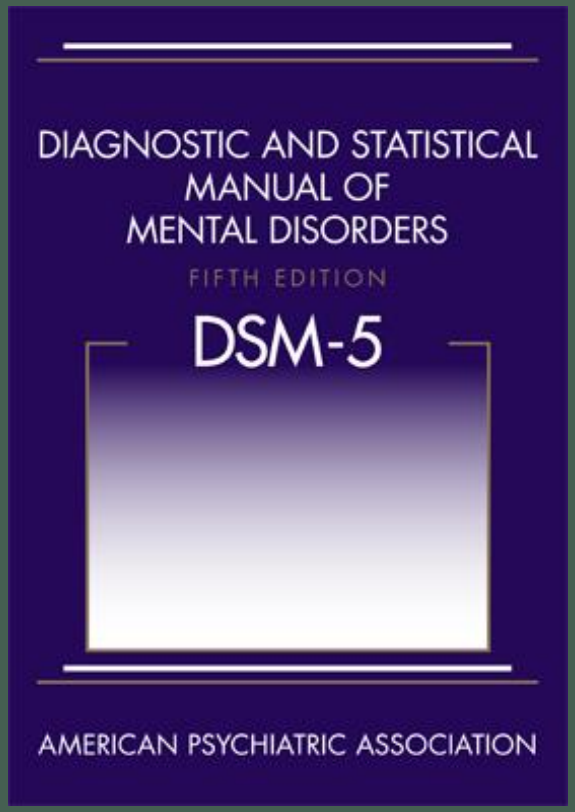

DSM-5 UPDATE FOR FORENSIC EVALUATORS

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Aaron Norton, LMHC, CAP, CRC

What We'll Cover…

- Brief Snapshot: **Overview** of Changes
- DSM-5 **Controversies**
- Overview of **Section II Chapter Changes**
- Overview of **Section II Disorder Changes**
- Overview of **Section III Changes**
- **DSM-5 Resources**
- **Q**uestion **&** **A**nswer Session

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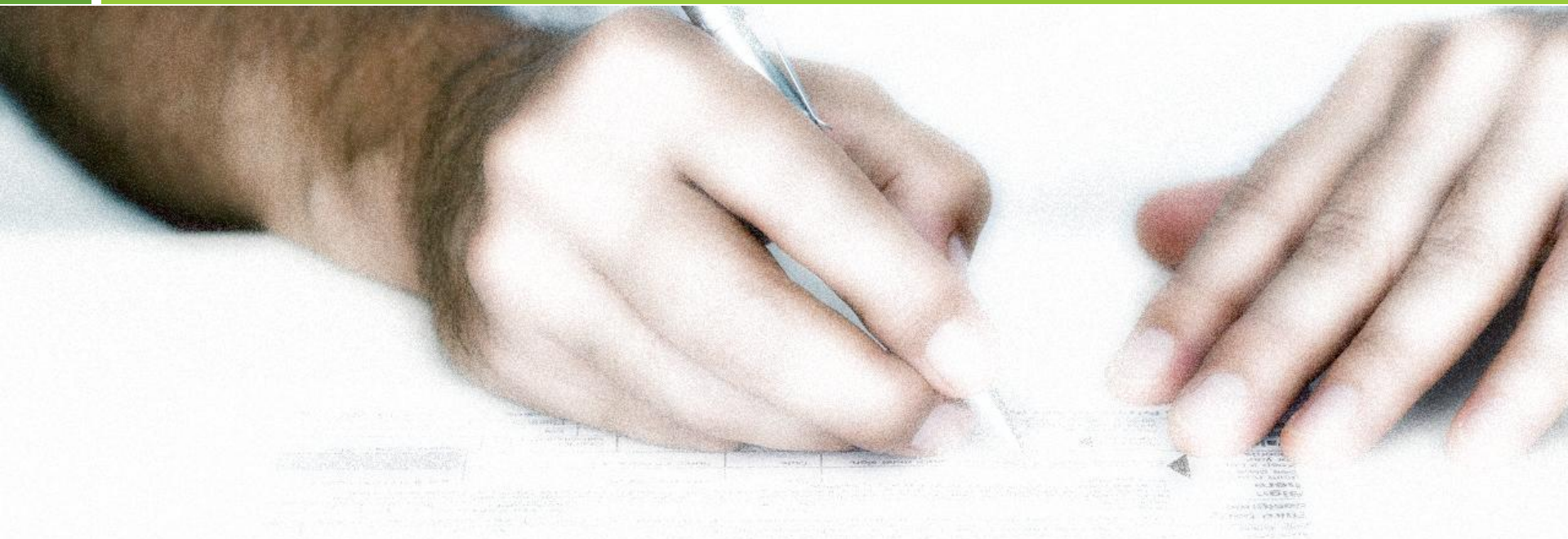
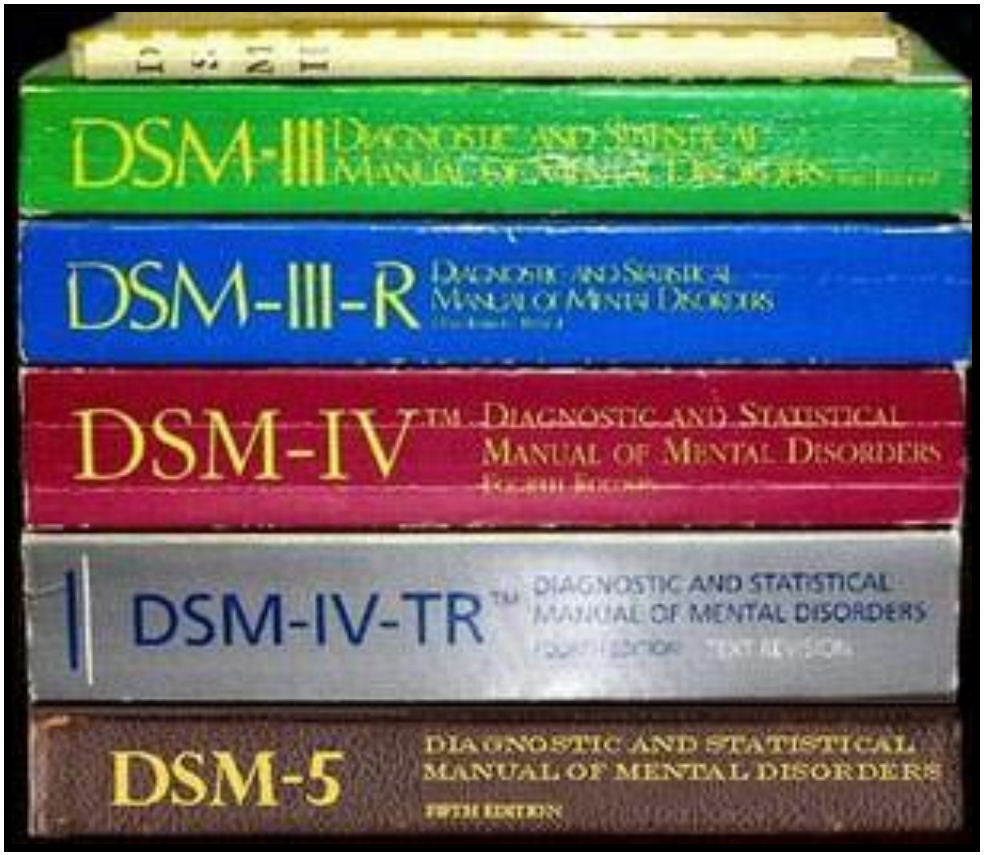
Why Do We Have a DSM?



- "…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*)

Looking Back



- 1952: DSM-I
- 1968: DSM-II
- 1980: DSM-III
- 1987: DSM-III-R
- 1994: DSM-IV
- 2000: DSM-IVTR
- 2013: DSM-5

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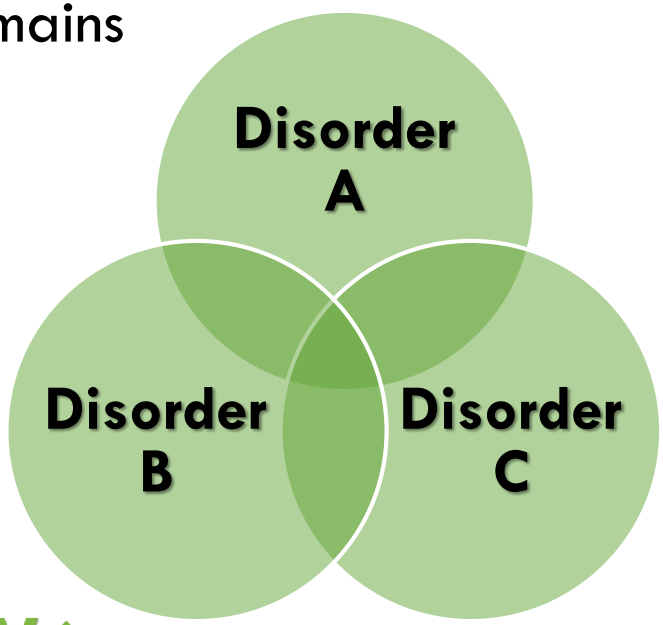
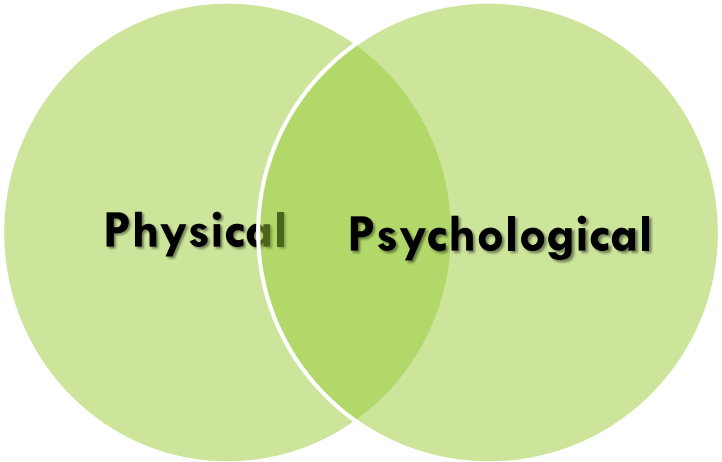
The DSM-5 Paradigm Shift

- Conceptualize **similar** disorders (based on common etiology) as one disorder on a spectrum of severity

- Recognize the **overlap** between physical and psychological domains





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The DSM-5 Paradigm Shift

- Specify why a client's **symptoms do not neatly fit** into the criteria for a disorder

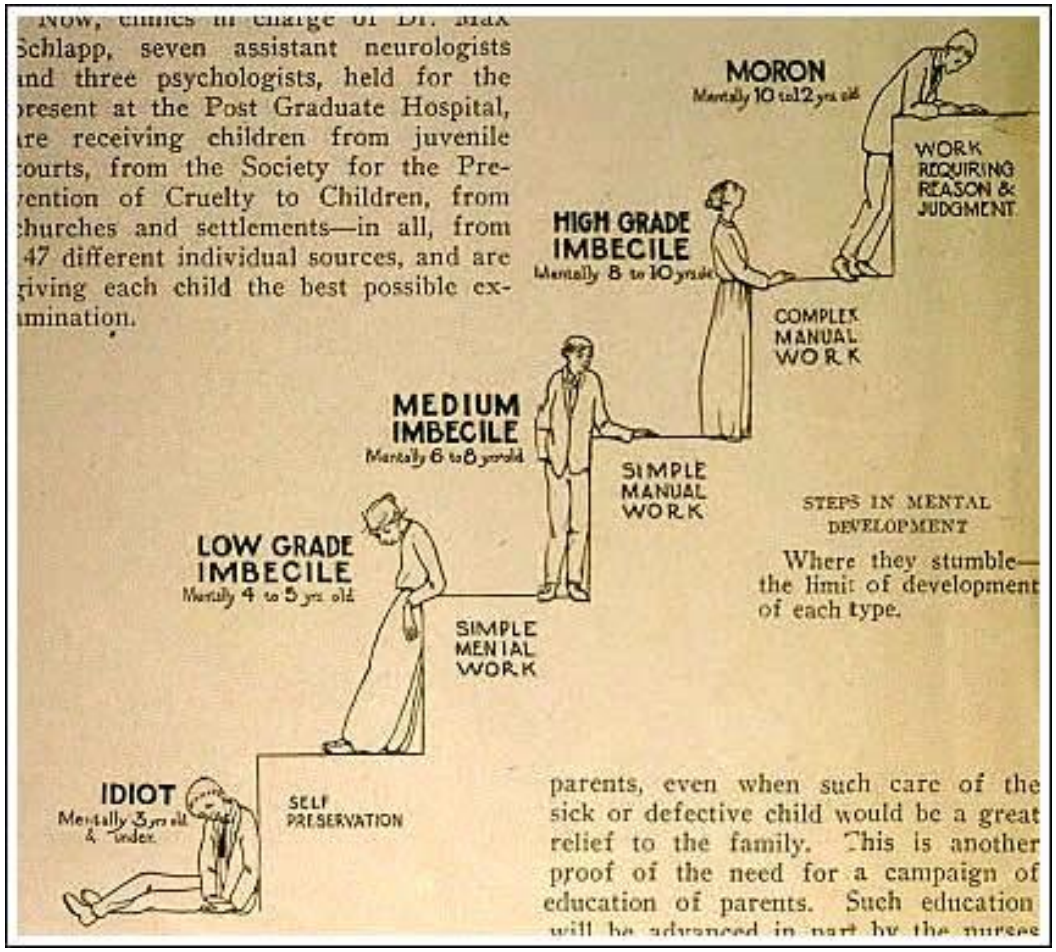
The DSM-5 Paradigm Shift

- Enhance understanding of **cultural and developmental** life span influences

The DSM-5 Paradigm Shift

- **De-pathologize** abnormal behaviors that do not constitute a "disorder"

Cleaning Up Some Language



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Overview of Changes

Item	Change	
General Medical Condition →	**Another Medical Condition**	
Multi-axial Classification System →	**Discontinued**	*Added more options for indicating severity*
Global Assessment of Functioning (GAF) →	**Discontinued**	
World Health Organization Disability Assessment Scale (WHODAS) – Section III →	**Recommended**	

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Definition of a Mental Disorder

- "A mental disorder is 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. 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 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)

Cautionary Statement for Forensic Use of DSM-5 (paraphrased by me)

- DSM-5 was created for assessment, case conceptualization, and treatment planning, not forensic application. Nonetheless, it is used in forensic settings.
- "When the presence of a mental disorder is the predicate for a subsequent legal determination," DSM-5 can be helpful if used properly. It may also "facilitate legal decision-makers' understanding of the relevant characteristics of mental disorders."
- May serve as a "check on ungrounded speculation about mental disorders and about the functioning of a particular individual."
- "…diagnostic information about longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time."

Cautionary Statement for Forensic Use of DSM-5 (paraphrased by me)

- Risks
  - Diagnostic information may be misused or misunderstood
  - "In most situations, the clinical diagnosis of a DSM-5 mental disorder…does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard."
  - Use of DSM-5 to assess the presence of a mental disorder by those without sufficient training or expertise is "not advised."

DSM-5 and ICD

- Codes in the DSM-IVTR were ICD-9CM codes
  - e.g. Generalized Anxiety Disorder (300.02)
- Because U.S. healthcare providers will be required to use ICD-10CM (alphanumeric) codes effective October 1, 2014, the DSM-5 includes ICD-10CM codes in parentheses
  - e.g. Generalized Anxiety Disorder 300.02 (F41.1)

What might a DSM-5 diagnosis look like?

- **Sample Diagnosis**

V62.21	Problem Related to Current Military Deployment Status
301.89	Other Specified Personality Disorder (mixed personality features—dependent and avoidant symptoms)
327.26	Comorbid Sleep-Related Hypoventilation
300.4	Persistent Depressive Disorder (Dysthymia), With anxious distress, In partial remission, Early onset, With pure dysthymic syndrome, Moderate
V62.89	Victim of Crime
278.00	Overweight or Obesity
WHODAS:	63

Source: King, J.H. (2013, August). Understanding and using the DSM-5. *Counseling Today*, 56(2).

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Overview of Changes

- **De-pathologizing**
  - e.g. Paraphilic disorders vs. paraphilias, Gender Dysphoria vs. Gender Identity Disorder
- **New Disorder Classifications** to capture individuals who need treatment but were technically just shy of meeting diagnostic criteria
  - e.g. Mild Neurocognitive Disorder, Binge-Eating D/O
- **Cutting back on the number of diagnoses per client** by providing more specifier options
- **Reducing the "Not Otherwise Specified "category** due to greater depth of detail about symptoms
  - "Other Specified" or "Unspecified"

"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

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

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DSM-5 Structure

DSM-5 Table of Contents

- **Section I: DSM-5 Basics**
  - Introduction
  - Use of DSM-5
  - Cautionary Statement for Forensic Use of DSM-5
- **Section II: Essential Elements: 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 - Binge-Eating Disorder
18. Personality Disorders
19. Paraphilic Disorders, Gender Dysphoria
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

DSM-IV TR	DSM-5
Disorders first diagnosed in infancy, childhood or adolescence	**Deleted** Disorders reorganized under other chapters
Delirium, Dementia and Amnestic and Other Cognitive Disorders	**Renamed** Neurocognitive Disorders

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

DSM-IV TR	DSM-5
Mental Disorders due to a General Medical Condition Not Elsewhere Classified	**Deleted**
Substance-related Disorders	**Renamed** Substance Use and Addictive Disorders (includes Gambling Disorder)

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Section II Chapter Comparison: DSM-IV TR to DSM-5

DSM-IV TR	DSM-5
Schizophrenia and Other Psychotic Disorders	**Renamed** "Schizophrenia Spectrum and Other Psychotic Disorders"
Mood Disorders	**Split into 2 chapters** "Bipolar and Related Disorders "Depressive Disorders"
Somatoform Disorders	**Renamed** "Somatic Symptom and Related Disorders"
Sexual and Gender Identity Disorders	**Broken into 3 chapters** "Sexual Dysfunctions" "Gender Dysphoria" "Paraphilic Disorder"

Section II Chapter Comparison: DSM-IV TR to DSM-5

DSM-IV TR	DSM-5
Adjustment Disorders	**Chapter Eliminated** Moved to "Trauma and Stress-related Disorders"
Other Conditions that May Be a Focus of Clinical Attention	**Several Disorders Shifted to** "Other Mental Disorders"

Section II Disorder Changes

Neurodevelopmental Disorders
"Mental Retardation" vs. "Intellectual Disability"

DSM-IV TR	DSM-5
Mental Retardation	**Renamed** "Intellectual Disability (Intellectual Developmental Disorder")
Severity	**Determined By** "Adaptive Functioning" **not** IQ score

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Specify Severity of Intellectual Disability

- Mild, Moderate, Severe, Profound
- Levels determined by functioning in the following domains: Conceptual, Social, and Practical

- Global Delay: Diagnosis reserved for individuals under 5 and cannot be reliably assessed.

ND 2
Communication Disorders

DSM-IV TR	DSM-5
Expressive Language D/O & Mixed Receptive-Expressive Language D/O	**Combines** both disorders into one—Language Disorder
Phonological Disorder	**Renamed** "Speech Sound Disorder"
Stuttering	**Renamed** "Childhood-Onset Fluency Disorder"

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Communication Disorders

DSM-IV TR	DSM-5

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

Autism Spectrum Disorder

- Autism
- Asperger's Disorder
- Childhood Disintegrative Disorder
- Pervasive Developmental Disorder

- Single Condition
  - (Different levels of symptom severity - 2 Core Domains
  - Level 1, 2 and 3, requiring support, substantial support, very substantial support, respectively)
  - Deficits in social communication and social interaction
  - Restricted repetitive behaviors, interests, and activities

Will Some Folks be Left Out?

- "Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autistic spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder (APA, 2013; p. 51)

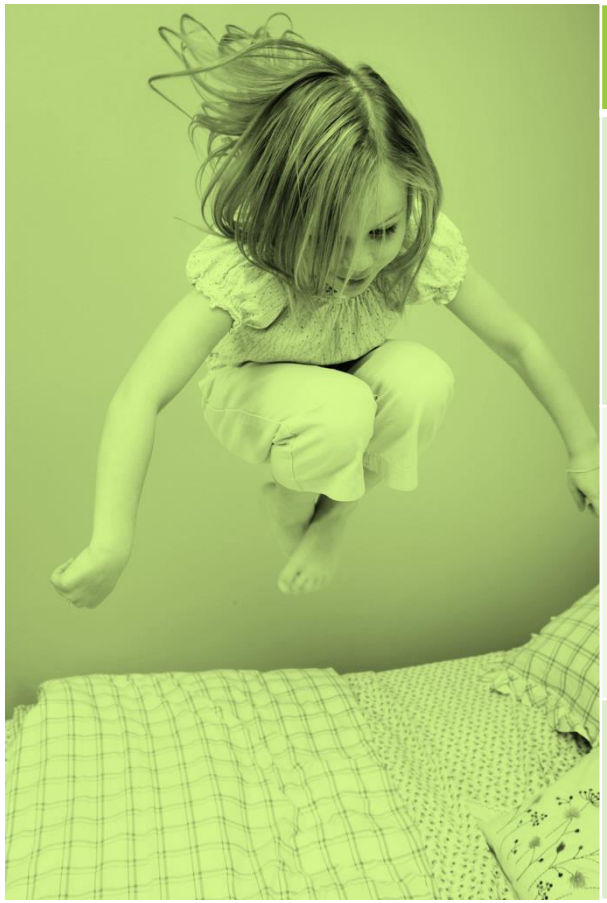
Autism Spectrum Disorder

- Specify current severity for each of the two psychopathological domains (deficits in social communication and restricted, repetitive behaviors):
  - Level 1: Requiring Support
  - Level 2: Requiring Substantial Support
  - Level 3: Requiring Very Substantial Support

Autism Spectrum Disorder

- Specify if:
  - 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 behavioral disorder
  - With catatonia

Attention-Deficit/Hyperactivity Disorder



DSM-IV TR	DSM-5
Criterion Items	**Examples Added** to facilitate application across the life span
Cross-situational requirement	**Strengthened** "several symptoms in each setting"
Onset Criterion Before Age 7	**Changed** "Before age 12"

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Attention-Deficit/Hyperactivity Disorder

DSM-IV TR	DSM-5
Subtypes	**Replaced** "Presentation specifiers that map directly to prior subtypes"
Comorbidity with Autistic Spectrum Disorder now allowed	
Criteria	**Adults** must meet **5** symptoms **Children** still require **6**

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ADHD Disorder

- Severity Rating – Depends on the number of symptoms
  - Mild: Few symptoms after criteria
  - Moderate: Between mild and severe
  - Severe: Many symptoms in excess of criteria

  - Each subtype can be rated as noted above

Specific Learning Disorder

- Reading Disorder
- Mathematics Disorder
- Disorder of Written Expression
- Learning Disorder, NOS

↓

- **Combined** into One Disorder
- **Rationale**: Learning Deficits co-occur

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Intervention Based Diagnosis

- At least six months of intervention, with little or no gains.
- Discrepancy formula no longer used (Achievement significantly below IQ and processing deficits)
- Use of academic area that is significantly below age, grade level and developmental maturation.
- Subtypes include: Reading (Reading rate, reading comprehenions, Math (Number sense, memorization of facts), Written Impairment (Spelling accuracy, grammar and punctuation).

ND 6
Motor Disorder

DSM-IV TR	DSM-5
Disorders first diagnosed in infancy, childhood or adolescence (e.g.) • Developmental Coordination Disorder • Stereotypic Movement Disorder (With or Without Self Injurious Behavior) • Tourette's Disorder • Persistent (Chronic) Motor of Vocal Tic Disorder • Provisional Tic Disorder • Other Specified Tic Disorder • Unspecified Tic Disorder	**Moved Under Motor Disorder**

Motor Disorder

DSM-IV TR	DSM-5
Tic Criteria	**Standardized:** Across all disorders
Stereotypic Movement Disorder – No purposefulness	**Differentiated - Purposefully Driven.** from Body-Focused Repetitive Behaviors that are new in the Obsessive-Compulsive Disorder Chapter

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Schizophrenia Spectrum and Other Psychotic Disorders

DSM-IV TR	DSM-5
Differentiations between "bizarre" and "non-bizarre" delusions **And** "Two or more voices conversing with each other"	**Removed** **Schizotypal (Personality) Disorder Listed- as part of the spectrum.**

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Schizophrenia

DSM-IV TR	DSM-5
Requirements	**New** Individual must have **at least 1 of 3 positive symptoms** (delusions, hallucinations, and disorganized speech)
Subtypes (paranoid, disorganized, catatonic, undifferentiated, residual)	**Eliminated** from Body-Focused Repetitive Behaviors that are new in the Obsessive-Compulsive Disorder Chapter

Schizoaffective Disorder & Delusional Disorder

DSM-IV TR	DSM-5
Requirement	**New** A **major mood episode must be present** for a majority of the disorder's total duration after Criterion A symptoms of Schizophrenia have been met, and at least one of the following (Delusions, Hallucinations and Disorganized Speech) has been met
Delusional Disorder	**Removed** Non-bizarre delusions no longer a requirement *Delusional Disorder Listed with Various Subtypes (Grandiose, Erotomanic, Persecutory, etc.)

Schizoaffective Subtypes

- Bipolar Type: Manic or depressive episode
- Depressive Type

- Specify with catatonia

Catatonia

DSM-IV TR	DSM-5
Criteria Used to Diagnose	**Same** Regardless of whether context is a psychotic, bipolar, depressive, other medical disorder, or unidentified medical condition
Symptom Requirements	**3 of 12 (i.e., Stupor, Catalepsy, Waxy Flexibility, Mutism, Posturing – and others)**

Catatonia

DSM-IV TR	DSM-5
	May be **diagnosed as a specifier** for • Depressive • Bipolar • psychotic disorders • as a separate diagnosis in the context of another medical condition • Or, as an other specified diagnosis

Bipolar & Related Disorders

DSM-IV TR	DSM-5
Criterion A for Manic and Hypomanic Episodes	**Now includes** Emphasis on changes in activity and energy as well as mood
Mixed Episode	**Removed** **Replaced** with a specifier "With Mixed Features"

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Bipolar & Related Disorders

DSM-IV TR	DSM-5
Diagnosis	**New Diagnosis** **"Other Specified Bipolar and Related Disorder"**
Specifier	**New** **"Anxious Distress"**

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Depressive Disorders

DSM-IV TR	DSM-5
Diagnoses	**New** "Disruptive Mood Dysregulation Disorder" "Premenstrual Dysphoric Disorder"
Dysthymic Disorder and Major Depressive Disorder, Chronic	**Merged** into one disorder Persistent Depressive Disorder

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Depressive Disorders

DSM-IV TR	DSM-5
Specifier for Major Depressive Episode	**New** **"With Mixed Features"** Designed for people who have at least 3 manic symptoms within a depressive episode (insufficient for label of "manic episode")
Bereavement Exclusion	**Removed**

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Anxiety Disorders

DSM-IV TR	DSM-5
Obsessive Compulsive Disorder (OCD) Post Traumatic Stress Disorder (PTSD) Acute Stress Disorder	**Moved** Out of this category and into others

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Anxiety Disorders

DSM-IV TR	DSM-5
Diagnosis Requirements of Agoraphobia, Specific Phobia or Social Anxiety Disorder (Social Phobia)	**No Longer Required** Recognition that one's anxiety is excessive or unreasonable
6 Month Duration Requirement for those under 18 years of age	**Extended** To include all individuals to minimize diagnosis of transient fears

Anxiety Disorders

DSM-IV TR	DSM-5
Panic Attacks	**Minor Verbiage Changes** • Made to simplify • Can be used as a specifier in other disorders
Panic Disorder and Agoraphobia	**Unlinked** Now separate disorders that can be co-occurring
Social Phobia Specifiers	**Verbiage Change**

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Anxiety Disorders

DSM-IV TR	DSM-5
Separation Anxiety Disorder Requirement (recruited from the old childhood disorders chapter of DSM-IV)	**Changed** No longer requires that onset be during childhood
Selective Mutism	**Recruited** from DSM-IV's old childhood disorders chapter

Obsessive Compulsive and Related Disorders

DSM-IV TR	DSM-5
Chapter	**New!**
Disorders	**New!** • Hoarding Disorder • Excoriation (Skin-Picking Disorder) • Substance/Medication-Induced Obsessive-Compulsive and Related Disorder • Obsessive-Compulsive and Related Disorder Due to Another Medical Condition

Obsessive Compulsive and Related Disorders

DSM-IV TR	DSM-5
Impulse-Control Disorder	**Recruited** Trichotillomania (Hair-Pulling Disorder)

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Obsessive Compulsive and Related Disorders

DSM-IV TR	DSM-5
Specifiers	**Refined Poor Insight** Includes "good or fair insight, poor insight, and absent /delusional beliefs" **New "Tic-related" specifier for OCD**

Obsessive Compulsive and Related Disorders

DSM-IV TR	DSM-5
Body Dysmorphic Disorder	**Diagnostic Criterion Added** Describes repetitive behaviors or mental acts in response to preoccupations with perceived defects or flaws in physical appearance **New Specifier** **"With Muscle Dysmorphia"**

Acute Stress Disorder & PTSD

DSM-IV TR	DSM-5
Qualifying Traumatic Events	**Must now be explicit** Were events experienced directly, witnessed or experienced indirectly?
Criterion regarding the subjective reaction to the traumatic event (intense fear, helplessness, or horror)	**Removed**

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Acute Stress Disorder & PTSD

DSM-IV TR	DSM-5
PTSD: 4 vs. 3 symptom clusters Avoidance/Numbing Cluster	**Divided into 2 Clusters**
PTSD Diagnostic Thresholds	**Lowered for Children and Adolescents** More "developmentally sensitive," and **Separate Criteria Added** for children under 6

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Reactive Attachment Disorder

DSM-IV TR	DSM-5
2 Subtypes ("emotionally withdraw/inhibited" and "indiscriminately social/disinhibited")	**Now defined as distinct separate disorders** "Reactive Attachment Disorder" and "Disinhibited Social Engagement Disorder"

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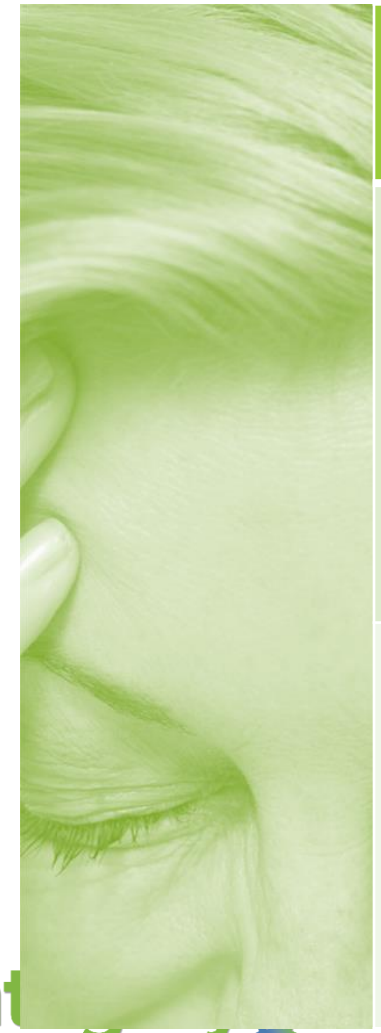
Dissociative Disorders

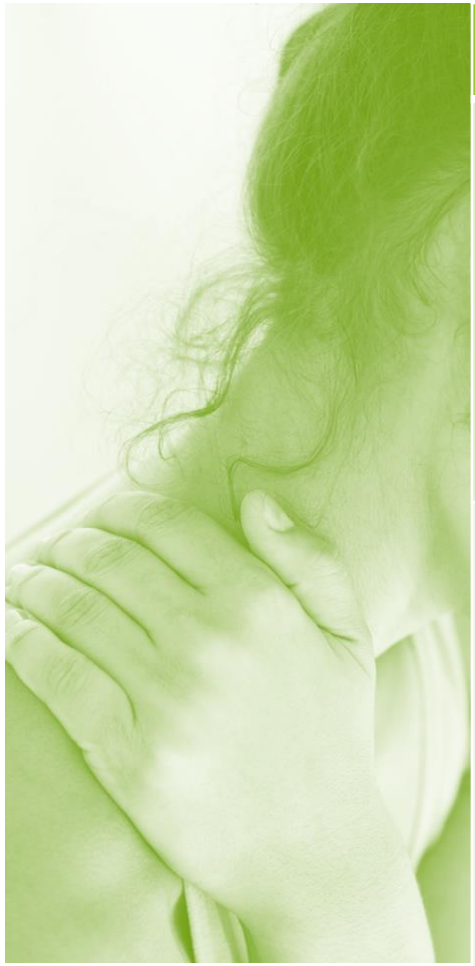


DSM-IV TR	DSM-5
Deperson-alization Disorder	**Changed to** Depersonalization/Dereali-zation Disorder
Dissociative Fugue	**Now a specifier** Instead of a separate disorder

Dissociative Disorders

DSM-IV TR	DSM-5
Criterion A for Dissociative Identity Disorder	**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



DSM-IV TR	DSM-5
Somatization Disorder and Undifferentiated Somatoform Disorder	**Merged** …into Somatic Symptom disorder No specifier required
Somatic Disorders Distinct and Separate	**Somatic disorder can accompany diagnosed medical disorders** New recognition Now thought of as a spectrum instead of a separate disorder

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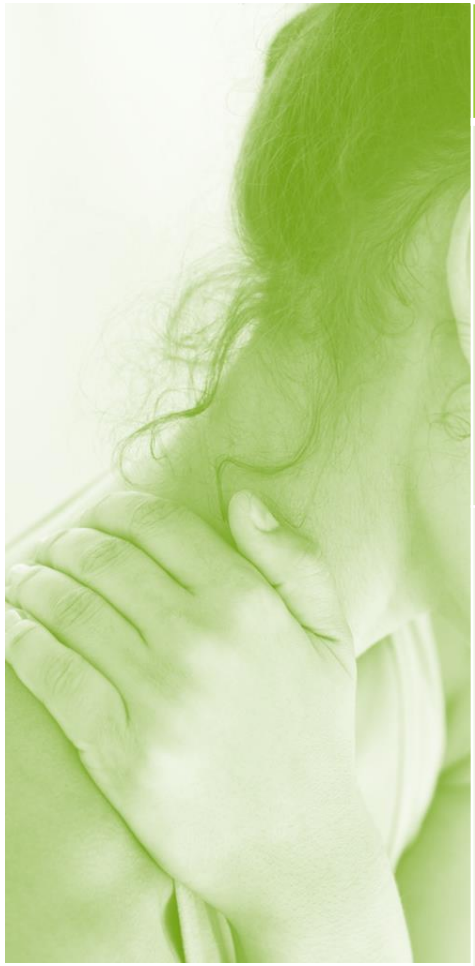
Somatic Symptoms and Related Disorders



DSM-IV TR	DSM-5
Hypochondriasis	**Eliminated** Most clients would meet criteria for Somatic Symptom Disorder; some Illness Anxiety Disorder
Pain Disorder	**Less emphasis on separating from medical** Now Diagnosed for people with chronic pain that can be medically explained Used as a specifier

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Feeding and Eating Disorders

DSM-IV TR	DSM-5
Feeding and Eating Disorders – Childhood Disorders Chapter	**Recruited disorders from DSM-IV** Now modified to include adult i.e. Avoidant/Restrictive Intake
Anorexia Nervosa and Bulimia Nervosa	**Minor Changes (Severity BMI)** Frequency of compensatory behavior and binge eating decreased for Bulimia – 1 x week

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Feeding and Eating Disorders

DSM-IV TR	DSM-5
	**New Disorder** **Binge-Eating Disorder (in essence, Bulimia Nervosa without recurrent inappropriate compensatory behavior, such as purging and driven exercise)**

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Sleep-Wake Disorders

DSM-IV TR	DSM-5
Medical vs. Mental	**Recognition of co-existence** Of medical and mental conditions vs. separating the two
Breathing-related Sleep Disorders	**Divided into 3 Distinct Disorders** Obstructive Sleep Apnea Hypopnea Central Sleep Apnea Sleep-Related Hypoventilation Depression can ensue

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Sleep-Wake Disorders

DSM-IV TR	DSM-5
Circadian Rhythm Sleep-Wake Disorders	**Expanded subtypes**
NOS Category	**Reduced** By adding Rapid Eye Movement Sleep Behavior Disorder, Non-REM Sleep Behavior D/O, and Restless Legs Syndrome

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Sexual Dysfunctions

DSM-IV TR	DSM-5
Dyspareunia and Vaginismus	**Merged** …into Genito-pelvic Pain/Penetration Disorder
Subtypes	**Reduced**
Duration requirement	**Updated** to 6 months minimum for all sexual dysfunctions

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Gender Dysphoria

DSM-IV TR	DSM-5
Category	**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"

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Gender Dysphoria

DSM-IV TR	DSM-5
"Gender" verbiage	**Versus "sex" verbiage**
"Repeatedly stated desire…"	**Replaced By** "Strong desire to be of the other gender" in order to be more developmentally sensitive
Subtyping based on sexual orientation	**Removed** Not clinically useful

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Why the Name Change?

- "It is important to note that many people do not believe that GID should be classified as a mental health disorder. In the upcoming DSM-5, gender identity disorder is referred to as gender dysphoria…Some experts maintain that the term should be removed form the list of diagnoses in the DSM-5. As stated by Dr. Madeline Wyndzen (2008), transgender individuals and many clinicians 'find the mental illness labels imposed on transgenderism just as disquieting as the label that used to be imposed on homosexuality.'" (Newsome & Gladding, 2013; p. 160)

Disruptive, Impulse Control, and Conduct Disorders

DSM-IV TR	DSM-5
	New Chapter **Consists of disorders that were linked due to their close association with Conduct Disorder**
Oppositional Defiant Disorder	**4 Changes** 1. Symptoms now grouped into 3 types a. Angry/irritable mood b. Argumentative/defiant behavior c. Vindictiveness 2. Exclusion criteria for Conduct Disorder removed 3. More guidance regarding frequency requirements 4. Severity rating added: Mild, Mod. Severe

Disruptive, Impulse Control, and Conduct Disorders

DSM-IV TR	DSM-5
Specifier for Conduct Disorder	**New** **"With Limited Pro-Social Emotions"** Denotes a more severe clinical presentation --- Antisocial Personality Disorder – Closely Related to Externalizing Disorders

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Disruptive, Impulse Control, and Conduct Disorders

DSM-IV TR	DSM-5
"Intermittent Explosive Disorder" Required physical aggression, verbal aggression and non-destructive/non-injurious physical aggression	**Now "Permissible"** • More guidance regarding frequency of symptoms • Minimum age of 6 years now required • Verbal aggression alone can meet criteria.

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What About "Sexual Addictions?"

- 312.89 (F91.8) Other Specified Disruptive, Impulse-Control, and Conduct Disorder, Sexual Addiction (or Non-Paraphilic Sexual Disorder)

Substance-Related and Addictive Disorders

DSM-IV TR	DSM-5
Category	**Expanded** May increasingly include non-substance-related addictive disorders that are similar in terms of neurobiological processes
Pathological Gambling	**Renamed "Gambling Disorder"**

Substance-Related and Addictive Disorders

DSM-IV TR	DSM-5
Substance Abuse and Dependence	**Merged in 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**
Threshold for a Substance Use Disorder (1 sx)	**Increased to 2 sx** DSM 5's Substance Use Disorder, Mild

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Substance-Related and Addictive Disorders

DSM-IV TR	DSM-5
	New **"Cannabis Withdrawal"** & **"Caffeine Withdrawal"**
No Nicotine Abuse present	**New** **Tobacco Use Disorder** **uses same criteria** as other substances in DSM-5

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Substance-Related and Addictive Disorders

DSM-IV TR	DSM-5
Early Remission as 1-less than 12 months of no sx	**New Definition** 3-less than 12 months of no sx (excluding Craving)
With or Without Physiological Dependence specifiers	**Removed**

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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

SUD Symptoms Reordered

Impaired Control (1-4)	1) The substance is often taken in larger amounts or over a longer period than intended
	2) There is a persistent desire or unsuccessful efforts to cut down or control substance use
	3) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
	4) Craving, or a strong desire or urge to use the substance.
Social Impairment (5-7)	5) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
	6) Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance
	7) Important social, occupational, or recreational activities are given up or reduced because of substance use
Risky Use (8-9)	8) Recurrent substance use in situations in which it is physically hazardous situations
	9) 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 effects of the substance
Pharmacological Criteria (10-11)	10) Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or the desire effect or (b) Markedly diminished effect with continued use of the same amount of the substance
	11) Withdrawal, as manifested by either of the following: (a) A The characteristic withdrawal syndrome for the substance or (b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms

Abuse vs. Dependence?

- **DSM-IVTR**
  - 305.00 Alcohol Abuse
  - 303.90 Alcohol Dependence
- **DSM-5**
  - 305.00 (F10.10) Mild Alcohol Use Disorder
  - 303.90 (F10.20) Moderate Alcohol Use Disorder
  - 303.90 (F10.20) Severe Alcohol Use Disorder

Neurocognitive Disorders

DSM-IV TR	DSM-5
Diagnoses of Dementia and Amnestic Disorder	**Combined Into New Diagnosis** "Major Neurocognitive Disorder"
Level of Cognitive Impairment Previously Cognitive Disorder (NOS)	**Now recognizes a less severe level** Mild Neurocognitive D/O

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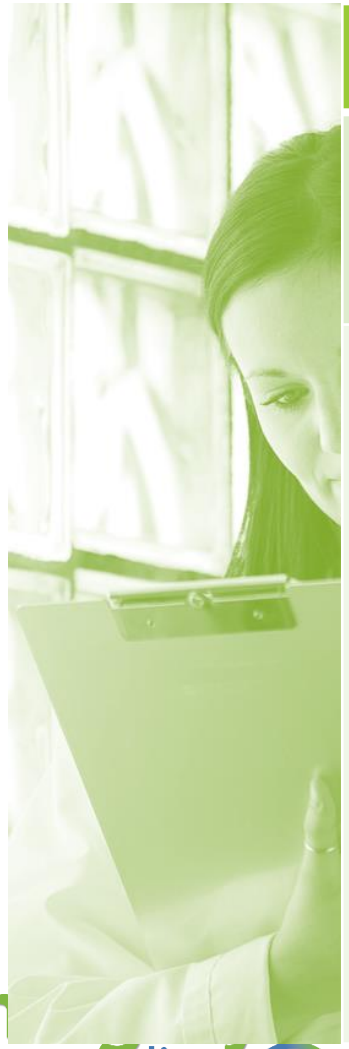
Personality Disorders



DSM-IV TR	DSM-5
Diagnostic Criteria	**No Changes: 10 personality disorders included.**
Method of Diagnosing Personality Disorders	**Alternative Method Included in Section III** • A model for further study • Called "Hybrid dimensional-categorical model" • Almost adapted into the DSM-5 but was not • May replace the current system in future revision

Paraphilic Disorders

DSM-IV TR	DSM-5
Course Specifiers	**New Course Specifiers Added** "In a Controlled Environment" and "In Remission." Controlled Environment - Jail
Paraphilias	**Names of disorders changed to add** …"Disorder" (e.g. Pedophilia is now Pedophilic Disorder) Recognizes Paraphilias are not necessarily Paraphilic Disorders

Paraphilic Disorders

DSM-IV TR	DSM-5
Criterion	**Must now meet Criterion A and Criterion B for diagnosis** • 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

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Section III Changes

"Emerging Measures and Models"

Section III Changes

- **Assessment Measures**
  - DSM-5 Cross-Cutting Symptoms Measure, Levels 1 and 2
  - World Health Organization Disability Assessment Schedule 2.0
  - Cultural Formulation Interview

- **Alternative DSM-5 Model for Personality Disorders**

Section III Changes

- **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
  - Non-suicidal Self-Injury

DSM-5 Resources

- www.dsm5.org
- DSM-5 Resource Page (visit www.anorton.com, click on "Resources," and then on "DSM-5 Resource Page")
- There's an app for that!
- Online Assessment Measures
  - Level 1 and Level 2 Cross Cutting Measures
  - World Health Organization Disability Assessment Scale (WHODAS 2.0)
  - Cultural Formulation Interview

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Substance-Related and Addictive Disorders

The substance-related disorders encompass 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencyclidine [or similarly acting arylcyclohexylamines] and other hallucinogens); inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances. These 10 classes are not fully distinct. All drugs that are taken in excess have in common direct activation of the brain reward system, which is involved in the reinforcement of behaviors and the production of memories. They produce such an intense activation of the reward system that normal activities may be neglected.

In addition to the substance-related disorders, this chapter also includes gambling disorder, reflecting evidence that gambling behaviors activate reward systems similar to those activated by drugs of abuse and produce some behavioral symptoms that appear comparable to the substance use disorders.

The substance-related disorders are divided into two groups: substance use disorders and substance-induced disorders. The following conditions may be classified as substance-induced: intoxication, withdrawal, and other substance/medication-induced mental disorders (psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, sleep disorders, sexual dysfunctions, delirium, and neurocognitive disorders).

Reflecting some unique aspects of the 10 substance classes relevant to this chapter, the remainder of the chapter is organized by the class of substance. To facilitate differential diagnosis, the criteria for the substance/medication-induced mental disorders are included with disorders with which they share phenomenology (e.g., substance/medication-induced depressive disorder is in the chapter "Depressive Disorders"). The broad diagnostic categories associated with each specific group of substances are shown in the Table 1.

TABLE 1 Diagnoses associated with substance class

Search Disorders

Alcohol Use Disorder

Alcohol Intoxication

Alcohol Withdrawal

Other Alcohol-Induced Disorders

Unspecified Alcohol-Related Disorder

Bookmark

Alcohol Use Disorder

A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.

2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.

3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

4. Craving, or a strong desire or urge to use alcohol.

5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.

6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

8. Recurrent alcohol use in situations in which it is physically hazardous.

9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

10. Tolerance, as defined by either of the following:

a. A need for markedly increased amounts of alcohol to achieve intoxication or desired eff

b. A mark diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following:

Autism Spectrum Disorder (Part I)

Done

About the Presenter

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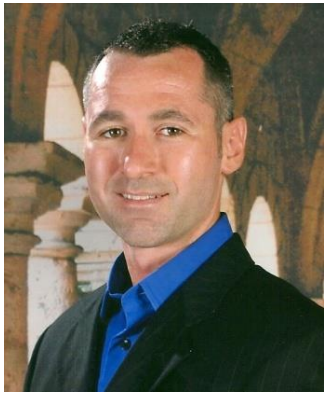

Mr. Norton is a Licensed Mental Health Counselor, Certified Addictions Professional, and Certified Rehabilitation Counselor working in private practice at Integrity Counseling, Inc. in Largo, FL, where he specializes in mental health and substance abuse evaluations, Motivational Interviewing, and cognitive behavioral therapies for anxiety, depressive, and addictive disorders. He provides professional consultation and training, and as a Qualified Supervisor he offers clinical supervision for Registered Mental Health Counselor Interns. He is the President Elect of the Suncoast Mental Health Counselors Association, a chapter of the Florida Mental Health Counselors Association, and an Adjunct Instructor at the University of South Florida's Department of Rehabilitation and Mental Health Counseling.