Who Are You?

- Clinical counselor in Private Practice
- Clinical Counselor in Agency/Hospital/Education/Community Setting
- Counselor Educator
- Student
- School Counselor
- Rehabilitation Counselor
- Psychologist
Introduction: The Critics

- Allen J. Frances, M.D. @ Huffington Post on 5/1/13
  - DSM-5 represents a wholesale, imperial medicalization of normality
  - DSM-5 is lowering the thresholds of various diagnoses, resulting in the medicalization of normal human experience and the creation of spurious epidemics of mental illness.
  - DSM-5 is creating new mental disorder diagnoses for the benefit of the profession and the pharmaceutical industry.
  - DSM-5 work group members are compromised by their declared and undeclared conflicts of interest.
  - DSM-5 continues to inappropriately impose categorical constructs on dimensional mental states or conditions.
  - DSM-5 is merely perpetuating and exacerbating the deficiencies of previous psychiatric classifications without working towards a truly scientific classification.

“In an interview with Psychiatric News, Katharine Phillips, M.D., chair of the Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group, said that the intention throughout DSM is to group together disorders that are similar to one another across a range of validators, including symptoms, neurobiological substrates, familiality, course of illness, and treatment response.”

DSM 5

David Kupfer, MD
DSM-5 Task Force Chair

1. “incorporation of a developmental approach to psychiatric disorders”
2. “a move toward the use of dimensional measures to rate severity and disaggregate symptoms that tend to occur across multiple disorders”
3. “harmonization of the text with ICD”
4. “integration of genetic and neurobiological findings by grouping clusters of disorders that share genetic or neurobiological substrates”
Sections and General Content

- Section I: DSM-5 Basics
  - Introduction
  - Use of the Manual
  - Cautionary Statement for Forensic Use of DSM-5
- Section II: Diagnostic Criteria and Codes
  - Present the categorical diagnoses according to a revised 20 chapter organization that eliminates the multiaxial system
- Section III: Emerging Measures and Models
  - Assessment Measures
  - Cultural Formulation
  - Alternative DSM-5 Model for Personality Disorders
  - Conditions for Further Study
- Appendix
  - Highlights of Changes From DSM-IV to DSM-5
  - Glossary of Technical Terms
  - Glossary of Cultural Concepts of Distress
  - DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)

Section I: DSM-5 Basics
A Brief History

- **Publication dates:**
  - 1844: Predecessor
  - 1952: DSM I
  - 1968: DSM II
  - 1980: DSM III
  - 1987: DSM III-R
  - 1994: DSM IV
  - 2000: DSM IV-TR
  - 2013: DSM 5

Harmonization and Dimensionality

- **Dimensional assessment versus Multiaxial assessment**
  - DSM-5 combines the first three DSM-IV-TR axes
    - “The multiaxial distinction among Axis I, Axis II, and Axis III disorders does not imply that there are fundamental differences in their conceptualization, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes” (APA, 2000)
  - Contributing psychosocial and environmental factors or other reasons for visits
    - Now represented through expanded selected set of ICD-9-CM V-codes and, from the forthcoming ICD-10-CM, Z-codes
    - Over 130!
Harmonization and Dimensionality

Dimensional assessment versus Multiaxial assessment

- The DSM-5 includes separate measures of symptom severity and disability for individual disorders
  - The World Health Organization Disability Assessment Schedule (WHODAS 2.0)
    - Download at: http://www.who.int/classifications/icf/whodasii/en/
    - Provided in Section III (pp. 745-748) as the best current alternative for measuring disability: various disorder-specific severity scales
  - WHODAS 2.0 covers 6 domains (http://www.who.int/classifications/icf/whodasii/en/)
    - Cognition – understanding & communication
    - Mobility– moving & getting around
    - Self-care– hygiene, dressing, eating & staying alone
    - Getting along– interacting with other people
    - Life activities– domestic responsibilities, leisure, work & school
    - Participation– joining in community activities

Definition of a Mental Disorder

- “A syndrome characterized by clinically significant disturbances 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.
- An expectable or culturally approved response to a common stressor or loss…is not a mental disorder.
- Socially deviant behavior…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).
## Approach to Clinical Case Formulation

- **Diagnostic content**
  - Diagnostic Features
  - Associated Features
  - Prevalence
  - Development and Course
  - Risk and Prognostic Factors
    - Environment
    - Genetic and physiological
    - Temperamental
    - Course modifiers
  - Culture-Related Diagnostic Issues
  - Gender-Related Diagnostic Issue
  - Suicide Risk

- **Diagnostic content**
  - Functional Consequences
  - Differential Diagnosis
  - Comorbidity
  - Subtypes
  - Specifiers — *course, severity, descriptive*
    - In Full/Partial Remission
    - Mild/Moderate/Severe/Extreme/Profound
    - Single/Recurrent/Episodic/Persistent
  - Acute/Subacute
  - Generalized/Situational
  - Lifelong/Acquired

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## Coding and Reporting Procedures

- **Coding Note and Coding and Reporting Procedures**
  - Pay attention for each disorder

- **Implementation**
  - CMS.gov
  - The Introductory material to the DSM-IV and DSM-5 code set indicates that the DSM-IV and DSM-5 are "compatible" with the ICD-9-CM diagnosis codes
  - The updated DSM-5 codes are cross walked to both ICD-9-CM and ICD-10-CM
  - As of October 1, 2014, the ICD-10-CM code set is the HIPAA adopted standard and required for reporting diagnosis for dates of service on and after October 1, 2014
Coding and Reporting Procedures

- **Procedures**
  - The focus of treatment or reason for visit is listed first
  - The exception is when a mental disorder is caused by a medical condition in which case the medical condition is listed first (ICD coding rule)
  - Then others in descending order of clinical importance including V/Z-codes

- **Sample DSM-5 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

Section II: Diagnostic Criteria and Codes
“Eliminating the category of dependence will better differentiate between the compulsive drug-seeking behavior of addiction and normal responses of tolerance and withdrawal that some patients experience when using prescribed medications that affect the central nervous system” And O’Brien said the term “abuse” is clinically meaningless, noting that “abuse, dependence, and addiction are all one continuous variable.”
## Substance-Related and Addictive Disorders

- **Substance Use Disorders**
  - No more Substance Abuse and Substance Dependence
  - **Read and follow the Recording Procedures and Coding Notes!**
  - **Criteria**
    - Nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list
    - Nearly all substances are diagnosed based on the same overarching criteria
    - Criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders
    - **Threshold = 2 of 11 symptoms**
      - **Imaired control** (criteria 1-4)
      - **Social impairment** (criteria 5-7)
      - **Risky use** (criteria 8-9)
      - **Pharmacological criteria** (criteria 10-11)
    - **Removed:** recurrent legal problems criterion
    - **Added:** craving or a strong desire or urge to use a substance

## Substance-Related and Addictive Disorders

- **Substance Use Disorders**
  - **Substance-Induced Disorders**
  - **Substance Intoxication and Withdrawal**
  - **Substance/Medication-Induced Mental Disorders**
  - **Alcohol-Related Disorders**
    - Kappa = .40
  - **Caffeine-Related Disorders**
  - **Cannabis-Related Disorders**
  - **Hallucinogen-Related Disorders**
  - **Inhalant-Related Disorders**
  - **Opioid-Related Disorders**
  - **Sedative-, Hypnotic-, or Anxiolytic-Related Disorders**
  - **Stimulant-Related Disorders**
  - **Tobacco-Related Disorders**
  - **Other (or Unknown) Substance–Related Disorders**
  - **Non-Substance-Related Disorders**
    - Gambling Disorder
Substance-Related and Addictive Disorders

Substance Use Disorders

Remission specifiers
- No more partial and full
- Early remission = at least 3 but less than 12 months without substance use disorder criteria (except craving)
- Sustained remission = at least 12 months without criteria (except craving)

Severity ratings
- 2–3 criteria indicate = a mild disorder
- 4–5 criteria = moderate disorder
- 6 or more = a severe disorder

Recent research: 1


Results:
- Whereas 80.5% of individuals positive for DSM-IV dependence were positive for DSM-5 severe AUD, only 58.0% of those positive for abuse were positive for moderate AUD.
- The profiles of individuals with DSM-IV dependence and DSM-5 severe AUD were almost identical.
  - In contrast, the profiles of individuals with DSM-5 moderate AUD and DSM-IV abuse differed substantially.
  - The former endorsed more AUD criteria, had higher rates of physiological dependence, were less likely to be White individuals and men, had lower incomes, were less likely to have private and more likely to have public health insurance, and had higher levels of comorbid anxiety disorders than the latter.

Conclusions:
- Similarities between the profiles of DSM-IV and DSM-5 AUD far outweigh differences; however, clinicians may face some changes with respect to appropriate screening and referral for cases at the milder end of the AUD severity spectrum.
Substance-Related and Addictive Disorders

Latest research: 2


Results:

When compared with the other abuse subgroup, those with abuse including hazard (irrespective of other abuse criteria endorsed) were more likely to report another drug use disorder.

- The 2 abuse subgroups could not be differentiated by any other clinical characteristics.
- There were no systematic relationships between the hazard criterion and indices of SES, with those no longer receiving a diagnosis more likely to be young males with drug use disorders and suicidal behaviors.

Conclusions:

The current results indicate that the elimination of the hazard criterion would lead to a considerable decline in the prevalence of DSM-5 AUD and risk excluding a potentially clinically significant subtype of AUD from future diagnosis.

Latest research: 3


Methods:

- US adults DSM-IV opioid (n = 264), cannabis (n = 1622), cocaine (n = 271) and alcohol (n = 23,013) dependence with past-year DSM-5 disorders at thresholds of 3+, 4+, 5+ and 6+ positive criteria

Results:

- For DSM-IV alcohol, cocaine and opioid dependence, optimal concordance occurred when 4+DSM-5 criteria were endorsed, corresponding to the threshold for moderate DSM-5.
- Maximal concordance of DSM-IV cannabis dependence and DSM-5 cannabis use disorder occurred when 6+ criteria were endorsed, corresponding to the threshold for severe DSM-5.

Conclusions:

- Overall, excellent correspondence of DSM-IV dependence with DSM-5 substance use disorders.
### Latest research: 4


**Methods:**
- Semi-Structured Assessment for Drug Dependence and Alcoholism to evaluate the lifetime presence for alcohol, cocaine, opioids, and cannabis in a sample of 7,543 individuals.

**Results:**
- Modestly greater prevalence for DSM-5 SUDs based largely on the assignment of DSM-5 diagnoses to DSM-IV “diagnostic orphans.”
- The vast majority of these diagnostic switches were attributable to the requirement that only two of 11 criteria be met for a DSM-5 SUD diagnosis.
- We found evidence to support the omission from DSM-5 of the legal criterion.
- The addition of craving as a criterion in DSM-5 did not substantially affect SUD diagnosis.

**Conclusion:**
- The greatest advantage of DSM-5 for the diagnosis of SUDs appears to be its ability to capture diagnostic orphans.
- In this sample, changes reflected in DSM-5 had a minimal impact on the prevalence of SUD diagnoses.

### Gambling Disorder

- “This change reflects the increasing and consistent evidence that some behaviors, such as gambling, activate the brain reward system with effects similar to those of drugs of abuse and that gambling disorder symptoms resemble substance use disorders to a certain extent.”
- Lowering of the pathological gambling threshold to 4 symptoms
- Removal of the “illegal acts” criterion for the disorder

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### Gambling Disorder

- Similar clinical expression, brain origin, comorbidity, physiology, and treatment
  - Why not other addictive disorders proposed by Dr. Kevin McCauley?
    - Sex
    - Relationships
    - Codependency
    - Cults
    - Performance
    - Compulsive spending
    - Rage/violence
    - Media/entertainment
    - included in Section III of the manual – Asian countries
Substance-Related and Addictive Disorders

Latest research


Findings:

- Eliminating the illegal acts criterion did not impact internal consistency and modestly improved variance accounted for in the factor structure.
- In comparing a classification system using four of 10 criteria versus one using four of nine, the four of nine system yielded equal or slightly better classification accuracy in all comparisons and across all samples.

Conclusions:

- The inclusion of the illegal acts criterion in the proposed DSM-V pathological gambling diagnosis does not appear necessary for diagnosis of pathological gambling and, if it is eliminated, reducing the cut-point to four results in more consistent diagnoses relative to the current classification system.
References


References


Q&A

For additional questions, please contact:
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- Please Join Us For the Rest of the DSM Series:
  - July 3
    Georgeanna Gibson, MAE, LPCC- ASD/Autism/Asperger’s
  - July 10
    Todd Lewis, PhD, LPC- Bi-Polar Disorders
  - July 17
    Shannon Ray, PhD, LMHC- Anxiety Disorders
  - July 24
    Gary Gimmer, PhD, LPC- Depressive Disorders
  - July 31
    Paul Peluso, PhD, LMHC, LMFT- Personality Disorders