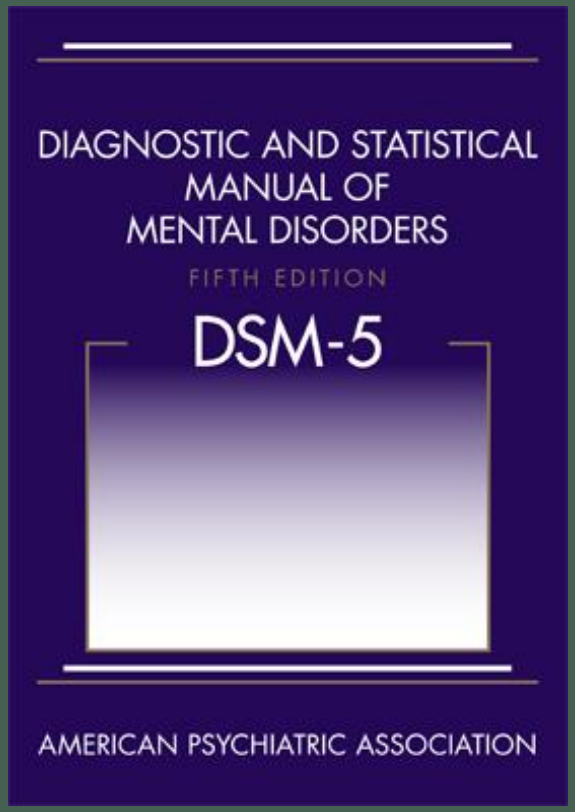

DSM-5 UPDATE FOR COUNSELORS

THE PROCRASTINATOR'S GUIDE

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About the Presenter

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Mr. Norton is a Licensed Mental Health Counselor, Licensed Marriage & Family Therapist, Certified Master's-Level Addictions Professional, Certified Rehabilitation Counselor, and Certified Forensic Mental Health Evaluator working in private practice at Integrity Counseling, Inc. in Largo, FL, where he specializes in mental health and substance abuse evaluations and integrative therapy 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 Past President and Chair of Public Relations of the Suncoast Mental Health Counselors Association, Chair of the Florida Mental Health Counselors Association's Education Committee, Chair of the National Board of Forensic Evaluator's Training Standards & Implementation Committee, and an Adjunct Instructor in the Dept. of Child & Family Studies at the University of South Florida's College of Behavioral and Community Sciences. He is pursuing a Ph.D. in Counselor Education & Supervision with a cognate in Cognitive Health from the University of South Florida.

What We'll Cover…

- **Counselors and the Medical Model**
- **DSM-5 Controversies & Criticisms**
- **Overview** of Changes (Bird's Eye View)
- 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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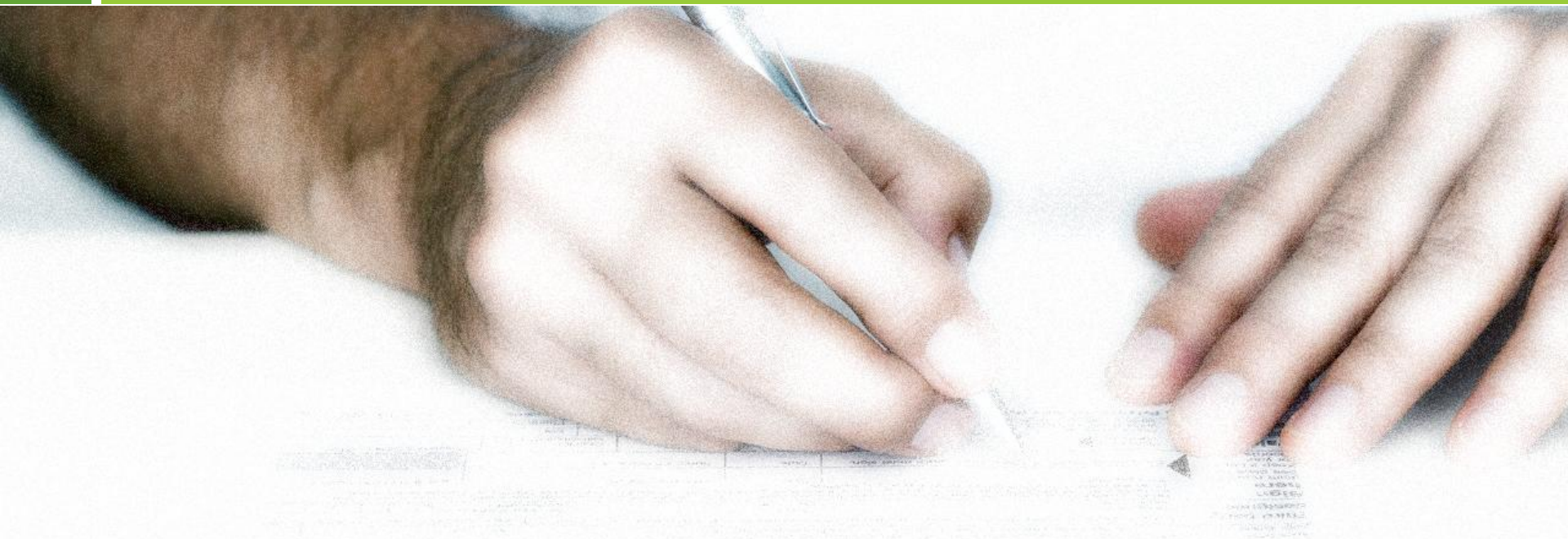
Why Do We Have a DSM?



- "…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*)

Counseling and the Medical Model

Medical Model	Counseling Profession
Pathology-oriented	Wellness-oriented
Treatment-oriented	Prevention-oriented
Scientific paradigm	Philosophic paradigm
Dichotomous	Spectrum-oriented

…So how can you feel better about using the DSM?

…But I Hate Labels!

- "Although professional counselors may espouse different theoretical orientations, they all tend to work from a preventive, developmental, holistic framework, building on clients' strengths and assets. Counselors help clients with issues ranging from developmental concerns and problems in living to issues associated with pathology. Thus, although counselors are trained to work with clients from a developmental, wellness-oriented perspective, they often are involved in diagnosing and treating mental and emotional disorders, including addictions."
- "I treat everyone developmentally, but I want to recognize pathology when it is in the room with me." –Robin Daniel, Ph.D., LPC, Dean of Student Life, Greensboro College (Newsome & Gladding, 2013)

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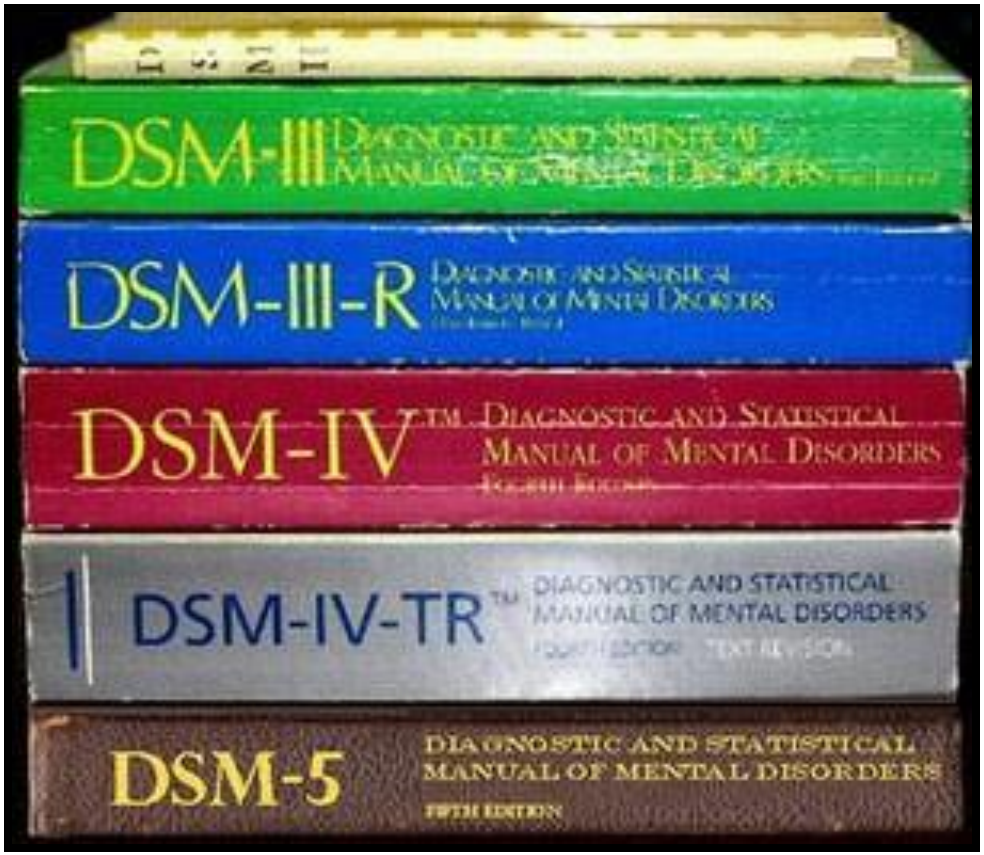
If It Makes You Feel Better…

- Language is, by necessity and definition, always labeling.
- Labeling can be used to help people (utilitarian).
- We label symptoms, not people.
- Labeling can be thought of as a form of model-dependent realism.
- DSM-5 makes attempts to stress that statistical abnormalities and political/cultural dissent are not, by themselves, mental disorders

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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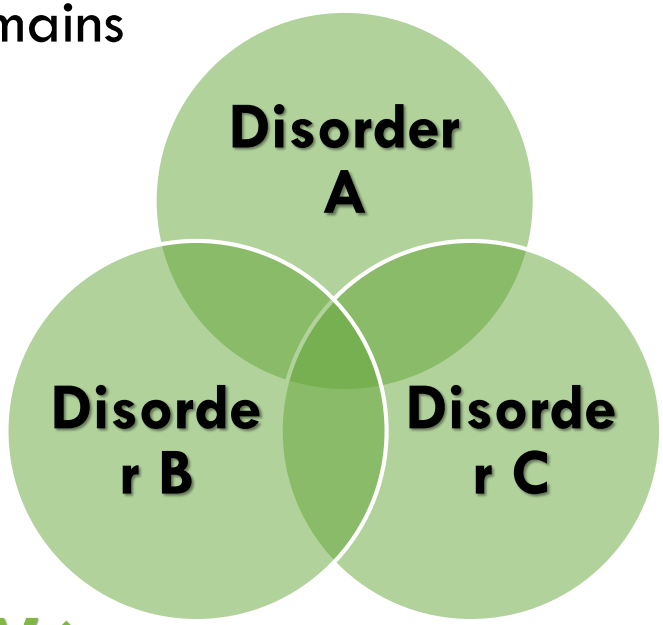
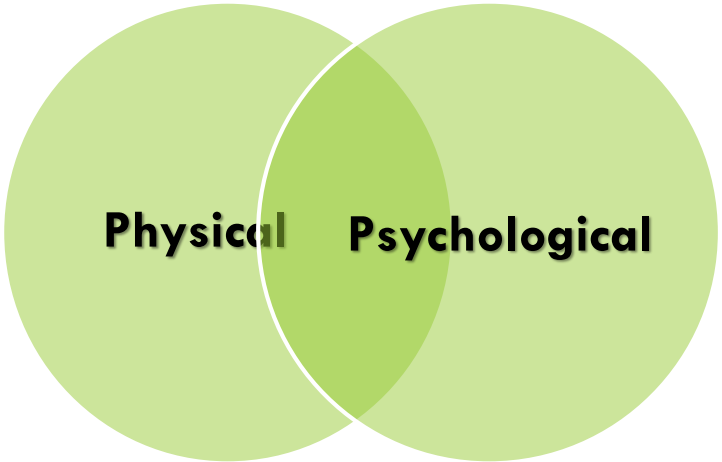
The DSM-5 Paradigm Shift

- 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

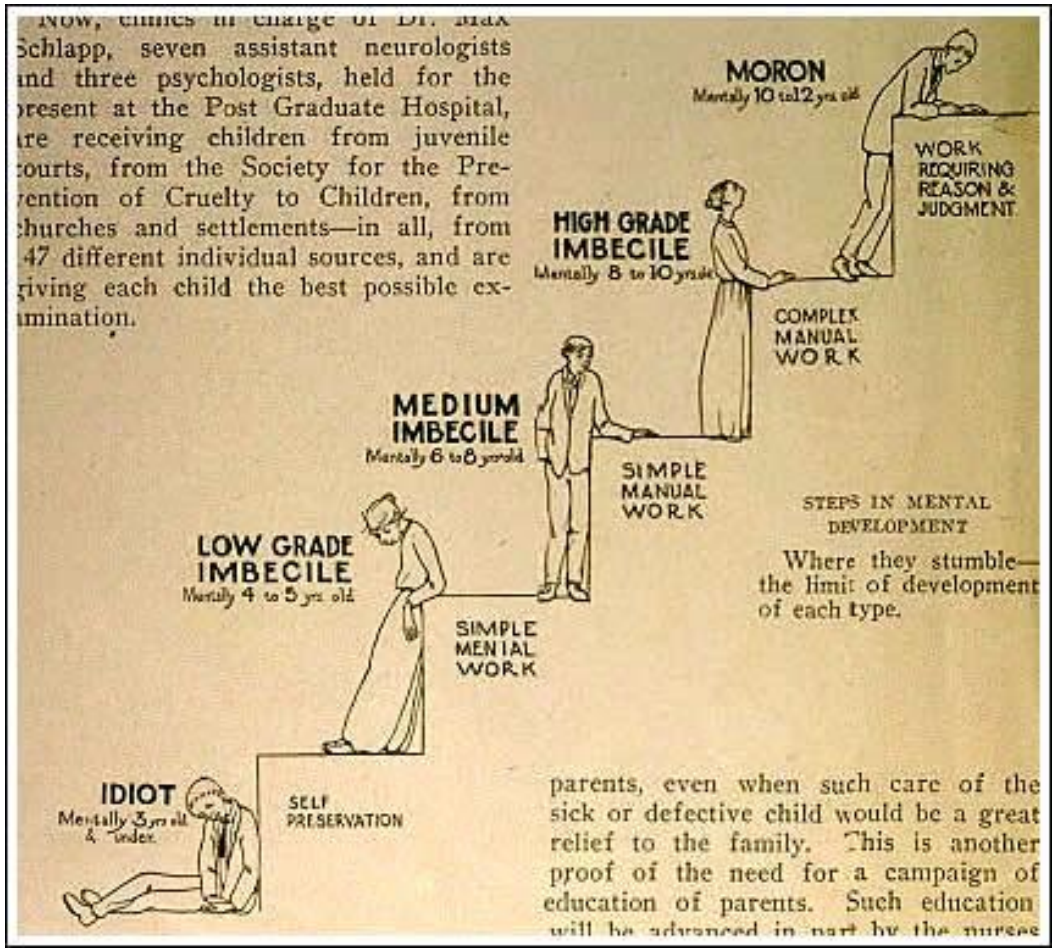
The DSM-5 Paradigm Shift

- 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 were required to use ICD-10CM (alphanumeric) codes effective October 1, 2015, 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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What two things on this slide would get you into trouble with third party payers?

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"

Just a Review…

Validity

- Measures what it purports to measure
  - Face Validity
  - Construct Validity
  - Criterion-Related Validity
  - Formative Validity
  - Sampling Validity

Reliability

- Replicability (stable and consistent results)
  - Test-Retest Reliability
  - Parallel Forms Reliability
  - Inter-Rater Reliability
  - Internal Consistency Reliability
    - Average Inter-Item Correlation
    - Split-Half Reliability

"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.

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

Social (Pragmatic) Communication Disorder

- A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following:
  - 1. Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.
  - 2. Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on a playground, talking differently to a child than to an adult, and avoiding use of overly formal language.
  - 3. Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction.
  - 4. Difficulties understanding what is not explicitly stated (e.g. making references) and nonliteral or ambiguous meanings of language (e.g. idioms, humor, metaphors, multiple meanings that depend on the context for interpretation).

Social (Pragmatic) Communication Disorder

- B. The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.
- C. The onset of symptoms is in the early developmental period (but deficits may not become fully manifest until social communication demands exceed limited capacities).
- The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains of word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability (intellectual developmental disorder), global developmental delay, or another mental disorder.

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

Autism Spectrum Disorder

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive):
  - 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal and social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
  - 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
  - 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
  - Specify current severity: Severity is based on social communication impairments and restricted, repetitive patterns of behavior

Autism Spectrum Disorder

- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive):
  - 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g. simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
  - 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g. extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food everyday).
  - 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g. strong attachment to or preouccupation with unusual objects, excessively circumscribed or perseverative interests).
  - 4. Hyper- or hyporeactivity to sensory input of unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).
  - Specify current severity: Severity is based on social communication impairments and restricted, repetitive patterns of behavior

Autism Spectrum Disorder

- C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- These disturbances are not better explained by intellectual disability or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

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

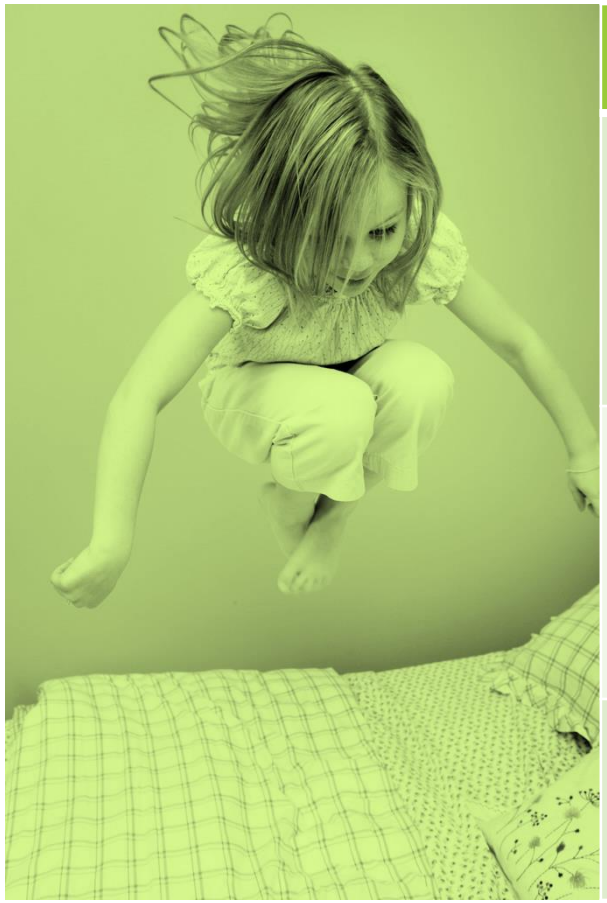
Autism Spectrum Disorder

- 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

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)

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 Autism 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

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)
- But still focuses on academic area that is significantly below age, grade level and developmental maturation.
- Subtypes include: Reading (reading rate, reading comprehension), Math (number sense, memorization of facts), Written Impairment (spelling accuracy, grammar and punctuation).

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**

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Motor Disorder

DSM-IV TR	DSM-5
Tic Criteria	**Standardized:** Across all disorders
Stereotypic Movement Disorder 	**Differentiated** from Body-Focused Repetitive Behaviors that are now in the Obsessive-Compulsive Disorder Chapter

How do you differentiate SMD from OCD?

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
No requirement for number of positive symptoms	**New** Individual must have **at least 1 of 3 positive symptoms** (delusions, hallucinations, and disorganized speech)
Subtypes (paranoid, disorganized, catatonic, undifferentiated, residual)	**Eliminated**

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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** requirement that delusions be non-bizarre *Delusional Disorder Listed with Various Subtypes (Grandiose, Erotomanic, Persecutory, etc.)

What's the difference between bizarre and non-bizarre?

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** as a separate diagnosis but **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** **"With 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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Disruptive Mood Dysregulation Disorder

- A. Severe recurrent temper outbursts manifested verbally (e.g. verbal rages) and/or behaviorally (e.g. physical aggression towards people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
- B. The temper outbursts are inconsistent with developmental level.
- C. The temper outbursts occur, on average, three or more times per week.
- D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g. parents, teachers, peers).
- E. Criteria A-D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A-D.

Disruptive Mood Dysregulation Disorder

- F. Criteria A and D are present in at least two of three settings (i.e. at home, at school, with peers) and are severe in at least one of these.
- G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.
- H. By history or observation, the age at onset of Criteria A-E is before 10 years.
- I. There has never been a distinct period lasting more than one day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met. Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

Disruptive Mood Dysregulation Disorder

- J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g. autism spectrum disorder, PTSD, separation anxiety disorder, persistent depressive disorder)
  - Dx can't be made with ODD, IED, or bipolar disorder, but can coexist with MDD, ADHD, Conduct D/O, substance use D/O's….
- K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

Premenstrual Dysphoric Disorder

- A. In the majority of menstrual cycles, at least 5 symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses.
- B. One (or more) of the following sx. must be present:
  - 1. Marked affective lability (e.g. mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).
  - 2. Marked irritability or anger or increased interpersonal conflicts.
  - 3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.
  - 4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.

Premenstrual Dysphoric Disorder

- C. One (or more) of the following sx must additionally be present, to reach a total of 5 symptoms when combined with symptoms from Criterion B.
  - 1. Decreased interest in usual activities (e.g. work, school, friends, hobbies)
  - 2. Subjective difficulty in concentration
  - 3. Lethargy, easy fatigability, or marked lack of energy
  - 4. Marked change in appetite; overeating; or specific food cravings.
  - 5. Hypersomnia or insomnia
  - 6. A sense of being overwhelmed or out of control
  - 7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating," or weight gain.
  - Note: Sx in Criteria A-C must have been met for most menstrual cycles that occurred in previous year.

Premenstrual Dysphoric Disorder

- D. Sx are associated with clinically significant distress or interference with…
- E. The disturbance is not merely an exacerbation of the sx of another disorder…
- F. Criterion A should be confirmed by prospective daily ratings during at least 2 symptomatic cycles
- G. The sx not attributable to physiological effects of a substance…

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

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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

Hoarding Disorder

- A. Persistent difficulty discarding or parting with possessions, regardless of their actual value
- B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
- C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g. family members, cleaners, authorities).
- D. The hoarding causes clinically significant distress or impairment…
- E. The hoarding is not attributable to another medical condition…

Hoarding Disorder

- F. The hoarding is not better explained by sx of another mental d/o…
- Specify if:
  - With excessive acquisition
  - With good or fair insight
  - With poor insight
  - With absent insight/delusional beliefs

Excoriation (Skin-Picking Disorder)

- A. Recurrent skin picking resulting in skin lesions
- B. Repeated attempts to decrease or stop skin picking
- C. The skin picking causes clinically significant distress or impairment…
- D. Not attributable to physiological effects of a substance…or another medical condition…
- E. Not better explained by sx of another mental d/o…

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**

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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"**

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Acute Stress Disorder & PTSD

DSM-IV TR	DSM-5
Qualifying Traumatic Events	Criterion A now **explicitly identifies** that the trauma can be 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: 3 symptom clusters (re-experiencing, avoidance/numbing, arousal)	**Now 4 symptom clusters** (avoidance/numbing split into (1) avoidance; and (2) persistent negative alterations in cognition and mood)
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 withdrawn/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** of Dissociative Amnesia instead of a separate disorder

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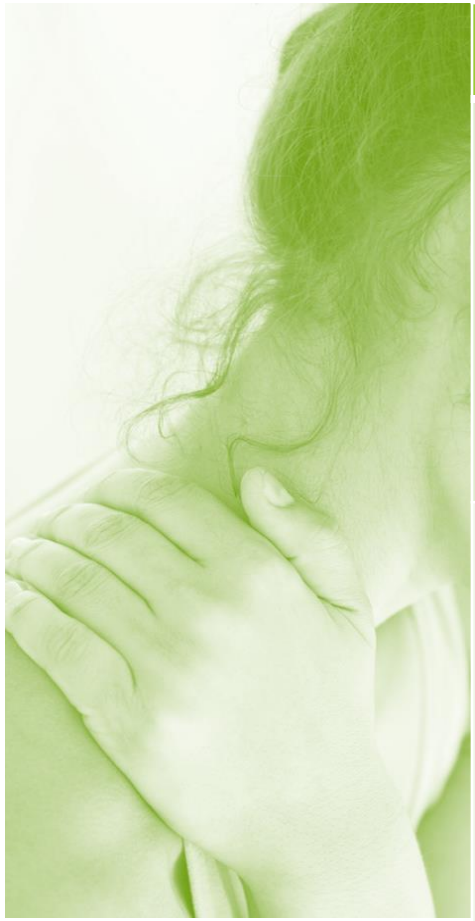
Dissociative Disorders

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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Somatic Symptom Disorder

- A.1 or more somatic sx that are distressing or result in significant disruption of daily life
- B. Excessive thoughts, feelings, or behaviors related to the somatic sx or associated health concerns as manifested by 1 of the following:
  - 1. Disproportionate and persistent thoughts about the seriousness of one's sx
  - 2. Persistently high level of anxiety about health or sx
  - 3. Excessive time and energy devoted to these sx or health concerns
- C. Although any 1 somatic sx may not be continuously present, the state of being symptomatic is persistent (typically > 6 months)

Somatic Symptom Disorder

- Specify if:
  - With predominant pain
  - Persistent (> 6 mos.)
- Specify current severity:
  - Mild: 1 sx
  - Moderate: 2 or more sx
  - Severe: 2 or more sx of Criterion B are fulfilled, plus multiple somatic complaints (or one very severe somatic sx)

Illness Anxiety Disorder

- A. Preoccupation with having or acquiring a serious illness
- B. Somatic sx are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g. strong family history is present), the preoccupation is clearly excessive or disproportionate
- C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
- D. The individual performs excessive health-related behaviors (e.g. repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g. avoids doctor appointments and hospitals).

Illness Anxiety Disorder

- E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time
- F. The illness-related preoccupation is not better explained by another mental d/o…
- Specify whether:
  - Care-seeking type
  - Care-avoidant type

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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Binge-Eating Disorder

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - 1. Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
  - 2. A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what/how much)
- B. the being-eating episodes are associated with 3 or more of the following:
  - 1. Eating much more rapidly than normal
  - 2. Eating until feeling uncomfortably full
  - 3. Eating large amounts of food when not feeling physically hungry
  - 4. Eating alone because of feeling embarrassed by how much one is eating
  - 5. Feeling disgusted with oneself, depressed, or very guilty afterward

Binge-Eating Disorder

- C. Marked distress
- D. The binge eating occurs, on average, at least once a week for 3 months
- E. The binge eating is not associated with recurrent use of compensatory behavior as in bulimia nervosa…
- Specify if:
  - In partial remission
  - In full remission
- Specify current severity:
  - Mild: 1-3 episodes per week
  - Moderate: 4-7
  - Severe: 8-13
  - Extreme: 14 or more

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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Rapid Eye Movement Sleep Behavior Disorder

- A. Repeated episodes of arousal during sleep associated with vocalization and/or complex motor behaviors.
- B. These behaviors arise during rapid eye movement (REM) sleep and therefore usually occur more than 90 minutes after sleep onset, are more frequent during the later portions of the sleep period, and uncommonly occur during daytime naps.
- C. Upon awakening from these episodes, the individual is completely awake, alert, and not confused or disoriented.

Rapid Eye Movement Sleep Behavior Disorder

- D. Either of the following:
  - 1. REM sleep without atonia or polysomnographic recording
  - 2. H/O suggestive of REM sleep behavior disorder and established synucleinopathy dx
- E. The behaviors cause clinically significant distress or impairment…
- F. The disturbance is not attributable to physiological effects of a substance…
- G. Coexisting mental and medical disorders do not explain the episodes
- Has been used in legal defense strategies.

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

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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Cannabis Withdrawal

- A. Cessation of cannabis use that has been heavy and prolonged (i.e. usually daily or almost daily for at least a few months)
- B. 3 or more of following S/S develop within approximately 1 week after Criterion A:
  - 1. Irritability, anger, or aggression
  - 2. Nervousness or anxiety
  - 3. Sleep difficulty (e.g. insomnia, disturbing dreams)
  - 4. Decreased appetite or weight loss
  - 5. Restlessness
  - 6. Depressed mood
  - 7. At least 1 of the following physical sx causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache.

Cannabis Withdrawal

- C. S/S in Criterion B cause clinically significant distress or impairment…
- D. S/S not attributable to another medical condition and not better explained by another mental d/o, including intoxication/withdrawal from another substance
- Can only co-exist with a moderate to severe cannabis use d/o

Caffeine Withdrawal

- A. Prolonged QD use of caffeine
- B. Abrupt cessation of or reduction in caffeine use, followed within 24 hrs. by 3 or more of the following s/s:
  - 1. Headache
  - 2. Marked fatigue or drowsiness
  - 3. Dysphoric mood, depressed mood, or irritability
  - 4. Difficulty concentrating
  - 5. Flu-like sx (nausea, vomiting, or muscle pain/stiffness)
- C. S/S in Criterion B cause clinically significant distress or impairment…
- D. S/S not associated w/ physiological effects of another medical condition…

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

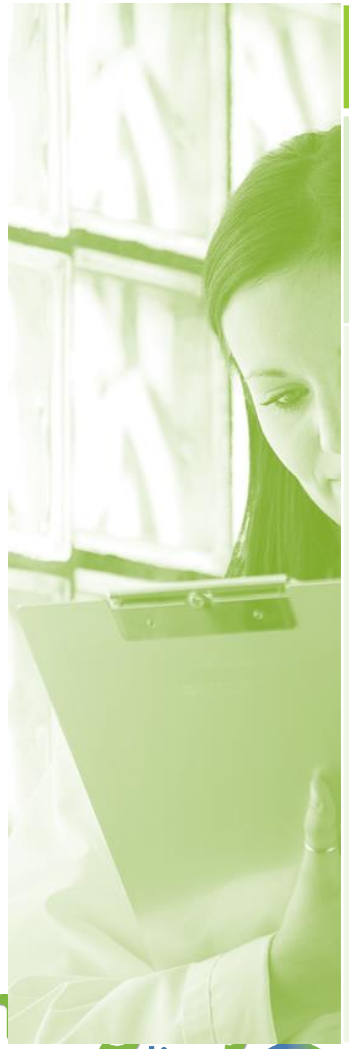
Abuse vs. Dependence?

- **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

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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