Introduction to DSM-5

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Historical Perspective of DSM-5

How we arrived at this edition of the DSM
Historical Perspective

• A predecessor of the DSM was published by APA in 1844
  – Established to classify institutionalized patients / promote communication

• Four major editions after 1945
  – Developed to describe essential features of mental disorders

• DSM-5 is built on DSM-IV
  – Revisions began in 1999, DSM-5 was published May 18, 2013
  – Use DSM-5/ICD-9 CM codes through September 30, 2014
  – Use DSM-5/ICD-10 CM codes starting October 1, 2014

• APA and NIMH leadership agreed that DSM-5 will harmonize with ICD-11
The DSM-5 Development Process

• **1999-2002:** The American Psychiatric Association (APA), National Institutes of Mental Health (NIMH), World Health Organization (WHO), and the World Psychiatric Association sponsored conferences to develop the research agenda for DSM-5
  – 13 diagnostic work groups convened
  – 90 academic and mental health institutions – 30% international – participated.
  – Multidisciplinary participation included: 100 psychiatrists, 47 psychologists, two pediatric neurologists, three epidemiologists, pediatrician, speech and hearing specialist, social worker, psychiatric nurse, consumer and family representatives

• **2004-2008:** APA, WHO, NIMH: 13 conferences
  – 400 participants from 39 countries
  – 10 monographs and hundreds of articles
The DSM-5 Development Process

- APA worked with WHO for consistency with ICD-11
- Scientific review committee: guidance on strength of evidence supporting changes
- Clinical utility, consistency and public health impact assessed
- Draft criteria released to public for comment three times – 11,000 comments
- Large academic medical centers and investigators tested DSM-5 feasibility and utility
What Is Included in DSM-5?
DSM-5 Definition of a Mental Disorder

All elements must be included

• Mental disorder – syndrome characterized by a clinically significant disturbance in cognition, emotion regulation or behavior – reflects dysfunction in psychological, biological or developmental processes underlying mental functioning.

• Associated with significant distress or disability in social, occupational or other important activities. Expected cultural response to a common stressor or loss – not a mental disorder.

• Socially deviant behavior (political, religious, sexual) and conflicts between the individual and society – not mental disorders unless the deviance results from dysfunction described above.
Diagnoses

- Much of DSM-5 is unchanged from DSM IV-TR
- Approximately the same number of diagnoses
- Some diagnoses reclassified
- Some diagnostic criteria clarified
- Only 15 new diagnoses added
- NO MORE AXES!
No more axes in DSM-5

DSM-5 – non-axial documentation of diagnosis

Axis III – combined with Axes I and II; physical health conditions are to be listed

Axis IV – eliminated; psychosocial and environmental issues – use ICD-9 V codes and ICD-10 Z codes

Axis V GAF – eliminated; scale developed by WHO (WHODAS) is recommended by DSM-5 task force – best global measure of disability
Scientifically-validated Assessment Measures Encouraged!

• DSM-5 recommends scientifically validated assessment measures, rating scales in diagnosis, monitoring and measuring treatment progress and assessing impact of culture of key aspects of clinical presentation and care

• Examples included in DSM-5
  – Adult or parent/guardian DSM-5 self-rated cross-cutting symptom measure
  – Disorder-specific severity measure (e.g., PHQ-9)
  – Cultural Formulation Interview (CFI)
DSM-5 Guiding Principles
All criteria are based on an extensive review of the literature

• Research evidence to support any addition or modification

• Maintain continuity with DSM-IV-TR if possible

• Routine clinical practices must be able to implement changes

• No restraints in limiting degree of change between DSM-5 and earlier editions
Evidence to support changes must meet these tests:

- Is the proposed diagnosis distinct enough to warrant separate consideration?
- Any potential harm to individuals or groups if the change was or was not adopted?
- Do the diagnostic criteria for a new entity reflect a true mental disorder or variations of normal behavior?
DSM-5 Organization and Other Changes

- DSM-5 organized by the developmental lifespan
  - Neurodevelopmental disorders in childhood
  - Neurocognitive disorders in older adulthood

- Restructuring of chapters based on disorders’ relatedness to one another

- Restructuring based on symptom vulnerabilities and symptom characteristics

- Moves away from categorical model – required clinician to determine whether disorder present or absent
DSM-5 Organization and Other Changes

• Sex differences – when variations are attributed to the presence of XX or XY chromosome or reproductive organs

• Gender differences – variations result from biological sex and perceived gender

• Uses dimensional approach – allows more latitude in assessing severity – no concrete threshold between normality and disorder

• Replaces NOS designation
  – Other specified disorder – used when reason specified
  – Unspecified disorder – reason not specified
DSM-5 Chapters and Sequence

1. Neurodevelopmental Disorders
2. Schizophrenia Spectrum and Other Psychotic Disorders
3. Bipolar and Related Disorders
4. Depressive Disorders
5. Anxiety Disorders
6. Obsessive-Compulsive and Related Disorders
7. Trauma- and Stressor-Related Disorder
8. Dissociative Disorders
9. Somatic Symptom Disorders
10. Feeding and Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse Control and Conduct Disorders
16. Substance-Use and Addictive Disorders
17. Neurocognitive Disorders
18. Personality Disorders
19. Paraphilic Disorders
20. Other Disorders
Highlights of Changes
DSM IV-TR to DSM-5
Neurodevelopmental Disorders

• Intellectual Disabilities
• Communication Disorders
• Autism Spectrum Disorders
• Attention-deficit Hyperactivity Disorder
• Specific Learning Disorder
• Motor Disorders
• Other Specified Neurodevelopmental Disorder
• Unspecified Neurodevelopmental Disorder

• 319  (F70, F71, F72, F73)
• 315.39  (F80.9, 80.0, F80.81)
• 299.00  (F84.0)
• 314.00, 314.01 (F90.0, 90.1, 90.2)
• 315.00, 315.1, 315.2 (F81.0)
• 315.4, 307.xx (F82), 307.3 (F98.4)
• 315.8 (F88)
• 315.9 (F89)
Intellectual Disability (Intellectual Developmental Disorder)

- Replaces the term “mental retardation”
- Requires adaptive-functioning assessments and cognitive capacity (IQ) for diagnosis
- Considered to be two standard deviations below the population (IQ~70)
- Codes: ICD-9 319
Communication Disorders

• Language Disorder (combines DSM-IV expressive and mixed receptive-expressive language disorders) 315.39 (F80.9)

• Speech Sound Disorder (new name for phonological disorder) 315.39 (F80.0)

• Childhood-onset Fluency Disorder (formerly stuttering) 315.35 (F80.81)

• Social (Pragmatic) Communication Disorder – new disorder – persistent difficulties in social uses of verbal and non-verbal communication 315.39 (F80.89)
Autism Spectrum Disorder (ASD) 299.00 (F84.0)

- New name for DSM-5
- Encompasses autistic disorder, Asperger’s disorder, childhood disintegrative disorder, PDD-NOS
- Single disorder with differing levels of severity based on level of support required
- Must show deficits in BOTH
  - (Criterion A) social communication and social interaction and
  - (Criterion B) restricted repetitive behaviors, interests and activities
- Includes expanded specifiers associated with known medical or genetic conditions
- Symptoms from early childhood
Specific Learning Disorder

• Specifiers related to deficits in reading, written expression and mathematics with severity ratings

• Learning deficits commonly occur together – allows for all academic domains and subskills that are impaired
  – with impairment in reading 315.00 (F81.0)
  – with impairment in written expression 315.2 (F81.81)
  – with impairment in mathematics 315.1 (F81.2)
Attention-Deficit/Hyperactivity Disorder (ADHD)

- Largely unchanged from DSM-IV
- Same 18 symptoms used in DSM-IV with additional examples applying to adults
- Two symptom domains – inattention and hyperactivity/impulsivity
  - 314.01 (F90.2) Combined presentation
  - 314.00 (F90.0) Predominantly inattentive presentation
  - 314.01 (F90.1) Predominantly hyperactive/impulsive presentation
- Onset criterion changed from symptoms present before age 7 to several symptoms present prior to age 12
Attention-Deficit/Hyperactivity Disorder (ADHD)

- *Inattentive, hyperactive* and *combined* are used to describe the current presentation rather than the subtype
- Comorbid diagnosis with ADHD allowed
- Threshold for adult diagnosis – adjusted to five symptoms in either domain
Motor Disorders – Largely Unchanged from DSM-IV

• Developmental Coordination Disorder 315.4 (F82)

• Stereotypic Movement Disorder 307.3 (F98.4)

• Tic Disorders
  – Tourette’s Disorder 307.23 (F95.2)
  – Persistent Chronic Motor or Vocal Tic Disorder 307.22 (F95.1)

• Tics may “wax and wane in frequency, but have persisted for more than a year.”
Schizophrenia and Other Psychotic Disorders
Schizophrenia Spectrum and Other Psychotic Disorders

- Schizotypal (Personality) Disorder 301.22 (F21)
- Delusional Disorder 297.1 (F22)
- Brief Psychotic Disorder 298.8 (F23)
- Schizophreniform Disorder 295.40 (F20.81)
- Schizophrenia 295.90 (F20.9)
- Schizoaffective Disorder (bipolar or depressive type) 295.70 (F25.0, F25.1)
- Substance/Medication-Induced Psychotic Disorder – see substance-specific codes
- Psychotic Disorder Due to Another Medical Condition (with delusions or with hallucinations) 293.81, 293.82 (F06.2, F06.0)
Schizophrenia Spectrum and Other Psychotic Disorders

- Catatonia Associated with Another Mental Disorder 293.89 (F06.1)
- Catatonic Disorder Due to Another Medical Condition 293.89 (F06.1)
- Unspecified Catatonia 293.89 (F06.1)
- Other Schizophrenia Spectrum and Other Psychotic Disorder (other specified or unspecified) 298.8 (F28)
General Changes in This Section

• Eliminates subtypes of schizophrenia such as paranoid, disorganized, catatonic, undifferentiated and residual types

• Limited diagnostic stability, low reliability and poor validity

• Catatonia specifier – can be used for psychotic, depressive and bipolar disorders. Requires three catatonic symptoms for this designation:
  – Stupor
  – Catalepsy
  – Waxy flexibility
  – Mutism
  – Negativism
  – Posturing

  Stereotypy
  Agitation, not influenced by internal stimuli
  Grimacing
  Echolalia
  Echopraxia
  Mannerism
General Changes in This Section

• Schizoaffective Disorder
  – Requires a major mood episode be present for the majority of the disorder’s duration
  – Bipolar type 295.70 (F25.0)
  – Depressive type 295.70 (F25.1)

• Delusional Disorder 297.1 (F22)
  – No longer requires that delusions must be non-bizarre
  – No longer separates Delusional Disorder from Shared Delusional Disorder
Bipolar and Related Disorders
Bipolar and Related Disorders Categories

- Bipolar I Disorder 296.40-296.46 (F31 series), 296.50-56 (F31 series)
- Bipolar II Disorder 296.89 (F31.81)
- Cyclothymic Disorder 301.13 (F34.0)
- Substance/Medication-Induced Bipolar and Related Disorder – see substance abuse section
- Bipolar Disorder Due to Another Medical Condition 293.83 (F06.33, F06.34)
- Other Bipolar and Related Disorder 296.89 (F31.89)
- Unspecified Bipolar and Related Disorder 296.80 (F31.9)
General Changes in This Section

- Bipolar and related disorders
  - Bipolar disorder includes emphasis on changes in activity and energy; not just mood
  - Anxious distress specifier for bipolar disorder

- Bipolar I Disorder
  - Mixed type has been eliminated
  - Now includes “mixed state” specifier when mania episodes include depressive symptoms and for depression that includes mania or hypomania
General Changes in This Section

• Other Specified Bipolar and Related Disorders
  – This designation – individuals with history of major depressive disorder who meet all criteria for hypomania except duration (four days)
  – Too few symptoms of hypomania to meet criteria for full bipolar II
QUESTIONS?