



DSM-5 UPDATE

Aaron Norton, LMHC, CAP, CRC

What We'll Cover...

- Brief Snapshot: Overview of Changes
- Sample of Perspectives on “Controversy” of DSM-5
- Overview of Section II Chapter Changes
- Overview of Section II Disorder Changes (with exploration of how changes in Autism and Substance Use Disorders may impact VR Counselors)
- Questions, Comments, Ideas

Disclaimers

- This is not an exhaustive review, but it should cover most of the significant changes
- It is not my role to tell VR Counselors how to perform their job duties or implement their agency's internal policies or best practices. Consult internally
- Primary source: "[Highlights of Changes from DSM-IV to DSM-5](#)," APA. All other sources will be reference through hyperlinks
- My opinions will be clearly delineated as my perspective, not fact
- DSM-5 is new; we're all still learning it (myself included)
- The purpose of including information about "controversy" surrounding the DSM-5 is not to endorse or promote any perspective; it is to increase awareness by exploring a range of perspectives

Why Do We Have a DSM?

- “The primary purpose of the DSM-5 is to assist trained clinicians in the diagnosis of their patients’ mental disorders as part of a case formulation assessment that leads to a fully informed treatment plan for each individual” (APA, 2013; p. 3)
 - ▣ American Psychiatric Association (2013). *Desk Reference to the Diagnostic Criteria From DSM-5*. American Psychiatric Publishing: Washington, DC.

Overview of Changes

- The term “general medical condition” replaced by the term “another medical condition” throughout the text
- Multiaxial classification system has been discontinued
- Global Assessment of Functioning (GAF) scale has been discontinued. Instead, more options for indicating severity have been worked into the individual disorders

Overview of Changes

- Some chapters have been renamed
- Chapter order has been restructured
- Some chapter names have been eliminated and disorders have been reclassified under other chapters
- Some new disorders have been added; others have been revised or renamed; others have been removed or categorized as subtypes of another disorder
- Shift towards a spectrum classification vs. more rigid, dichotomous categories (e.g. autistic spectrum, substance use disorder)

Overview of Changes

- Some instances of de-pathologizing (e.g. paraphilias vs. paraphilic disorders)
- Some new disorder classifications to capture individuals who need tx. but were technically just shy of meeting diagnostic criteria (e.g Mild Neurocognitive Disorder)
- Attempts at reducing the “Not Otherwise Specified” category due to greater depth of detail about symptoms. You’ll now see verbiage like “Other Specified” or “Unspecified.”

My, My, The “Controversy!”

- [Federal Mental Health Agency to Drop DSM Use](#) (NBC, 5/3/13)
- [The DSM-5 is here: What the controversial new changes mean for mental health care](#) (Fox News, 5/21/13)
- [Chorus of critics greets new psychiatric manual release](#) (NBC, 5/17/13)
- [Controversial update to psychiatry manual, DSM-5, arrives](#) (CBS News, 5/18/13)
- [Reflection on DSM V: 'Being Human is Itself Fast Becoming a Condition'](#) (MedPage Today, 5/6/13)
- [Psychiatrists under fire in mental health battle](#) (The Guardian [UK], 5/11/13)
- [Controversial psychiatry 'bible' about to launch](#) (Canada.com, 5/23/13)
- [Two Fatal Technical Flaws in the DSM-5 Definition of Autism](#) (Huffington Post, 5/25/13)
- [Grief Differs From Depression: Our Mental Health Guidelines Should Clarify, Not Distort](#) (Huffington Post, 5/22/13)
- [The new DSM-5 fails to accurately describe mental illness](#) (Fox News, 5/22/13)
- [Goodbye to the DSM-5](#) (Huffington Post, 5/22/13)



“The goal of this new manual, as with all previous editions, is to provide a common language for describing psychopathology. While DSM has been described as a “Bible” for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been “reliability” – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever. Indeed, symptom-based diagnosis, once common in other areas of medicine, has been largely replaced in the past half century as we have understood that symptoms alone rarely indicate the best choice of treatment.. Patients with mental disorders deserve better. ”

Thomas Insel, Director, National Institutes of Mental Health

[Director's Blog](#), 4/29/13

What Are Critics Alleging?

- Categories are arbitrary; not sufficiently based on underlying neurobiology
 - ▣ “The weakness is its lack of validity,” - NIMH Director Thomas Insel ([CBS News](#), 5/18/13)
 - ▣ “Psychiatric diagnosis is often presented as an objective statement of fact, but is, in essence, a clinical judgment based on observation and interpretation of behavior and self-report, and thus subject to variation and bias” ([British Psychological Society](#), 5/12/13)
- Pathologizing (e.g. Bereavement, Disruptive Mood Dysregulation Disorder)
- Changes in diagnosing autism may result in some children with Aspergers being pushed out of diagnosis
- Psychiatrists maintain monopoly on the classification system-tainted by “Big Pharma”

But then again...

- “Basically anytime you change something, it’s always met with resistance.” - Dr. Max Wiznitzer, a pediatric neurologist for UH Rainbow Babies & Children’s Hospital in Cleveland, Ohio ([Fox News](#), 5/21/13)
- “Today, the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM), along with the International Classification of Diseases (ICD) represents the best information currently available for clinical diagnosis of mental disorders. Patients, families, and insurers can be confident that effective treatments are available and that the DSM is the key resource for delivering the best available care. The National Institute of Mental Health (NIMH) has not changed its position on DSM-5. As NIMH's [Research Domain Criteria \(RDoC\)](#) project website states, ‘The diagnostic categories represented in the DSM-IV and the International Classification of Diseases-10 (ICD-10, containing virtually identical disorder codes) remain the contemporary consensus standard for how mental disorders are diagnosed and treated.’” – [Press Release 5/13/13](#), Thomas R. Insel, M.D., Director, NIMH, & Jeffrey A. Lieberman, M.D., President-elect, APA

DSM 5 Table of Contents

- Section I: DSM-5 Basics
- Section II: Diagnostic Criteria and Codes
- Section III: Emerging Measures and Models
 - ▣ Assessment Measures
 - ▣ Cultural Formulation
 - ▣ Alternative DSM-5 Model for Personality Disorders
 - ▣ Conditions for Further Study
- Appendix

Section II: 22 Chapters

1. Neurodevelopmental Disorders
2. Schizophrenia Spectrum and other Psychotic Disorders
3. Bipolar and Related Disorders
4. Depressive Disorders
5. Anxiety Disorders
6. Obsessive-Compulsive and Related Disorders
7. Trauma-and Stressor-Related Disorders
8. Dissociative Disorders
9. Somatic Symptoms and Related Disorders
10. Feeding and Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse-Control and Conduct Disorders
16. Substance-Related and Addictive Disorders
17. Neurocognitive Disorders
18. Personality Disorders
19. Paraphilic Disorders
20. Other Mental Disorders
21. Medication-Induced Movement Disorders and Other Adverse Effects of Medication
22. Other Conditions that May be a Focus of Clinical Attention (V and Z Codes)



Section II Chapter Changes

Section II Chapter Comparison: DSM-IVTR to DSM-5

- “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence” scrapped. Disorders reorganized under other chapters
- “Delirium, Dementia, and Amnestic and Other Cognitive Disorders” renamed “Neurocognitive Disorders”
- “Mental Disorders Due to a General Medical Condition Not Elsewhere Classified” scrapped.
- “Substance-Related Disorders” renamed “Substance Use and Addictive Disorders;” inclusive of “Gambling Disorder”

Section II Chapter Comparison: DSM-IVTR to DSM-5

- “Schizophrenia and Other Psychotic Disorders” renamed “Schizophrenia Spectrum and Other Psychotic Disorders”
- “Mood Disorders” chapter has been split into 2 separate chapters: “Bipolar and Related Disorders” and “Depressive Disorders”
- “Somatoform Disorders” renamed “Somatic Symptom and Related Disorders”
- “Sexual and Gender Identity Disorders” broken into 3 separate chapters: “Sexual Dysfunctions,” “Gender Dysphoria,” and “Paraphilic Disorders”

Section II Chapter Comparison: DSM-IVTR to DSM-5

- “Eating Disorders” chapter renamed “Feeding and Eating Disorders” and includes some disorders previously listed in other sections (e.g. Pica”)
- “Sleep Disorders” chapter renamed “Sleep-Wake Disorders”
- “Adjustment Disorders” chapter eliminated; adjustment disorders shifted to “Trauma and Stress-Related Disorders”
- Several disorders shifted from “Other Conditions that May Be a Focus of Clinical Attention” to “Other Mental Disorders”

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Section II Disorder Changes

“Mental Retardation” vs. “Intellectual Disability”

- “Mental Retardation” renamed “Intellectual Disability (Intellectual Developmental Disorder)”
- Severity now determined by adaptive functioning, not IQ score

Communication Disorders

- “Language Disorder” (combines DSM-IV’s expressive and mixed receptive-expressive language disorders)
- “Phonological Disorder” renamed “Speech Sound Disorder”
- “Stuttering” renamed “Childhood-Onset Fluency Disorder”
- New diagnosis: “Social (Pragmatic) Communication Disorder” (persistent difficulties in the social cues of verbal and nonverbal communication...not to overlap disorders in the Autistic Spectrum Disorder classification)

Autistic Spectrum Disorder

- Four previously separate disorders (Autism, Asperger's, childhood disintegrative disorder, pervasive developmental disorder) now viewed as a single condition with different levels of symptom severity in 2 core domains : (1) deficits in social communication and social interaction, and (2) restricted repetitive behaviors, interests, and activities

Why the Changes?

- Check out this thorough [presentation](#) by Dr. Walter Kaufmann, Dept. of Neurology, Boston Childrens Hospital, Harvard Medical School

School to Work Counselors...

- Will customers who were previously excluded from the Medicaid Waiver administered by APD due to an Aspergers diagnosis (vs. Autism) now be eligible for this source of Phase II Supported Employment funding for developmental disorders?
- Hmmmmm.....

Attention-Deficit/Hyperactivity Disorder

- Examples have been added to the criterion items to facilitate application across the life span
- The cross-situational requirement has been strengthened to “several” symptoms in each setting
- Onset criterion changed from symptoms “before age 7 years” to before 12 years
- Subtypes replaced with presentation specifiers that map directly to the prior subtypes
- Comorbidity with Aspergers now allowed
- Adults need only meet 5 symptoms, whereas children still require 6

Specific Learning Disorder

- Combines the DSM-IV diagnoses of Reading Disorder, Mathematics Disorder, Disorder of Written Expression, and Learning Disorder, NOS into one disorder but allows coded specifiers for deficit types.
- Rationale: learning deficits often co-occur.

Motor Disorder

- Includes several disorders that were previously classified under the “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence” chapter (i.e. Developmental Coordination Disorder, Stereotypic Movement Disorder, Tourette’s Disorder, Persistent (Chronic) Motor or vocal Tic Disorder, Provisional Tic Disorder, Other Specified Tic Disorder, Unspecified Tic Disorder)
- Tic criteria have been standardized across all disorders
- Stereotypic Movement Disorder has been more clearly differentiated from Body-Focused Repetitive Behaviors disorders that are in the new Obsessive-Compulsive Disorder chapter

Schizophrenia

- No longer a differentiation between bizarre and non-bizarre delusions or on the question of whether or not two or more voices are conversing with each other
- New requirement: individual must have at least 1 of 3 positive symptoms (delusions, hallucinations, and disorganized speech)
- Subtypes have been eliminated (paranoid, disorganized, catatonic, undifferentiated, residual)

Schizoaffective Disorder & Delusional Disorder

- New requirement for Schizoaffective Disorder: A major mood episode must be present for a majority of the disorder's total duration after Criterion A symptoms of Schizophrenia (positive and negative symptoms) has been met
- Delusional Disorder: Non-bizarre delusions no longer a requirement

Catatonia

- Same criteria used to diagnose it regardless of whether the context is a psychotic, bipolar, depressive, other medical disorder, or unidentified medical condition
- 3 of 12 symptoms required
- May be diagnosed as a specifier for depressive, bipolar, and psychotic disorders; as a separate diagnosis in the context of another medical condition, or as an other specified diagnosis

Bipolar & Related Disorders

- Criterion A for manic and hypomanic episodes now includes an emphasis on changes in activity and energy as well as mood
- “Mixed Episode” removed and replaced with a specifier “With Mixed Features.”
- New diagnosis: “Other Specified Bipolar and Related Disorder”
- New specifier: “Anxious Distress”

Depressive Disorders

- New diagnoses: Disruptive Mood Dysregulation Disorder, Premenstrual Dysphoric Disorder
- Dysthymic Disorder and Major Depressive Disorder, Chronic have merged into 1 disorder: Persistent Depressive Disorder
- New specifier for Major Depressive Episode (“With Mixed Features”) designed for people who have at least 3 manic symptoms within a depressive episode (insufficient for label of “manic episode”)
- No more Bereavement exclusion!!!

Anxiety Disorders

- OCD, PTSD, and Acute Stress Disorder all moved out of this category and into others
- Recognition that one's anxiety is excessive or unreasonable is no longer required for diagnosis of Agoraphobia, Specific Phobia, or Social Anxiety Disorder (Social Phobia)
- 6 month duration requirement extended to all individuals (vs. just those under 18 years of age) to minimize diagnosis of transient fears

Anxiety Disorders

- Panic attacks: minor verbiage changes to simplify. Can be used as a specifier in other disorders.
- Panic Disorder and Agoraphobia no longer linked together. They are now separate disorders that can be co-occurring.
- Verbiage change for Social Phobia specifiers
- Separation Anxiety Disorder recruited from the old childhood disorders chapter of DSM-IV; no longer requires that onset be during childhood
- Selective Mutism recruited from DSM-IV's old childhood disorders chapter

Obsessive Compulsive and Related Disorders

- New Chapter!
- New disorders:
 - ▣ Hoarding Disorder
 - ▣ Excoriation (Skin-Picking Disorder)
 - ▣ Substance-/Medication-Induced Obsessive-Compulsive and Related Disorder
 - ▣ Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
- Recruited Trichotillomania (Hair-Pulling Disorder) from DSM-IV's Impulse-Control Disorders, NEC

Obsessive Compulsive and Related Disorders

- **Specifiers:**
 - ▣ With Poor Insight refined. New options include: with good or fair insight, poor insight, and absent insight/delusional beliefs
 - ▣ New “Tic-Related” specifier for OCD
- **Body Dysmorphic Disorder**
 - ▣ Diagnostic criterion has been added that describes repetitive behaviors or mental acts in response to preoccupations with perceived defects or flaw in physical appearance
 - ▣ New specifier: “With Muscle Dysmorphia”

Acute Stress Disorder & PTSD

- Must now be explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly
- DSM-IV's Criterion regarding the subjective reaction to the traumatic event (intense fear, helplessness, or horror) removed
- PTSD: 4 vs. 3 symptom clusters (avoidance/numbing cluster divided into 2 separate clusters)
- PTSD diagnostic thresholds have been lowered for children and adolescents to be more “developmentally sensitive,” and separate criteria have been added for children under 6

Reactive Attachment Disorder

- The 2 subtypes from DSM-IV (emotionally withdraw/inhibited and indiscriminately social/disinhibited) are now defined as distinctly separate disorders: Reactive Attachment Disorder and Disinhibited Social Engagement Disorder

Dissociative Disorders

- Depersonalization Disorder is now Depersonalization/Derealization Disorder
- Dissociate Fugue is now a specifier instead of a separate disorder
- Criterion A for Dissociative Identity Disorder has been expanded to include certain possession-from phenomena and functional neurological symptoms. Also, transitions in identity may be observable by others or self-reported and recurrent gaps in memory can be for everyday events, not just for traumatic experiences.

Somatic Symptoms and Related Disorders

- Somatization Disorder and Undifferentiated Somatoform Disorder merged into Somatic Symptom Disorder with no specifier required.
- New recognition that somatic disorders can accompany diagnosed medical disorders; they need not be distinct and separate; now thought of more as a spectrum
- Hypochondriasis eliminated; most of these clients would meet criteria for Somatic Symptom Disorder
- Pain Disorder: Can now be diagnosed for people who have legitimate chronic pain that can be medically explained. Less emphasis on separating psychological from medical

Feeding and Eating Disorders

- Includes several disorders recruited from the DSM-IV's childhood disorders chapter; now modified to include adults
- Minor changes to Anorexia Nervosa and Bulimia Nervosa (e.g. frequency of compensatory behavior and binge eating decreased for Bulimia)
- New disorder: Binge-Eating Disorder

Sleep-Wake Disorders

- Shift to recognition of co-existing medical and mental conditions vs. separating the two
- Breathing-related sleep disorders divided into 3 distinct disorders: Obstructive Sleep Apnea Hypopnea, Central Sleep Apnea, and Sleep-Related Hypoventilation
- Expanded subtypes for Circadian Rhythm Sleep-Wake Disorders
- NOS category reduced by adding Rapid Eye Movement Sleep Behavior Disorder and Restless Legs Syndrome

Sexual Dysfunctions

- Dyspareunia and Vaginismus merged into Genito-Pelvic Pain/Penetration Disorder
- Reduction in subtypes

Gender Dysphoria

- New category because gender dysphoria is neither a paraphilia nor a sexual dysfunction. “Gender Identity Disorder” verbiage is perhaps misleading and/or outdated; new paradigm shift away from “cross gender identification” per se to “gender incongruence”
- “Gender” verbiage vs. “sex” verbiage
- “Strong desire to be of the other gender” replaces “repeatedly stated desire” to be more developmentally sensitive
- Subtyping based on sexual orientation removed-not clinically useful

Disruptive, Impulse Control, and Conduct Disorders

- New chapter in DSM-5
- Consists of disorders that were linked due to their close association with Conduct Disorder
- 4 changes for Oppositional Defiant Disorder: (1) symptoms now grouped into 3 types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness; (2) exclusion criteria for Conduct Disorder removed; (3) more guidance regarding frequency requirements; and (4) severity rating added

Disruptive, Impulse Control, and Conduct Disorders

- New specifier for Conduct Disorder: With Limited Pro-Social Emotions (denotes a more severe clinical presentation)
- Intermittent Explosive Disorder: Whereas DSM-IV required physical aggression, verbal aggression and non-destructive/noninjurious physical aggression are permissible in DSM-5. Also, more guidance re. frequency of symptoms. Finally, minimum age of 6 years now required

Substance-Related and Addictive Disorders

- Category expanded-may increasingly include non-substance-related addictive disorders that are similar in terms of neurobiological processes
- “Pathological Gambling” renamed “Gambling Disorder” and shifted from “Impulse Control Disorders Not Elsewhere Classified” chapter to “Substance-Related and Addictive Disorders” chapter
- Substance Abuse and Dependence merged into 1 disorder (Substance Use Disorder) with a spectrum from mild to severe (2-3 sx = mild; 4-5 sx = moderate; 6 or more sx = severe. Legal problems criteria removed and craving added
- The threshold for a substance use disorder has increased from 1 sx (DSM-IV’s Abuse dx) to 2 sx (DSM 5’s Substance Use Disorder, Mild)
- New: Cannabis Withdrawal & Caffeine Withdrawal
- No Nicotine Abuse in DSM-IV, but Nicotine Use Disorder uses same criteria as other substances in DSM-5
- Remission: Whereas DSM-IV defined Early Remission as 1-less than 12 months of no sx, DSM-5 defines Early Remission as 3-less than 12 months of no sx (excluding Craving)

DSM-IVTR

Abuse: 1 or more...

- 1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
- 2) Recurrent substance use in situations in which it is physically hazardous
- 3) Recurrent substance-related legal problems (such as arrests for substance related disorderly conduct
- 4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

Dependence: 3 or more...

1. Tolerance,
2. Withdrawal
3. The substance is often taken in larger amounts or over a longer period than intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance

DSM-5

Substance Use Disorder 2 or more...

(2-3: Mild; 4-5-Moderate; 6 or More-Severe)

- 1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
- 2) Recurrent substance use in situations in which it is physically hazardous
- ~~3) Recurrent substance-related legal problems (such as arrests for substance-related disorderly conduct~~
- 3) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
- 4) Tolerance
- 5) Withdrawal
- 6) The substance is often taken in larger amounts or over a longer period than intended.
- 7) There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- 8) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- 9) Important social, occupational, or recreational activities are given up or reduced because of substance use.
- 10) The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance
- 11) Craving**

Why the Changes?

- Dr. Yasmin Hurd, Professor of Psychiatry at Mt. Sinai in a [Fox News article](#) 5/21/13:
 - ▣ “It was quite confusing, especially with the term dependence...It had association with severe psychological dependencies, generating a lot of confusion. Now the DSM-5 just talks about addiction, in context, being about the compulsive nature of the disorder.”
- On Cannabis Withdrawal: “Experts in the field know that people who have severe cannabis use – they’ll go through cannabis withdrawal...There is a misnomer in our society that people can’t get addicted to marijuana. That’s not true. There are more people that meet the criteria for abuse of cannabis than any other illicit drug.”
- On spectrum (Mild-Severe): “You’re going to have many people with alcohol and cannabis addiction who have mild addiction, but very few heroin addicts are going to be mild.”

Impact of Substance Use Disorder Revisions on Disability & VR

- [ADA: Title III](#), Part 36, Section 36.104(1)(iii) “The phrase physical or mental impairment includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism”
- Section 36.209: “A distinction is also made between the use of a substance and the status of being addicted to that substance. Addiction is a disability, and addicts are individuals with disabilities protected by the Act. The protection, however, does not extend to actions based on the illegal use of the substance. In other words, an addict cannot use the fact of his or her addiction as a defense to an action based on illegal use of drugs. This distinction is not artificial. Congress intended to deny protection to people who engage in the illegal use of drugs, whether or not they are addicted, but to provide protection to addicts so long as they are not currently using drugs.”

Impact of Substance Use Disorder Revisions on Disability & VR

- Rehabilitation Act only allows the exclusion of Alcoholism or Drug Addiction if the individual is currently using
 - **“(v) Employment; exclusion of alcoholics** For purposes of sections 503 and 504 as such sections relate to employment, the term ‘individual with a disability’ does not include any individual who is an alcoholic whose current use of alcohol prevents such individual from performing the duties of the job in question or whose employment, by reason of such current alcohol abuse, would constitute a direct threat to property or the safety of others.”
 - **“(F) Rights provisions; exclusion of individuals on basis of certain disorders** For the purposes of sections 501, 503, and 504, the term ‘individual with a disability’ does not include an individual on the basis of...(iii) psychoactive substance use disorders resulting from current illegal use of drugs.”

VR Counselor Policy Manual, Ch. 4

(Downloaded 5/27/13)

4.13 Chemical Dependency

1. The eligibility decision by the counselor should be based upon a current assessment of psychological functioning and a demonstrated desire by the individual to remain substance free and participate with available resources, e.g., Alcoholics Anonymous/Narcotics Anonymous (AA/NA), local community drug and alcohol awareness centers.
2. Individuals who are actively abusing drugs shall not fall under the category "individual with a disability". In the context of chemical dependency, an individual is an "individual with a disability" who:
 - a. has successfully completed a supervised drug rehabilitation program and is no longer engaging in such use;
 - b. participates in a supervised rehabilitation program and is no longer engaging in such use; or
 - c. is mistakenly regarded as engaging in such use but is, in fact, not engaging in such use. Alcohol or drug testing may be used to ensure that the individual is no longer engaging in the use of alcohol or illegal drugs.

So...What constitutes “Chemical Dependency?”

- Historically, a DSM-IVTR diagnosis of Substance Dependence, NOT Substance Abuse
- ...But now that these terms have been eliminated from the DSM-5, what shall we consider to be “Chemical Dependency?”
- Maybe someone will clarify, but my recommendation from a clinician's perspective is to consider a mild to moderate Substance Use Disorder the equivalent of Chemical Dependency-seems logical given the overlap between this area on the spectrum and the prior criteria for Substance Dependence

...And When Are They Ready for VR Services?

Rule of thumb: They should at LEAST be in Remission (now defined by DSM as 3 or more months of no sx)

Length of Abstinence for VR Eligibility

- Must be decided on a case-by-case basis
- ...But there are some “rules of thumb”
 - ▣ NIDA: “Individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes.”

Length of Abstinence for VR Eligibility

- Clients who have been abstinent for 90 days or less are at the greatest risk for relapse. Because of this, modest vocational goals are more appropriate. However, some individuals have significant cognitive dysfunction and have difficulty making plans and structuring time. It is generally best to limit stress and make only gradual changes in life activities, keeping the client focused on the recovery process and the ‘here and now’....”

Length of Abstinence for VR Eligibility

- ... “If it is essential to address vocational goals prior to 90 days of abstinence, then strong supports will be needed to maximize the individual’s chance of success...Individuals who have maintained their abstinence for more than 3 months have a diminished risk of relapse and, in general, a greater success rate for engaging in new activities and tolerating stress.” ([Moore, 2008](#))

Moore, E. (ed.). (2008). *Substance use disorder treatment for people with physical and cognitive disabilities: Vol. 29. Treatment improvement protocol series*. Rockville, MD: U.S. Dept. of Health and Human Services, Substance

Length of Abstinence for VR Eligibility

- New York VR: “There is no minimum sobriety period that an individual is required to have prior to referral or application for VR services.”
- Dr. Brown, Psychological Consultant, Area 1 Florida DVR prefers 6 months
- North Dakota VR: “A good rule to follow is 6 months of sobriety for alcohol dependency and 6 to 9 months of sobriety (clean) for use of illicit/illegal drugs including synthetic drugs.”

Neurocognitive Disorders

- DSM-IV diagnoses of Dementia and Amnesic Disorder now combined into new diagnosis of Major Neurocognitive Disorder
- DSM-5 now recognizes a less severe level of cognitive impairment, mild Neurocognitive Disorder

Etiological Subtypes

In DSM-IV, individual criteria sets were designated for dementia of the Alzheimer's type, vascular dementia, and substance-induced dementia, whereas the other neurodegenerative disorders were classified as dementia due to another medical condition, with HIV, head trauma, Parkinson's disease, Huntington's disease, Pick's disease, Creutzfeldt-Jakob disease, and other medical conditions specified. In DSM-5, major or mild vascular NCD and major or mild NCD due to Alzheimer's disease have been retained, whereas new separate criteria are now presented for major or mild NCD due to frontotemporal NCD, Lewy bodies, traumatic brain injury, Parkinson's disease, HIV infection, Huntington's disease, prion disease, another medical condition, and multiple etiologies. Substance/medication-induced NCD and unspecified NCD are also included as diagnoses.

Personality Disorders

- No changes in diagnostic criteria (despite all the buzz)
- However, an alternative method for diagnosing Personality Disorders will be included in Section III as a model to use for further study. Its called a “hybrid dimensional-categorical model.” It was almost adapted into the DSM-5 but was not. It may replace the current system in a future revision.

Paraphilic Disorders

- New course specifiers added: “In a Controlled Environment” and “In Remission.”
- DSM-5 recognizes that paraphilias are not necessarily paraphilic disorders; so names of disorders have been changed to add the verbiage “Disorder” (e.g. Pedophilia is now Pedophilic Disorder)
- An individual must now meet Criterion A AND Criterion B for the diagnosis (A=qualitative nature of the disorder; B=negative consequences, i.e. distress, impairment, harm/risk of harm to self/others)
 - De-pathologizing? Differentiating non-normal behavior from disordered behavior

Thoughts? Questions? Discussion?

Integrity
Counseling & Coaching

Aaron Norton, LMHC, CRC, CAP
Licensed Mental Health Counselor • #9953
Certified Rehabilitation Counselor • #00101220
Certified Addictions Professional • #3199

1101 S. Belcher Road, Suite J
Largo, FL 33771
www.anorton.com
me@anorton.com

Cell: (727) 403-6208
Phone: (727) 531-7988
Fax: (727) 531-0950

Resource: [APA's DSM-5 website](#)