DSM-5 Update

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Welcome & Introductions
Overview

**Morning**
- Getting to know the *DSM – 5*
  - Philosophical changes
  - Structural changes
  - Reporting
  - Assessment tools
- Digging in

**Afternoon**
- Digging further
- Practice implications and resources
Our Focus

- Philosophical and structural changes
  - What
  - Why
  - So what

- Major changes to disorders and new disorders
  - What
  - Why
  - So what
Getting to Know the *DSM-5*

DSM & Revision Process

Structural Changes

Nonaxial Assessment

Cross-cutting & Dimensional Assessments
Pre-Release Chatter

- Highly controversial and widely criticized
- The end of multiaxial diagnosis
- Structural reorganization - etiology and development
- Widespread neurobiological assumptions
- Mandates use of unvalidated assessments
- Lowered diagnostic thresholds
- Changes lead to harm for vulnerable populations
- Questionable engagement in field trials
- Questionable empirical basis for many changes
- Very limited involvement of professional counselors
The Reality
DSM History & DSM-5 Revision Process
From *DSM-IV-TR* to *DSM-5*

**Concerns with *DSM-IV-TR***
- Medical model / rigid classification system
- Comorbidity
- Questionable reliability
- Overuse of NOS
- Controversial diagnoses

**Hopes for *DSM-5***
- Holistic or dimensional ax
- Psychometrically sound ax
- Reduce comorbidity
- Reduce reliance on NOS
- Incorporation of advances in psychiatric research, genetics, neuroimaging, cognitive science, and pathophysiology
DSM-5 Revision Process

Dates

1999-2001 Development of research agenda, 6 workgroups
2002-2007 APA/WHO/NIMH research planning conferences
2006 Appointment of DSM-5 Task Force
2007 Appointment of 13 workgroups
2007-2011 Literature review and data re-analysis
2010-2011 1st phase field trials (large medical/academic)
2010-2012 2nd phase field trials (private practice)
July 2012 Final draft submitted for review
May 2013 DSM-5 released to the public

13 workgroups

ADHD and Disruptive Behavior
Anxiety, OCD, PTSD, and Dissociative
Childhood and Adolescent Eating
Mood
Neurocognitive Neurodevelopmental
Personality Psychotic
Sexual and Gender Identity
Sleep-Wake
Somatic symptoms
Substance-related
Revision Controversies

- ACA Concerns
  - Applicability across professions
  - Gender and culture
  - Organization of multiaxial system
  - Lowering of diagnostic thresholds
  - Use of unvalidated dimensional assessments

- Society for Humanistic Psychology iPetition
  - 9 of 19 ACA divisions endorsed
  - 15,000 signatures
“DSM 5 is Guide Not Bible – Ignore its Ten Worst Changes”
(Frances, 2012)

- DMDD
- Grief & MDD
- Mild neurocognitive
- Adult ADD
- Binge eating disorder
- Autism prevalence
- Range of SUDs
- Behavioral addictions
- Generalized anxiety
- PTSD floodgates
From **phenomenological interpretations** (symptoms & behaviors; medical model) **toward pathophysiologial origins** (functional changes associated with disease or injury; biological model)

- New groupings of disorders
- New text coverage within disorder descriptions
- Expected to be area of increased attention
From **categorical groupings** toward **dimensional conceptualizations**
Categorical Diagnosis

**Advantages**
- Discrete clinical criteria for disorder
- Common language
- Empirically based criteria
- Led to development of ESTs

**Disadvantages**
- Assumes little variation within disorder
- Assumes homogeneous populations
- Low diagnostic agreement
- High comorbidity
- Overuse of NOS
### Dimensional Diagnosis

#### Advantages
- Potential to capture increased complexity
- Potential in program and practice evaluation

#### Disadvantages
- Administrative burden
- Lack of consistency
- Lack rigorous validation
- Practice reality – lack confidence, training, time
- DSM-III severity ratings largely ignored
Dimensional Diagnosis

- Relatively minor compared to proposed
- Capture frequency, duration, and severity of experience with disorders
  - e.g., Substance Use Disorder, Autism Spectrum Disorder, Persistent Depressive Disorder
- New severity indicators throughout
- Movement toward specifying measures
- Billing and utilization implications unclear
The Reality
Structural Changes
## Key Structural Changes

<table>
<thead>
<tr>
<th>DSM-IV-TR</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 diagnostic classes, one general section, 11 appendices</td>
<td>3 sections with 20 diagnostic classes, 2 general sections, and 7 appendices</td>
</tr>
<tr>
<td>ICD-9-CM codes</td>
<td>ICD-9-CM &amp; ICD-10-CM codes; ICD-11 harmonization</td>
</tr>
<tr>
<td>Multiaxial assessment</td>
<td>Nonaxial system</td>
</tr>
<tr>
<td>General medical condition</td>
<td>Another medical condition</td>
</tr>
<tr>
<td>Not otherwise specified (NOS)</td>
<td>Other-specified and unspecified</td>
</tr>
</tbody>
</table>
Section I: DSM-5 Basics

- Introduction
- Use of Manual
A Disorder Is

**DSM-IV-TR**
“a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom” (APA, 2000, p. xxxi)

**DSM-5**
“a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities… (APA, 2013, p. 20)
A Disorder Is Not

**DSM-IV-TR**

“merely an expectable and culturally sanctioned response to a particular event...deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above” (APA, 2000, p. xxxi)

**DSM-5**

“an expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above” (APA, 2013, p. 20)
**DSM-IV Multiaxial System**

Axis I: Clinical d/o & other conditions that are focus of treatment

Axis II: Personality disorders and mental retardation

Axis III: General medical conditions

Axis IV: Psychosocial and environmental stressors

Axis V: Global assessment of functioning

**DSM-5 Nonaxial System**

Combined attention to clinical disorders, including personality disorders and intellectual disability; other conditions that are the focus of treatment; and medical conditions

Reason for visit, psychosocial, and contextual factors listed via an expanded list of V Codes and Z Codes

Disability listed using V or Z Codes. World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option
Expanded V- and Z-Codes
(pp. 715-727)

- Include in official diagnosis if focus of treatment
- Greatly expanded, for example
  - Child affected by parental relationship distress
  - Problem related to current military deployment status
  - Homelessness
  - Social exclusion or rejection
  - Target of (perceived) adverse discrimination or persecution
  - Sex counseling
APA’s Message Regarding GAF

- GAF alone is not clinically meaningful
- Assess risk of suicidal and homicidal behaviors
- Use standardized assessments for symptom severity, diagnostic severity, and disability

More to come in a bit…
Nonaxial Questions

- How will we implement?
- What medical issues should be included? If we cannot diagnose them, are we qualified to include them?
- How can we make sure we remember contextual issues?
- How can we make sure we assess and track distress/impairment?
- How will 3rd party payers adjust?
My Recommendations

- List all relevant diagnoses in order of focus
- Make tentative with “provisional” as necessary
- Increase use of V/Z-codes
- Include medical conditions only if confirmed and relevant to conceptualization
- If medical conditions are by client report, make tentative with “by client report”
### Situation

- Child referred for counseling because of numerous disciplinary problems at school. Upon assessment, child is found to meet criteria for ADHD

### DSM-5 Diagnosis

- F90.2 attention-deficit hyperactivity disorder, combined presentation, moderate (principal diagnosis) and
- Z55.9 academic or educational problem (reason for visit)
<table>
<thead>
<tr>
<th>Situation</th>
<th>DSM-5 Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client meets criteria for depression, uses alcohol excessively, and is unable to control diabetes as a result of the disturbance</td>
<td>F32.2 major depressive disorder, single episode, severe</td>
</tr>
<tr>
<td></td>
<td>F10.10 alcohol use disorder, mild</td>
</tr>
<tr>
<td></td>
<td>E11 Type 2 diabetes mellitus</td>
</tr>
</tbody>
</table>
Sample Diagnosis

Client has more than 2 years of depressed mood, including major depressive episodes, a degree of anxiety, and intermittent panic attacks

**DSM-IV-TR Axis I**
- 296.35 major depressive disorder, recurrent, in partial remission
- 300.00 anxiety disorder NOS

**DSM-5 Diagnosis**
- F34.1 Persistent depressive disorder; with anxious distress; with panic attacks; late onset; with intermittent major depressive episodes; without current episode; moderate
End of Not Otherwise Specified

- **Other-specified [category] disorder**
  - Must include specific reason another diagnosis does not fit
  - e.g., Other specified anxiety disorder, generalized anxiety not occurring more days than not

- **Unspecified [category] disorder**
  - Use when unable or unwilling to include specifics for other-specified
Section II: Diagnostic Criteria and Codes

Attempted to change to empirically-based developmental perspective

- Grouped by presumed underlying vulnerabilities
- Internalizing vs. externalizing clusters
- Adjacencies important
- Listed in order of development within and between chapters

Grouping Indicators

1. shared neural substrates
2. family traits
3. genetic risk factors
4. specific environmental risk factors
5. biomarkers
6. temperamental antecedents
7. abnormalities of emotional or cognitive processing
8. symptom similarity
9. course of illness
10. high comorbidity
11. shared treatment response
# Table of Contents Crosswalk

<table>
<thead>
<tr>
<th>DSM-5</th>
<th>DSM-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurodevelopmental</td>
<td>Most usually first diagnosed in infancy, childhood, or adulthood</td>
</tr>
<tr>
<td>Schizophrenia spectrum and other psychotic</td>
<td>Schizophrenia and other psychotic</td>
</tr>
<tr>
<td>Bipolar and related</td>
<td>Mood</td>
</tr>
<tr>
<td>Depressive</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Obsessive-compulsive and related</td>
<td>Some anxiety + adjustment</td>
</tr>
<tr>
<td>Trauma- and stressor-related</td>
<td>Dissociative</td>
</tr>
<tr>
<td>Dissociative</td>
<td>Dissociative</td>
</tr>
</tbody>
</table>
# Table of Contents Crosswalk

<table>
<thead>
<tr>
<th>DSM-5</th>
<th>DSM-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatic symptom and related</td>
<td>Somatoform + Factitious</td>
</tr>
<tr>
<td>Feeding and eating</td>
<td>Eating + some childhood</td>
</tr>
<tr>
<td>Elimination</td>
<td>Some childhood</td>
</tr>
<tr>
<td>Sleep-wake</td>
<td>Sleep</td>
</tr>
<tr>
<td>Sexual dysfunctions</td>
<td>Some sexual and gender identity</td>
</tr>
<tr>
<td>Gender dysphoria</td>
<td></td>
</tr>
<tr>
<td>Disruptive, impulse-control, and</td>
<td>Impulse + some childhood</td>
</tr>
<tr>
<td>conduct</td>
<td></td>
</tr>
<tr>
<td>Substance-related and addictive</td>
<td>Substance-related</td>
</tr>
<tr>
<td>DSM-5</td>
<td>DSM-IV</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Neurocognitive</td>
<td>Delirium, dementia, and amnestic and other cognitive</td>
</tr>
<tr>
<td>Personality</td>
<td>Personality</td>
</tr>
<tr>
<td>Paraphilic</td>
<td>Some sexual and gender id</td>
</tr>
<tr>
<td>Other mental</td>
<td></td>
</tr>
<tr>
<td>Medication-induced movement</td>
<td></td>
</tr>
<tr>
<td>Other conditions that may be a focus of clinical attention</td>
<td></td>
</tr>
</tbody>
</table>
Section II: Text

- Diagnostic features
- Associated features supporting diagnosis
- Prevalence
- Development and course
- Risk and prognostic features (environmental, genetic & physiological)
- Culture-related diagnostic issues
- Gender-related diagnostic issues
- Suicide risk
- Functional consequences
- Differential diagnosis
- Comorbidity
Section III: Emerging Measures and Models

- *DSM-5* provides a number of emerging measures for use and further study.
- These will continue to grow.
- These are not required for diagnosis.
- Counselors are responsible for utility.
- Counselors are responsible for ethical use.
Specified Measures

- Level 1 Cross-Cutting Symptom
- Level 2 Cross-Cutting Symptom
- Disorder-Specific Measures
- Disability Measure (WHODAS 2.0)

- Some available in paper
- Most available via [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5)
Cross-Cutting Assessments
(pp. 734-741)

- Included for research and exploration
- Symptoms of high importance to all clinicians
- Developed by NIH Patient-Reported Outcomes Measurement Information System
  - Level 1 Major clinical domains
  - Level 2 More detailed assessment for Level 1 areas considered clinically significant
- Unspecified psychometric rigor
Self-Rated Level 1 Cross-Cutting Assessment Measure - Adult

- 23 questions over 13 domains
- Self-report (or informant)
- Past 2 weeks
- 5 point scale
  - 0 = none or not at all
  - 1 = slight or rare, less than a day or two
  - 2 = mild or several days
  - 3 = moderate or more than half the days
  - 4 = severe or nearly every day
- Thresholds provided for Level 2 follow-up

- Depression
- Anger
- Mania
- Anxiety
- Somatic symptoms
- Suicidal ideation
- Psychosis
- Sleep problems
- Memory
- Repetitive thoughts and behaviors
- Dissociation
- Personality functioning
- Substance use
## DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: ___________________________  Age: _____  Sex: □ Male □ Female  Date: __________

*If this questionnaire is completed by an informant, what is your relationship with the individual? ________________*

In a typical week, approximately how much time do you spend with the individual? ________________ hours/week

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past **TWO** (2) WEEKS.

<table>
<thead>
<tr>
<th>During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?</th>
<th>None</th>
<th>Slight Rare, less than a day or two</th>
<th>Mild Several days</th>
<th>Moderate More than half the days</th>
<th>Severe Nearly every day</th>
<th>Highest Domain Score (clinician)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. 1. Little interest or pleasure in doing things?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>II. 3. Feeling more irritated, grouchy, or angry than usual?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>III. 4. Sleeping less than usual, but still have a lot of energy?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5. Starting lots more projects than usual or doing more risky things than usual?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>IV. 6. Feeling nervous, anxious, frightened, worried, or on edge?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>7. Feeling panic or being frightened?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>8. Avoiding situations that make you anxious?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
Other Level 1 Assessments

- DSM-5 Parent/Guardian Rated Level 1 Cross-Cutting Symptom Measure – Child Age 6-17
  - In DSM and Online

- DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Child Age 11-17
  - Online only
Level 2 Cross-Cutting Symptom Measures

- Recommended to administer for all Level 1 areas in which threshold is met
- Mostly established instruments that have been adapted for DSM-5
- **DSM-5 Website** includes links to measures and scoring/psychometric information
LEVEL 2—Somatic Symptom—Adult Patient

*Adapted from the Patient Health Questionnaire Physical Symptoms (PHQ-15)

Name: ____________________________  Age: ___  Sex: ☐ Male  ☑ Female  Date:________________ 

If the measure is being completed by an informant, what is your relationship with the individual receiving care? ______________

In a typical week, approximately how much time do you spend with the individual receiving care? ________________ hours/week

**Instructions:** On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you (the individual receiving care) have been bothered by “unexplained aches and pains”, and/or “feeling that your illnesses are not being taken seriously enough” at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.

<table>
<thead>
<tr>
<th>During the past 7 days, how much have you been bothered by any of the following problems?</th>
<th>Clinician Use</th>
<th>Item Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not bothered at all (0)</td>
<td>Bothered a little (1)</td>
</tr>
<tr>
<td>1. Stomach pain</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>2. Back pain</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>3. Pain in your arms, legs, or joints (knees, hips, etc.)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>4. Menstrual cramps or other problems with your periods <strong>WOMEN ONLY</strong></td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>
Disorder Specific Severity Measures

- Provided on DSM-5 Website
- Self-report or clinician-rated measures
- Highly variable in rigor and structure
  - Established instruments (e.g., Patient Health Questionnaire [PHQ-9] for depression; National Stressful Events Survey PTSD Short Scale for PTSD)
  - Homemade instruments (e.g., Severity Measure for Specific Phobia – adult)
  - 1-item “measures” (e.g., Clinician-Rated Severity of Oppositional Defiant Disorder)
# Severity Measure for Depression—Adult

*Adapted from the Patient Health Questionnaire—9 (PHQ-9)*

Name: ___________________________ Age: _____ Sex: Male ☐ Female ☐ Date: ______________

**Instructions:** Over the last 7 days, how often have you been bothered by any of the following problems? (Use “✓” to indicate your answer)

<table>
<thead>
<tr>
<th>Item</th>
<th>Clinician Use</th>
<th>Item score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>Not at all</td>
<td>Several days</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total/Partial Raw Score:**

**Prorated Total Raw Score:** (if 1-2 items left unanswered)

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Adapted from Patient Health Questionnaire—9 (PHQ-9) for research and evaluation purposes.
Severity Measure for Specific Phobia—Adult

Name: ___________________________  Age: _____  Sex: Male ☐  Female ☐  Date: ________________

The following questions ask about thoughts, feelings, and behaviors that you may have had in a variety of situations. Please check (✓) the item below that makes you most anxious. Choose only one item and make your ratings based on the situations included in that item.

- Driving, flying, tunnels, bridges, or enclosed spaces
- Animals or insects
- Heights, storms, or water
- Blood, needles, or injections
- Choking or vomiting

Please respond to each item by marking (✓ or x) one box per row.

**During the PAST 7 DAYS, I have...**

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Occasionally</th>
<th>Half of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
<th>Clinician Use Item Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. felt moments of sudden terror, fear, or fright in these situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2. felt anxious, worried, or nervous about these situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3. had thoughts of being injured, overcome with fear, or other bad things happening in these situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>4. felt a racing heart, sweaty, trouble breathing, faint, or shaky in these situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5. felt tense muscles, felt on edge or restless, or had trouble relaxing in these situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>6. avoided, or did not approach or enter, these situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>7. moved away from these situations or left them early</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>8. spent a lot of time preparing for, or procrastinating about (i.e., putting off), these situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>9. distracted myself to avoid thinking about these situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>10. needed help to cope with these situations (e.g., alcohol or medications, superstitious objects, other people)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Total/Partial Raw Score:**

**Prorated Total Raw Score: (if 1-2 items left unanswered)**

**Average Total Score:**

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## CLINICIAN-RATED SEVERITY OF

**OPPOSITIONAL DEFIANT DISORDER**

Name: ____________________________  Age: ___  Sex: □ Male  □ Female  Date: ______________

### Instructions:
This clinician-rated severity measure is used for the assessment of the presence and severity of any OPPOSITIONAL DEFIANT DISORDER symptoms.

Based on all the information you have on the individual receiving care and using your clinical judgment, please rate (✓) the presence and severity of the oppositional defiant problems as experienced by the individual in the past seven (7) days.

<table>
<thead>
<tr>
<th>Rate the level or severity of the OPPOSITIONAL DEFIANT problems that are present for this individual.</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ None (No oppositional defiant symptoms)</td>
<td>□ Mild (Symptoms are confined to only one setting [e.g., at home, at school, at work, with peers])</td>
<td>□ Moderate (Some symptoms are present in at least two settings)</td>
<td>□ Severe (Some symptoms are present in three or more settings)</td>
<td></td>
</tr>
</tbody>
</table>

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WHO Disability Assessment Schedule (WHODAS 2.0)

- Self- (in DSM) or informant- (online) measure
- Measures presence or absence of impairment
- General Disability Factor and 6 Life Domains
  - **Cognition** - Understanding and communicating
  - **Mobility** - Getting around
  - **Self-care** - Hygiene, dressing, eating & staying alone
  - **Getting along** - interacting with other people
  - **Life activities** - domestic responsibilities, leisure, work & school
  - **Participation** - joining in community activities
WHODAS 2.0

- 36 items rated 1 = none to 5 = extreme
- Rate past 30 days
- 5-20 minute administration
- Appropriate for adults across cultures
- Ok for repeat administration
- Scoring
  - Simple – hand sum or scale average
  - Complex – WHO algorithm - 0 to 100
  - Population norms available from WHO
WHODAS 2.0

- Free to use for research and clinical practice
- Training through manual
- Reliability
  - Test-retest: 0.93-0.96 domains, 0.98 overall
  - Cronbach’s α: 0.94-0.96 domains, 0.98 overall
- Factor structure
  - Strong general disability factor
  - Consistently stable for six domains
- Appears sensitive to change
- Strong evidence of validity
World Health Organization Disability Assessment Schedule 2.0

36-item version, self-administered

Patient Name: ____________________  Age: _____  Sex: [ ] Male  [ ] Female  Date: ____________

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the past 30 days and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

<table>
<thead>
<tr>
<th>Understanding and communicating</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1.1 Concentrating on doing something for ten minutes?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
</tr>
<tr>
<td>D1.2 Remembering to do important things?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
</tr>
<tr>
<td>D1.3 Analyzing and finding solutions to problems in day-to-day life?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
</tr>
<tr>
<td>D1.4 Learning a new task, for example, learning how to get to a new place?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
</tr>
<tr>
<td>D1.5 Generally understanding what people say?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
</tr>
</tbody>
</table>

Clinician Use Only

<table>
<thead>
<tr>
<th>Raw Item Score</th>
<th>Raw Domain Score</th>
<th>Average Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
Cultural Formulation Interview

- Method for systematic assessment
  - Cultural identity
  - Cultural conceptualizations of distress
  - Psychosocial stressors and cultural features of vulnerability and resilience
  - Cultural features of relationship between the individual and the clinician
- Overall cultural assessment
- Semi-structured interview provided
- Supplemental modules available online
Other Tools Provided

- Personality inventories based on alternate diagnostic system
- Early development and home background forms (parent & clinician)
Ethical Considerations

- Face/clinical utility
- (un)known psychometrics
- *DSM-5* use may not align with purpose, populations, settings initially intended
- Minor adaptations with minors
- Unknown implications of *DSM-5* adaptations
- See *Schmit & Balkin (2014)*
Section III: Emerging Areas

- Alternative model for personality disorders
- Conditions for further study
  - Attenuated psychosis syndrome
  - Depressive episodes with short-duration hypomania
  - Persistent complex bereavement disorder
  - Caffeine use disorder
  - Internet gaming disorder
  - Neurobehavioral disorder associated with prenatal alcohol exposure
  - Suicidal behavior disorder
  - Nonsuicidal self-injury
Implementation and Implications
Adoption Timeline

- *DSM-5* compatible with ICD coding
  - Prior to 10/1/2015 – ICD-9-CM codes
  - 10/1/2015 and beyond – ICD-10-CM codes

- *DSM-5* and ICD names/codes may not match
  - Always include narrative descriptions + codes

- CMS approved for immediate use

- APA anticipated industry transition by 12/2013
DSM-5 as Living Document

- New naming convention
  - DSM III, DSM III-R, DSM-IV, DSM IV-TR
  - DSM 5, DSM 5.1, DSM 5.2...

- Multiple coding errors in initial runs. Coding update and email subscription available
  - [http://dsm.psychiatryonline.org/DSM5CodingSupplement](http://dsm.psychiatryonline.org/DSM5CodingSupplement)
Lingering Questions

- Will changed criteria result in drastic changes in some diagnoses?
- Will lowered thresholds lead to increased
  - access to services?
  - stigma?
  - psychotropic treatment?
  - costs?
  - help-seeking?
  - normalization of mental health concerns?
- Will clinicians use the dimensional assessments and new specifiers?
Checking in...
Neurodevelopmental Disorders

New Chapter!
What’s in the Chapter?

- Intellectual Disability
- Global Developmental Delay
- Language Disorder
- Speech Sound Disorder
- Childhood-Onset Fluency Disorder
- Social (Pragmatic) Communication Disorder
- Autism Spectrum Disorder
- Attention-Deficit/Hyperactivity Disorder
- Specific Learning Disorder
- Developmental Coordination Disorder
- Stereotypic Movement Disorder
- Tic Disorders
- Other specifieds....
- Unspecifieds....
Primary Changes

- Mental retardation became intellectual disability
- Collapsed communication disorders
- Collapsed pervasive developmental disorders onto the autism spectrum
- Lifted ADHD age restrictions
- Collapsed academic areas into one specific learning disorder with specifiers
Intellectual Disability
(319 / F7x)

- New name matches WHO language change
- Reduced reliance on IQ for intellectual functions
- Increased focus on adaptive functioning
  - Conceptual, social, and practical domains
  - Qualitative descriptors in each domain inform level of severity:
    - Mild, moderate, severe, and profound
- Before age 5 may use global developmental delay
Collapsed expressive and mixed receptive-expressive language disorder into **Language Disorder**

Renamed phonological disorder **Speech Sound Disorder**

Renamed stuttering **Childhood-Onset Fluency Disorder**

New disorder: **Social (Pragmatic) Communication Disorder**

Differentiated from Autism Spectrum Disorder by absence of repetitive behaviors
Autism Spectrum Disorder
(299.00 / F84.0)

- Previously: Autism Disorder, Asperger’s Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder NOS
- DSM-IV-TR diagnoses honored
- Specifiers:
  - Severity levels (see chart on next slide)
  - With or without accompanying 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 behavior disorder
  - With catatonia
### Autism Spectrum Disorder

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Social Communication</th>
<th>Restricted, Repetitive Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 3</strong></td>
<td><strong>Criterion A</strong></td>
<td><strong>Criterion B</strong></td>
</tr>
<tr>
<td>Requiring very substantial support</td>
<td>Very limited speech and nonverbal communication</td>
<td>Very limited coping, repetitive activities interfere with functioning</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td><strong>Requiring substantial support</strong></td>
<td>With supports simplistic verbal/nonverbal; social interactions of interest</td>
</tr>
<tr>
<td><strong>Level 1</strong></td>
<td><strong>Requiring support</strong></td>
<td>Difficulty initiating social interactions (e.g., making friends); good language skills—communication may be ‘odd’ in social contexts</td>
</tr>
</tbody>
</table>

**DIAGNOSIS EXAMPLE:** Autism spectrum disorder, level 1 social communication, level 1 restricted, repetitive behaviors, without accompanying intellectual impairment, without accompanying language impairment.
Age threshold for signs of first symptoms increased from 7 years old to 12 years old

Increased attention to ADHD presentation across the lifespan
- Minor changes to some criteria
- Older adolescents and adults need 5 symptoms rather than 6
Specific Learning Disorder
(315.x / F81.x)

- Collapses previous learning disorders into **Specific Learning Disorder** with a specifier
  - With impairment in reading
  - With impairment in written expression
  - With impairment in mathematics
  - Include severity level: mild, moderate, severe

*Example*: mathematics disorder is now Specific Learning Disorder with impairment in mathematics
Impact of Changes

- ASD – limits potential overdiagnosis
- Advocates of those diagnosed with Asperger’s disorder worry about loss of identity
- Concern about increasing rates of ADHD and access to stimulants with increased age threshold
Schizophrenia Spectrum and Other Psychotic Disorders
Major Areas of Change

- Cross-referencing Schizotypal Personality Disorder
- Criterion A removes special treatment of bizarre delusions and Schneiderian first-rank auditory hallucinations
- Schizophrenia loses its subtypes
- Schizoaffective Disorder becomes longitudinal
- Catatonia becomes specifier and specified diagnosis
- Shared delusional disorder subsumed
- Severity specified by Clinician-Rated Dimensions of Psychosis Symptom Severity measure
Criterion A (p. 99)

- Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
  1. Delusions
  2. Hallucinations
  3. Disorganized speech
  4. Grossly disorganized or catatonic behavior
  5. Negative symptoms
Delusional Disorder
(297.1 / F22)

- **Criterion A impacts**
  - Can include hallucinations if related to the delusion
  - No longer excludes bizarre delusions

- **Exclusionary criteria**
  - differentiates from poor-insight OCD or body dysmorphic
- **Severity to be specified**
- **No longer excludes shared delusional disorder**

- **New specifiers**
  - with bizarre content
  - First episode, currently in acute episode
  - First episode, currently in partial remission
  - First episode, currently in full remission
  - Multiple episodes, currently in acute episode
  - Multiple episodes, currently in partial remission
  - Multiple episodes, currently in full remission
  - Continuous
  - Unspecified
Schizophrenia
(295.90 / F20.9)

- Changes to Criterion A central
- Subtypes eliminated due to poor validity and utility
- Use dimensional assessment for severity
- New specifiers
  - First or multiple episodes x currently in acute episode, partial remission, full remission
  - Continuous
  - Unspecified
  - With catatonia
Schizoaffective Disorder
(295.70/F24.x)

- Criterion A changes
- Substantial change
  - “Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness”
- Rate severity using dimensional assessment
- Specifiers match previous
Catatonia

- Revised to have consistent criteria throughout *DSM-5*

- Revised to be
  - Stand-alone code with another mental disorder (catatonia specifier)
  - Stand-alone code with another medical condition
  - Stand-alone disorder (unspecified catatonia)

- 3+ symptoms
  1. Stupor
  2. Catalepsy
  3. Waxy flexibility
  4. Mutism
  5. Negativism
  6. Posturing
  7. Mannerism
  8. Stereotypy
  9. Agitation
  10. Grimacing
  11. Echolalia
  12. Echopraxia
293.89 (F06.1) Catatonia Associated with [Another Mental Disorder]
- Neurodevelopmental
- Psychotic
- Bipolar
- Depressive

293.89 (F06.1) Catatonia Associated with [Another Medical Condition]

293.89 (F06.1) unspecified Catatonia
Remember to code specific reason

Examples provided

- Persistent auditory hallucinations
- Delusions with significant overlapping mood episodes
- Attenuated psychosis syndrome (see research criteria)
- Delusional symptoms in partner of individual with delusional disorder
Former Mood Disorders

Bipolar and Related Disorders
Depressive Disorders
Major Areas of Change

- DSM-IV-TR Mood Disorders recategorized as
  - Bipolar and Related Disorders
  - Depressive Disorders
- New: Disruptive Mood Dysregulation Disorder
- New: Premenstrual Dysphoric Disorder
- Reconceptualized
  - Mixed episode removed
  - Bereavement exclusion removed
  - Dysthymia becomes persistent depressive disorder
- Revised specifiers
Bipolar I & II Disorders

- Reformatting from episodes to disorder focus
- Minimal changes and impacts throughout
- Manic & hypomanic episodes Criterion A
  - A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting…
- Captures changes in mood and activity/energy
- Mixed episode deleted in favor of new mixed features specifier
Disruptive Mood Dysregulation Disorder
(p. 156; 296.99 / F34.8)

A. Severe, recurrent temper outbursts
B. Inconsistent with dev level
C. 3+ times/week
D. Mood persistently irritable or angry between outbursts
E. At least 1 year (no more than 3 months without all)
F. At least 2 of 3 settings; severe in at least 1
G. Dx not prior to 6 or after 18
H. Onset before age 10
I. Never more than 1 day of mania or hypomania
J. Not exclusively during depression or another mental disorder; not coexist with ODD, IED, or bipolar
K. Not due to substance, medical, or neurological condition
Key issue: temper outbursts + chronic, persistent irritable, angry mood

Prevalence: DSM-5 says 2-5%, higher in males, lower over time; other studies say <1%

Course: At risk for depressive and anxiety disorders over time, poor outcomes, very low risk for bipolar disorder

Differential: Bipolar, ODD, ADHD, MDD, anxiety, autism spectrum, intermittent explosive
Controversy regarding empirical basis
Intent to decrease inappropriate diagnosis, ineffective treatment, and overmedication a la bipolar disorder
Concerns that the diagnosis may increase stigma, pathologizing developmental issues, and medications
High comorbidity (63-92%) with internalizing and externalizing disorders
No clinical treatment trials – cues from aggression + irritability
Premenstrual Dysphoric Disorder
(p. 171, 625.4 / N94.3)

A. Majority of cycles, 5+ symptoms week before menses, improve after start, minimal/absent week

B. One or more, marked…
   1. Affective liability
   2. Irritability, anger, conflicts
   3. Depressed mood, hopelessness, self-deprecation
   4. Anxiety, tension, keyed up

C. One or more (B+C = 5)
   1. Decreased interest
   2. Difficulty concentrating
   3. Lethargy, fatigability, low energy
   4. Change in appetite, cravings
   5. Change in sleep
   6. Overwhelmed / out of control
   7. Physical symptoms

D. Distress or impairment
E. Not exacerbation of other d/o
F. Based on prospective daily ratings during at least 2 cycles
G. Not d/t substance or AMC

New Disorder!
**PMDD**

- **Key issue**: marked mood fluctuations w/cycles
- **Provisional**: diagnosis requires daily ratings for at least 2 cycles, provisional prior to ratings
- **Prevalence**: 1.8-5.8% menstruating women
- **Course**: Worse with age, most severe 20s-30s, cease after menopause
- **Differential**: PMS, dysmenorrhea, worsening of other mood disorders, hormonal treatment side effects
PMDD: Impact of Changes

- Included in DSM-III and DSM-IV study sets; strong validity evidence
- Stigma concerns regarding normal biological processes
- Elevated risk of suicidal ideation, plans, attempts
- Considerably more likely to have experienced traumatic events and PTSD, especially sexual abuse
- Targeted treatment options (intermittent SSRIs, education, CBT, wellness)
Major Depressive Disorder
(p. 160)

- Same core symptoms and time requirement
- DSM-IV-TR bereavement exclusion lifted
  
  Note: responses to a significant loss (e.g., bereavement, financial ruin, losses for a national disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual’s history and the cultural norms for the expression of distress in the context of loss.
Impact of Change

- Concerns regarding stigmatizing grief addressed by workgroup
  - Is death loss different from other losses?
  - Is previous 2 month limit unrealistic?
  - Grief + MDD = greater risk
  - History of MDD → greater risk for grief with MDD
  - Those with MDD + grief benefit from treatment

- Extensive note regarding differentiating grief and clinical depression
Persistent Depressive Disorder (Dysthymia)
(p. 166, 300.4 / F34.1)

- Criteria largely unchanged
- Reconceptualized from long-term low-grade depression to long-term depression
- Includes variety of new specifiers
- Course specifiers
  - With pure dysthymic syndrome
  - With persistent major depressive episode
  - With intermittent major depressive episodes, with current episode
  - With intermittent major depressive episodes, without current episode
Substance-Medication Induced Depressive & Bipolar Disorders

- Criteria largely unchanged

- ICD-10-CM coding procedures require new coding based on comorbid substance use disorder
  - With use disorder, mild
  - With use disorder, moderate or severe
  - Without use disorder
Other Specified Disorders

- Remember to include specific reason
- Examples
  - Recurrent brief depression
  - Short-duration depressive episode
  - Depressive episode with insufficient symptoms
  - Short-duration hypomanic episodes and major depressive episodes
  - Hypomanic episodes with insufficient symptoms and major depressive episodes
  - Hypomanic episode without prior major depressive episode
  - Short-duration cyclothymia
Bipolar (p. 149) & Depressive (p. 184) Specifiers

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern
- With rapid cycling
- Chronic
Impact of Changes

- Mixed symptom specifier should assist with identifying manic features (of depression) and depressive features (of mania)
- Anxious distress specifier should reduce inflated comorbidity with anxiety disorders
- Both useful in noting suicide risk
Checking in...
Anxiety Disorders
Major Areas of Change

- DSM-IV-TR anxiety disorders recategorized
  - Anxiety disorders
  - Obsessive-compulsive and related disorders
  - Trauma- and stressor-related disorders

- Relocated from childhood disorders
  - Separation anxiety disorder
  - Selective mutism

- Removed insight and added time requirement for adults
- Panic attack becomes a specifier
- Panic disorder and agoraphobia unlinked
- Despite chatter, GAD unchanged
Panic Attack Specifier (p. 214)

- Not a mental disorder
- Cannot be coded
- Can be added to ANY disorder in the DSM-5 (except panic disorder)
- Surge can be from calm or anxious state
- Culture-specific symptoms named but do not count

- Abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur…
Separation Anxiety Disorder
(309.21 / F93.0)

- Relocated from childhood disorders
- Largely unchanged
- Removed requirement for onset prior to 18
- Increased attention to presentation in adulthood
Social Anxiety Disorder
(300.23 / F40.10)

- Renamed from social phobia
- Removed expectation that adults understand fear as excessive or unreasonable
- Require 6 month duration for all ages
- Deleted generalized specifier and replaced with “performance-only” specifier
- Added developmental language regarding features in childhood
Panic Disorder & Agoraphobia
Unlinked

- Panic attacks largely unchanged
- Disorders can be diagnosed separately or together
- Panic disorder criteria unchanged
- Agoraphobia criteria greatly expanded
Agoraphobia
(300.22 / F40.00)

A. Marked fear or anxiety about 2+ situations (public transportation, open spaces, enclosed spaces, line/crowd, outside home alone)
B. Fears or avoids b/c escape difficult or help not available
C. Situations provoke fear or anxiety
D. Situations actively avoided, require presence, or endured with intense distress
F. Out of proportion to danger posed and sociocultural context
G. Lasts 6+ months
H. Distress or impairment
I. If medical condition present, symptoms out of proportion
J. Not better explained by another disorder
Substance-Medication Induced Anxiety Disorders

- Criteria largely unchanged
- ICD-10-CM coding procedures will require new coding based on comorbid substance use disorder
  - With use disorder, mild
  - With use disorder, moderate or severe
  - Without use disorder
Other Specified Anxiety Disorder
(300.09 / F41.8)

- Remember to code specific reason

- Examples provided
  - Limited-symptom attacks
  - Generalized anxiety not more days than not
  - Khyâl cap (wind attacks)
  - Ataque de nervios (attack of nerves)
Obsessive Compulsive and Related Disorders

New Chapter!
Areas of Change

- **New disorders**
  - Hoarding disorder
  - Excoriation (skin-picking)
  - Substance/medication-induced OCD
  - Obsessive compulsive and related disorder due to another medical condition

- **Existing disorders moved**
  - OCD
  - Body dysmorphic disorder
  - Trichotillomania (hair-pulling)
Areas of Change

- New lingo
  - Urge instead of impulse
  - Unwanted instead of inappropriate

- Removal of criterion
  - Individuals no longer need to self-assess that obsession and/or compulsions are in excess or unreasonable.
Hoarding Disorder
(APA, 2013, p. 247; 300.3 / F42)

A. Persistent difficulty discarding / parting with possessions, regardless of value
B. Perceived need to save items / distress discarding
C. Accumulation of possessions that congest, clutter, compromise living areas
D. Clinically significant distress or impairment

E. Not due to AMC
F. Not better explained by OCD, MDD, psychotic, major neurocognitive, autism spectrum

With excessive acquisition
With good or fair insight
With poor insight
With absent insight / delusional beliefs
Hoarding Disorder

- **Key issues:** Persistent difficulty discarding / parting with possessions
- **Prevalence:** DSM-5 says 2-6%, > males in community, > females seek help, 3x more prevalent at ages 55-94 vs. 34-44
- **Course:** Emerges adolescence, impairment by mid-30s, continues to worsen, often chronic
- **Comorbidity:** 75% meet criteria for mood or anxiety disorder
- **Differential:** brain injury, neurodevelopmental, schizophrenia, MDD, OCD, neurocognitive disorders
Excoriation (Skin-Picking) Disorder
(APA, 2013, p. 254; 698.4/L98.1)

A. Recurrent skin picking resulting in lesions
B. Repeated attempts to decrease or stop skin picking
C. Clinically significant distress or impairment
D. Not attributable to physiological effects of substance or medical condition
E. Not explained by another disorder or its impacts, not NSSI
Excoriation (Skin-Picking) Disorder

- **Key issues:** Recurrent skin picking
- **Prevalence:** DSM-5 says 1.4% adults, 75% female
- **Course:** Often emerges puberty w/ dermatological condition, chronic course
- **Comorbidity:** OCD, trichotillomania, MDD, body-related concerns
- **Differential:** psychotic disorder, OCD, neurodevelopmental, NSSI, medical or substance-related
Impact of Changes

- Separation from anxiety and trauma and stressor-related disorders
  - Requires more attention to differential diagnosis

- Mindful use of other specified obsessive-compulsive and related disorders
  - Are we creating pathology unnecessarily?
New Chapter!
Major Areas of Change

- Includes
  - Reactive attachment disorder (from childhood)
  - Disinhibited social engagement disorder (from childhood)
  - Posttraumatic stress disorder (from anxiety)
  - Acute stress disorder (from anxiety)
  - Adjustment disorders (from adjustment)
- Reactive attachment subtypes become distinct disorders
- ASD & PTSD stressor criterion refined
- Unique PTSD criteria for young children
Reactive Attachment Disorder
(p. 265 / 313.89 / F94.1)

A. Pattern of inhibited, emotionally withdrawn behavior toward adult caregivers
B. Social and emotional disturbance
C. Experienced a pattern of extremes of insufficient care
D. Care criterion responsible for A
E. Not autism spectrum disorder
F. Evident before age 5
G. Developmental age of at least 9 months

Specify if: persistent (12+ months)

Specify: severity

Subtypes relocated
Disinhibited Social Engagement Disorder
(p. 268 / 313.89 / F94.2)

A. Pattern of actively approaching and interacting with unfamiliar adults

B. Disinhibited behavior not due to impulsivity (ADHD)

C. Experienced a pattern of extremes of insufficient care

A. Care criterion responsible for A

E. Developmental age of at least 9 months

Specify if: persistent (12+ months)

Specify: severity
**Posttraumatic Stress Disorder**

(p. 271 / 309.81 / F43.10)

**Criterion A**

- Exposure to actual or threatened death, serious injury, or sexual violence:
  - Directly experiencing
  - Witnessing, in person
  - Learning events occurred to close family member or friend
  - Experiencing repeated extreme exposure to aversive details of the events (not exposure through media unless work related)

**Key Changes**

- Removed required “intense fear, helplessness, or horror”
- From 3 to 4 symptom clusters
- Distinct criteria set < 6 years
- Lower thresholds 6-17 years
- New specifiers
  - With dissociative symptoms
  - With delayed expression
Posttraumatic Stress Disorder
(309.81 / F43.10)

- **Criterion A**
  - **1+ intrusion**
    - Memories*
    - Dreams*
    - Dissociative reactions*
    - Distress at cues
    - Phy reactions to cues
  - **2+ cognition or mood**
    - Memory loss
    - Negative beliefs or expectations
    - Distorted cognitions about cause/consequences
    - Negative emotional state
    - Diminished interest or participation
    - Detachment or estrangement
    - Inability to experience positive

- **1+ avoidance**
  - Internal
  - External reminders

- **2+ arousal/reactivity**
  - Irritable / angry
  - Reckless or self-destructive
  - Hypervigilance
  - Exaggerated startle
  - Problems with concentration
  - Sleep disturbance

- More than 1 month
- Causes distress or impairment
- Not due to medical or substance
PTSD – Child (up to age 6)  
(309.81 / F43.10)

A. Criterion A

B. 1+ intrusion (same)

C. 1+ avoidance or negative cognitions
   1. Activities, places, or physical reminders
   2. People, conversations, or interpersonal situations
   3. Increased negative emotional states
   4. Diminished interest or participation (play)
   5. Socially withdrawn behavior
   6. Reduced positive emotions

D. 2+ Arousal/reactivity
   1. Irritable / angry
   2. Hypervigilance
   3. Exaggerated startle
   4. Problems with concentration
   5. Sleep disturbance

E. Duration more than 1 month

F. Causes distress or impairment

G. Not due to medical or substance New Distinction!
Acute Stress Disorder
(308.3 / F43.0)

- Criterion A matches PTSD
- Reduced focus on dissociative requirement
- 5 clusters of symptoms (need 9 total)
  - Intrusion
  - Negative mood
  - Dissociative symptoms
  - Avoidance symptoms
  - Arousal symptoms
Acute Stress Disorder
(308.3 / F43.0)

- Distressing memories
- Dreams
- Dissociative reactions (flashbacks)
- Distress or reactions at cues
- Inability to experience positive emotions
- Altered sense of reality
- Inability to remember important aspect of traumatic event
- Avoid internal
- Avoid external
- Sleep disturbance
- Irritable behavior / outbursts
- Hypervigilance
- Problems with concentration
- Exaggerated startle
- Lasts 3 days to 1 month
Adjustment Disorders
(309.x / F42.xx)

- Reconceptualized as stress response rather than residual
- Core criteria unchanged
- Specifiers unchanged
  - With depressed mood
  - With anxiety
  - With mixed anxiety and depressed mood
  - With disturbance of conduct
  - With mixed disturbance of emotions and conduct
  - Unspecified
- Coding errors
Other Specified Trauma- and Stressor-Related Disorder (309.89 / F43.8)

- Remember to code specific reason

- Examples provided
  - Adjustment-like disorders with delayed onset of symptoms that occur more than 3 months after the stressor
  - Adjustment-like disorders with prolonged duration of more than 6 months without prolonged duration of stressor
  - Ataque de nervios
  - Other cultural syndromes
  - Persistent complex bereavement disorder (See Conditions for Further Study)
Impact of Changes

- Strong research base for 4 PTSD clusters
- Pros and cons regarding loosening of restrictions on acute stress disorder and PTSD-child criteria
- Don’t forget expanded list of stressors (V-codes, Z-codes) available at the end of your *DSM-5*
Dissociative Disorders
Key Points

- Intentionally close to trauma
- Dissociative identity disorder criteria allow for self-reported experiences, everyday experiences, more culturally sensitive language
- Depersonalization disorder renamed depersonalization/derealization disorder
- Dissociative fugue subsumed as special case of dissociative amnesia
Somatic Symptom and Related Disorders

Overhauled Chapter!
Somatoform + factitious $\rightarrow$ Somatic symptom

Reduce

- Stigmatizing and ambiguous terminology
- Focus on medically unexplained symptoms (rather than experiences around symptoms)
- Unclear boundaries
- Rare use in practice despite prevalence
New Disorders

Somatic Symptom Disorder

- Distressing or disruptive somatic symptoms
- "Excessive thoughts, feelings, or behaviors related to the somatic symptoms"
- Replaces somatization, 75% hypochondriasis, pain, and undifferentiated somatoform disorders

Illness Anxiety Disorder

- "Preoccupation with having or acquiring a serious illness" in absence of symptoms (or very mild symptoms)
- Engagement in excessive or maladaptive health-related behaviors

Farewell to...

- Somatization disorder
- Hypochondriasis
- Pain disorder
- Undifferentiated somatoform disorder
Impact of Change

- Expected increase in rate of diagnosis to rates similar to anxiety, depression, substance use

- Now appropriate for non-medical professionals to diagnose

- Be careful with
  - judgments regarding “excessive”
  - cultural considerations
  - connectedness to trauma
Feeding and Eating Disorders

Revised chapter name/content!
Areas of Change

- New disorders
  - Binge eating disorder
  - Other specified feeding and eating disorder
  - Unspecified feeding and eating disorder

- Existing disorders that moved
  - Pica
  - Rumination
  - Avoidant/restrictive food intake disorder (renamed from Feeding Disorder of Infancy)
Binge Eating Disorder
(p. 350; 307.51 / F50.8)

A. Recurrent binge episodes
   1. Discrete time, larger amount than most under similar circumstances
   2. Sense of lack of control over eating during episode

B. Episodes associated 3+
   1. Eating much more rapidly
   2. Eating until uncomfortably full
   3. Eating large amounts food when not physically hungry
   4. Eating alone b/c embarrassed
   5. Feeling disgusted with self, depressed, or very guilty

C. Marked distress

D. Average at least once a week for 3 months

E. Not associated with recurrent, inappropriate compensatory behavior; not exclusively during anorexia or bulimia

In partial remission, in full remission
Mild, moderate, severe, extreme
Binge Eating Disorder

- **Key Issue:** Recurrent episodes of binge eating without inappropriate compensatory behaviors
- **Prevalence:** DSM-5 says 1.6% in females and 0.8% in males, similar across racial and ethnic groups
- **Course:** Tends to begin in adolescence or early adulthood, comparable to bulimia (severity, duration)
- **Comorbidities:** mood, anxiety, substance use
- **Differential:** Bulimia nervosa, obesity, bipolar and depressive disorders, borderline personality disorder
Revised Criteria

- **Anorexia nervosa**
  - Removal of body weight %, instead use BMI calculations to note severity
    - Mild (17+)
    - Moderate (16-16.99)
    - Severe (15-15.99)
    - Extreme (less than 15)
  - Removal of amenorrhea criterion

- **Bulimia nervosa**
  - Change in frequency criterion
    - Now 1x/week for 3 months (compared to 2x/week)
Impact of Changes

- Potential challenges related to BMI
- Frequency changes might alleviate the potential overuse of eating disorder NOS (now other specified eating disorder)
Checking in
Elimination disorders
- Moved to own chapter from childhood disorders

Sleep-wake disorders
- Clarifies when to refer to sleep specialist; more attention to co-existing conditions

Sexual dysfunctions
- Moved to own chapter, separate from gender dysphoria and paraphilic disorders

Gender dysphoria
- Goal to decrease stigma (i.e., dysphoria rather than disorder), while allowing for a dx to help access of mental health & medical care

Paraphilic disorders
- Feel personal distress about interest/behavior; Sexual interests cause distress, injury, or death other others; or others cannot give consent
Disruptive, Impulse-Control, and Conduct Disorders

New Chapter!
Areas of Change

- **New disorders**
  - Other specified disruptive, impulse-control and conduct disorder
  - Unspecified disruptive, impulse-control and conduct disorder

- **Existing disorders that moved**
  - Oppositional defiant disorder
  - Intermittent explosive disorder
  - Conduct disorder
  - Pyromania
  - Kleptomania
Revised Disorders

- **Oppositional Defiant Disorder**
  - Removed restriction of co-occurring ODD and CD
  - New clustering of symptoms and severity specifiers
    - Angry/irritable mood; argumentative/defiant behavior; vindictiveness
    - Mild (one setting), moderate (two settings), severe (three or more settings)

- **Conduct disorder**
  - New specifier: with limited prosocial emotions
Impact of Change

- Mindfulness of co-occurrence of ODD and CD
Substance-Related and Addictive Disorders
Areas of Change

- Elimination of abuse and dependence
  - Introduction of substance use on continuum
- Elimination of physiological specifier
- Elimination of partial remission
- Elimination of polysubstance disorder

New Disorders
- Caffeine Withdrawal
- Cannabis Withdrawal
- Gambling Disorder
Substance Use Disorder
Core Criteria

**Over 12-month Period:**

1. Larger amounts, longer time than intended
2. Attempts to cut down
3. Time spent to obtain, use, recover
4. Craving
5. Failure to fulfill major obligations
6. Continued use despite recurrent problems
7. Giving up activities
8. Use when physically hazardous
9. Continued use despite physical or psychological problems
10. Tolerance
11. Withdrawal

**Severity and Specifiers:**

- Mild = 2-3 symptoms
- Moderate = 4-5 symptoms
- Severe = 6 + symptoms
- Early remission
- Sustained remission
- Controlled environment
- Maintenance therapy (for opioid use only)
Gambling Disorder
(p. 585; 312.31/F63.0)

A. Persistent, recurrent problematic gambling bx leading to CSID, 4+ in 12 month period
1. Tolerance
2. Restless/irritable trying to cut down
3. Unsuccessful efforts to control, cut back, stop
4. Often preoccupied
5. Often gambles when feeling distressed
6. After loses, returns to get even
7. Lies to conceal extent
8. Jeopardized or lost relationship, job, ed, career
9. Relies on others to relieve desperate financial situations

B. Not manic episode

Episodic, persistent
Early remission, sustained remission
Mild, moderate, severe
Gambling Disorder

- **Key Issue:** Persistent, recurrent problematic gambling

- **Prevalence:** *DSM-5* says 0.2-0.3% past year, 0.4-1.0% lifetime, 3x higher males, 2x higher African Americans

- **Course:** Tends to begin in adolescents or young adulthood, develops over years, episodic or persistent

- **Comorbidities:** poor general health, substance use, depressive, anxiety, personality

- **Differential:** nondisordered gambling, manic episode, personality disorders, medical conditions
Impact of Changes

- Some surprise other potential addictions were not included in *DSM-5* revisions
  - Internet gaming disorder
    - In conditions for further study
  - Sex, shopping, and exercise addiction not mentioned

- Some debate regarding elimination of abuse, especially when working with young people

- In general, most researchers believe substance use on a spectrum will assist with access to treatment.
Neurocognitive Disorders

New Chapter!
Areas of Change

- Removal of dementia, amnestic, and “other cognitive disorders”—now neurocognitive disorder (NCD)
- Evidence of decline within six cognitive domains
  - complex attention
  - executive function
  - learning and memory
  - language
  - perceptual-motor
  - social cognition
- Delirium remains unchanged
Major and Mild NCD

**Major NCD = significant decline among 1+ of six domains**
- Informant evidence + neuropsychological or quantified ax
- Interfere with independence
- Mild, moderate, or severe

**Mild NCD = modest decline**
- Informant + modest impairment in quantified ax
- Does not interfere with ADLs

**Specify:**
- Without behavioral disturbance
- With behavioral disturbance

**Specify due to:**
- Alzheimer’s disease
- Frontotemporal lobar degeneration
- Lewy body disease
- Traumatic brain injury
- Substance/medication use
- HIV infection
- Prion disease
- Parkinson’s disease
- Huntington’s disease
- Another medical condition
- Multiple etiologies
- Unspecified
Impact of Change

- Counselors can intervene as NCD progresses
- Pathologizing “pre-disease?”
- Early intervention may lead to better long term prognosis
Personality Disorders
Personality Disorders

Business as usual

but / and

new model proposed
Applications
DSM-5 Resources

Direct DSM-5 Links
- Individual change/disorder fact sheets (www.psychiatry.org/dsm5)
- Online assessment measures (http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures)
- Coding updates (http://dsm.psychiatryonline.org/DSM5CodingSupplement)

Publications from DSM-5 Development
http://www.dsm5.org/research/pages/publications.aspx
Peer-reviewed publications regarding DSM-5 development process and decisions

World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)
http://www.who.int/classifications/icf/en/
Psychometric and clinical information regarding the proposed disability assessment measure. Second link will take one directly to the WHODAS 2.0 manual

Patient Reported Outcomes Measurement Information System (PROMIS)
http://www.nihpromis.org/
Federal resource to aid in understanding many of the Level 2 assessments

Responsibilities of Users of Standardized Tests (3rd edition)
Accessible standards regarding responsible assessment practice

The Professional Counselor: Volume 4, Issue 3, Special Issue “Counseling and the DSM-5”
Series of articles focused on DSM-5 revisions and implications for professional counselors. Topics include historical/philosophical shifts, conceptual changes, removal of multiaxial system, private practice implications, evaluating emerging measures, revising diagnoses, eating disorders, trauma changes, multicultural and strength-based considerations, and medicalization.

Start Here Readings


More Specialized Readings


