

UPMC SYNERGIES



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Disclosures

Dr. Lubetsky has reported no relationships with entities producing health care goods or services.

Dr. Birmaher has received research support from the National Institute of Mental Health (NIMH), and has received royalties from Random House LLC and UpToDate.

Instructions

To take the CME evaluation and receive credit, please visit UPMCPhysicianResources.com/Psychiatry and click on the course *UPMC Synergies* Spring 2015.

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DSM-5: Part II

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When the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* was being researched and written, the DSM-5 Task Force decided it wanted rather stringent criteria to be met before making changes to DSM-IV. The result is that some sections had relatively few changes while other chapters had significant changes.

Autism Spectrum Disorder (ASD)

Martin J. Lubetsky, MD, service chief of child and adolescent psychiatry and the Center for Autism and Developmental Disorders at Western Psychiatric Institute and Clinic of UPMC and chief of the Behavioral Science Division at Children's Hospital of Pittsburgh of UPMC, explains changes in the chapter on neurodevelopmental disorders that have received a lot of attention, specifically those related to autism spectrum disorder.

The most impactful change in neurodevelopmental disorders stems from combining the subcategories of autism in the DSM-IV into a single disorder in DSM-5 — Autism Spectrum Disorder — and defining the disorder by using a range of severity. ASD now includes: autistic disorder, Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS), Asperger's disorder, and childhood disintegrative disorder. The work group determined that the subcategories used in DSM-IV were poorly defined and not well-differentiated, based upon multiple practitioners seeing the same child.

In developing the new definitions, the Neurodevelopmental Disorders Work Group contended that clinicians have been applying DSM-IV criteria inconsistently, so the reliability of data to support the continued separation of the subcategories was very poor.

Questions About Asperger's Syndrome

One of the high visibility issues came with folding Asperger's syndrome into Autism Spectrum Disorder (ASD). Critics expressed concern about the elimination of the Asperger's diagnosis. The work group took the stand, however, that there were no clearly defined and accepted differences in criteria between Asperger's and high-functioning autism.

Another issue facing the work group was that a diagnosis of ASD focuses on communication deficits, social impairments, and restricted, repetitive behaviors, but some individuals who were being diagnosed under DSM-IV criteria did not meet the restricted, repetitive behaviors criteria and only had some of the communication difficulties and social impairments.

The group maintained that if patients were accurately diagnosed with autism under DSM-IV, the vast majority — 91 percent — will meet DSM-5 criteria. Those that don't fit the criteria may fall under social pragmatic communication disorder, exhibiting social and communication issues, but not the restricted, repetitive patterns of behavior that are key in an autism diagnosis.

Changes in Criteria and Domains

The second big change in neurodevelopment disorders is that the three primary domains of deficits in DSM-IV were collapsed into two for DSM-5. Deficits in social communication and deficits in social interaction were combined. DSM-IV stated that deficits in social

emotional reciprocity focused on the social category, while a deficit in communication was a separate issue. The Neurodevelopmental Disorder Work Group felt that social communication and social interaction occur in conjunction with each other. When a person suffers a deficit in social interaction, communication issues contribute to the problem, and vice versa. The decision was made that separating the two impairments was not as accurate as combining them. Restricted, repetitive patterns of behaviors, interests, or activities continue to be the second primary domain.

A third significant change is that the number of criteria in the diagnosis, and the number that have to be met to qualify, have changed. These modifications have been somewhat controversial as well. DSM-IV contained 12 criteria across three areas, with six of 12 needed for a diagnosis of autism and two needed for PDD-NOS, with one or more coming from restricted, repetitive behaviors. DSM-5 recognizes seven criteria across two domains, and a patient needs to meet five out of seven criteria, with at least two coming under restricted, repetitive behaviors.

DSM-5 focuses on restricted, repetitive interests, activities, and behaviors as key components of autism. That criterion separates it from other disorders, such as social pragmatic communication disorder. While DSM-IV required only two out of 12 criteria to be diagnosed as PDD-NOS, DSM-5 requires five of seven criteria be met to qualify for ASD, which includes the PDD-NOS diagnosis. Although two out of 12 criteria might be considered low, some clinicians suggest the five of seven may be too strict, causing some controversy. The scientific research committee that made the change determined that requiring just two out of 12 might have allowed patients into the diagnosis who didn't really fit, especially those who exhibited restricted, repetitive behaviors.

In a fourth change, restricted, repetitive behaviors were expanded to include abnormalities in sensory processing in DSM-5. Sensory processing problems have been identified by clinicians for years, but weren't included in the criteria.

DSM-5 also removes a specific age requirement for the onset of autism symptoms and diagnosis. Rather than setting an exact age — 3 years old in DSM-IV — onset now must occur during early developmental years. A child can be as young as 12 to 18 months or as old as 4 or 5, depending on their stage of development.

“Even as a young adult being identified with Asperger's for the first time, or ASD for the first time, the clinician must go back, do the history, get records, and be able to say, ‘yes, the symptoms existed during early development.’ The signs were there, they just weren't diagnosed,” Dr. Lubetsky says.

Changes that help clarify the diagnosis of ASD use added specifiers to better describe the individual patient's condition (*see Figure 1*), and three severity levels based on the amount of support required by the patient: support, substantial support, and very substantial support.

Dr. Lubetsky explains how a person, previously diagnosed with Asperger's, would be diagnosed under DSM-5. “With Asperger's disorder being removed from the DSM, how do you define that person? That person could be diagnosed as Autism Spectrum Disorder with the added specifiers — without intellectual impairment and without language impairment. That's where we can identify how much of a component the language impairment is. We can also identify if behaviors are associated with a known medical condition, such as Rett syndrome or Fragile X syndrome, because in some cases the etiology has been identified, but in most cases it has not.”

FIGURE 1: Specifiers for Autism Spectrum Disorder in DSM-5

- With or without accompanying intellectual impairment
- With or without accompanying language impairment
- Associated with known medical or genetic condition or environmental factor
- Associated with another neurodevelopmental, mental, or behavioral disorder
- With catatonia
- Onset (i.e., with regression) is to be described

Dr. Lubetsky suggests that clinicians will find diagnosing autism easier because they can focus on one disorder — Autism Spectrum Disorder — rather than trying to figure out how to separate out one of five subcategories. It will be easier to look at the criteria; to be clear about meeting the criteria; and then by using the specifiers, to accurately describe what is unique about the individual. At the same time, it does not make a critical difference to the treatment, the school placement, or insurance reimbursement, whether it is called Autism Spectrum Disorder, instead of PDD-NOS, or Asperger's.

Disruptive Mood Dysregulation Disorder (DMDD)

Another change in DSM-5 that generated a lot of conversation was the creation of a new disorder under the category of depressive disorders. Disruptive Mood Dysregulation Disorder (DMDD) was developed by the work group in response to an upsurge in the number of bipolar diagnoses being made in children. Boris Birmaher, MD, co-director of Child and Adolescent Bipolar Services (CABS), explains that the DSM work

group decided that, in order to controvert the increase in childhood bipolar diagnoses in children, the DSM-5 should include another disorder that would better represent the youth that are persistently irritable and have recurrent temper outbursts but not recurrent episodes of mania/hypomania and depression characteristic of bipolar disorder.

DMDD Criteria

The criteria for DMDD include:

- 1) Severe temper outbursts — verbal or physical — with inappropriate intensity or duration in response to the provocation.
- 2) Tantrums inconsistent with developmental level.
- 3) Averaging three or more times per week.
- 4) Persistently irritable or angry most of time between outbursts in a manner that can be noticed by others.
- 5) Criteria have been present for a year or more, and subject has not gone without symptoms for three or more consecutive months.
- 6) Tantrums and irritability occur in more than one setting (i.e. school, home, play) and are severe in at least one setting.
- 7) Diagnosis should be made between the ages of 6 and 18, but the onset should be traceable to before the age of 10.
- 8) Never experience more than a day when patient meets full symptom criteria for manic or hypomanic episode.
- 9) Does not occur only during major depressive disorder, and is not better explained by other psychiatric disorders.
- 10) Cannot coexist with oppositional defiant disorder (ODD), but can coexist with ADHD, conduct disorder, and substance use disorders.

Some DMDD symptoms overlap with other child psychiatric disorders, such as depression, bipolar disorder, and oppositional defiance disorder, which is why a complete evaluation is needed. According to the DSM-5, if patients meet the criteria of DMDD and oppositional defiance disorder (ODD), they cannot be diagnosed with ODD. However, the overlap with ODD can create a diagnostic conundrum with significant clinical implications. Moreover, the diagnosis of DMDD can overshadow for the presence of underlying disorder because irritability and temper outbursts are common symptoms in many psychiatric disorders, such as mood and anxiety disorders.

DMDD also overlaps with ADHD, but under DSM-5 guidelines, those two diagnoses can coexist.

The DMDD diagnosis is the result of research into severe mood dysregulation (SMD), conducted primarily by the National Institute of Mental Health (NIMH). The work group changed some of the criteria of SMD and created the DMDD diagnosis for DSM-5. But Dr. Birmaher questions whether there is enough research to justify the inclusion of DMDD in DSM-5. He suggests that the better option may have been to place DMDD into the section slated for further study. Then if evidence supported the criteria, it could have been moved to the body of DSM-5 when it was updated.

Save the Date: **May 1, 2015** — Pittsburgh, Pa.

Understanding Adversity and Helping Youth to Overcome It

This conference, designed for clinical and educational personnel, will review the psychological effects of maltreatment, summarize the effects of maltreatment on brain structure and function, and outline implications of these findings for clinical care, prevention, and future research. Elements of a comprehensive school-based prevention program, key research findings and the best practices they support, and resources for suicide prevention in schools and communities also will be highlighted. **David Brent, MD**, director of Services for Teens At Risk (STAR-Center), and **Mary Margaret Kerr, EdD**, professor of applied developmental psychology and psychiatry at the University of Pittsburgh, will present the keynote lectures.

STAR-Center combines clinical and outreach services designed to combat adolescent suicide. The center's missions include offering state-of-the-art, responsive care for youth and their families with depression, anxiety, and those at risk for suicidal behavior; training professionals in best practices; and to improving these practices through continued research. STAR-Center is committed to the integration of education, prevention, treatment, and research in order to offer the best possible care for our youth.

For more information, or to register for the conference, please visit STARCenter.Pitt.edu.

Western Psychiatric Institute and Clinic of UPMC

Integrating Clinical and Technological Innovation, Research, and Education

UPMC and its academic partner, the Department of Psychiatry of the University of Pittsburgh School of Medicine, constitute one of the leading centers for research and treatment of individuals who have challenging or particularly difficult mental health conditions and/or addictive disorders. For more than 60 years, the integration of research, academia, and clinical services has infused best-practice research into clinical settings for the individuals who need it most.

The Department of Psychiatry ranks near the top nationally in research funding received from the National Institutes of Health (NIH), including primary research grants from 12 different NIH institutes, such as the National Institute of Mental Health, the National Institute on Aging, and the National Institute of Drug Abuse.

Numbers at a Glance

- Psychiatrists: **More than 150**
- Residents and clinical fellows: **More than 80**
- Licensed beds: **More than 300 adult, child, and adolescent**
- Network inpatient admission: **More than 13,000 adult, child, and adolescent**
- Network inpatient occupancy: **90 percent**
- Emergency department visits: **More than 11,000**
- Outpatient programs: **More than 50 throughout western Pennsylvania**
- Ambulatory/outpatient visits: **More than 390,000**
- Total research funding: **More than \$80 million**

This information represents the most current data available for UPMC Behavioral Health.

UPMCPhysicianResources.com/ Psychiatry



ONLINE CME OPPORTUNITIES

UPMC Synergies Fall 2014

In this issue, **David J. Kupfer, MD**, **Ellen Frank, PhD**, and **Charles F. Reynolds III, MD**, discuss the diagnostic criteria changes in sleep/wake and mood disorders in DSM-5, and present a sleep/wake disorder case study.

Reconceptualizing the Diagnosis of Dementia to Meet Real World Needs

In this presentation, **Ellen M. Whyte, MD**, discusses the changes to the diagnostic criteria for dementia in DSM-5.

Anxiety Disorders in Older Adults

In this course, **Jordan Karp, MD**, provides a discussion on improving the management of older adults with anxiety disorders with treatments such as sedatives, placebos, anti-depressants, and cognitive behavioral therapy.

Assessment of Decision-Making Capacity in the Older Patient

James Tew, MD, presents an overview of the key elements in a capacity assessment with the ultimate goal of ensuring that older patients are making decision consistent with their own values.

Neurodevelopmental Disorders: Autism Spectrum Disorder, Intellectual Disability, Communication and Learning Disorders, and More

Martin Lubetsky, MD, discusses neurodevelopmental disorders with a focus on Autism Spectrum Disorder, intellectual disability, and a brief overview of communication and learning disorders.

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A world-renowned health care provider and insurer, Pittsburgh-based UPMC is inventing new models of accountable, cost-effective, patient-centered care. It provides more than \$887 million a year in benefits to its communities, including more care to the region's most vulnerable citizens than any other health care institution. The largest nongovernmental employer in Pennsylvania, UPMC integrates more than 60,000 employees, more than 20 hospitals, more than 500 doctors' offices and outpatient sites, a more than 2.5-million-member health insurance division, and international and commercial operations. Affiliated with the University of Pittsburgh Schools of the Health Sciences, UPMC ranks No. 12 in the prestigious *U.S. News & World Report* annual Honor Roll of America's Best Hospitals — and No. 1 in Pennsylvania. For more information, go to UPMC.com.