notoriously problematic. Studies exist that show great variance in scores based on discipline (counseling, psychology, medical, social work), degree attainment (Master’s or doctoral), and setting (community mental health, hospitals, schools, private practice).

DSM-5 Workgroups were concerned that the GAF addressed the very different constructs of severity, dangerousness, and disability and the need for “special training” in order for GAF reliability between raters.
<table>
<thead>
<tr>
<th>DSM IV-TR Example</th>
<th>DSM-5 Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I.</strong> 309.81 PTSD with acute onset 311 Depressive Disorder NOS; 300.01 Panic Disorder without Agoraphobia; 300.6 Depersonalization Disorder</td>
<td>309.81 PTSD with dissociative symptoms (depersonalization) and with panic attacks. 333.94 Restless legs syndrome 995.83 Adult sexual abuse by non-partner (rape) V62.89 Victim of crime V61.10 Relationship problem with intimate partner V62.29 Other problem related to employment</td>
</tr>
<tr>
<td><strong>II.</strong> None</td>
<td></td>
</tr>
<tr>
<td><strong>III.</strong> 333.94 Restless legs syndrome</td>
<td></td>
</tr>
<tr>
<td><strong>IV.</strong> Occupational problems (on leave), problems with primary support (conflict with partner), problems related to crime (victim of rape)</td>
<td></td>
</tr>
<tr>
<td><strong>V.</strong> GAF = 41</td>
<td></td>
</tr>
</tbody>
</table>
## 5-AXES DSM-IV VS. NO AXES DSM-5

<table>
<thead>
<tr>
<th>DSM IV-TR Examples</th>
<th>DSM-5 Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. 307.6 Enuresis—not due to a general medical condition (nocturnal only)</td>
<td>319 Intellectual Disability with severity levels of conceptual domain (moderate), social domain (mild) and practical domain (mild).</td>
</tr>
<tr>
<td>II. 317 Mild Mental Retardation (FSIQ of 60)</td>
<td>758.0 Down’s Syndrome</td>
</tr>
<tr>
<td>III. 758.0 Down’s Syndrome</td>
<td>307.6 Enuresis (nocturnal only).</td>
</tr>
<tr>
<td>IV. Problems related to the social environment (few recreational outlets),</td>
<td>V62.4 Social exclusion</td>
</tr>
<tr>
<td>Occupational problems (temporarily laid off from job).</td>
<td>V62.29 Other problem related to employment</td>
</tr>
<tr>
<td>V. GAF: 50</td>
<td></td>
</tr>
<tr>
<td>DSM IV-TR Examples</td>
<td>DSM-5 Examples</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>I. 299.80 Asperger’s Disorder</td>
<td>299.00 Autism Spectrum Disorder without intellectual impairment and without accompanying language impairment. Requiring substantial support for social communication and requiring support for RRBs</td>
</tr>
<tr>
<td>II. None</td>
<td></td>
</tr>
<tr>
<td>III. 278.00 Obesity</td>
<td>278.00 Obesity</td>
</tr>
<tr>
<td>IV. Problems related to the social environment (no friends) and problems related to primary support (parent’s divorcing)</td>
<td>V62.4 Social exclusion</td>
</tr>
<tr>
<td>V. GAF = 49</td>
<td>V61.29 Child affected by parental relational distress</td>
</tr>
<tr>
<td>DSM IV-TR Example</td>
<td>DSM-5 Example*</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>I. 295.20 Schizophrenia-Catatonic Type with prominent negative symptoms</td>
<td>295.90 Schizophrenia with catatonia (hallucinations - present but mild; delusions-not present; disorganized speech - present &amp; severe; abnormal psychomotor activity- present and severe; negative symptoms -present and severe; impaired cognition-present &amp; moderate; depression-equivocal; and mania-none)</td>
</tr>
<tr>
<td>II. V71.09 None</td>
<td>682.9 Cellulitis-arm</td>
</tr>
<tr>
<td>III. 682.9 Cellulitis-arm</td>
<td>V60 Homelessness</td>
</tr>
<tr>
<td>IV. Problems with primary support group (no family); Housing problem (homeless)</td>
<td>V60.3 Problems related to living alone</td>
</tr>
<tr>
<td>V. GAF= 35</td>
<td>* If one were to employ the Clinician-Rated Dimensions of Psychosis Symptom Severity Scale (p.743)</td>
</tr>
</tbody>
</table>
Scales III-V have often not been afforded the prominence required, though the DSM-5 permits clinicians to rank-order issues according to overall impact.

Logical problems in differentiating AXIS I and AXIS II disorders can be left in the dust bin of history:

- How has Intellectual Disability been Axis II and Autism been AXIS I?
- Are Schizotypal Axis II traits that distinct from schizophrenia or delusional states?

The role of V-codes and AXIS IV psychosocial & environmental issues can be addressed as being central to, as opposed to separate from, the etiology of classic AXIS I disorders.
ADDITIONAL QUESTIONS?
REFERENCES