Diagnostic and Statistical Manual, 5th edition, (DSM-5) Update for VA Mental Health Providers – Diagnostic and Clinical Issues

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Disclosures

• None
Specific Aims

• To understand the changes in framework from DSM-IV to DSM-5
• To appreciate specific changes in diagnostic criteria for commonly occurring disorders in the Veteran population
• To review the new cross-cutting symptom measures and disease severity measures found in DSM-5
Criticisms of DSM-IV

- High rates of comorbidity
- High use of “Not Otherwise Specified” (NOS) category
- Lack of laboratory markers
- DSM–IV criteria are a decade old. Neuroscience has moved very quickly in that time span.
- Criteria lack validity/not based in etiology
- American document
DSM-5 Development

• 2006–2007 DSM–5 Task Forces
• 2007–2013 DSM–5 Workgroups
• Cross–cutting study groups
• >50% of participants from outside US
• 13 conferences, 10 monographs, and >200 journal articles published prior to release of DSM–5
Three Sections of DSM-5

- Section I: Preamble, definitions, cautionary statements
- Section II: 20 Mental disorder chapters
- Section III: Items requiring further research
  - Emerging diagnoses
  - Dimensional model of personality disorders
  - Emerging measures
    - Cross-cutting
    - Symptom severity
- Appendix
Changes in Framework I

• Abandon Roman numerals!
• Fewer total disorders (15 new, 2 discarded, and 28 combined)
• Not Otherwise Specified now called Unspecified or Other Specified
Changes in Framework II

• Transition to International Classification of Diseases, 10th Edition (ICD–10), embedded in text
• Differences with online version
  – References/bibliography available online
  – All severity measures available online
Loss of the Multi-axial System

• Discard the multi-axial system
  – Axes I, II, and III: All psychiatric and medical diagnoses given equal status; personality disorders remain intact (more or less)
  – Axis IV: now coded as V codes (ICD-9) and Z/T codes (ICD-10)
  – Axis V: replaced by World Health Organization Disability Assessment Schedule (WHODAS) 2.0
## Highlights of Specific Diagnoses

- **Neurodevelopmental Disorders**
  - Attention-Deficit/Hyperactivity Disorder (ADHD)

- **Schizophrenia Spectrum**
  - Schizophrenia, Schizoaffective Disorder, Catatonia

- **Bipolar and Related Disorders**
  - Bipolar disorder

- **Depressive Disorders**
  - Major Depressive Disorder

- **Anxiety Disorders (4 chapters)**
  - Panic attacks, Hoarding Disorder, Posttraumatic Stress Disorder (PTSD)

- **Sleep–Wake Disorders**
  - Insomnia, REM Behavior Disorder (RBD), Restless Legs Syndrome (RLS), Sleep Apneas

- **Substance Use Disorders**

- **Neurocognitive Disorders**
  - Traumatic subtype, Alzheimer’s subtype

- **Personality Disorders**
ADHD

• The number of symptoms required to make the diagnosis was reduced to five from six
  – Studies show that adults manifest fewer ADHD symptoms than children
  – This change should not lead to a significant change in prevalence of the adult ADHD diagnosis
Schizophrenia

- Elimination of Schneider’s first rank symptoms
  - No longer prioritizes special hallucinations and special delusions
- Positive symptoms must be present to make diagnosis
- Removal of schizophrenia subtypes
Schizoaffective Disorder

- Criteria now based on lifetime of co-occurring mood symptoms and psychotic symptoms in patients with mood-free residual psychosis.
- No longer cross-sectional, no longer emphasizes the current episode of co-occurring symptoms.
- Should lead to fewer patients receiving this diagnosis.
Catatonia

- Now a specifier for many different mental disorders including mood, psychotic, and others
- Can also be diagnosed as Catatonia Due to Another Medical Condition
Bipolar Disorder

- Increased energy now a diagnostic criterion choice (was conspicuously absent before)
- “Mixed features” better captures subthreshold mixed states than the previous “Mixed episode” diagnosis
  - No longer requires full criteria of a major depressive episode and a concurrent manic episode
Major Depressive Disorder

- Bereavement exclusion dropped
  - Some healthcare systems were too literal in adhering to the old 8 week exclusion
    - Clear major depressive episodes (MDE) during periods of grief were not treated until the 9th week
    - Conversely, grief was being mislabeled as MDE if it persisted into the 9th week
- “With anxious distress” is now a modifier for unipolar and bipolar disorders
Anxiety Disorders

• Research in the past decade supports the separation of the DSM-IV Anxiety Disorders chapter into four distinct chapters in DSM-5
  – Anxiety disorders that are fear-based (i.e., phobias)
  – Obsessive Compulsive Disorder (OCD) and related disorders
  – Trauma-related anxiety disorders
  – Dissociative disorders
Panic attacks specifier

- Growing evidence supports the idea that panic attacks can occur in a variety of mental disorders (anxiety, mood, psychotic) without meeting criteria for full Panic Disorder
Hoarding Disorder

• Clinically significant hoarding behavior is now recognized as a distinct entity from OCD
Posttraumatic Stress Disorder I

• Criterion A (the stressor criterion) is more precise
  – Exclusion of nonviolent death of a loved one
  – Elimination of subjective experience of helplessness or horror
• Military and first responders (i.e., police and fire fighters) rarely endorsed this criterion
Posttraumatic Stress Disorder II

DSM–IV Three Symptom Clusters

- Criterion B: Re-experiencing
- Criterion C: Avoidance/numbing
- Criterion D: Increased Arousal

DSM–5 Four Symptom Clusters

- Criterion B: Re-experiencing
- Criterion C: Avoidance
- Criterion D: Negative alterations in thoughts and mood
- Criterion E: Increased arousal
Posttraumatic Stress Disorder III

• New Criterion D: “Negative alterations in thoughts and mood” (2 required)
  – Inability to recall key aspects of the trauma
  – Persistent negative beliefs about the oneself or the world
  – Persistent distorted blame of self or others in causing the trauma
  – Diminished interest/anhedonia
  – Feeling alienated or detached from others
  – Constricted affect
Sleep-wake Disorders

• Primary Insomnia renamed Insomnia Disorder
• Rapid Eye Movement Sleep Behavior Disorder and Restless Legs Syndrome now moved to Section II
• Specific diagnostic criteria now found in DSM–5 for a variety of sleep apneas (obstructive, central, etc.)
• Substance Abuse and Substance Dependence now combined into Substance Use Disorder (SUD)
  – Mild (2–3/11)
  – Moderate (4–5/11)
  – Severe (6+/11)
Substance Use Disorders II

• Removal of legal criteria
  – Legality of specific substances in different jurisdictions should not indicate presence or absence of a mental or medical disorder
• Addition of craving criteria
  – Based on growing addictions research
Neurocognitive Disorders

• Replaces the term Dementia
  – Broadens the range of etiologies beyond diagnoses commonly seen in the elderly

• Ten subtypes
  – Includes Traumatic Brain Injury
  – Includes Human Immunodeficiency Virus (HIV)

• Can be Major or Mild
The ten classic personality disorders remain unchanged in Section II.

These diagnoses can continue to be used in the absence of an Axis II section.
Personality Disorders II

• A new dimensional model is available in Section III
  – Six personality subtypes
    • Antisocial, Avoidant, Borderline, Narcissistic, Obsessive Compulsive, Schizotypal, Personality Disorder–Trait Specified (PD–TS)
  – Five trait domains
    • Negative affectivity, detachment, antagonism, disinhibition, psychoticism
    • 25 trait facets within the five trait domains
Optional Measures

- Assess and track severity of symptoms
  - Cross-cutting measures: Self-administered
    - Level 1
      - Screening tool
      - Relevant to most mental disorders
      - 13 symptom domains
    - Level 2
      - More detailed analysis of positive Level 1 domain
      - Based on pre-existing scales
      - Diagnosis-specific measures: Self and Clinician-rated
WHODAS

- World Health Organization Disability Assessment Scale, Version 2.0
  - Self-administered scales covering several domains of function
  - Not only related to mental disorder disability
- Includes understanding and communicating, getting around, self care, getting along with people, household activities, work or school activities, participation in society
Availability of Scales

- All scales available for free download at:
  - [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5)
- Scales can also be found in the electronic version of DSM–5
- Limited scales are reproduced in the print version of DSM–5
DSM-5, ICD-9, and ICD-10

- DSM–5 is compliant with both ICD–9 and ICD–10
  - Diagnoses have a six digit code listed next to them which corresponds with ICD–9
  - Diagnoses have an alphanumerical code listed in parentheses which corresponds to ICD–10
  - Some codes (particularly in ICD–9) have to be used for more than one disorder due to limited number of available entries
DSM-5 Update for VA Mental Health Providers – Implementation Issues

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Disclosures

• None
Coding of Diagnosis on Encounter Forms

- VA uses ICD coding terminology for all outpatient diagnosis
- Centers for Medicare and Medicaid Services (CMS) requirement to convert from ICD–9 to ICD–10 effective 10/1/2014—applies to all US healthcare systems covered under the Health Insurance Portability and Accountability Act (HIPAA)
- VA encounter forms use currently ICD–9 diagnosis (not DSM)
- Encounter forms will continue to use ICD–9 codes and terminology until conversion to ICD–10 in October 2014.
Implications in Implementing DSM-5 and ICD-10

• Clinical Guidance is to use DSM–5 effective approximately 10/1/13
  – What does this mean for provider?
  – Encounter forms will still be based on ICD–9 terminology (which is equivalent of DSM–IV)
  – What constitutes “implement”?
    • Diagnostic criteria
    • Clinical decision making
    • But NOT a change in coding—DSM is for clinical decision making, ICD is the accepted coding terminology for all HIPAA covered healthcare organizations
    • Document that DSM–5 criteria are being used through 1st Quarter, FY14
Encounter Forms

- Linked to clinic
- Based on national encounter forms
- Sites can use national form or customize their own
  - Use of national forms preferred—customized forms have to be manually updated (such as new CPT codes)
- Provides pick-list of diagnostic codes (based on ICD-9 coding terminology)
- Can use Lexicon to search for “other diagnosis”
  - By code
  - By Text
You’ll continue to use the current DSM-IV codes and ICD-9 terminology. Encounter forms will not use DSM-5 codes or terms.
Global Assessment of Functioning (GAF)

- GAF is no longer part of the comprehensive diagnosis in DSM-5
- DSM-5 has moved to a nonaxial documentation of diagnosis
- Dropped for several reasons
  - Lack of conceptual clarity
  - Questionable psychometrics in routine practice
  - Separate concepts of mental disorder and disability
WHODAS

- World Health Organization Disability Assessment Schedule 2.0
  - Recommended by APA for disability/functional assessment
  - Not required by VHA
Computerized Patient Record System (CPRS)/Mental Health Assistant (MHA) Updates

• Patch YS*5.01*108 will make several updates based on DSM–5:
  – Elimination of GAF entries—will maintain historic entries for record review, but will no longer prompt for GAF or provide entry of new GAF scores
  – WHODAS 2.0 new instrument in MHA
  – Current versions of PCL (PTSD Checklist) will be retired; new PCL–5 will be introduced
  – National clinical reminders updated to introduce new PCL–5

• Anticipate release to field 3rd quarter FY14
Other Updates

- Mental Health Suite v4.0 will remove GAF, change diagnosis prompt to be nonaxial
- Catastrophic Disability Determination will remove GAF references (has to be published in Federal Register first)
- More information when ICD-10 implementation nears.
General Guidance on DSM-5 Changes

• Diagnostic codes (former Axes I, II, III) should be listed together, followed by codes for contributing factors (current V codes, former Axis IV)

• GAF (former Axis V) is no longer a component of formal diagnosis and its use is discouraged (special cases: MHICM, PRRC)

• Use of Emerging Measures and Models (Section III) is not required but should be considered where appropriate
  – E.g. WHODAS 2.0, Cross-cutting Measures, Cultural Formulation Interview
  – In time, some measures may become required (or be discontinued) in certain settings/programs
  – Note, however, that Conditions for Future Study are not yet ready for clinical use
Questions?

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