A Brief Overview of the New DSM 5 With Ethical Citations

General Overview

The DSM 5 should be used now for guidance in diagnosing your clients. The current ICD 9 Codes can be used until October 2014 at which time the ICD 10 Codes must be used. The ICD 10 codes most pertinent to our use will be F Codes and can be found in the back of DSM5 under the numerical listing of disorders beginning at pg. 877. It is critical that we all become very familiar with these codes as **NBCC will begin testing for licensure using these codes in the summer of 2014.**

The new DSM is designed to help clinicians form more systematic and objective means of assessment. **According to our ACA Code of Ethics, E.1.a states "The primary purpose of educational, psychological, and career assessment is to provide measures that are valid and reliable in either comparative or absolute terms. These include, but are not limited to, measurements of ability, personality, interest, intelligence, achievement, and performance. Counselors recognize the need to interpret the statements in this section (evaluation, assessment, and interpretation) as applying to both quantitative and qualitative assessments.** One reason for this ethics training is to maintain compliance in diagnosis with our ACA Code of Ethics. **E.5.a states, "Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care (e.g., locus of treatment, type of treatment, or recommended follow-up) are carefully selected and appropriately".**
It is essential that you read and understand the section that begins on page 19 on the proper use of the manual. It is recommended that you first concentrate on Sections I and III. These sections cover use of the manual and assessment measurements and cultural formulation. It will be required that we use some sort of measurement in our assessment to corroborate our diagnosis. **E.1.a- "Counselors responsible for decisions involving individuals or policies that are based on assessment results have a thorough understanding of educational, psychological, and career measurement, including validation criteria, assessment research, and guidelines for assessment development and use."E.2.a- "Counselors utilize only those testing and assessment services for which they have been trained and are competent. Counselors using technology assisted test interpretations are trained in the construct being measured and the specific instrument being used prior to using its technology based application. Counselors take reasonable measures to ensure the proper use of psychological and career assessment techniques by persons under their supervision."** A website for simple and easy to use measurements is provided at the back of this document. They can be downloaded for free from the APA website and they are also in the back section of the DSM 5. **E.2.b-"Counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments relevant to the needs of the client, whether they score and interpret such assessments themselves or use technology or other services."**

Section III is critical because the DSM 5 collapses the presently used 5 Axis model of diagnosis. Axes I and II are combined and even Axis III can be combined as well. The emphasis is less

restrictive and more comprehensive in that it uses more descriptive language. Axes I, II, and III become one element with disorders listed in order of why the client came into treatment. Axis IV descriptions remain but are now combined with the new value for assessment of functioning formally known as the GAF. GAF has been replaced with the WHODAS 2.0. WHODAS stands for the World Health Organization Disability Assessment Schedule. It can be self-administered by the client or proxy administered by the clinician. Both versions can be downloaded for free at: www.psyciatry.org/practice/dsm/dsm5/onlineassessmentmeasures and they are in the back of the DSM 5. These inventories cover the following aspects of functionality:

Cognition
Mobility
Self-care
Getting along or socialization
Life activities and
Participation

Diagnosis is now more descriptive charting the course and severity of the disorder as well as the symptomology. The new format provides more precision so that the reader has a clear and comprehensive picture of the client.

Diagnostic criteria are almost less important than factors that led to the issue in the first place. Because the DSM now defines mental disorder as "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 distress or disability in social, occupational, or other important activities", the intake or assessment interview process must include brain or neurological function, hereditary factors, and environmental or experiential factors. Assessment now is much more culturally based. This is discussed more fully in Section III of the DSM 5.

E.5.b-"Counselors recognize that culture affects the manner in which clients' problems are defined. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders."

E.6.c-"Counselors recognize that culture affects the manner in which clients' problems are defined. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders."

Assessment should no longer be a matter of checking symptoms or criteria off a check list. Now it is more a formulated conceptualization of the dysfunction. Items to assess for conceptualization include:

APPROACH TO CLINICAL CASE FORMULATION	
Diagnostic Content	Diagnostic Content
Diagnostic Features	Functional Consequences
Associated Features	Differential Diagnosis
Prevalence	Comorbidity
Development and course	Subtypes
Risk and prognostic features	Specifiers-course, severity

Environment	Descriptive
Genetic and physiological	In full/partial remission
Temperamental	Mild/Moderate/Severe/
Course modifiers	Extreme/Profound
Culture-Related Diagnostic issues	Single/recurrent/
Gender-Related Diagnostic issue	Episodic/persistent
Suicide Risk	Acute/subacute
	Generalized/Situational
	Lifelong/acquired

It is now more important that we pay attention to the narrative content in the DSM about the disorder in question so that all aspects of assessment are reviewed. Disorders are grouped under 20 chapter headings and there are 13 new diagnoses. The chapters are grouped in a life span concept from neurodevelopmental disorders to dementia of later life.

Coding Issues

As to Coding, we presently use ICD 9 codes such as 296.32 for major depressive disorder, moderate. When ICD 10 Codes become mandatory October 1, 2014, that particular code will change to F33.1. DSM 5 provides both the current codes and the codes coming into play next year. There are V Codes and Z Codes as well. Whether we get paid for those codes will still be up to the individual insurance carriers. However, we should be listing them in our diagnostic assessments as they are more descriptive now and more have been added.

When creating a case conceptualization for diagnostic purposes the first diagnosis listed should be the issue the client came in for. After that, codes should be listed in descending severity. If a disorder is due to a medical condition THAT condition should be coded first.

As an example the following diagnostic assessment is provided;

V62.21 Problem related to current military deployment status
301.89 Other specified Personality Disorder (mixed personality features- dependent and Avoidant symptoms…*state what you see here*
327.26 Co-morbid sleep related hyperventilation
300.4 Persistent Depressive Disorder (Dysthymia) with anxious distress in early remission. early onset with pure dysthymic syndrome, moderate
V62.89 victim of a crime…*state what the crime is*
278.00 overweight or Obesity…*listed as a reflection of compliance with treatment*
WHODAS:63

Note that personality disorders are listed prior to what used to be Axis I disorders. The WHODAS can be stated first or last. A sample of issues to be covered in the diagnostic assessment interview is in the back of this handout. It is taken from the website of the American Psychiatric Association and should only be viewed as a suggestion not as a guideline.

Substance Related and Addictive Disorders

You will notice in this section that the use of the terms abuse and dependence has been eliminated. The emphasis is more on the assessment of the impact of the substance use on the person's ability to live without significant disability.

Diagnostic criteria for this section are embedded in the narrative discussion of the chapter. It is critical that the recording procedures and coding be followed carefully.

The criteria are combined into a single list. Most are diagnosed by broad criteria. What is added is a list of threshold criteria that includes 2 of 11 symptoms. This is an increase of 1 for abuse and a decrease of 1 for dependence as seen in the DSM IV-TR. The threshold criteria are:

-Impaired control criteria 1-4
-social impairment criteria 5-7
-risky use criteria 8-9
-pharmacological use criteria 10-11

As you can see the emphasis is on impairment severity and how wide the use is. There is an addition of craving criteria as well. Legal problems due to substance use has been eliminated as it was not shown to be a statistically significant factor in the research.

Substance use diagnosis must address the following qualifiers:

Remission specifier: i.e. early remission (3 to less than 12 months)
Sustained remission (12 or more months)
Severity rating: i.e. 2-3 criteria = mild
4-5 criteria = moderate
6 or more criteria = severe.
Gone is partial and/or full remission. Calibrating diagnosis in this manner communicates the severity of the disorder and makes it easier to reflect the course of the disorder which will influence the course of treatment in the treatment plan.

By giving clinicians the elements to assess—impairment, the course of the disorder, the severity of the symptoms, the hereditary factors, and the environmental or experiential factors—placing disorders on a spectrum becomes much easier because the instructions are in the narrative and in the codes as well.

Although specific substance use diagnoses such as amphetamine use are eliminated specifically, they are covered under the new criteria of stimulant related disorders. The notation of amphetamine use as the substance would now be noted as the description while the code would be 305.70 (F15.10) which is the code for mild or 304.40 (F 15.20) for moderate or severe. This breakdown can be further reviewed on pages 561-567 of DSM 5.

There is an additional section on gambling as an addictive behavior but is not yet deemed a disorder as the research has not yet been seen as robust enough to qualify it as a disorder, but it could be listed as an impaired behavior.

Autism Spectrum Disorder

The new spectrum is arising out of a need for a more descriptive assessment so that there is more accuracy in diagnosing. It is hoped that this way of diagnosing the disorders will result in more and better services being made available where now they are lacking.

Pervasive Developmental Disorder covers the basic diagnostic criteria for Autism Spectrum Disorder. The main and required elements are:

1. Severe and pervasive impairment in ALL the following area:
    a. <u>reciprocal social interaction skills</u>-under developed or missing attachment signals such as appropriate eye contact, following conversations, difficulty sharing, or playing with others
    b. <u>Communication skills</u>-shows early regression of language skills, difficulty combining words, or they can be very articulate but not with other children, delayed babbling
    c. <u>Stereotyped behaviors</u>, interests and activities- these would include echolalia, rocking, spinning, self-soothing rituals, arranging and re-arranging objects, need for rigid schedules and routines, extreme obsessions

These criteria must be present in the first 3 years of life. They are often associated with some degree of mental retardation now referred to as an Intellectual Development Disorder. And some types are accompanied by a GENERAL MEDICAL CONDITION. There may be genetic factors that influence the gastrointestinal function, possibly manifested as both dietary and food rituals. Seizures occur in about 39% of those with PDD. There is often sleep dysfunction, processory sensory input issues and pica.

Pervasive Developmental Disorder now breaks down into:
Autism Disorder
Rhetts Disorder
Childhood Disintegrative Disorder
And PDD-NOS

Concentrating on Autism Disorder refer to the DSM 5 starting on page 50. The basic criteria are at least 6 items causing qualitative impairment from social interaction (minimum 2), and communication (minimum 1), and restrictive or stereotyped behaviors (minimum 1). There must be evidence of abnormal behavior prior to the age of 3 in at least one 1. Social interaction, 2. language, or 3. symbolic play. The symptomology can NOT be better accounted for by another diagnosis.

Impairment must be in multiple issues including non-verbal communication, peer relationships, and lack of support. Additionally, there will be marked evidence of lack or delay of verbal skills, inability to initiate connection, and idiosyncratic language. There will be tenacity to behaviors beyond the norm for that developmental stage and culture. This will usually manifest in rigid structured movements, rocking, and a pre-occupation with the parts of things.

Asperger's Disorder

The criteria in general are the same as for ASD but the intensity and level of severity is less restrictive. Specifically, Asperger's requires impairment in social interactions (minimum 2), restrictive or repetitive behaviors (minimum 1), and significant impairment in social, occupational, or other important areas of functioning. There is usually no clinically significant language delay or delay in cognitive development or the ability to attend appropriately to ADLs. Asperger's is not better accounted for by another PDD or schizophrenia.

Pervasive Developmental Disorder NOS must show severe impairment in reciprocal social interactions, impairment in *either* verbal or non-verbal skills, OR stereotyped behaviors. PDD-NOS does not meet the criteria for another PDD, schizophrenia, schizotypal, or avoidant Personality Disorder.

So, why the changes? To offer umbrella criteria that will most likely NOT result in more diagnoses as feared, but for more accurate assessments with more specific symptomology.

For Autism Spectrum Disorder the deficits must be persistent across multiple contexts. This must be assessed against the norm for the developmental stage and must be assessed for specific severity. There is a new criterion that must be present and that is hyper or hypo reactivity to sensory input or unusual interest in sensory aspects of the environment.

Even though symptoms must be present in the first 3 years of life it is often discovered or realized later through a review of the history or parent report.

Specifiers and Modifiers

Specifiers are going to include a more thorough assessment of history. This can be gained from other people on the care team such as the pediatrician, parent report, and neurological testing. They **must** include:

-with or without intellectual impairment

-with or without accompanying language impairment

-associated with a known medical condition or genetic condition or environmental factors such as fetal alcohol syndrome, pre-natal environment, cerebral palsy, seizure disorder, Rhetts

-associated with another neuro-developmental, mental or behavioral disorder

-with or without catatonia

You must use ICD 9 Codes for accompanying medical conditions. As of October 1, 2014, the ICD 10 Codes will be required, but now we should be using the new DSM diagnostic criteria for our assessments. You must also chart anxiety, depression, and construct issues which quite often manifest with ASD.

Levels of Severity

Severity must be based on social communication and repetitive behaviors. The table on page 52 of the DSM 5 states:

Level 1: client requires some support
Level 2: client requires substantial support and
Level 3: client requires VERY substantial support.

These levels look at first the deficit and impairment, marked deficits in language, coping, and change, and severe deficits such as intense inflexibility equaling extreme impairment.

Focus of Assessment

Age of perceived onset
Pattern of onset
Cultural related issues ***critical***
Gender related issues

Autism Spectrum is 4 times more likely to be found in boys than girls. Girls show more intellectual impairment.

E.5.c- "Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment."

Factors to include in your assessment are:

Parental age during gestation and at birth…older parents tend to have more autistic children

Genetic comparison with another with the same diagnosis 15% of cases are attributed to genetic factors

You must be able to create a differentiated diagnosis by process of elimination. Rhetts is no longer a mental disorder. It is a medical condition that often accompanies Autism. So look at the following for elimination purposes:

Selective mutism
Language only disorders
Intellectual disabilities with ASD
Attention deficit disorder with or without hyperactivity
Schizophrenia

It is highly recommended that your diagnosis be corroborated by clinical testing done by a psychologist, or neurologist…not just by a parent report. The more you can back up your diagnosis with some clinical measureable data the better.

Sample Diagnoses

- Autism Spectrum Disorder, Level 2, with mild intellectual disability and language impairment, onset age 20 months loss of previously acquired language
- Autism Spectrum Disorder, Level 1, associated with ADHD without intellectual disability and without language impairment
- Autism Spectrum Disorder, Level 2, associated with Cerebral Palsy, mild intellectual impairment and stuttering

Major changes include:

1. It is now a spectrum of disorders
2. Focus is on 2 key areas rather than 3
3. More focus on history
4. Use of specifiers and modifiers

5. Addition of Social Communication Disorder where there is persistent difficulty with social interaction, rules, and story telling

Implications of the Changes

1. Elimination of Asperger's Disorder and PDD-NOS
2. Better history screening
3. Co-morbid diagnoses
4. Availability of more and better services particularly for those with Asperger's
5. Intellectual disability
6. New testing measures as old tests must be updated for accuracy

Care must be a team effort with early intervention/behavioral approaches, speech therapy, occupational therapy, physical therapy and nutrition.

Types of early interventions could include:
Applied behavioral analysis
Pivotal response treatment
Verbal behavior
Early Start Denver Model
Floor time and
Relationship Development Intervention

Where to find services:
Screenings
Local testing
Children's hospitals
Local universities
Community mental health
Private practitioners specializing in ASD
www.Autismspeaks.org for tool kits
Support groups

Bi-Polar Disorders

The section of DSM 5 covering Bi-Polar Disorders has been separated out as a standalone section found between schizophrenia and depressive disorders. You are directed to page 123.

This section is not significantly different than that in in DSM IV-TR. The definitions remain the same but diagnostic criteria are simplified and stream lined. These disorders include Bi-Polar I, and II, Cyclothymia, substance induced bi-polar and unspecified bi-polar to name a few.

Diagnostic criteria represent the current understanding of the manic-depressive disorder without the presence of psychosis or lifetime experience of a major depressive episode being required. Specifiers and modifiers will now be added to give a more descriptive and accurate assessment of the clients condition. All new clients should be screened for mood disorders and it should never be assumed that a mood disorder is a client's only diagnosis. There is more co-morbidity with Bi-Polar disorders than previously addressed.

Mood episodes are not disorders, but rather components of disorders. The following factors must be met for a diagnosis of Bi-Polar:

1. Quality of the mood…high or low
2. Required time frame
3. Required symptomology
4. Degree of disability…socially, occupationally
5. Exclusions…not the result of a general medical condition or due to substance or medication use

Manic Episodes

The building blocks of mood disorders must include impairment in 3 of the following criteria areas:

1. Self esteem
2. Decreased sleep
3. Pressured speech
4. Racing thoughts
5. Activity at heightened levels
6. Goal agitation
7. Risk taking behaviors

These must be manifest in 1 weeks' time…4 if there is irritability. Mania must have manifested a minimum of one lifetime episode in order to diagnose Bi-Polar I.

Hypomanic Episode

For a diagnosis of Hypomanic episode the following must be present:

1. High or elevated mood without the driven quality of a manic episode
2. Mood must be qualitatively different from a normal non-depressed mood
3. Mood disturbance must be noticeable by others
4. Not severe enough to result in marked impairment

Symptoms must be present for at least 4 days and they are taken from the same criteria as for a manic episode. Remember that hypomanic episodes are common in Bi-Polar I but are not required for a diagnosis of Bi-Polar I.

Major Depressive Episode

Timing must be assessed as symptoms are evident over a 2 week period with 5 symptoms present. Symptoms are depressed mood or loss of interest or pleasure and the symptom must manifest for most of the day, every day, for the 2 weeks.

There must be 5 of the following:

1. Depressed mood
2. Loss of pleasure
3. Insomnia
4. Fatigue
5. Hypo-motor activity
6. Irritability
7. Lack of focus
8. Suicidal ideation

Major depressive episodes are common in Bi-Polar I but are not required for diagnosis.

Changes in Recording Procedures

You must determine the severity, psychotic features, and remission status if you suspect a Bi-Polar I diagnosis related to the current or most recent episode. Current severity and psychotic features are only indicated if full criteria are met for a manic or major depressive episode. Severity is not used in hypomanic episodes.

Bi-Polar I Disorders: Diagnostic Criteria
Bipolar I disorder, current or most recent episode manic:
Choose one of the following for coding purposes:
Mild 296.41 (F31.11)
Moderate, 296.42 (F31.12)
Severe 296.43(F31.13)
With psychotic features 296.44 (F31.2)
In partial remission 296.45 (F31.73)
In full remission 296.46 (F31.74)
Unspecified...meaning you just don't know...296.40 (F31.9)

Bi-Polar I disorder, current or most recent episode depressed
Clients current or most recent episode is depressed and criteria have been met of at least one manic episode

Choose ONE of the following for coding purposes
Mild 296.51 (F31.31)
Moderate 296.52 (F31.32)
Severe 296.53 (F31.4)
With psychotic features 296.54 (F31.5)
In partial remission 296.55(F31.75)
In full remission 296.56 (F31.76)
Unspecified 296.50 (F31.9)

Bi-Polar I Disorder: current or most recent episode hypomanic
Clients current or most recent episode is hypomanic and has met the criteria for at least one manic episode

Choose one of the following:
Severity and psychotic specifiers do NOT apply…always code 296.40(F31.0)
In partial remission 296.45 (F31.73)
In full remission 296.46 (F31.74)
Unspecified 296.40 (F31.9)

Bi-Polar Disorder current or most recent episode unspecified
Clients current or most recent episode is unspecified and criteria have been met for at least one manic episode

Choose the following for coding purposes:
Severity, psychotic, and remission specifiers do NOT apply. Always use code 296.7 (F31.9)

For a Bi-polar diagnosis, the symptoms must not be better accounted for by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other psychotic disorder exclusions. The clinician has the option to add other specifiers that are not associated with a code…(applies ONLY to current or most recent episode, except with rapid cycling)

Some things to consider in this area are hallucinations, delusions, grandiosity, anxious distress, euphoria, dysphoria, related to pregnancy or within 4 weeks post pregnancy. The pregnancy criteria are new.

In making a Bi-Polar diagnosis record the name of the disorder, type of current or most recent episode, severity/psychotic features/remission status, specifiers including as many without codes that apply. Examples:

296.52 (F31.32) Bi-Polar I disorder, current episode depressed, moderate severity, with atypical features

296.44 (F31.2) Bipolar I disorder, most recent episode manic, with psychotic features, with anxious distress, with rapid cycling

Bi-Polar Disorder II Diagnostic coding Criteria have been met for at least one hypomanic episode and at least one major depressive episode, no history of manic episode Choose the following for coding purposes: ONLY one diagnostic code: 296.89 (F31.81) Current severity, psychotic features, (depressive episode only) , course and other specifiers cannot be coded but can be expressed in writing NOTE: there is NO history of a manic episode

You can use the lists of specifiers in the DSM 5 written out in the diagnostic description for Bi-Polar II even though they are not coded. It adds a more full description of the client's current condition that is required for accuracy. If the full criteria for mood episode are not currently met use in partial remission or in full remission. If full criteria for mood episode are not currently met use mild, moderate, or severe in terms of impairment.

When writing out the Bi-Polar II diagnosis you should show the following pattern:

Name of disorder, current or most recent episode, additional specifiers, course specifiers, severity specifiers. Such as:

296.89 (F31.81) Bi-Polar II disorder, current or most recent episode depressed, With seasonal pattern, moderate severity.

Key Issues to Address

The most critical task in diagnosing a Bi-Polar Disorder is to determine if the depression is uni-polar or bi-polar. Always rule out medical disorders or substance use or abuse that may cause secondary depression or mania. Diagnostic assessment should search strategically for periods of hypomania in client's history….look for periods of "normal" happiness without adequate sleep, more energy with less sleep, or an episode followed by depression.

Assess across multiple criteria including family history, onset of symptoms, reactions to medications.

Bipolarity Index:
Assess the client on 6 dimensions:

1. Episode characteristics
2. Age of onset
3. Illness course
4. Other features
5. Response to medications
6. Family history

Remember that even if a client has NOT had a manic episode some characteristics are highly predictive of bipolar disorder…early onset of depression, brief depressive episodes and the like.

Treatment options:
CBT
Family focused
Interpersonal
Psychodrama about disorder
Be sure to chart the precipitants, nature, duration, frequency, and seasonality of dysfunctional mood to avoid future episodes

Medications to consider:
Lithium
Anticonvulsants (Depakote, Tegretal, Lamictal)
Atypical antipsychotics (Risperdal, Seroquel)

Anxiety Disorders

Anxiety is defined as "A state of intense apprehension, uncertainty, and fear resulting from the anticipation of a threatening event or situation, often to a degree that normal physical and psychological functioning is disrupted". In the formulation of disorders for the DSM 5 all the anxiety disorders share features of fear and anxiety.

Fear is the **response** to a real or perceived threat. Anxiety is the **anticipation** of a threat that has not yet occurred.

Physiological symptoms of anxiety include muscle tension, heart palpitations, sweating, dizziness or shortness of breath. The emotional symptoms include restlessness, a sense of impending doom, fear of dying, fear of embarrassment or humiliation, or fear of something terrible happening.

MAJOR CHANGES IN DSM 5

The pattern and onset of anxiety disorders are listed in developmental order with selective mutism and separation anxiety listed first. Additionally, social phobias is now referred to as social anxiety disorder. Panic attack has been dropped as a specifier for agoraphobia. It can be used as a specifier for many diagnoses in the new DSM.

Obsessive Compulsive disorder is now a standalone disorder as are Post Traumatic Stress Disorder and Acute Stress Disorder.

As close to 50% of those diagnosed with an anxiety disorder also meet the criteria for a depressive disorder, the need for differential diagnosis becomes more critical.
There are common characteristics such as sleep disturbance, fatigue, and difficulty with focus and concentration. One must discern between depression with anhedonia and anxious worry and anxious anticipation, worry, uncertainty, and fear. It appears that a key element in a differential diagnosis is the presence or lack of fear.

Looking at specific anxiety disorders for changes we find that separation anxiety was moved from disorders of infancy and early childhood in DSM IV. The age of onset, previously 18 months, has been eliminated allowing for the diagnosis to be used with people of all ages…even adults. The duration criteria now states 6 months for adults and one month for children. This disorder is most prevalent in children with girls being more susceptible than boys.
Functional impairment should be noted in school, work, or social settings.

Selective Mutism

This is the voluntary refusal to speak. It is a new diagnosis in the anxiety disorders chapter. Characteristics include voluntary refusal to verbally communicate usually outside the presence of the immediate family or away from the home. They may use non-verbals such as head nodding and grunting. Children with selective mutism do not have language deficits such as may be seen in the autism spectrum disorders. Onset typically is prior to age 5 and first noticed for the most part in early school years.

Specific Phobias

Specific phobias represent fear and anxiety relative to a specific phobic stimulus such as spiders or snakes or enclosed spaces. The fear and anxiety must be markedly greater in intensity than the actual threat of the stimulus, object, or situation.

Specific phobias can result from experiencing a traumatic event or witnessing a traumatic event. There will be avoidant behaviors in regards to the phobic stimulus. The manifestation of the fear or anxiety will be consistent with EVERY exposure to the stimulus.

The average age of onset is 13. It is no longer a requirement that the adult recognize that their fear is unreasonable. That aspect is left up to clinical judgment.

To code specific phobia keep in mind that if the person has multiple phobias more than one diagnosis is given. The codes are issue or stimulus specific. The ICD 9 codes use one code for phobia whereas ICD 10 has multiple codes. This is one example where the specifier panic attack might be used if warranted.

Social Anxiety Disorder (SAD)

Previously called social phobia, this disorder is now found in the chapter on Anxiety Disorders. The central characteristics are fear and worry in myriad social situations. The majority are diagnosed in childhood and early adolescence.

There is usually co-morbidity with major depressive disorders and other anxiety disorders. Substance use disorders are also seen in conjunction with SAD. However, clinicians must be able to discern if the substance use is a result of the anxiety disorder or if the anxiety disorder is a result of substance use.

People who experience SAD typically have a fear of being negatively evaluated, embarrassed or humiliated in terms of performance, interaction, or situations where they might be observed.

A performance only specifier is now possible providing its duration is at least 6 months. Additionally, both children and adults share the same duration criteria. Insight on the part of the adult has been dropped. The performance only specifier is used if the anxiety is specifically due to speaking or performing in public. Therefore, it would most likely be occupational for adults and school related for children and teens.

Panic Disorder

Panic Disorder is defined as recurrent, unexpected panic attacks with the median age of onset at 20 -24 years. It is rare to see a first episode over the age of 45.

Essential features include persistent fear of inappropriate response with recurrent and unexpected panic attacks. Physical symptoms include sweating, accelerated heart rate, dizziness, trembling, and chest pain. If panic is used as a specifier it must be unexpected in nature.

Differential diagnosis includes other specified or unspecified anxiety disorders, anxiety disorder due to a medical condition, substance or medication induced anxiety disorder, other mental disorder with panic as a specifier. Hypochondriasis is now called Illness Anxiety Disorder. It is often associated or co-morbid with Panic Disorder.

Specifiers:
Panic attack is not a disorder and therefore has no code. Panic attacks are abrupt bursts of fear and can occur in conjunction with many diagnoses. It can be a specifier for both mental and physical disorders. Because the characteristics of a panic attack are in the criteria for a panic disorder it should NOT be listed as a specifier for Panic Disorder.

Agoraphobia

This disorder is now code-able under DSM 5 as it has been unlinked with panic disorder . It is an intense fear resulting from real or imagined exposure to a wide range of situations. It results in moderate to severe impairment in functioning.

The essential features of this disorder include intense fear of situations where escape is difficult or perceived to be impossible. The response is consistently manifested with **each** exposure to the stimulus. Avoidance of the stimulus must be present and can include both cognitive and behavioral aspects. This response differs from PTSD and ASD in that avoidance with PTSD and ASD are in the context of a memory of a stimulus event.

Generalized Anxiety Disorder

This disorder remains relatively unchanged from the DSM IV-TR. The person MUST experience 3 of the following:
Restlessness
Easily fatigued
Difficulty focusing
Irritability
Muscle tension and
Sleep disturbance

We must be able to differentiate the diagnosis from many other anxiety based disorders, depressive disorders, and psychotic disorders.

When substance use is indicated clinical judgment is necessary to distinguish between substance use induced anxiety or self-medicating in response to the anxiety.

In regards to anxiety disorders due to other medical conditions it is critical that clinicians rule out differential diagnoses and that they consult with medical team members. Some of the more commonly seen medial conditions with resultant anxiety are endocrine disease,

cardiovascular disease, respiratory disease, metabolic disturbances, and neurological conditions. What is **required** is the anxiety symptoms **must be directly attributable** to the physiological effects of the medical condition.

DEPRESSIVE DISORDERS

The chapter on Depressive Disorders is seen as the one with the most changes and perhaps with the most controversy although the controversy is a subjective view so the readier should decide for themselves if this is true. The highlights are the new diagnosis of chronic depressive spectrum disorder called Persistent Depressive Disorder previously known as Dysthymia. There are changes to Major Depressive Disorder that include the elimination of the bereavement exclusion. There are new specifiers and other new disorders such as Disruptive Mood Dysregulation Disorder.

The organization of the chapter, like the others, is developmental in nature with the first disorders covered beginning in early childhood and ending with dementia and late in life disorders. The addition of Other Specified Depressive Disorder and Unspecified Depressive Disorder eliminates the NOS specification that we sometimes code today. Specified Depressive Disorder includes cases where the person is clearly depressed but does not meet all the criteria for a Major Depressive Disorder. When coding this disorder you add the description of the criteria that are met. Unspecified is the way to code for what is now an NOS case.

DISRUPTIVE MOOD DYSREGULATION DISORDER

This disorder was added because research has shown that from 1994 with the printing of DSM IV to 2003 with the DSM IV-TR the incidence of diagnoses of BiPolar Disorder in children increased 40%. And yet that disorder looks significantly different in children and the recommended treatment for BiPolar Disorder is not effective in children. Mood stabilizers do not work in children. This created a diagnositc gap. This new disorder fills that gap.

The essential feature of Disruptive Mood Dysregulation Disorder is severe temper outbursts with underlying persistent angry or irritable mood. These temper outbursts must occur three or more times a week for at least 12 months. They must be present in at least two settings and severe in at least one setting. The onset of the disorder is prior to age 10 but cannot be diagnosed prior to age 6 as temper outbursts are considered developmentally appropriate in the younger ages.

Clinicians must rule out BiPolar Disorder, intermittent explosive disorder, depressive disorder, ADHD, autism spectrum disorder, separation anxiety disorder, substance use disorder or a medical condition. If Oppositional Deviant Disorder is present do not diagnose it as well. Be sure to always ask if there has been an episode of mania or hypomania and get full and complete family history of depressive disorders or BiPolar Disorder as BiPolar Disorder has the

highest rate of inheritability. DMDD peaks in the elementary school years. It is more common in males.

Although more research is needed consider using CBT for treatment of the child and parent training and support groups for parents in the treatment plan. Avoid the use of BiPolar medications.

MAJOR DEPRESSIVE DISORDER

The essential features are critical to note. There must be **either** depressed mood ***or*** loss of interest or pleasure **plus 4 of the 9** listed depressive symptoms. These symptoms must have a duration of at least four weeks. It is important to rule out medical conditions, medication induced, substance use induced, BiPolar Disorder, or a psychotic disorder. Be careful about diagnosing major depression following a significant loss because normal grief may resemble a depressive episode. Complex bereavement is more pathological than "normal" grief. Significant loss does not have to mean a death. It could be the loss of a close friend, a job, a marriage or anything that is significant to the person grieving. Bereavement symptoms must be beyond the "normal" response to grief and therefore treatment should wait at least two months after the loss that triggered the grief as most "normal" grief resolves in about two months.

Grief vs. a Major Depressive Episode in DSM 5 (pg 161)

Grief	Major Depression
-Dominant affect is feelings of emptiness and loss	-Dominant affect is depressed mood
-Dysphoria occurs in waves, vacillates with exposure to reminders and decreases with time	-Persistent dysphoria that is accompanied by self-critical preoccupation and negative thoughts about the future
-Capacity for positive emotional experiences	-Limited capacity to experience happiness or pleasure
-Self esteem preserved	-Worthlessness clouds esteem
-Fleeting thoughts of joining decreased	-Suicidal ideas about escaping life vs joining a loved one

In writing the diagnosis follow the example below:
Essential features:
Meets criteria for Major Depressive Episode
No history of a manic or hypomanic episode

Coding starts with noting whether it is a single episode or recurrent . There is a table on page 162 of the DSM 5 to guide in the coding:
Major Depressive Disorder, single episode
Major Depressive Episode, recurrent episode

The code number must indicate the type of episode as well as the severity, presence of psychotic features, and remission status (partial or full). Find the correct code number by dropping down your selected episode column to locate the applicable severity, psychosis or remission term. For a recurrent episode that is moderate in severity you would write:

-296.32 Major Depressive Disorder, recurrent episode, moderate severity
Finally add any of the specifiers that apply:
-296.32 Major Depressive Disorder, recurrent episode, moderate severity with peripartum onset.

You must state the word severity in your description. In terms of the old GAF mild would be 60 or up, moderate would be 40 to 60 and severe would be 40 or less.

Specifiers for Major Depressive Disorder:

The specifiers generally do not have code numbers but should be added if they apply. The list includes:
-with anxious distress...indicates more aggressive treatment and there must be 2 symptoms
-with mixed features…complicates treatment
-with melancholic features…will see profound anhedonia
-with atypical features…sleeping more, intermittent lifting of mood
-with mood-congruent psychotic features…thoughts of inadequacy, guilt, deserved punishment
-with incongruent psychotic features…thoughts in their head, atypical depressive themes
-with catatonia….code this one separately
-with peripartum onset…includes during pregnancy and up to one month post delivery
-with seasonal pattern…onset and remission of symptoms characteristically happening at the same time of year

Persistent Depressive Disorder
(Dysthymia)

The essential feature is depressed mood plus at least two other depressive symptoms from criterion B. The duration must be a minimum of two years for adults or one year for children and teens. The symptoms must be present for more days than not in that time frame. There may be periods of major depressive episodes and if they are present for a period of 2 years both diagnoses of PDD and MDD should be given.

Specifiers of Persistent Depressive Disorder include:
Severity: mild, moderate, severe
Remission status: in partial or full remission
Onset: Early before age 21 or late after age 21
Specify mood features as listed above
Course specifiers:
With pure dysthymic syndrome

With persistent major depressive episode
With intermittent major depressive episodes, with current episode
With intermittent major depressive episodes, without current episode

Example:
300.4 Persistent Depressive Disorder, mild severity, late onset, with atypical features, with pure dysthymic syndrome

Rule out other psychotic disorders, substance use, medication induced, or other medical conditions.

Premenstrual Dysphoric Disorder (PMDD)

This disorder is new to the DSM 5. The essential feature is significant affective symptoms that emerge in the week prior to menses and quickly disappear with the onset of menses. There must be at least 5 symptoms which include marked affective lability, depressed mood, irritability, or tension . The duration requires the presence of the symptoms in all menstrual cycles in the past year and should be documented prospectively for two cycles. Charting of the course of the disorder for two months should be done on a rating system and the impairment must be significant. Rule out other mental disorders that are pre-existing, other medical conditions, and substance use or medication use. The difference between PMDD and PMS is that PMS must have only 3 symptoms and the impairment is not clinically significant.

With PMDD there is an increased risk of postpartum depression, and increased risk of suicidal thinking, planning and gestures. The impact on the person's quality of life is great. There is significant impact on psychosocial functioning.

PERSONALITY DISORDERS

The original plan for DSM 5 included eliminating several of the personality disorders such as paranoid, schizoid, histrionic and dependent. There was also talk of eliminated Borderline Personality Disorder and Narcissistic Personality Disorder. The personality disorders with the most research behind them such as anti-social, borderline and schizotypal could not in good conscience be eliminated because of that research. Those with little research were paranoid, histrionic and schizoid. There was no significant co-morbidity found between the disorders either. So a compromise was made…to leave them all there!

Another question was how to organize them in the design of the DSM 5. There was difficulty in making the personality disorders fit into the developmental model being placed after neurocognitive disorders and are found in Section II of DSM 5. The Cluster arrangement of

these disorders remains. The first part of the chapter discusses the features that are present in all the personality disorders and then the individual disorders are more specifically discussed under their own heading.

The common features that must be present for all personality disorders include impairment in:

Cognition… such as ways of perceiving and interpreting self, other people and events
Affectivity…the range, intensity, lability and appropriateness of emotional response
Interpersonal functioning and
Impulse control issues

You will find that the wording in the DSM 5 about personality disorders has only subtle changes. There is no substantive change in this area. However, in assessment of these disorders there is a stronger emphasis on cultural input. For instance, Haitians and religious people who might practice VooDoo or value speaking in tongues might sound to us like a schizotypal disorder. People with anti-social personality disorder tend to be over diagnosed among those from a lower socio economic status. Avoidant Personality Disorder may be seen in people struggling to acculturate in a new environment. Some cultures encourage dependence so do they really have a Dependent Personality Disorder? Obsessive Compulsive Personality Disorder may be no more than a person stressing what is stressed in their original culture...an intense attention to detail or to how things should be done.

There is consensus that the present system is not sufficient in that there is not enough empirical research to support even the cluster system. Additionally it is difficult to make the personality disorders line up well with the developmental model used in DSM 5. Section III of the DSM 5 includes the "new approach" that addresses many shortcomings of the current approach.

Criterion A includes assessment of personality functioning toward self, and interpersonally. Criterion B looks at pathological personality traits. It lists 5 broad traits of negative affectivity, detachment, antagonism, disinihibition, and psychotisim. There are 25 trait facets altogether. Criteria C & D include assessment of pervasiveness in different areas of life and stability looking as far back as adolescence. Criteria E, F, and G cover an assessment of alternative explanations for personality pathology. This is where the differential diagnosis is used. One must rule out other mental illnesses, substance use or medication induced conditions, and conditions better understood by the developmental stage or sociocultural environment.

The DSM 5 discusses trait domains and looks at them in terms of each diagnosis. Even though we are just getting ready use the ICD 10 Codes in 2014, the ICD 11 Codes are already being developed and will probably go into effect in 2015-16. The ICD 11 team proposes that all categories of personality disorders be eliminated! They would be replaced by 4 trait domains. The domains are: internalizing, externalizing, schizoid or anankastic which means being obsessive or compulsive in some way. Within each domain the pathological traits would be added.

The severity categories would become no personality disturbance, personality difficulty which would not be coded as it is only seen as problematic, personality disorder present which would be the first level of clinical severity, complex personality disorder which is the first level of focus for treatment as it shows more difficulty with interpersonal functioning, and severe personality disorder which would show major complications.

Future concerns and changes

There will be increased emphasis on the bio-psycho-social aspects of disorders in the future. Potential new groups under consideration include:

- Shared neural substrates (CT scans MRIs)
- Family traits
- Genetic risk factors
- Specific environmental risk factors
- Bio-markers (organ functioning)
- Tempermental anticedents
- Abnormalities of emotional or cognitive processing
- Symptom similarity…this is getting a lot of attention
- Course of illness
- High co-morbidity
- Shared treatment response…how do disorders react to different approaches

Future changes will include clustering diagnoses according to "internalizing"groups (prominent anxiety, depressive, and somatic disorders) vs. "externalizing" groups (impulsive, conduct, and substance use disorders). The belief is that this way of looking at and grouping disorders should encourage advances in identifying diagnoses, markers, and underlying mechanisms.

Section III of the DSM 5 looks at conditions for further study that include:

- 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 Behavioral Disorder
- Non-suicidal Self Injury

Although all of these were considered for DSM 5, there was not sufficient research or empirical support for including them at this time. These disorders are ripe for research now for those who wish to conduct research and share their work.

This document was constructed based on personal notes taken during the 6 part ACA webinar series on DSM 5. A list of their references will be made available if people desire it.

For cross cutting and diagnostic severity measures go to:
www.psychiatry.org/dsm5

For the WHODAS 2.0 and many assessment measures go to:
www.psyciatry.org/practice/dsm/dsm5/onlineassessmentmeasures they are also in the back of the DSM 5

Guidelines for assessment of clients:

Name of client: DOB:
Pre-natal environment and conditions of delivery
Age of mother during pregnancy
Early infancy development
Age of onset of symptoms
Course of illness development
Description of symptoms
Severity of symptoms
Cultural considerations
School years development
Tempermental status
Genetic issues in the family
History of mental illness in the family
Full Medical history of client and family
Areas of impairment
Level of impairment severity
Substance use /medication use history
In the case of substance use or medication induced conditions be sure to assess which came first…the use or the disorder