DSM5

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EVOLUTION OF THE DSM
Since 1917 we have been challenged to appropriately define mental disorders.
From 1917-1945 there were four classifications: 1) idiot 2) imbecile 3) lunatic 4) insane
1945—psychologists working with returning WWII vets realized there were issues that didn't fit into any of these four classifications

CURRENT DEFINITION OF MENTAL DISORDER (DSM-IV-TR)
"Clinically significant behavioral or psychological or biological syndromes that are associated with present distress, disability, or significant impairment in important areas of functioning."

IMPORTANT TO KNOW THIS, because…
If a person's behavior does NOT cause them distress, disability or impairment then they cannot be diagnosed with a mental disorder.

EVOLUTION OF THE DSM AND THE DEFINITION OF A MENTAL DISORDER
Additions to the definition of mental disorder:

1) "Must draw concern from others in a relational, social, occupational, or vocational setting that requires a referral for treatment."

A persona can be syntonic (unaware, unconcerned) but the family has concerns = involuntary commitment for court-ordered evaluations

2) "Must incorporate respect for age, gender, and culture-specific factors and sensitivity to these factors when making a diagnosis."

Diagnoses must be respectful of cultural idiosyncratic behaviors
Culturally sanctioned behavior or cultural idiosyncratic behavior are to be considered

EXAMPLE: Native Americans in MN (special group of citizens) – direct eye contact mean someone is being critical or challenging – direct eye contact in western society is considered assertive communication or validation. Also, elders have great wisdom and given great respect. The young communicate with the deceased elders when seeking wisdom.

Behaviors that are an expected response to a particular situation/event

EXAMPLE: Depression in response to grief—not a mental disorder

Behaviors may, or may not, be medical or biological illness

THE GOAL: to reduce pharmacological treatment, especially with children

Conditions are something people HAVE and they do NOT define the person

THE GOAL: DSM Task Force has placed on counselors the task of helping clients to NOT see the diagnosis as a self-definition

Disorders are quite often early life defense mechanisms that are now seen as dysfunctional and causing great distress in adult life.

This shows a respect for DSM's initial icon: Harry Stack Sullivan: "We bring into adulthood early childhood defense mechanisms." 1951

Many children go through childhood traumas and these kids develop defense mechanisms to survive and these become a part of who they are and how they react to stress. –Someone who is narcissistic could have developed such traits to overcome self-loathing or self-hate to survive.

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DSM5 CLASSIFICATIONS

- Multi-axial has been eliminated
- More has been added into the expanded diagnostic definitions
- Classifications are listed chronologically, beginning with childhood disorders

[= major changes or new additions]*

Neurodevelopmental Disorders*
Schizophrenia Spectrum* and other Psychotic Disorders
Bipolar and Related Disorders*
Depressive Disorders*
Anxiety Disorders
Obsessive-Compulsive* and Related Disorders
Trauma and Stress-Related Disorders*
Dissociative Disorders
Somatic Symptom Disorders*
Feeding and Eating Disorders*
Elimination Disorders*
Sleep-Wake Disorders*
Sexual Dysfunctions
Gender Dysphoria*
Disruptive, Impulse-Control, and Conduct Disorders*
Substance Use* and Addiction Disorders
Neurocognitive Disorders*
Personality Disorders*
Paraphilias*
Other Disorders

CNEC

CNEC [Conditions Not Elsewhere Classified] -- no longer have NOS (not otherwise specified) categories
This help to "AVOID THE RUSH TO CERTAINTY"
This is used when:

- Guidelines for classifications are met, but the specific disorder remains unclear
- There is uncertainty regarding the nature of the disorder because the client is unable to provide accurate information, or there is limited time to DX, or the clinician is not trained in a particular area
  - EXAMPLE: Depressive Disorder CNEC
  - Counselors are given 6 months to bill insurances under CNEC coding

THE FOUR SPECIAL FEATURES FOUND IN EACH DIAGNOSIS CATEGORY

1) SYNTONIC vs DYSTONIC

Syntonic – emotionally responsive to surroundings: describes somebody who is emotionally attuned to his or her environment – according to beliefs: in ego psychology, used to describe behavior that does not conflict with somebody's basic attitudes and beliefs and, therefore, is not anxiety-provoking.

Dystonic -- denoting aspects of a person's thoughts, impulses, and behavior that are felt to be repugnant, distressing, unacceptable, or inconsistent with the self-conception, or inconsistent with the rest of the personality. Describing elements of a person's behavior, thoughts, impulses, drives, and attitudes that are unacceptable to him or her and cause anxiety.

NOTE:
ATTITUDE CONSIDERATIONS: Clients eagerness/motivation for therapy and Client's awareness of a problem
KIDS are (by nature) syntonic and ADOLESCENTS become more dystonic
Clients with ADDICTIONS are often syntonic
DO NOT PATHOLOGIZE syntonic/dystonic—all behavior is purposeful.

DSM5 RATINGS:

1. Good/Fair Insight = dystoninc; client knows they have a problem and have insight into their problem(s); the "locu" of the client's pain; the client is in the "contemplation stage of change"
2. Poor Insight = ambivalence; they know others are concerned but they are not. They see there's a problem because others have a problem with them. Reluctant to change.
3. Absent Insight = syntonic; client does not see the problem or any problem at all. Resistant to therapy; no motivation to change.

2) CORRELATED DISORDERS AND SUICIDE RISKS

Each DX category comments risks

3) RESPECT FOR AGE, GENDER, AND CULTURE

THE FOUR SPECIAL FEATURES FOUND IN EACH DIAGNOSIS CATEGORY

4) SEVERITY INDEX ACROSS TIME AND CIRCUMSTANCES

- This will be an essential specified in all DX categories
- Assures that the individual does qualify for a mental disorder by definition and that there is a severe (enough) impairment
- Assures clinician is taking their time in diagnosing

SEVERITY INDEX is the revision of the Global Assessment Functioning (GAF) Axis 5 in prior DSM manuals

THE SEVERITY INDEX:
0 = no impairment
1= mild impairment
2= moderate impairment
3= severe impairment

The 0-1 means the person does NOT qualify for a mental health disorder DX; insurance will not reimburse. You can see the person but it's private pay.

The 2-3 means they require a mental health disorder; insurance reimburses; at these levels a Dx is valid.

ANHEDONIA: *the inability to receive pleasure from previous activities that brought pleasure*

THE FIVE PATHOGENIC CARE REALMS for:

(G) Trauma and Stress Related Disorders*

- Reactive Attachment
- Disinhibited
- PTSD in children
- Disruptive mood
- Dissociation Disorder in Children
- Oppositional Disorders
- Conduct Disorders

AND with _____ Disorders

THE FIVE PATHOGENIC CARE REALMS:

1) Persistent disregard for a child's emotional needs
2) Persistent disregard for a child's physical needs
3) Repeated changes in primary caregivers
4) Children raised in settings with limited opportunities for stable attachment
5) Persistent harsh punishment or other types of grossly inept parenting

The DSM5 is putting child welfare at the feet of parenting—done so as to reduce the use of meds for children.

THE PROBLEM: Can we offer a behavioral measurement definition of "grossly inept parenting"? **THIS MUST BE DEVELOPED** by a group of clinicians/administrators/community leaders taking into consideration the community, faith/beliefs, cultures of the populations you work with.
A POLICY AND PROCEDURE manual for "inept parenting:" will be needed.

SUICIDE BEHAVIOR DISORDER SPECIFIER*

Not a diagnosis; it is a specifier under several specific disorders
Not to be pathologized—rather noted

1) SUICIDE IDEATION
    a. For 2 months or more; there are psychiatric, psychological, or physical pain so severe it defines the person's capacity to cope. Client views death as a remedy.
2) CHRONIC SUICIDE IDEATION
    a. For over one year in duration
        i. NOTE: Could be coupled with secondary gain: retaining a relationship; continue in counseling; getting SS disability benefits
3) SUICIDE ATTEMPTS
    a. Lethal actions with intent to die
        i. The act is accidentally rescued or lethality misjudged, or self-rescued

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Neurodevelopmental Disorders*

A00 et al
Autism Spectrum Disorder (lots of controversy/syntonic/Asperger's going away)

Schizophrenia Spectrum* and other Psychotic Disorders

B00 et al
DSM Task Force was committed to reduce the stigma of this disorder
All subtypes have been eliminated to help reduce the stigmas
The overwhelming (60-70%) of people with this disorder are high functioning; high IQ is related to this disorder

Bipolar and Related Disorders*

C00 et al
Bipolar 1 vs. 2 vs. Cyclothymic (Bipolar 3) THERE ARE VERY IMPORTANT DISTINCTIONS between the three types
It's ego-dystonic (with the exception of bipolar 1)
Vulnerable to co-occurring disorders of substance abuse
Remain alert for post-partum onset specifier*
DX specific risks of suicide
No modification for childhood onset

BIPOLAR 1 → Psychotic manic episodes (grandiosity) SYNTONIC
Disabling depressive episodes DYSTONIC
Increased risk for accidental death
Low risk of suicide

BIPOLAR 2 → Most vulnerable to risk of suicide
The differentiation is in the manic stage (lack of one)
Disabling depressive episodes
Hypo mania (more a return to normal) with irritability—it is during this time risk of suicide to avoid next depression

BIPOLAR 3 → Cyclothymic Disorder
For DX it requires a 2 year+ period of Bipolar 2 behavior

Depressive Disorders*

D00 et al

NEW: Disruptive Mood Dysregulation Disorder (Replaces Childhood Bipolar)

Premenstrual Dysphoric [ie: depression] Disorder*

Five months out of 12; prior to cycles; depression; hopelessness; self-critical; lack of concentration; lethargy; easily fatigued, ANHEDONIA (lack of pleasure) –ALL CRITERIA MUST BE MET with a severity of 3 or 4 over time and circumstances

Anxiety Disorders

E00 et al

NEW: Separation Anxiety

NEW: Selective mutism is a qualifier for Social Anxiety Disorder

GENERALIZED ANXIETY DISORDER:

The most prevalent of all mental disorders

It is the most challenging to treat; it is a chronic disorder

Typically starts in childhood and continues life-long

COPING SKILLS: to keep busy with productive tasks

PROBLEM: They can't relax

This makes people vulnerable to cannabis use because they can relax WITHOUT worrying (but today's pot is NOT the pot of the 60s THC levels now 13 vs. 5 in the 60s)

Obsessive-Compulsive* and Related Disorders

NEW: Body Dysmorphic Disorder*

Hoarding Disorder* (if NOT due to psychosis, depression, PTSD, or TBI (Traumatic Brain Injury)

Hair pulling Disorder* (The older Trichotillomania)

Skin picking Disorder* (Cause Dopamine levels to increase)

Substance abuse induced disorders (self-medicated; thoughts are not psychotic driven; they are anxiety driven

Trauma and Stress-Related Disorders*

G00 et al

Reactive attachment disorder 1-8 criteria #6 behavior is a consequence of inconsistent nurturing from the FIVE PATHOGENIC CARE REALMS (refer to this section)

SUICIDE: 70% PTSD (G05) when these four conditions exist: (complex PTSD)

1) Symptoms have been experienced for more than 1 year
2) The adult experienced childhood trauma
3) There is a depression component
4) The client is self-medicating with cannabis or alcohol

TX Guide for PTSD: refer to the works of Gold; Follette/Ruzek; and Edna Foa

Edna Foa believes CISM for PTSD makes the condition worse

Dissociative Disorders

H00 et al

Depersonalization-DErealization Disorder (occurs in response to stress, anxiety, PTSD)

Dissociative Amnesia (Dissociative Fugue was eliminated from DSM5—too close to malingering)

DID: Dissociative Identity Disorder (The very old Multiple Personality Disorder)

A childhood defense mechanism brought into adulthood

Victims of significant childhood abuse

There is the primary personality; the protector personality; and significant Borderline Personality Traits

MOTIVATIONAL INTERVIEWING suggests to roll with clients resistance; do not engage with it

Defense mechanisms children adopt keep them alive and safe – but some, as an adult, can be maladaptive

Somatic Symptom Disorders*

J00 et al

NEW: Complex Somatic Symptom Disorder* (Hypochondriacs)

NEW: Illness Anxiety Disorder* They are in perfect health but convinced they are sick

NEW: Psychological Factors Affecting Medical Conditions* A medical condition exists; the person has psychological or behavioral patterns that adversely effect the medical condition

Feeding and Eating Disorders*

K00 et al

Rumination* (moved to here)

NEW: Avoidant/Restrictive Food Intake Disorder* (Exercise addiction is included under this)

NEW: Binge Eating Disorder*

Rapid eating when not hungry; eat alone; high life stressors; self-devaluation; feels addicted to the process

Elimination Disorders*

LOO et al

Enuresis*

Encopresis – NO CHANGES

Sleep-Wake Disorders*

M00 et al

Trouble falling and staying asleep; REM Beh Disorder; restless leg syndrome, etc

Sexual Dysfunctions

N00 et al

Gender Dysphoria*

P00 et al

A dystonic condition when it has behavioral manifestations; may result from peer rejection, bullying & counseling

Disruptive, Impulse-Control, and Conduct Disorders*

Q00 et al

Oppositional Defiant; Intermittent Explosive Disorder; Conduct Disorder

NEW: Callus and Unemotional Specifier for conduct disorders

Not a disorder, rather a specifier for conduct disorders

BEHAVIORS: lack remorse or guilt; callus lack of empathy; unconcerned about people; shallow affect

ALL FIVE PATHOGENIC CARE REALMS MUST BE PRESENT

All the above behaviors must be present and OBSERVED by multiple sources over 12 months (no ONE clinicina can make this diagnosis)

These are the Psychopaths of society!

NEW: Dyssocial Personality Disorder*

Replaces the Antisocial Personality Disorder

These are the damaged kids

ALL FIVE PATHOGENIC CARE REALMS MUST BE PRESENT

Substance Use* and Addiction Disorders

R00 et al

13 classes of drugs: alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opiods, phencyclidines (PCP), sedatives, hypnotics, anxiolytics

4 Groups: Use, Abuse, Withdraw, Intoxication

Dependency: Physiological Dependence; Tolerance; Increase use to achieve desired effects; Unsuccessful attempts to cut down; Frantic attempts to access the substance; Impairment in functioning; Continued use despite effects

ALL THESE SYMPTOMS must be met with a severity index of 3 or 4 across time and circumstances.

POLY SUBSTANCE Disorders has been eliminated

Substance-Induced Mental Disorder: (intoxification/withdraw) Delerium; Persisting Dementia; Amnestic Disorder; Psychotic Disorder; Anxiety Disorder; Sexual Disorder

THE Diagnostic Delimma of Dual Disorders: Is the substance use to manage or control or eliminate a mood or anxiety disorder OR is the substance use causing or exacerbating other disorders.

ADDICTIVE DISORDERS: Gambling Disorder

Gambling helps manage dysphoria [ie: depression]; behavior is NOT due to manic episode; Multiple losses due to behavior; Unsuccessful attempts to stop; becomes irritable if can't gamble NOTE: all symptoms must be met with a severity index of 3 or 4 across time and circumstances.

OTHER ADDICTION DISORDERS CONSIDERED (But not included under addictions)

Pornography (Absexual Disorder is under Sexual Disorder)

Sex (Hypersexual disorder is under sexual disorder)

Exercise Disorder (under feeding-eating disorders)

Technology – none

Eating addictions (under feeding-eating disorders)

Body concepts (body piercing, tattooing, et al)

NOTE: CAC [certified addiction counselor] or CDP [chemical Dependency Professionals] et al – CANNOT BILL FOR THESE BECAUSE THEY WERE NOT PUT UNDER "ADDICTIVE DISORDERS"

Neurocognitive Disorders*

S00 et al

Contains diagnoses that were listed in DSM-IV under the chapter of Delirium, Dementia, Amnestic, and Other Cognitive Disorders

Personality Disorders*

BPD – 301 – there is a 90% false positive with this DX – person did not meet the full criteria for the personality disorder (John Hopkins/CDC Atlanta studies)

DSM5 goal is to make personality disorder so overwhelming, time consuming, cumbersome that clinicians won't want to DX personality disorders

There is a 12 month mandate for children and 12 months recommended for adults before giving this DX

DSM5 → DX slowly and cautiously—avoid the rush to certainty

There is a code for "Personality Disorder CNEC"

Clusters are now gone!

Paranoid Personality Disorder is now gone

Schizoid is merged with Schizotypal and moved to the Schizophrenia Section

Antisocial has been reformulated and moved to Disruptive/Conduct Disorders

BPD and Histrionic are now combined

Narcissistic ??

Avoidant/Dependent have been eliminated (some symptoms merged with BPD)

Obsessive Compulsive Personality Disorder ??

BORDERLINE PERSONALITY DISORDER

Dystonic BPD do come to therapy; all other personality disorders are ego-syntonic

1A) self-functioning – identity is poorly developed; unstable; self-critical; feelings of emptiness; lacks sefl-direction

1B) interpersonal functioning – empathy is limited; unable to recognize feelings and needs of others; fears rejection and abandonment

2) Pathological Personality Traits – negative affectivity; impulsivity; antagonistic; hostility

3) Severity Level of 2 or 3 consistent across time and circumstances

OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

Very dangerous people (Stalkers); very controlling; predatory acts; they look for victims that have NO assertive skills

1A) Self functioning – sense of self derived from work productivity ONLY; controlling in relationships; rigid and unreasonable; high expectation of others (standards they don't keep)
1B) Interpersonal Functions – challenged in understanding and accepting the feelings of others, others' ideas, thoughts – lacks empathy in a huge way. Relationships are secondary to work. Rigid and controlling.
2) Pathological Personality Traits – negative affectivity; compulsivity; rigid perfectionism
3) Severity Level of 2 or 3 consistent across time and circumstances

Standard approach to assessment of personality disorders:

1) Core impairments in personality functions
    a. Self-functioning
    b. Interpersonal
2) Pathological Personality Traits
    a. Negative affectivity
    b. Detachment
    c. Antagonism
    d. Disinhibiting or compulsivity
    e. Psychoticism

Paraphilias*

U00 et al
Contains DX that were under DSM4 Sexual and Gender Identity Disorders
Two course specifies: in a control environment and in remission)

Other Disorders

V00 et all
Currently only V01 Non-suicidal self-injury (NSSI) [old self-harm syndrome]
And V02 suicide behavior disorder are coded under OTHER

V01→continuous, intentional self-harm but NOT suicide attempts
Done for psychological relief; emotional regulation
V02→acts NOT done during a confused or delirious state

NOTE: Masochistic behaviors do Not fall under NSSI—they are under sexual disorders

OUTCOME STUDIES

No model for this is in the DMS5
Left to agencies and individuals to develop their own
Outcome studies are coming – the GAF (Global Assessment fo Functioning) will be used in this

<u>SAMPLE OUTCOME STUDY could be a document that measures the following:</u>

Noted DECREASE in maladaptive coping
Noted INCREASE in adaptive coping, such as: (CORE TASKS from DBT)
- Mindfulness skills
- Stress tolerance skills
- Emotional regulation skills
- Radical acceptance skills
- Interpersonal relationship skills

Noted changes in SYNTONIC vs. DYSTONIC
Noted ADVANCE in the STAGES OF CHANGE
- Pre-contemplation
- Contemplation
- Action
- Relapse

Noted INCREASE in the GAF (*insurance won't reimburse 71-100*)
GAF measures psychological,, social, occupational functioning and it does NOT measure impairment due to physical and/or environmental limitations
- Determine the category: 01-30 Emergency; 31-70 Urgent; 71-100 Normative
- Determine the range: 10-point increments
  - Assess in increments of 10 point scales and then settle on number that most accurately reflects your sense of client's functioning
- Determine the number in the range: reflects the client's worst functioning
- <u>GAF SCORES:</u>
- 0 – Inadequate information
- 1-10 – most extreme level of impairment; persistent danger to self/others
- 11-20 – extreme impairment; some danger to self/others
- 21-30 – moderately extreme impairment; unable to function
- 31-40 – major impairment
- 41-50 - serious symptoms
- 51-60 – moderate symptoms

61-70 – mild symptoms or impairment
71-80 – slight symptoms
81-90 – minimal symptoms
91-100 – optimal mental health