DSM-5 Changes in Intellectual Disabilities and Mental Health Disorders

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Complete the attendance sheet and evaluation by the end of session.
MESSENGER
Objectives

By the end of this presentation, participants will be able to:

– Explain the process of diagnosing mental illnesses and developmental disabilities without the traditional five-axis format

– List at least three changes in specific diagnostic categories listed in the DSM-5
  
  • Change in name and criteria for intellectual disability, including shift away from primary reliance on IQ scores
  
  • Impact of change in criteria for autism spectrum disorder upon patients who may no longer meet diagnostic criteria
  
  • Changes in criteria of major mental illnesses treated in public MH system in Texas: schizophrenia, bipolar disorder and major depression

– Discuss implications for impact in healthcare, educational and other systems
The Diagnostic and Statistical Manual of Mental Disorders

DSM
American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders

• The manual that guides the diagnostic process.
• The origins of the DSM date back to 1840 — when the government wanted to collect data on mental illness.
  — The term “idiocy/insanity” appeared in that year’s census.
• Forty years later, the census expanded to feature these seven categories: “mania, melancholia, monomania, paresis, dementia, dipsomania and epilepsy.”
• In 1917, the Bureau of the Census embraced a publication called the Statistical Manual for the Use of Institutions for the Insane.
• It was created by the Committee on Statistics of the American Medico-Psychological Association (now the American Psychiatric Association) and the National Commission on Mental Hygiene.
• The committees separated mental illness into 22 groups. The manual went through 10 editions until 1942.

American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders

• 1952
  – DSM-I featured descriptions of 106 disorders, which were referred to as “reactions.” Disorders also were split into two groups based on causality.

• 1968
  – The DSM-II came out. It was only slightly different from the first edition. It increased the number of disorders to 182 and eliminated the term “reactions” because it implied causality and referred to psychoanalysis.

• 1980
  – The DSM III was published with a major shift from its earlier editions. DSM-III dropped the psychodynamic perspective in favor of empiricism and expanded to 494 pages with 265 diagnostic categories.
  – Leaned more toward German psychiatrist Emil Kraepelin’s position that biology and genetics played a key role in mental disorders.
American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders

• 1994
  – There was another increase in the number of disorders (over 300), and this time, the committee was more conservative in their approval process.
  – In order for disorders to be included, they had to have more empirical research to substantiate the diagnosis.

• 2000
  – DSM-IV was revised once, DSM IV TR, but the disorders remained unchanged.
  – Only the background information, such as prevalence and familial patterns, was updated to reflect current research.

• The DSM-5 was released in mid-May 2013
  – A number of significant changes
  – Attempt to make the new diagnostic symptom be compatible with ICD-10 and ICD-11 (expected in 2015)
  – Future revisions will be made online
Overview of Changes in the DSM-5

• Developmental focus
  – Depends on thorough assessment of developmental characteristics of disorders
• Discontinuation of five-axis diagnostic profile
• Category: Neurodevelopmental Disorders, now includes...
  – Autism Spectrum Disorders
  – Intellectual Disability
• Changes in...
  – Schizophrenia and Schizoaffective Disorder
  – Bipolar Disorder
  – Depressive Disorders
• Additional changes in many other disorders
A New Approach
Case Formulation

• A synthesis of the assessments and observations in a case, which organizes and integrates relevant information around identified core factors around which the person’s difficulties revolve. The case formulation drives treatment planning and therapy.

• This is a thoughtful approach, not achieved through checklist or time-limited evaluations

• The process requires clinical training to identify symptomatic excesses and deficits.
The Diagnosis

• Diagnoses should have utility
  – Help determine prognosis, treatment plans and potential treatment outcomes

• Having a diagnosis ≠ Need for treatment

• Diagnostic criteria are guidelines, not strict criteria
  – Heavy emphasis on clinical judgment
Anatomy of a Diagnosis

Diagnostic Criteria?
• Are the symptoms described by a disorder?
Anatomy of a Diagnosis

Diagnostic Criteria?
• Are the symptoms described by a disorder?

Subtype?
• Mutually exclusive subgroupings under a diagnosis
• “Specify whether...”
Anatomy of a Diagnosis

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Specifiers?
- One person may have several
- Information relevant to treatment
  - Course
  - Descriptive features
  - "Specify if..."
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• “Specify if...”

Severity?
• Loosely connected to level of need for support
• “Specify current severity...”
No More Axes

**DSM-IV**
- **Axis I**
  - Clinical Disorders
  - Pervasive Developmental Disorders
- **Axis II**
  - Developmental Conditions
  - Personality Disorders
- **Axis III**
  - General medical conditions
- **Axis IV**
  - Psychosocial and Environmental Problems
- **Axis V**
  - Global Assessment of Functioning

**DSM-5**
- Axes I, II & III are combined
- **Axis IV discontinued**
  - ICD—10-CM Z codes are being examined as possible alternative for capturing psychosocial and environmental factors
- **Axis V discontinued**
  - Lack of content clarity
  - Lack of psychometric integrity
  - Will explore possible use of World Health Organizations’ Disability Assessment Schedule (WHODAS)
Neurodevelopmental Disorders
From PDD to ASD

**DSM IV TR**
- Pervasive Developmental Disorder
  - Autistic Disorder
  - Asperger’s Disorder
  - Pervasive developmental Disorder, NOS
  - Childhood Disintegrative Disorder
  - Rett’s Disorder

**DSM-5**
- Autism Spectrum Disorder (ASD)
Rationale

• The distinctions among the disorders have been inconsistent and often based on variables other than criteria for the diagnosis

• ASD is defined by a common set of behaviors and is best represented as a single diagnostic category.

Dr. Pat Craig, http://www.aaiddtx.org/2012-feb-policy-change.php
## Comparison

### DSM IV TR
- Qualitative impairment in social interaction (2 out of 4)
- Qualitative impairments in communication (2 out of 4)
- Restricted repetitive and stereotyped patterns of behavior, interests, and activities (1 out of 4)
- Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.
- The disturbance is not better accounted for by Rett’s Disorder or Childhood Disintegrative Disorder.

### DSM 5
- Persistent deficits in social communication and social interaction across multiple contexts, (3 out of 3)
- Restricted, repetitive patterns of behavior, interests, or activities (2 out of 4)
- Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life)
- Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning
- Not better explained by intellectual disability or global developmental delay.
Rationale

• The rationale is that deficits in communication and social behaviors are inseparable.
• The second major criterion remains fixated interests and repetitive behaviors.
Severity

Level One
- “Requiring support”
- Social communication problems would be noted without supports; inflexibility of behavior interferes with functioning in more than one setting

Level Two
- “Requiring substantial support”
- Marked deficits in verbal and nonverbal social communication impair functioning; inflexibility of behavior is seen often enough to be noted by casual observer

Level Three
- “Requiring very substantial support”
- Severe deficits in verbal and nonverbal social communication cause severe impairments in functioning
Initial Fears

• January 2012 conference in Iceland
  – Reported that only 45% of people diagnosed with Asperger’s disorder or PDD-NOS would retain an autism spectrum diagnosis under the new guidelines.
  – Those findings were preliminary and controversial, but worried many

• March 2012, Peer-reviewed version of the study presented in Iceland
  – Suggested that “the new criteria would be pretty good at excluding appropriately people who aren’t on the autism spectrum but have limited ability to capture people who are.”
  – According to that study, the autistic people who would be overlooked under the new guidelines happen to be those without intellectual disability and who would fit the current criteria for Asperger’s disorder or PDD-NOS.

Research

Application of DSM-5 Criteria for Autism Spectrum Disorder to Three Samples of Children With DSM-IV Diagnoses of Pervasive Developmental Disorders


- N = 4453 with PDD Dx & 690 with non-PDD dx (e.g., language d/o)
- Used parent report data to match on the 96-item Autism Diagnostic Interview-Revised & the Autism Diagnostic Observation Schedule, a clinician based measure of ASD impairment with DSM V criteria
Research

• 91% of PDD Dx children were confirmed using DSM V criteria
• Data suggest that 9 out of 10 children would continue to be diagnosed with ASD
• Sensitivity
  – “High functioning”, 0.86 – 0.91
  – Nonverbal IQ ≤ 70, 0.93 – 0.97
  – Children under age 4, 0.90 – 0.98
• Of the 4453, most that did not meet criteria did so in social communication domain, not in restricted and repetitive behavior
  – 320 in the Social Communication domain
  – 75 in the Restricted & Repetitive domain
Where do the 10% go?

• Social (Pragmatic) Communication Disorder
  – Primary difficulty in pragmatics, the social use of language and communication
  – Deficits in understanding and following rules of verbal and nonverbal communication in naturalistic situations
  – Difficulty changing language according to the needs of the listener
  – Difficulty following rules of conversation and storytelling
  – May have language impairments
  – Often avoid social interactions
ASD Summary

- People who share the common symptoms of
  - (1) Persistent deficits in social communication and social interaction across contexts and
  - (2) Restricted, repetitive patterns of behavior may qualify for a diagnosis of ASD, regardless of IQ level.
- Diagnosis not longer limited to before age 3
- Estimated 10% may no longer have a diagnosable condition.
- The diagnosis of Asperger’s Disorder will be removed from the manual, but the people with this diagnosis may still qualify under the single diagnosis of ASD.
- People without the restricted, repetitive patterns and interests may be diagnosed with Social (Pragmatic) Communication Disorder
- Recommendation is to “grandfather” people with current diagnoses
Intellectual Disability

Mental Retardation

Becomes

ID: Intellectual Disability
( Intellectual Developmental Disorder)

Prevalence: 1%
# Intellectual Disability

<table>
<thead>
<tr>
<th>DSM IV TR</th>
<th>DSM 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• IQ 70 or below</td>
<td>• Deficits in general mental abilities</td>
</tr>
<tr>
<td>• Concurrent deficits or impairments in present adaptive functioning</td>
<td>• Impairment in adaptive functioning for the individual’s age and sociocultural background</td>
</tr>
<tr>
<td>• The onset is before age 18 years</td>
<td>• All symptoms must have an onset during the developmental period</td>
</tr>
<tr>
<td>• Severity: Mild, Moderate, Severe, Profound, Based on IQ level</td>
<td>• Severity: Mild, Moderate, Severe, based on Adaptive Behavior</td>
</tr>
</tbody>
</table>
• IQ testing moved to the body of the text in the DSM-5.
• However, DSM-5 continues to specify that standardized psychological testing must be included in the assessment of affected persons but that psychological testing should accompany clinical assessment. 

   Emphasis is on adaptive behavior

• The DSM-5 proposal is consistent with the proposed ICD-11 criteria which do not list IQ test score requirements in the formal diagnostic criteria and instead place testing requirements in the text.
Rationale for IQ Change

• **Misuse of IQ tests.** IQ test number has often been used inappropriately to define a person’s overall ability in forensic cases without adequately considering adaptive functioning.

• **Definition of Intelligence.** Both the AAIDD and DSM-5 define intelligence as a general mental ability that involves reasoning, problem solving, planning, thinking abstractly, comprehending complex ideas, judgment, academic learning, and learning from experience.

• **IQ tests in DSM-5.** Assessment procedures and diagnosis must take into account factors other than IDD that may limit performance (e.g., sociocultural background, native language, associated communication/language disorder, motor or sensory handicap). Cognitive profiles are generally more useful for describing intellectual abilities than a single full-scale IQ score, and clinical training and judgment are required for interpretation of test results.

• **Elimination of IQ based Subtypes.** DSM-5 does not list mild, moderate, severe, and profound subtypes. Instead, it lists mild, moderate, and severe severity levels.
Severity Table

• Mild, Moderate, Severe & Profound Severity Levels
• Table based on three domains:
  – Conceptual
    • language, reading, writing, math, reasoning, knowledge, and memory, among others, used to solve problems.
  – Social
    • awareness of others’ experiences, empathy, interpersonal communication skills, friendship abilities, social judgment, and self-regulation, among others.
  – Practical
    • self management across life settings, including personal care, job responsibilities, money management, recreation, managing one’s behavior, and organizing school and work tasks, among others.
Summary

• Name changed to Intellectual Disability
• Diagnosis will be based on the level of adaptive functioning in three domains: social, conceptual, and practical skills
• Four severity levels: Mild, Moderate, Severe and Profound, based on the three domains of adaptive behavior
• IQ criteria no longer central to the diagnosis
Schizophrenia Spectrum and Other Psychotic Disorders
Schizophrenia

Criterion A: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms

**DSM IV**
- Criterion A allowed for just one symptom if delusions were “bizarre” or hallucinations included “running commentary” or “two or more voices.”

**DSM-5**
- Eliminated these special attributions
- Requires two criterion A symptoms
- Plus, must have one of the following core positive symptoms:
  - Delusions
  - Hallucinations or
  - Disorganized speech
### Schizophrenia

**DSM IV**

- **Subtypes:**
  - Paranoid
  - Disorganized
  - Catatonic
  - Undifferentiated
  - Residual

**DSM-5**

- **Subtypes eliminated**
  - Limited diagnostic stability
  - Low reliability
  - Poor validity
  - Not clearly related to differential treatment
Schizophrenia

• Specify if...
  – First episode, currently in acute episode
  – First episode, currently in partial remission
  – First episode, currently in full remission
  – Multiple episodes, currently acute episode
  – Multiple episodes, currently in partial remission
  – Multiple episodes, currently in full remission
  – Continuous
  – Unspecified

• Specify if...
  – With catatonia

• Specify current severity...
  – Rate each primary symptom for current severity (most severe in last 7 days) on 5-pt Likert scale provided in section three of the manual
  – Can diagnose schizophrenia without severity specifies
Summary

• Criterion A has been modified
• Subtypes have been removed
• Specifiers allow for more descriptive diagnosing
• Use of assessment tool to evaluate symptoms
Bipolar and Related Disorders
Bipolar Disorders

• Separated from depressive disorders
• Includes:
  – Bipolar I d/o, bipolar II d/o, cyclothymic d/o
  – Substance/medication induced bipolar & related /do
  – Bipolar and related d/o due to another medical condition
  – Other specified bipolar and related d/o
  – Unspecified bipolar and related d/o
• Realigns vision of bipolar disorders as their own category of conditions
# Bipolar Disorder

## DSM IV
1. Manic and hypomanic episodes emphasize mood
2. Bipolar I, Mixed Episode, required that the person exhibit full symptoms of both mania and major depressive disorder

## DSM-5
1. Addition of changes in energy and activity levels (e.g., “abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day…”)
2. Added a new specifier, “with mixed features,” for mania or hypomania when depression is present, or episodes of depression when mania/hypomania are present
3. Extensive list of specifiers for each
Depressive Disorders
Depressive Disorders

- New disorders
  - Disruptive Mood Dysregulation Disorder
    - To address possible overdiagnosis of Bipolar D/O in children up to age 18
  - Premenstrual Dysphoric Disorder
- Persistent depressive disorder now includes;
  - Chronic major depressive disorder
  - Dysthymic disorder
- Emphasis on assessing for suicidality
- New specifiers to note co-existing anxiety
Depressive Disorders

• Major Depressive Disorders: criteria remain the same!

• Bereavement Exclusion Omitted
  – Unreliability of 2 month limit
  – Bereavement is recognized as a stressor that can trigger major depression
  – Major depression in people with bereavement-related depression appears to have a genetic influence
  – Bereavement related depression is responsive to the same psychosocial and medication treatments as non-bereavement related depression
Other Tidbits...

• ADHD
  – Additional considerations for lifespan diagnosing
  – Onset changed from age 7 to 12
  – Can be diagnosed concurrently with Autism Spectrum Disorder

• Specific Learning Disorder
  – Collapses learning disorders of reading, math, written expression and not-otherwise specified, adding “with impairment in reading/written expression/mathematics” and severity of each

• Obsessive Compulsive Disorders and Related Disorders
  – Comprise a new category, not part of Anxiety Disorders
  – Includes Body Dysmorphic Disorder and Hoarding Disorder

• Trauma and Stressor-Related Disorders
  – Includes acute stress disorder, adjustment disorders, posttraumatic stress disorder and reactive attachment disorder
And there’s so much more!


APA. Recent updates to Proposed revisions of the DSM-5 (June 2012). Retrieved from http://www.dsm5.org/Pages/RecentUpdates.aspx


References


