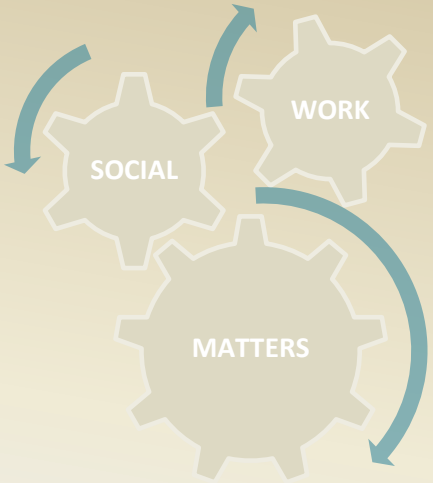

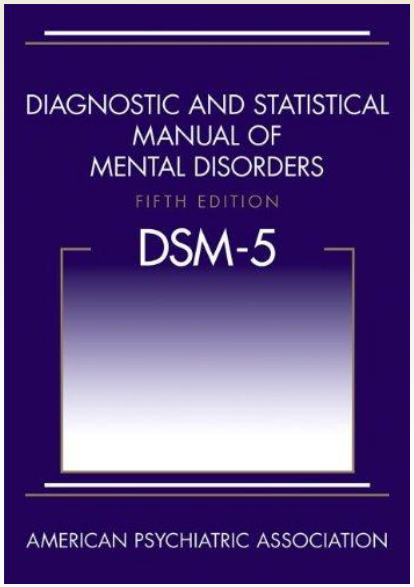

DSM–5

An Overview for Social Workers

NASW VIRGINIA CHAPTER
National Association of Social Workers

DSM-5 Overview

NASW VIRGINIA CHAPTER
National Association of Social Workers

DSM-5 Overview (Cont.)

DSM-5 Overview (Cont.)

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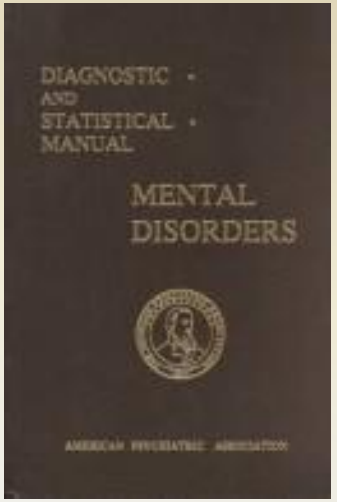
Overview and Key Points



- How we got here…a brief history.

1840…1 Diagnosis *"Idiocy/Insanity"*
1880…7 Diagnoses
1940…26 Diagnoses (ICD-6)
1952…DSM I
1968…DSM II (Revised, 1974)
1980…DSM III (Roughly coincided with ICD-9, multiaxial)
1987…DSM III-R
1994…DSM-IV
2000…DSM-IV-TR
2013…DSM-5
?… DSM-5.1

Overview and Key Points

- Huge undertaking involving hundreds of people working over a 12 year process…6 study groups, 13 diagnostic work groups, a task force of advocates from the professional and public sectors, and – for the first time – online feedback mechanisms for public comment.
- DSM-5 improves the accuracy of diagnosis by measuring the severity of a disorder, aligning with the ICD system and incorporating recent advances in neuroscience.
- Regarding the evolution of understanding mental disorders - Now an emphasis is placed on ***continuity*** between disorders, the relatively porous borders between disorders as opposed to strict categorization of disorders.

Overview and Key Points

- In addition to the public process, the signal advance of DSM-5 is the introduction of ***"dimensions,"*** psychiatric symptoms that occur within and across specific disorders.
- Dimensional approach introduced to reduce comorbidity and to begin moving toward a diagnostic system based on signs that indicate the dysfunction of neural circuits, rather than a strict categorical diagnostic system based on symptoms. ***This marks a departure from previous DSM versions.***

Structure of the DSM-5

- DSM-5 Classification
- Preface
- Section I: DSM-5 Basics
- Section II: Diagnostic Criteria and Codes
- Section III: Emerging Measures and Models
- Appendix
- Index

Section I: DSM-5 Basics

- Introduction
- DSM-5 Revision Process
- Harmonization with ICD-11
- Dimensional Approach to Diagnosis
- Developmental and Lifespan Considerations
- Removal of the Multiaxial System
- *Use of the Manual*
- Important Definitions (*"Mental Disorder"*)
- Cautionary Statement for Forensic use of the DSM-5

Section II: Diagnostic Criteria and Codes

- The main "body" of DSM-5. The chapter structure has changed from previous versions.
- More consistent with ICD-10 and ICD-11.
- Revised structure reflects a number of notions:

- Elimination of multiaxial system and the integration of developmental and temperamental considerations;

- Grouping based on the presence of either internalizing or externalizing factors;

- Work going on in genetics, neuroscience, epidemiology, etc.

Section II: Overview

- All *diagnostic criteria* contained here along with the ICD-9-CM and ICD-10-CM (shown parenthetically) codes.
- Descriptive text (updated/revised): READ IT.
- Specific recording procedures
- *Medication-induced movement disorders and other adverse effects of medication*
- *Other Conditions that may be a focus of clinical attention* (V Codes, Z Codes, T Codes)

*Italicized components represent the key elements of the clinical diagnostic process and are presented together in Section II

Section II: Listing of Disorders

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 Symptom and Related Disorders
10. Feeding and Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse-Control, and Conduct Disorders
16. Substance-Related and Addictive Disorders
17. Neurocognitive Disorders
18. Personality Disorders
19. Paraphilic Disorders
20. Other Mental Disorders
21. Medication-Induced Movement Disorders and Other Adverse Effects of Medication
22. Other Conditions That May Be a Focus of Clinical Attention

Section III: Emerging Measures and Models

- Serves as a designated location, separate from diagnostic criteria, text, and clinical codes, for items that appear to have initial support in terms of clinical use but *require further research* before being officially recommended as part of the main body of the manual (Section II).
- This separation clearly conveys to readers that the content may be clinically useful and warrants review but is not a part of an official diagnosis of a mental disorder and cannot be used as such.

Section III: Content

- Assessment Measures
- Cultural Formulation
- Alternative DSM-5 Model for Personality Disorders
- Conditions for Further Study

Section III: Conditions for Further Study

- Attenuated Psychosis Syndrome
- Depressive Episodes With Short-Duration Hypomania
- Persistent Complex Bereavement Disorder
- Caffeine Use Disorder
- Internet Gaming Disorder
- Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure
- Suicidal Behavior Disorder
- Nonsuicidal Self-Injury

Appendix

- Comparison – Highlights of changes from DSM-IV-TR to DSM-5
- Glossary of technical terms
- Glossary of cultural concepts of distress
- Alphabetical listing of DSM-5 diagnoses and codes (ICD-9-CM and ICD-10-CM)
- Numerical listing of DSM-5 diagnoses and codes (ICD-9-CM)
- **Numerical listing of DSM-5 diagnoses and codes (ICD-10-CM)*
- DSM-5 advisors and contributors

**ICD-10 codes are to be used for coding purposes in the United States starting October 1, 2014. DO NOT USE BEFORE OFFICIAL IMPLEMENTATION OCCURS . Will be alphanumeric starting with letters (E, F, G, L, N, R, T, Z)*

DSM-5: Definition of "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 *between the individual and society* are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above."

DSM-5 p. 20.

DSM-5: Definition of "Mental Disorder"

"The diagnosis of a mental disorder should have *clinical utility*: it should help clinicians to determine prognosis, treatment plans, and potential treatment outcomes for their patients…

…However, the diagnosis of a mental disorder is not equivalent to a need for treatment."

DSM-5 p. 20

Changes in Specific DSM Disorder Numbers:

Combination of New, Eliminated and Combined Disorders

Net Difference = -15

	DSM-IV-TR	DSM-5
Specific Mental Disorders	**172**	**157**

(Not including Other Specified/Unspecified Disorders that are a residual category)

New and Eliminated Disorders in DSM-5:

Net Difference = +13

New Disorders:

1. Social (Pragmatic) Communication Disorder
2. Disruptive Mood Dysregulation Disorder
3. Premenstrual Dysphoric Disorder (DSM-IV Appendix)
4. Hoarding Disorder
5. Excoriation (Skin Picking) Disorder
6. Disinhibited Social Engagement Disorder (split from Reactive Attachment Disorder)
7. Binge Eating Disorder (DSM-IV Appendix)
8. Central Sleep Apnea (split from Breathing-Related Sleep Disorder)
9. Sleep-Related Hypoventilation (split from Breathing-Related Sleep Disorder)
10. Rapid Eye Movement Sleep Behavior Disorder (Parasomnia NOS)
11. Restless Legs Syndrome (Dyssomnia NOS)
12. Caffeine Withdrawal (DSM-IV Appendix)
13. Cannabis Withdrawal
14. Major Neurocognitive Disorder with Lewy Body Disease (Dementia Due to other Medical Conditions)
15. Mild Neurocognitive Disorder (DSM-IV Appendix)

Eliminated Disorders:

1. Sexual Aversion Disorder
2. Polysubstance-Related Disorder

Combined Specific Disorders in DSM-5

Net Difference = -28 (from **50** in DSM-IV to **22** in DSM-5)

1. Language Disorder (Expressive Language Disorder & Mixed Receptive Expressive Language Disorder)
2. Autism Spectrum Disorder (Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder, & Rett's Disorder)
3. Specific Learning Disorder (Reading Disorder, Math Disorder, & Disorder of Written Expression)
4. Delusional Disorder (Shared Psychotic Disorder & Delusional Disorder)
5. Panic Disorder (Panic Disorder Without Agoraphobia & Panic Disorder With Agoraphobia)
6. Dissociative Amnesia (Dissociative Fugue & Dissociative Amnesia)
7. Somatic Symptom Disorder (Somatization Disorder, Undifferentiated Somatoform Disorder, & Pain Disorder)
8. Insomnia Disorder (Primary Insomnia & Insomnia Related to Another Mental Disorder)
9. Hypersomnolence (Primary Hypersomnia & Hypersomnia Related to Another Mental Disorder)
10. Non-Rapid Eye Movement Sleep Arousal Disorders (Sleepwalking Disorder & Sleep Terror Disorder)

Combined Disorders in DSM-5 (Cont.)

Net Difference = - 28

11. Genito-Pelvic Pain/Penetration Disorder (Vaginismus & Dysparuenia)
12. Alcohol Use Disorder (Alcohol Abuse and Alcohol Dependence)
13. Cannabis Use Disorder (Cannabis Abuse and Cannabis Dependence)
14. Phencyclidine Use Disorder (Phencyclidine Abuse and Phencyclidine Dependence)
15. Other Hallucinogen Use Disorder (Hallucinogen Abuse and Hallucinogen Dependence)
16. Inhalant Use Disorder (Inhalant Abuse and Hallucinogen Dependence)
17. Opioid Use Disorder (Opioid Abuse and Opioid Dependence)
18. Sedative, Hypnotic, or Anxiolytic Use Disorder (Sedative, Hypnotic, or Anxiolytic Abuse and Sedative, Hypnotic, or Anxiolytic Dependence)
19. Stimulant Use Disorder (Stimulant Abuse and Stimulant Dependence)
20. Stimulant Intoxication (Amphetamine Intoxication and Cocaine Intoxication)
21. Stimulant Withdrawal (Amphetamine Withdrawal and Cocaine Withdrawal)
22. Substance/Medication-Induced Disorders (aggregate of Mood (+1), Anxiety (+1), and Neurocognitve (-3).

Changes from **NOS** to Other Specified/Unspecified

Net Difference = + 24

Other Specified and *Unspecified* Disorders in DSM-5 replaced the Not Otherwise Specified (NOS) conditions in DSM-IV to maintain greater concordance with the official International Classification of Diseases (ICD) coding system. This statistical accounting change does not signify any new specific mental disorders.

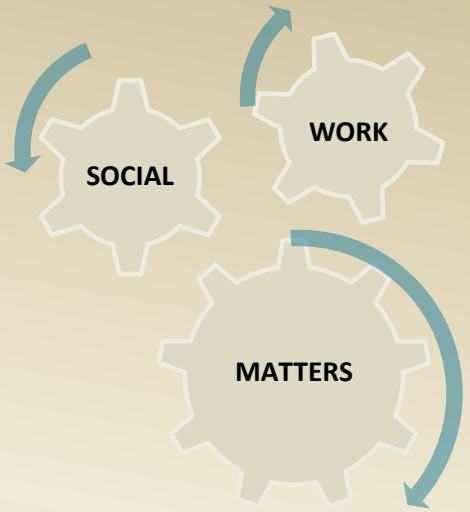
	DSM-IV-TR	DSM-5
NOS (DSM-IV-TR); Other Specified/Unspecified (DSM-5)	**41**	**65**

Other Specified/Unspecified in DSM-5

- DSM-IV's **NOS** diagnosis allowed a clinician to initiate treatment for an individual whose presentation was not consistent with a more specific diagnosis.
- The "*Other Specified*" and "*Unspecified*" criteria are found in each chapter of DSM-5 and provide more details than the comparable NOS sections of the DSM-IV.
- Interviewers are advised to consider "unspecified" diagnoses when a person experiences symptoms characteristic of a mental disorder that cause clinically significant distress but do not meet full criteria for a named diagnosis.
- If an interviewer wishes to communicate the specific reason a person does not meet criteria, the interviewer is encouraged to use the "other specified" diagnosis.

Structure of Disorder Groups in DSM-5

- Criteria
- Subtypes and/or Specifiers
- Severity (Codes and Recording Procedures)
- Explanatory Text (*New or Expanded)*
- Diagnostic and associated features; prevalence; *development and course; risk and prognosis; culture and gender-related factors; diagnostic markers; functional consequences;* differential diagnoses; comorbidity



Key Changes in DSM-5 Diagnostic Criteria

Neurodevelopmental Disorders

- Onset during the "developmental period" and negatively impact developmental trajectory.
- Different from neurocognitive disorders which represent a decline from a known level of functioning.

Intellectual Disability (Intellectual Developmental Disorder)

- Has parentheses as a reminder that this is a *disorder* and not necessarily just a disability. Also reflects the WHO's classification system.
- Not an IQ specific diagnosis any longer
- Requires both deficits in intellectual functioning (generally 2 SDs or more below expected mean), but also deficits in adaptive functioning.
- Note phrase "*Without on-going support, the adaptive deficits limit functioning…*" Can still make the diagnosis if the individual has necessary supports and can function relatively "normally."

Communication Disorders

- DSM-5 got rid of Expressive and Mixed Expressive-Receptive Disorders because it was often difficult to distinguish between the two.
- Speech Sound Disorder replaces Phonological Disorder
- Childhood-Onset Fluency Disorder replaces Stuttering
- Social (Pragmatic) Communication Disorder focuses on persistent deficits in the social use of verbal and nonverbal communication. CANNOT be diagnosed in the presence of RRBs, interests, and activities.

Autism Spectrum Disorder

- ASD replaces DSM-IV's autistic disorder (Autism), Asperger's Disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified.
- Criteria have been simplified by having just the two domains:

  A. persistent deficits in social communication and social interaction across multiple contexts and…

  B. Restrictive, repetitive patterns of behavior, interests, or activities (RRBs)…
- Both components are required for a diagnosis of ASD (social communication disorder may be diagnosed if no RRBs are present).
- DSM-IV required onset of symptoms before age 3. DSM-5 allows for social demands to make those symptoms manifest.
- Rate Severity of Symptoms (both social communication and RRBs) separately.

Attention Deficit/Hyperactivity Disorder

- Age of onset of impairing symptoms changed from prior to age 7 to prior to age 12.
- Change to accommodate a lifespan relevance of each symptom
- Cross-situational requirement changed to “several” symptoms in each setting (two or more informants).
- Subtypes replaced with “Presentation” Specifiers (4 total)
- Can now diagnosis concurrently with ASD
- Symptom threshold change made for adults (5 symptoms vs. 6 for children)

Specific Learning Disorder

- Combines DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder NOS.
- Coded specifiers for the deficit types are provided.
- Keep in mind that learning difficulties might not become fully manifest until demands exceed the individual's limited capacities.

Schizophrenia Spectrum and Other Psychotic Disorders

- Schizotypal (listed in this chapter but discussed in detail in Personality Disorders chapter)
- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Substance/Medication Induced Psychotic Disorder

Schizophrenia

- Elimination of special treatment of bizarre delusions and "special" hallucinations (e.g., two or more voices conversing) in Criterion A. This was removed due to the poor reliability in distinguishing bizarre from non-bizarre delusions.
- In DSM-5 ***two*** Criterion A symptoms are required for any diagnosis of schizophrenia.
- ***At least one*** of two required symptoms to meet Criterion A must be delusions, hallucinations, or disorganized speech (core "positive symptoms").

Schizophrenia Subtypes

- Schizophrenia Subtypes in DSM-IV (paranoid, disorganized, catatonic, undifferentiated, residual types) are eliminated in DSM-5.
- Dimensional approach to rating severity of core symptoms is available in Section III.

Schizoaffective Disorder

- DSM-5 now requires that a major mood episode be present for a majority of the disorder's total duration after Criterion A has been met.
- Based on the lifetime (rather than episodic) duration of illness in which the mood and psychotic symptoms described (in Criterion A) occur.

Catatonia

- In DSM-5, catatonia may be diagnosed as a specifier, a separate diagnosis in the context of another medical condition, or as an other specified diagnosis.
- *Can code as a* Specifier for neurodevelopmental, psychotic, mood and other mental disorders; as well as for other medical disorders (catatonia associated with another medical condition).
- In DSM-5, all contexts require 3 or more symptoms (out of 12 psychomotor features).

Bipolar and Related Disorders

- Placed between Schizophrenia Spectrum and Depressive Disorders recognizing their place as a bridge between the two categories.
- Criterion A for manic and hypomanic episodes now includes an emphasis on *changes in energy and increased goal directed activity* as well as mood.
- New specifier "***with mixed features***" for any episodes of mania/hypomania when depressive features are present (Bipolar I, Mixed State dropped from DSM-5).
- ***Anxious Distress*** specifier added to all bipolar diagnoses.

Depressive Disorders

- DSM-5 adds ***Disruptive Mood Dysregulation Disorder*** (addresses concern about childhood bipolar and potential overdiagnosis). A potential alternative to bipolar NOS.
- Criteria do not allow a dual diagnosis with oppositional-defiant disorder (ODD) or intermittent explosive disorder (IED), but it can be diagnosed with conduct disorder (CD). Children who meet criteria for DMDD and ODD would be diagnosed with DMDD only.

- ***Premenstrual Dysphoric Disorder*** moved from DSM-IV "…further study" section to DSM-5 Section II. Assessed to be markedly separable from major depression and other disorders.

Depressive Disorders (Cont.)

- DSM-5 adds ***Persistent Depressive Disorder***. Incorporates both dysthymia and chronic major depression. Persistence or chronicity of symptoms really trumps number of symptoms and severity.
- Post Partum Depression changed to ***Peri-Partum*** specifier to reflect that a major depressive episode can occur *during* pregnancy as well as after parturation.

Depressive Disorders (Cont.)

- Like with bipolar and related disorders, DSM-5 includes the additions of a ***mixed specifer*** and a ***anxious distress*** specifier.

The Bereavement Exclusion

- ***Dropped*** in DSM-5.
- There is a note in DSM-5 distinguishing grief from a major depressive episode (completely different presentations, but they can overlap).
- DSM-5 recognizes that bereavement is a severe psychosocial stressor that can *precipitate* major depression in vulnerable individuals.
- Research indicates the duration of bereavement is more commonly 1-2 years.
- Differentiation is left for the clinician's decision.

Anxiety Disorders

- Share features of ***fear*** and ***anxiety*** related behavioral disturbances. Highly comorbid with one another.
- No longer includes obsessive-compulsive disorder (OCD), acute stress disorder (ASD), and posttraumatic stress disorder (PTSD).
- Separation anxiety disorder and selective mutism now included in this chapter.
- Panic attacks can now be listed as a specifier applicable to all DSM-5 disorders (new terminology "*unexpected*" and "*expected*").

Obsessive-Compulsive and Related Disorders

- New chapter in DSM-5.
- ***Hoarding Disorder*** added.
- ***Excoriation (Skin-picking) Disorder*** added.
- ***Body Dysmorphic Disorder*** moved from the somatoform section.
- ***Trichotillomania (Hair-Pulling) Disorder*** moved from Impulse Control Disorders.

Obsessive-Compulsive and Related Disorders (Cont).

- DSM-5 refines the old “with poor insight” specifier for OCD to include “good or fair insight,” “poor insight,” or “absent insight/delusional.”

Trauma-and Stressor-Related Disorders

- New category in DSM-5 (includes **PTSD, ASD, Ads, RAD, DSED**).
- Placing of the chapter in DSM-5 is meaningful (near anxiety and obsessive-compulsive disorders and followed by dissociative disorders)
- Characterized by exposure/responses (often mixed) to trauma or stress.

Acute Stress Disorder

- DSM-5 requires being explicit as to whether the stress was…
  - experienced directly
  - witnessed “in person”
  - experienced indirectly
- Eliminated criterion regarding subjective reaction to the traumatic reaction (fear, helplessness, horror)
- No “mandatory” (e.g., dissociative) symptoms
- Meet 9 of 14 symptoms from the following categories: intrusion (4), negative mood (1), dissociative (2), avoidance (2), arousal (5).

Posttraumatic Stress Disorder

- Stressor criterion (Criterion A) more explicit with regard to events qualifying as traumatic.
- Subjective reaction has been eliminated.
- 4 major symptom clusters in DSM-5 (3 in DSM-IV):
  - Intrusion Symptoms
  - Persistent avoidance of stimuli
  - Negative alterations in cognitions and mood associated with the traumatic event
  - Marked alterations in arousal and reactivity

Posttraumatic Stress Disorder (Cont.)

- Diagnostic thresholds lowered for both children and adolescents (reduced number of symptoms in certain clusters). Focus is more on behaviors vs. cognitive development/verbal expression.
- Separate criteria added for children under 6 years of age ***(Preschool Subtype)***

Posttraumatic Stress Disorder (Cont.)

- New Subtype Specifiers (PTSD phenotypes):
  - ***With dissociative symptoms*** (including depersonalization and derealization)
  - ***With delayed expression*** (full diagnostic criteria not met until after 6 months post event)

Reactive Attachment Disorder

- Reconfigured from one disorder with two subtypes in DSM-IV into two distinctive disorders in DSM-5:
  - ***Reactive Attachment Disorder.*** More closely resembles internalizing disorders (withdrawn/inhibited phenotype)
  - ***Disinhibited Social Engagement Disorder.*** Respond with disinhibition, don't show stranger anxiety, go home with almost any adult (indiscriminately social/disinhibited phenotype)
- Both disorders have to be present before the age of 5.

Dissociative Disorders

- Major changes are to ***Dissociative Identity Disorder.*** Text revised to better characterize the disorder and to increase clinical utility.
- DSM-5 has incorporated "possession" as an alternate cultural expression.
- ***Dissociative Fugue*** is now a *specifier* of ***Dissociative Amnesia***
- Combined ***Depersonalization and Derealization Disorders*** into a single disorder.

Somatic Symptom and Related Disorders

- The central focus of medically unexplained symptoms has been de-emphasized throughout the chapter, and instead emphasis is placed on disproportionate thoughts, feelings, and behaviors that accompany symptoms
- The reliability of medically unexplained symptoms is low. Presence of medically explained symptoms *does not* rule out the possibility of a somatic symptom or related disorder being present.

Binge Eating Disorder (Feeding and Eating Disorders)

- Elevated to the main body of the manual from DSM-IV's Appendix
- BED is highly recognized in the clinical literature as a valid and clinically useful diagnosis. Further, a significant proportion of cases of DSM-IV's eating disorder not otherwise specified (EDNOS) would meet criteria for BED; therefore, this should reduce use of the unspecified eating and feeding disorder designation in DSM-5.

Gender Dysphoria

- Newly added as a separate diagnostic class in DSM-5
- New diagnostic class reflects a change in the conceptualization of gender identity disorder's (GID) defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification, as in DSM-IV.
- The name change responds to concerns from consumers and advocates that the term *gender identity disorder* was stigmatizing. The revised term is already familiar to clinicians working with these populations and better reflects the emotional component of the diagnostic criteria.
- Criteria now includes two separate sets for children and for adults/adolescents

Disruptive, Impulse Control, and Conduct Disorders

- New chapter in DSM-5.
- All characterized by problems in emotional and behavioral self-control.
- Because of its close association with conduct disorder, antisocial personality disorder has a dual listing in this chapter and in the chapter on personality disorders.

Oppositional Defiant Disorder

- DSM-5 groups symptoms into 3 types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness.
- Exclusion criterion for conduct disorder removed.
- Guidance provided on the frequency typically needed for a behavior to be considered symptomatic of the disorder
- Severity rating added (pervasiveness of symptoms across settings)

Conduct Disorder

- Addition of a conduct disorder specifier called "***with limited prosocial emotions***" ("callous and unemotional" interpersonal style) across multiple settings and relationships.
- Data have identified a subgroup of children with CD that display a lack of guilt and empathy, lack of concern over performance in important activities, and shallow affect.
- Compared to other children with CD, this subgroup appears to have more severe symptoms, a more stable course, and greater levels of aggression. Addition of this specifier will inform the development of specialized treatments separate from those used with other CD populations.

Substance-Related and Addictive Disorders

- Expanded to include ***Gambling Disorder.***
- ***Cannabis Withdrawal*** and ***Caffeine Withdrawal*** are new disorders.
- DSM-5 does not separate abuse and dependence but provides criteria for ***Substance Use Disorder.***

Substance-Related and Addictive Disorders

- Recurrent substance-related legal problems criterion is deleted.
- Added new criterion ***craving or a strong desire or urge to use a substance***.
- Diagnosis of polysubstance dependence in DSM-IV has been eliminated.
- Threshold for diagnosis in DSM-5 is set at two or more criteria (out of 11).

Substance-Related and Addictive Disorders (Cont.)

- General Estimate of Severity

2-3 Criteria	Mild
4-5 Criteria	Moderate
6+ Criteria	Severe

Mild will be coded in ICD terms with old abuse code.

Moderate and above will be coded with old dependence code.

Neurocognitive Disorders

- The terms *dementia* and *amnestic disorder were* replaced with ***Major Neurocognitive Disorder (NCD)***.
- DSM-5 now recognizes a less severe level of cognitive impairment, ***Mild Neurocognitive Disorder***. Permits the diagnosis of less disabling syndromes that may still be the focus of clinical intervention.

Personality Disorders

- All 10 DSM-IV PDs remain intact in Section II of DSM-5. Text descriptions have been updated.
- Section III contains an alternate, trait-based approach to assessing personality and PDs that includes 6 specific PD types (antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, schizotypal) and allows for the rating of traits and facets, facilitating diagnosis in individuals who meet core criteria for a PD but do not otherwise meet a specific PD type.
- The hybrid model in Section III calls for evaluation of impairments in personality functioning and characterizes five broad areas of pathological personality traits. The APA plans to evaluate the strengths and weaknesses of the model, leading to greater understanding of the causes and treatments of PDs.

Paraphilic Disorders

- DSM-5 adds course specifiers “in a controlled environment” and “in remission” to the criteria sets for all the paraphilic disorders.
- Distinction made between paraphilias and paraphilic disorders.

Dimensional Approach to Diagnosis

Dimensionality in DSM-5

- It is demonstrated that the clustering of disorders according to *internalizing* and *externalizing* factors represent an empirically supported framework.
- Within both the internalizing group (*anxiety, depression, and somatic*) and externalizing group (*impulsive, disruptive conduct, and substance use*), the sharing of genetic and environmental risk factors likely explains the comorbidities.

Dimensionality in DSM-5

- Shared neural substrates
- Family traits
- Genetic risk factors
- Specific environmental risk factors
- Biomarkers
- Temperamental antecedents
- Abnormalities of emotional or cognitive processing
- Symptom similarity
- Course of illness
- High comorbidity
- Shared treatment response

Dimensionality in DSM-5

- Historically the DSM diagnostic system could not always distinguish normality from pathology and one mental disorder from another.
- DSM-5 incorporates dimensions into its diagnostic system (measures of psychiatric symptoms) 3 ways:

1. **Provide a way to acknowledge psychiatric symptoms that are not part of the diagnostic criteria of an individual's primary mental disorder;**
2. **Dimensions allow assessors to measure the magnitude of a symptom;**
3. **Provide a way to screen for mental health problems in general clinical settings.**

Optional Measures and Assessment Tools

- Assist in the assessment of a patient including diagnosis, prognosis, treatment planning and outcome.
- In DSM-5, these include:
  - Level 1 and Level 2 Cross-Cutting Symptom assessments
  - Diagnosis-specific severity ratings
  - Disability assessment (WHODAS 2.0)
- May be completed by patient, informant, or clinician, depending on the measure

Assessment/Diagnostic Interview Using the DSM-5

Assessment Using the DSM-5: Considerations (Handout)

- The relationship comes first. Seek first…and always…to *hear* and *understand.*
- More than just gathering of information – the clinical interview is the initiation of building a trusting, helping, healing relationship – the forging of an alliance upon which to build a plan responsive to the individual's and family's needs.
- More than just a diagnostic interview, you are developing a *case formulation.* The diagnosis and case conceptualization need to have *clinical utility.*

Assessment Considerations (Cont.)

- Address the tenets of DSM-5's *Definition of a Mental Disorder*
- Have a working knowledge of Section II so you know where you need to go/what you need to do to winnow down your questions.
- Consider utilization of the Cultural Formulation Interview in ALL assessments.

Assessment Using the DSM-5: *Suggested* Process (handout)

- Administer cross-cutting assessment measures (levels I and II).
- Conduct Clinical Interview (informed, if possible, by assessment scores).
- Determine whether or not diagnostic threshold is met.
- Consider subtypes and specifiers.
- Consider additional contextual information.

Assessment Using the DSM-5: *Suggested* Process (Cont.)

- Decide on the most clinically appropriate diagnosis.
- Administer severity assessments (where applicable).
- Apply codes and follow instructions in DSM-5 for coding and recording procedures.
- Place all mental health and other medical disorders on a single list. With ICD code and name of disorder. Typically, the issue/disorder you're focusing on as the reason for visit/admission is listed first.

Assessment Using the DSM-5: *Suggested* Process (Cont.)

- In place of Axis IV, use DSM-5's V/Z/T codes.
- Administer WHODAS 2.0 (suggested, not required). Formerly Axis V.
- Develop initial service plan and outcome monitoring plan.
- Use assessment measures to monitor and assess progress at appropriate intervals.
- Refine diagnosis as appropriate and adjust service plan.

Coding and Recording

- READ THE TEXT. DSM-5 is written in a way that clearly explains what and how to code in every diagnostic category.
- Always record both the code and the diagnosis "title."
- ICD-9-CM/ICD-10-CM Crosswalk
- Some Coding Issues…

Understanding Needs: The Clinical Summary

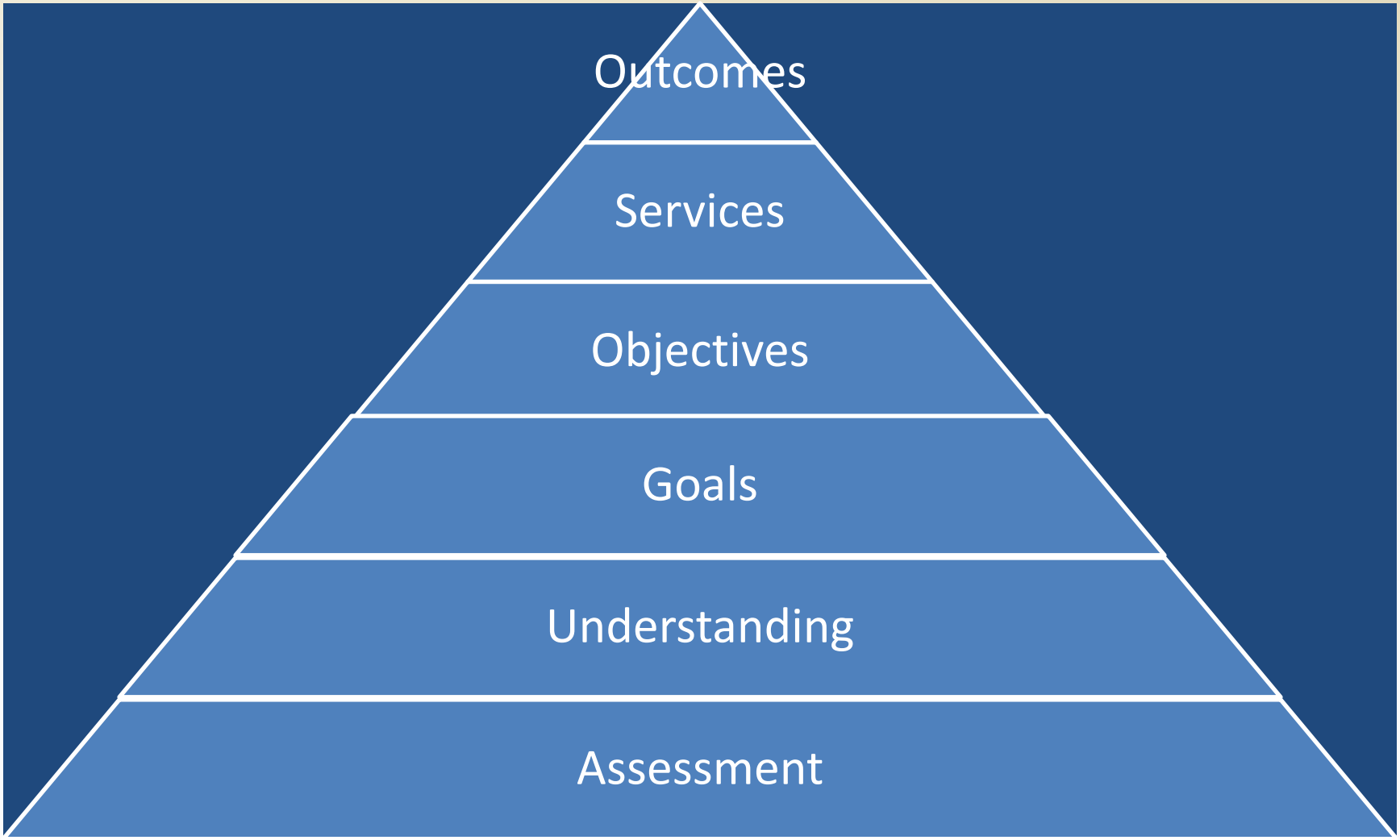
- The gathering of information in the assessment is only the beginning. Integration and summary of data and clinical formulation are essential but often-overlooked steps in the process of developing an individual plan.
- The assessment data is about *what*, and the narrative summary and formulation is about *how* and *why*. Preparing a clinical formulation/narrative summary is the next step in moving towards creating an individual plan.
- This involves integration of the data and draws upon the assessor's insights and interpretation. Out of the assessment information, we can create an understanding of the individual and family that extends beyond the mere facts.

The Narrative/Clinical Summary: Your Unique Contribution

- The ability of the assessor to integrate data into understanding, and the sharing of this insight and perspective with the individual and family is often in and of itself a powerful intervention. It is the essence of empathy.
- The written narrative summary documents the rationalization and justification for our recommendations and suggestions. It creates the platform from which the individual and team launch into creating the individual plan and charting the course for change (road map).
- *The summary explains the goals, identifies the barriers, orders the priority of tasks and objectives, substantiates eligibility and level of care, clarifies the diagnosis, explains the role of culture, and ultimately justifies the interventions or services provided for each individual and family.*

The narrative summary provides an opportunity for the assessor to record the rationale for a diagnosis.

Case Formulation, Treatment Planning and Outcome Measures



What You Can Do Now (handout)

- Use DSM-IV/DSM-5 with **ICD-9-CM codes** until September 30, 2014.
- Get the DSM-5 text (and other recommended publications), visit the APA website and begin to familiarize yourself with the content and material. Download and review the assessment measures and "pilot" the tools in diagnostic evaluations.

What You Can Do Now (Cont.)

- Become familiar with the crosswalk of ICD-9 to ICD-10 to prepare for implementation of new codes on October 1, 2014.
- Take a look at documentation for the most often-used ICD-9 codes in your practice and begin identifying corresponding ICD-10 codes (become familiar with changes for those disorders in DSM-5).
- Pay attention to your online messages from insurance companies regarding adoption of DSM-5 criteria.
- MASTER your material, seek additional training, ask questions.

Summary and Q&A

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