What School Psychologists Need to Know about DSM-5

Stephen E. Brock, PhD, NCSP
Melissa A. Reeves, PhD, NCSP
&
Melissa Holland, PhD, NCSP
California State University, Sacramento

Seminar Objectives

Participants will understand:

- the history and development of DSM
- DSM's shift from a categorical to a dimensional approach
- changes made to specific DSM-5 criteria
- the relevance of these changes to school-employed mental health professionals
- how there changes might influence IDEA eligibility determinations

2

Disclaimer

- This workshop is not designed to train you on how to use *DSM-5*
  - It is designed to help school psychologists better understand this important resource used by our colleagues in community mental health
- Disorders relevant to the educational setting (e.g., IDEA/504 accommodations) and with substantive changes will be emphasized
- *DSM-5* is a registered trademark of the American Psychiatric Association
- The APA is not affiliated with nor does it endorse this workshop
- Neither of the presenters, Melissa Reeves or Stephen Brock, has a known financial interest related to this workshop presentation.

3

Caution

- DSM-5 should direct our attention.
- DSM-5 should not dictate any IEP team action.

4

Introduction

- What is *DSM* and How is it Used?
  - Descriptions, symptoms, and other criteria for diagnosing mental disorders
    - Strives to ensure diagnoses are accurate and consistent
    - Identifies prevalence rates for mental health service planning
    - Linked to ICD codes to report diagnoses to insurers for reimbursement and used by public health authorities for causes of illness/death classifications.
    - Does not provide treatment recommendations.

From APA (2012)

5

Introduction

- How is it Used by Schools?
  - May direct the attention of school psychologists, but NEVER (in an of itself) dictates the actions of IEP/504 teams
  - Can help inform interventions in the schools/counseling framework
  - **Handout 1** provides a listing of *DSM-5* diagnoses that may be associated with IDEA eligibility, as well as those that are typically not associated with special education eligibility

Source: Hart, Pate, & Brock (2013)

6

Seminar Outline

- The Classification of Mental Illness in the United States
- Development of *DSM-5*
- Controversies associated with *DSM-5*
- Changes to the Classification System
- Changes to Specific Criteria

The Classification of Mental Illness in the United States

Source	Sets of Criteria	Document Length
1840 US Census	2	2 sentences
1888 US Census	7	4 sentences

By the 1880s different categories of insanity were established.

1. Mania
2. Melancholia
3. Paresis (motor weakness or partial paralysis)
4. Dipsomania (craving alcohol)
5. Dementia
6. Monomania (single pathological preoccupation, otherwise sound mind)
7. Epilepsy

Sources: Douglas & Yates (1981), Wines (1988)

The Classification of Mental Illness in the United States

Source	Sets of Criteria	Document Length
1918 APA	63	40 pages
1938 AMA	98	7 pages

Sources: Committee on Statistics (1918), National Conference on Nomenclature (1938)

The Classification of Mental Illness in the United States

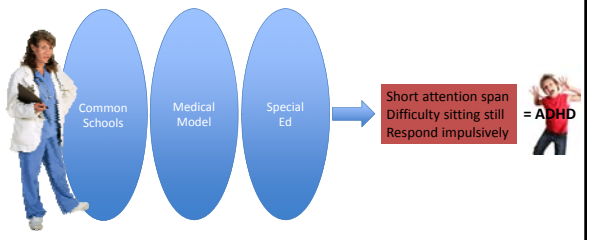
Source	Sets of Criteria	Document Length
1952 *DSM*	117	144 pages
1968 *DSM-II*	156	135 pages
1980 *DSM-III*	210	505 pages
1987 *DSM-III-R*	235	582 pages
1994 *DSM-IV*	322	914 pages
2000 *DSM-IV-TR*	324	980 pages

- What does the title Diagnostic & "*Statistical*" Manual imply?
- What is a primary use of the *DSM*?

Source: Brock & Hart (2013b, October)

The Classification of Mental Illness in the United States

Social Constructionism Example



Discussion: Can you identify how DSM has been influenced by society and culture?

The Classification of Mental Illness in the United States

Source	Sets of Criteria	Document Length
2013 *DSM-5*	392	1009 pages

- Diagnostic Inflation?
  - In the 61 years since *DSM* was first published 275 new diagnoses have been added
    - *M* = 4.5 new Diagnoses per year
  - In the 38 years since IDEA was first regulated 3 new disability categories have been added
    - *M* = 0.08 new categories per year

Source: Brock & Hart (2013b, October)

The Classification of Mental Illness in the United States

Source	Sets of Criteria	Document Length
2013 *DSM-5*	392	1009 pages

- Diagnostic Inflation?
  - However, *DSM-5* has actually reduced the number of different sets of specific diagnostic criteria
    - Sets of criteria in *DSM-IV-TR*; *n* = 243
    - Sets of criteria in *DSM-5*; *n* = 228
      - For example, the 5 PDDs are now 1 ASD; the 3 specific learning disorders are now 1 diagnosis with three separate codes for reading, written expression, and mathematic impairments.

Source: Brock & Hart (2013b, October)

13

Seminar Outline

- The Classification of Mental Illness in the United States
- Development of *DSM-5*
- Controversies associated with *DSM-5*
- Changes to the Classification System
- Changes to Specific Criteria

14

DSM-5 Development

- **Origins can be traced to 1999**
  - APA and NIMH leaders agree on importance of working together to further scientific basis for psychiatric diagnoses/classifications
- **1999-2000**
  - APA and NIMH co-sponsored research planning conferences
    - Included NIH and international liaisons
    - *DSM-5* research agenda set
    - "A Research Agenda for *DSM-5*" published by APA in 2002

Source: APA (2012), Hart, Pate, & Brock (2013)

15

DSM-5 Development

- **2004 to 2008**
  - 13 conferences held
    - Conference steering committee included representatives from APIRE, NIH, and WHO
    - Participants wrote papers addressing specific diagnostic questions
    - Results of 11 published
- **2006-2007**
  - *DSM-5* development taskforce established
  - Specific workgroup members appointed

Source: APA (2012), Hart, Pate, & Brock (2013)

16

DSM-5 Development

- **2008-2010**
  - Work Group members propose draft criteria
- **2010-2012**
  - Field Trial Testing
- **2011-2012**
  - Text for *DSM-5* developed
- **2012**
  - Revised draft diagnostic criteria posted on www.dsm5.org and open to a round of public comment for 2 months.
- **May 18-22, 2013**
  - *DSM-5* released during APA's 2013 Annual Meeting in San Francisco, CA

Source: APA (2012), Hart, Pate, & Brock (2013)

17

DSM-5 Development

- Workgroups
  - Met regularly since late 2007.
  - Identified *DSM IV* strengths and challenges
  - Developed research questions/hypotheses
  - Conducted literature reviews and analyses of existing data
  - Developed draft criteria

Source: APA (2012), Hart, Pate, & Brock (2013)

18

DSM-5 Development

Members of the *DSM-5* Task Force and *DSM-5* Work Groups agreed to:

- Serve without remuneration.
- Not serve on a work group with a significant other.
- Receive no more than $10,000 annually from pharmaceutical companies/device makers/ biotechnology companies and similar industry entities for their services.
- Not hold stock or shares worth more than $50,000 in the aggregate in pharmaceutical companies/device makers/biotechnology companies, etc., or receive more than $10,000 annually in the aggregate in dividends from such sources.
- Abstain from participating in any capacity in Industry Sponsored Symposia at an APA Annual Meeting during their task force and/or work group tenure after 2007.

Source: APA (2012)

19

DSM-5 Development

Members of the *DSM-5* Task Force and *DSM-5* Work Groups agreed to:

- Sign a *DSM* Member "Acceptance" Form.
  - To prevent the premature dissemination of internal deliberations
  - To prohibit *DSM-5* members from using information derived from their work for personal gain.
  - Not intended to "prohibit timely discussion or public dissemination of research findings or issues" relevant to criteria options.
  - Resulted in the perception of secrecy and was a major source of controversy.

Source: APA (2012)

20

Seminar Outline

- The Classification of Mental Illness in the United States
- Development of *DSM-5*
- Controversies associated with *DSM-5*
- Changes to the Classification System
- Changes to Specific Criteria

21

Controversies Associated with *DSM-5*

- 51 mental health organizations suggested to APA that an independent scientific review is needed.
- Field testing cancelled due to deadlines
- Many changes viewed as loosening Dx criteria
- Two primary sources of controversy
  1. NIMH statements on *DSM-5*
  2. Allen Frances, MD (*DSM-IV* Task Force Chair)

Source: Brock & Hart (2013, September)

22

Controversies Associated with *DSM-5*

- NIMH statements on *DSM-5*
  - Director, Dr. Thomas Insel called *DSM-5* less a bible of mental health and more a flawed dictionary of diagnostic terms
  - Moved NIMH's research agenda away from *DSM* categories and toward its Research Domain Criteria (RDoC)
    - A classification system based on genetics, biomarkers, neural circuitry
    - Aims to better understand the biological components of mental illness

Source: Brock & Hart (2013, September)

23

Controversies Associated with *DSM-5*

- NIMH statements on *DSM-5*
  - RDoC is a matrix of constructs
    - Functional dimensions of behavior and classes or units of analysis used to study the constructs
      - 5 domains of behavior (Negative Valence, Positive Valence, Cognitive, Social Processes, and Arousal/Regulatory Systems)
      - 7 classes (genes, molecules, cells, neural circuits, physiology, behaviors, and self-reports)
  - Dr. Insel has indicated that NIMH funding decisions will be based on researchers utilizing RDoC versus diagnosis-specific projects

Source: Brock & Hart (2013, September)

24

Controversies Associated with *DSM-5*

- NIMH statements on *DSM-5*
  - From the high rates of comorbidity with most Dx categories + recurrence of particular symptoms across categories = frequent overlap in *DSM*'s boundaries
  - RDoC framework attempts to make this overlap of Sx less important **in research**
  - Encourages researchers to cut across categories to develop a system based on the domains of behavior, and not constricted by the of *DSM* categories

Source: Brock & Hart (2013, September)

25

Controversies Associated with *DSM-5*

- NIMH statements on *DSM-5*
  - Dr. Insel's post were been given much attention by the popular press
  - Referred to a as a "humiliating blow," a "bombshell," and a "potentially seismic move"
  - This NIMH paradigm shift has been associated with the release of *DSM-5*

Source: Brock & Hart (2013, September)

26

Controversies Associated with *DSM-5*

- NIMH statements on *DSM-5*
  - However, the funding changes Insel discussed have been part of the NIMH strategic plan **since 2008**.
  - Insel never stated that the RDoC should supplant *DSM-5*
    - He acknowledged, that the *DSM* as it currently stands is an imperfect system, and we need to do better for those dealing with mental health challenges.
  - The RDoC is an attempt to provide researchers the resources needed to uncover that better system of classification
    - It is **not currently** an alternative to *DSM-5*

Source: Brock & Hart (2013, September)

27

Controversies Associated with *DSM-5*

- Allen Frances, MD (*DSM-IV* Task Force Chair)
  - Professor Emeritus at Duke University
  - Chair of the *DSM-IV* Task force
  - Author of 2 books critical of *DSM-5*
    - *Essentials of Psychiatric Diagnosis:* (2013a)
    - *Saving Normal* (2013b)
  - Was initially reluctant to come out of a decade-long retirement and comment publicly on *DSM-5*.
  - Initially declined an invitation from Dr. Robert Spitzer (lead Ed. of *DSM-III*; APA, 1980) to sign an open letter to *Psychiatric News* (the APA version of the *Communiqué*) complaining about *DSM-5* task force secrecy

Source: Brock & Hart (2013, September)

28

Controversies Associated with *DSM-5*

- Allen Frances, MD (*DSM-IV* Task Force Chair)
  - A conversation with Dr. William Carpenter during the 2009 APA convention lead Dr. Frances to change his mind
  - Carpenter's Psychotic Disorders *DSM-5* workgroup was considering a new previously unrecognized diagnosis.
  - Frances' concerns about this proposed new diagnosis got him into the *DSM-5* fray

Source: Brock & Hart (2013, September); Frances (2013b)

29

Controversies Associated with *DSM-5*

- Allen Frances, MD (*DSM-IV* Task Force Chair)
  - Frances' concerns about Psychosis Risk Syndrome lead to his highly publicized comments about diagnostic inflation.

    "… boundaries of psychiatry are easily expanded because no bright line separates patients who are simply worried from those with mild mental disorders."
  - His frustration over this issue is clearly revealed in his December 2010 *Wired Magazine* interview wherein he was quoted:

    "there is no definition of a mental disorder. It's bullshit. I mean, you just can't define it."

Sources: Brock & Hart (2013, September); Frances (2013, May); Greenberg (2010)

30

Controversies Associated with *DSM-5*

- Allen Frances, MD (*DSM-IV* Task Force Chair)
  - Argues *DSM-5* will result in mislabeling everyday problems as a mental illness
  - Acknowledges problems generated by his work on *DSM-IV*, and asserts that *DSM-5* will make matters worse
  - Fears drug companies will to use "loose DSM definitions" and promote …
    - "the misleading idea that everyday life problems are actually undiagnosed psychiatric illness caused by a chemical imbalance and requiring a solution in pill form."

Source: Frances (2013, May)

31

Controversies Associated with *DSM-5*

- Allen Frances, MD (*DSM-IV* Task Force Chair)

"With DSM-5, patients worried about having a medical illness will often be diagnosed with somatic symptom disorder, normal grief will be misidentified as major depressive disorder, the forgetfulness of old age will be confused with mild neurocognitive disorder, temper tantrums will be labeled disruptive mood dysregulation disorder, overeating will become binge eating disorder, and the already overused diagnosis of attention-deficit disorder will be even easier to apply to adults thanks to criteria that have been loosed further."

Source: Frances (2013, May, p. 1)

32

Controversies Associated with *DSM-5*

- Discussion:
  - What are some of the "concerns" you have heard (or have questions about) regarding APA's (2013*) DSM-5*

33

Seminar Outline

- The Classification of Mental Illness in the United States
- Development of *DSM-5*
- Controversies associated with *DSM-5*
- Changes to the Classification System
- Changes to Specific Criteria

34

Changes to the Classification System

- Has been periodically reviewed since initial publication in 1952 as understanding of mental illness evolves
  - Current revision guided by 4 principles
    1. Clinical utility
    2. Research evidence
    3. Maintaining continuity
    4. No a priori restraints

From APA (2012)

35

Changes to the Classification System

- No more Roman Numerals (DSM-5 not DSM-V)
  - Look for DSM-5.1, DSM-5.2, etc.
- Elimination of multi-axial format
- No longer wanting separateness among psychiatric, psychosocial, and physical conditions
- GAF eliminated due to its lack of clarity and questionable psychometrics in routine practice

From APA (2013b)

36

Changes to the Classification System

- Use of **Dimensional** Assessments
  - *DSM-IV-TR* disorders were described and arranged by category
    - A person either had a symptom or they didn't
    - A certain number of symptoms were required
  - *DSM-5's* moves toward a dimensional approach, which will allows for evaluation of the range of symptoms and other factors in an individual presentation
    - Behaviors will be viewed as existing on a continuum of severity
    - Got to http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Disorder for APA online severity assessment measures

From APA (2012)

37

Changes to the Classification System

- Diagnoses **re-organized** to reflect scientific advances in understanding underlying symptoms of disorders and interaction of genetics, biology, and environment on behavior and mental health
  - For example, Bipolar Disorder became its own chapter rather than being subsumed under the mood disorders category, and is placed between Schizophrenia Spectrum and Depressive Disorders due to its relation to both

From Hart, Pate, & Brock (2013)

38

Changes to the Classification System

- *DSM-5's* **Organization**
  - Section I: *DSM-5* Basics (pp. 1-25)
  - Section II: Diagnostic Criteria and Codes (pp. 27-727)
  - Section III: Emerging Measures and Models (pp. 729-806)
    - Includes "Conditions for Further Study" (candidates for *DSM 5.1*)
  - Appendix (pp. 807-916)

From APA (2013b)

39

Changes to the Classification System

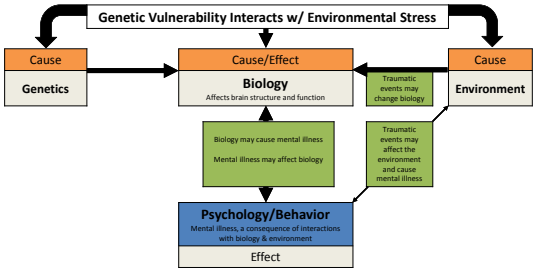
- Meta Structure of How Diagnoses are Organized
  - Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence eliminated
  - Disorders sequenced to incorporate a more developmental, **lifespan approach**
    - Neurodevelopmental disorders begin on p. 31
    - Neurocognitive disorder begin on p. 591
  - **See Handout 2 for how diagnoses are now organized**

From APA (2013b)

40

Changes to the Classification System

An interpretation of *DMS-5's* conceptualization of mental illness



41

Seminar Outline

- The Classification of Mental Illness in the United States
- Development of *DSM-5*
- Controversies associated with *DSM-5*
- Changes to the Classification System
- Changes to Specific Criteria

42

Neurodevelopmental Disorders

- Intellectual Disabilities
- Communication Disorders
- Autism Spectrum Disorders
- Attention-Deficit/Hyperactivity Disorder
- Specific Learning Disorder
- Motor Disorders

Source: APA (2013b)

43

Intellectual Disabilities

- Definition
  - "… a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains."

Source: APA (2013b, p. 33)

44

Intellectual Disabilities

- Changes from *DSM-IV-TR*
  - Name change
    - No longer referred to as Mental Retardation
    - "Intellectual Development Disorder" in ICD-11
  - Severity determined by adaptive functioning
    - No longer determined by IQ scores (no specific IQ score specified)
    - Severity level specifiers "mild," "moderate," "severe," "profound" (see pp. 34-36)
  - Defines adaptive functioning in 3 domains (vs. 11 areas)
  - Requires BOTH standardized testing and clinical assessment
  - "Global Developmental Delay" used for children under age 5 years & unable to be tested.
  - "Unspecified Intellectual Delay" use for children over age 5 when testing is difficult or impossible

Sources: APA (2013b), Morera (2014)

45

Intellectual Disabilities

- Rationale for *DSM-5* Changes
  - Intellectual disabilities is now the more common (preferred) term
    - MR had become pejorative (as had "mental deficiency" when DSM-II was published in 1968).
  - PL 111-256, Rosa's Law
    - ID is quite literally PC
  - Criteria encourage a more comprehensive assessment
    - Emphasizes clinical assessment AND standardized cognitive testing
    - It is not the test that identifies ID, rather it is the mental health professionals clinical judgment that does so

Sources: APA (2013b), Morera (2014)

46

Intellectual Disabilities

- Consequences of *DSM-5* Changes
  - Less stigmatizing
    - But with the passage of time ID may also become pejorative
  - Less reliance on the IQ score
    - Ensures IQ tests are not over emphasized
    - Requires a more comprehensive assessment
  - Greater emphasis on adaptive functioning
    - Severity levels (mild, moderate, severe, profound) based on conceptual, social, and practical behaviors
  - Elimination of multi-axial format (was Axis II) may mean comorbid conditions are overlooked

Sources: APA (2013b); Morera (2014)

47

Intellectual Disabilities

- Implications for School Psychologists
  - Same terminology as IDEA
  - A neurocognitive disorder may also be appropriate for students in the TBI category
  - Can be more certain that clinical assessments have given adequate consideration to adaptive behavior
  - Not the same as IDEA's ID
    - Which adds a 4th criteria (adverse impact on educational functioning)

Source: Morera (2014)

48

Intellectual Disabilities

Alternative Diagnosis	Differential Consideration
Borderline Intellectual Functioning	IQ above 70
Autism Spectrum Disorder	Significant deficits in social interaction and stereotypical behaviors not accounted for by IQ
Learning Disorder	Problem specific to learning, not generalized to all intellectual functions
Major Neurocognitive Disorder (Dementia)	Onset is after age 18
Malingering	Person seeks to avoid legal or other responsibilities by feigning intellectual incapacity
Other mental disorders	Depressive Disorder, Anxiety Disorders, and others may interfere with intellectual functioning

Source: Francis (2013a)

49

Social (Pragmatic) Communication Disorder

- Definition
  - Difficulty with verbal and nonverbal communication that cannot be explained by cognitive ability
  - Characterized primarily by poor pragmatics

Source: APA (2013b, pp. 47-48)

50

Social (Pragmatic) Communication Disorder

- Changes from *DSM-IV-TR*
  - A new diagnosis
  - Not found in *DSM-IV-TR*

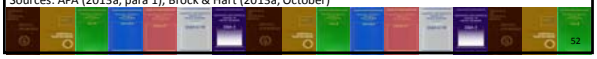
Source: Brock & Hart (2013a, October)

51

Social (Pragmatic) Communication Disorder

- Rationale for *DSM-5* changes
  - Need to recognize individuals who have problems using language for social purposes
  - Brings "… social and communication defects out of the shadows of a "not otherwise specified" label to help them get the services and treatment they need"

Sources: APA (2013a, para 1), Brock & Hart (2013a, October)



52

Social (Pragmatic) Communication Disorder

- Possible Consequences of *DSM-5* Changes
  - A new diagnoses for some individuals who were previously identified as PDD-NOS

Sources: APA (2013a), Brock & Hart (2013a, October)

53

Social (Pragmatic) Communication Disorder

- Implications for School Psychologists
  - Would most likely direct IEP team attention to "Speech or Language Impaired" criteria
  - May make it less likely that "Autism" criteria is used for some students

Source: Brock & Hart (2013a, October)

54

Autism Spectrum Disorder (ASD)

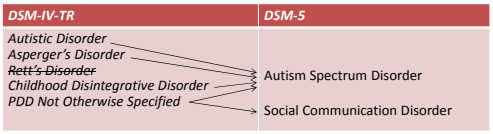
- Definition
  - Impaired reciprocal social communication; and restricted, repetitive patterns of behaviors, interests or activities (RRB).

Sources: APA (2013b, p. 53)

55

Autism Spectrum Disorder

- Changes from *DSM-IV-TR*
  - Drops the 5 different PDDs, in favor of a single unifying ASD diagnosis.
  - Three symptoms groups becomes two.



Sources: APA (2013b); Brock & Hart (2013a, October)

56

Autism Spectrum Disorder

- Changes from *DSM-IV-TR* (continued)
  - Criteria do not specify a specific number of social communication and interaction symptoms.
  - Criteria specify that 2 of 4 symptoms of RRB must be present
  - For both criterions A & B, clinicians are directed to specify the severity level
  - Symptoms may be displayed currently or that there may be a history of such dating back to early childhood.
  - **See Handout 3 for Sx changes**

Sources: APA (2013b); Brock & Hart (2013a, October)

57

Autism Spectrum Disorder

- Changes from *DSM-IV-TR* (continued)
  - Added 5 specifiers
    1. Intellectual impairment
    2. Language impairment, whether the ASD diagnosis is a
    3. Associated with a "known medical or genetic condition or environmental factor"
    4. Associated with another neurodevelopmental, mental, or behavioral disorder"
    5. Associated with "catatonia"

Sources: APA (2013b, p. 51); Brock & Hart (2013a, October)

58

Autism Spectrum Disorder

- Rationale for *DSM-5* Changes
  - Autism symptoms are better thought of as existing on a continuum
  - Evidence does not robustly support a distinction between Asperger's and autistic disorder
  - The differentiation is not reliably made in practice
  - Genetic studies indicate more commonalities between Asperger's and autism than differences
  - Diagnostic conversion between these disorders may be common

Source: Brock & Hart (2013a, October)

59

Autism Spectrum Disorder

- Possible Consequences of *DSM-5* Changes
  - A more homogeneous ASD population
    - 2,037 Sx combinations to 11 (to 77) Sx combinations
  - Recognition of sensory issues will facilitate program planning
  - Specifiers for ID and symptom severity will facilitate program planning
  - Appears to have affected the epidemiology of ASD

Source: Brock & Hart (2013a, October); Kulage, Smaldone, & Cohn (2014); Tsai (2014)

60

Autism Spectrum Disorder

- Implications for School Psychologists
  - Educational placements use education codes and regulations, and are more restrictive than are *DSM*
    - While approximately 20 out of every 1,000 school age youth have ASD, only about 6 out of every 1,000 students are eligible for special education using autism criteria
    - *DSM-5's* use of severity level and specifiers will help IEP teams determine the likelihood of a given student with ASD meeting IDEA autism eligibility criteria
  - Remains to be seen how new "labeling" will impact parents accessibility to community services, but should not affect IDEA numbers

Sources: Brock & Hart (2013a, October)

61

Autism Spectrum Disorder

Alternative Diagnosis	Differential Consideration
Intellectual Disabilities	Low IQ score without social disconnectedness and ritualistic behaviors
Learning Disorder	Academic deficits without the characteristic autistic behaviors
OCD	Strange RRB-like rituals, but OCD usually has later onset, normal attachment, & intact language
Social Anxiety Disorder (Social Phobia)	Socially awkward, but not the other social, speech, and RRBs
Schizophrenia	Much later onset, with delusions or hallucinations
Schizotypal Personality Disorder	Later onset, but there is considerable overlap
Normal eccentricity	Behaviors don't cause clinically significant distress or impairment

Source: Francis (2013a)

62

Attention-Deficit/Hyperactivity Disorder

- Definition
  - A neurodevelopmental disorder that begins in childhood
  - Characterized by significant inattention and/or hyperactivity-impulsivity that impact functioning or development

Source: APA (2013b)

63

Attention-Deficit/Hyperactivity Disorder

- Changes from *DSM-IV-TR*
  - Re-categorized within Neurodevelopmental Disorders
    - Differentiates it from other impulse-related and behavioral disorders (e.g., Conduct Disorder), and the emphasis is on the neurobiological nature of the disorder.
      - Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence category eliminated
  - Examples added to differentiate between ADHD in children vs. older adolescents/adults
  - Persons 17+ required to demonstrate only 5 symptoms for both inattention and hyperactivity/impulsivity
    - Children still required to demonstrate a persistent pattern of at least 6 symptoms for each

Sources: APA (2000; 2013b); Gibbons (2013)

64

Attention-Deficit/Hyperactivity Disorder

- Changes from *DSM-IV-TR* (continued)
  - Age of onset criterion changed
    - *DSM-IV-TR* required that some symptoms of inattention and/or hyperactivity/impulsivity have been present and caused significant impairment by age 7, *DSM-5* requires that symptoms were present before age 12
  - Specifiers are now included
    - Mild, Moderate, or Severe; and Partial Remission
      - Aid in describing the course and prognosis of the disorder
    - Shift from subtypes to presentation specifiers in *DSM-5*
      - *Combined Presentation, Predominantly Inattentive Presentation, Predominantly Hyperactive/Impulsive Presentation*

Sources: APA (2000; 2013b); Gibbons (2013)

65

Attention-Deficit/Hyperactivity Disorder

- Changes from *DSM-IV-TR* (continued)
  - Impairment criteria wording changes
    - *DSM-IV-TR* required *some impairment* be present in at least 2 settings
    - *DSM-5* requires that *several symptoms* be present in 2 or more settings
  - *DSM-IV-TR* prohibited a comorbid diagnosis of ADHD in those with a Pervasive Developmental Disorder
  - *DSM-5* allows for comorbid diagnosis of ADHD and Autism Spectrum Disorder

Sources: APA (2000; 2013b); Gibbons (2013)

66

Attention-Deficit/Hyperactivity Disorder

- Rationale for *DSM-5* Changes
  - ADHD viewed as a lifespan disorder
  - Onset criterion in *DSM-IV-TR* acknowledged as having been arbitrary
  - Use of subtypes not supported by empirical data
  - Specifiers improve clinical utility of diagnosis
  - ASD and ADHD can co-occur

Source: APA (2013b); Gibbons (2013)

67

Attention-Deficit/Hyperactivity Disorder

- Possible Consequences of *DSM-5* Changes
  - Reliable diagnosis (Kappa Coefficient of .61)
  - Facilitate diagnosis in adolescents and adults
    - May increase prevalence
  - Being viewed as a neurodevelopmental (vs. disruptive behavior) disorder may reduce stigma
  - With older children, symptoms could be related to other causes that get overlooked

Source: APA (2013b); Gibbons (2013); Frances (2013b)

68

Attention-Deficit/Hyperactivity Disorder

- Implications for School Psychologists
  - May affect eligibility decisions and school psychologists may be called on to consider these criteria
  - May require school psychologists to alter assessment approaches
  - Severity specifiers result in the need to determine the impact of ADHD on student functioning.
  - Satisfying the requirement that several symptoms be present in two or more settings will be dependent upon observation and information from across multiple settings.

Source: Gibbons (2013)

69

Attention-Deficit/Hyperactivity Disorder

Alternative Diagnosis	Differential Consideration
Normal Immaturity	Developmentally appropriate at 4 may be ADHD at 7
Oppositional Defiant Disorder (ODD)	Willful refusal to comply with structure or authority
Conduct Disorder	Pattern of severe violation of rules
Intellectual Developmental Disorder	Child seems inattentive or disorganized because can't keep up with work
Adjustment Disorder	Sx are response to chaotic environment, family stress, or life changes
Other mental disorders	Hyperactivity, impulsivity, and inattentiveness are common across many Dx (e.g., substance use, mania, dementia)
Malingering	Obtaining prescription for stimulant drugs for performance enhancement, recreation, or resale

Source: Francis (2013a)

70

Specific Learning Disorder

- Definition
  - "… a neurodevelopmental disorder with a biological origin that is the basis for abnormalities at a cognitive level that are associated with the behavioral sins of the disorder. The biological origin includes an interaction of genetic, epigenetic, and environmental factors, which affect the brain's ability to perceive or process verbal or non-verbal information efficiently and accurately."

Source: APA (2013b, p. 68)

71

Specific Learning Disorder

- Changes from *DSM-IV-TR*
  - Now a single overall diagnosis of deficits that impact academic achievement
  - Includes specifiers for "impairment in" reading, written expression, and mathematics.
  - Requires identification of impaired subskills
    - Reading subskills: word reading accuracy, reading rate or fluency, reading comprehension
    - Written expression subskills: spelling accuracy, grammar and punctuation accuracy, clarity or organization of written expression
    - Mathematics subskills: number sense, memorization of arithmetic facts, accurate or fluent calculation, accurate math reasoning

Source: APA (2013b)

72

Specific Learning Disorder

- Rationale for *DSM-5* Changes
  - Increase diagnostic accuracy
  - Effectively target care

Source: APA (2013b)

73

Specific Learning Disorder

- Possible Consequences of *DSM-5* Changes
  - Clinical diagnoses may more accurately direct the attention of IEP teams
  - Will be easier to identify – could increase prevalence of diagnosis!

Source: APA (2013b)

74

Specific Learning Disorder

- Implications for School Psychologists
  - Identifies Dyslexia and Dyscalculia as alternative terms
  - Specifically identifies "school reports," and "psychoeducational assessment" as bases for documenting diagnostic criteria
  - Evaluations done outside school setting may find SLD easier to identify due to broad criteria

75

Specific Learning Disorder

Alternative Diagnosis	Differential Consideration
Intellectual Disabilities	Learning problems no greater than what would be expected given IQ.
Autism Spectrum Disorder	This is the primary cause of poor functioning. Both diagnoses can be given if a specific academic area is disproportionately impaired.
Sensory Deficit	Accounts for learning problems.
ADHD	Causes poor test taking. Both diagnoses can be given when appropriate.

Source: Francis (2013a)

76

Schizophrenia Spectrum and Other Psychotic Disorders

- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Catatonia

Source: APA (2013b)

77

Schizophrenia Spectrum

- Definition
  - Includes disorders defined by one or more of the following:
    - delusions
    - hallucinations
    - disorganized thinking
    - grossly disorganize/abnormal motor behavior,
    - negative symptoms (diminished emotional expression or avolition)

Source: APA (2013b)

78

Schizophrenia Spectrum

- Changes from *DSM-IV-TR*
  - Organized from least to most severe
    - Delusional Disorder
    - Brief Psychotic Disorder
    - Schizophreniform Disorder
    - Schizophrenia
    - Schizoaffective Disorder
    - Substance/Medication Induced Psychotic Disorder
    - Psychotic Disorder due to Another Medical Condition
    - Catatonia

Sources: APA (2013b); Gubi, McDonnell, & Bocanegra (2014)

79

Schizophrenia Spectrum

- Changes from *DSM-IV-TR*
  - Qualification that only one characteristic symptom is required if a Schneiderian first-rank symptom is present removed
    - these symptoms include bizarre delusions, thought broadcasting, auditory hallucinations that comment on one's behavior, a voice keeping up a running commentary, or two plus voices conversing
  - Changes to some of the descriptors involving negative symptoms associated with the diagnosis of schizophrenia.
    - Negative symptoms, previously defined as affective flattening, alogia, or avolition, are now defined as diminished emotional expression, or avolition.

Sources: APA (2013b); Gubi, McDonnell, & Bocanegra (2014)

80

Schizophrenia Spectrum

- Changes from *DSM-IV-TR*
  - Criterion F previously stated that diagnosis required prominent delusions or hallucinations be present for at least a month (or less if untreated) in cases with a history of autistic disorder or pervasive developmental disorder.
    - In *DSM-5*, this caveat is also applied to cases with a history of other communication disorders of childhood onset, as these (like autism spectrum disorders) may be associated with disorganized speech and diminished emotional expression.

Sources: APA (2013b); Gubi, McDonnell, & Bocanegra (2014)

81

Schizophrenia Spectrum

- Changes from *DSM-IV-TR*
  - Discontinuation of distinguishing between four distinct "subtypes" of schizophrenia (disorganized, catatonic, paranoid, and undifferentiated).
    - Validity of these subtypes has not been supported by research.
    - In lieu of subtypes, *DSM-5* utilizes a dimensional psychopathological description that allows for specification of the course of the disorder.

Sources: APA (2013b); Gubi, McDonnell, & Bocanegra (2014)

82

Schizophrenia Spectrum

- Rationale for *DSM-5* Changes
  - For schizophrenia
    - Subtypes often changed and presented overlapping subtype symptoms that blurred distinction and decreased validity
      - Some previous subtypes are now specifiers (e.g., catatonia)
    - Elimination of bizarre delusions qualification will improve Dx reliability
    - Specifiers address current presentation
      - Important given the significant presentation variability

Source2: APA (2013e), Gubi, McDonnell, & Bocanegra (2014)

83

Schizophrenia Spectrum

- Possible Consequences of *DSM-5* Changes
  - Used research results to try and better fine-tune criteria to minimize overlap
  - Some argue schizophrenia is not a disease but a syndrome (vast differences in presentation)
  - Hopefully will lead to continued research

Source: Paris (2013)

84

Schizophrenia Spectrum

- Implications for School Psychologists
  - Hard to distinguish schizophrenia from other mental disorders that have psychotic symptoms -
    - Looking for presence of psychosis, disorganization, and negative symptoms along with absence of other etiologies (e.g., bipolar)
  - Attenuated Psychosis Syndrome
    - A Section III "Condition for Further Study"
    - Psychosis-like, but below diagnostic threshold for a psychotic disorder
    - Onset is usually in mid to late adolescence or early adulthood.
      - Appears to best apply to person aged 15- to 35-years.
    - 18% meet diagnostic criteria for a psychotic disorder within 1 years of identification
    - 32% meet diagnostic criteria for a psychotic disorder within 3 years of identification

Source: Francis (2013a)

85

Schizophrenia Spectrum

Alternative Diagnosis	Differential Consideration
Schizoaffective Disorder	Mood Sx are prominent in presentation, but psychotic symptoms persist even absent mood episodes
Major Depressive Disorder, severe with psychotic features	Psychotic symptoms restricted to depressive episodes
Bipolar I, Severe with Psychotic Features	Psychotic symptoms restricted to manic or depressive episodes
Schizotypal Personality Disorder	No psychotic symptoms
Schizophreniform Disorder	Same Sx as schizophrenia, but last for >1 month and <6 months
Brief Psychotic Disorder	Same Sx as schizophrenia, but last for <1 month
Delusional Disorder	Only delusions – no hallucinations, disorganization, or negative symptoms
Autism Spectrum Disorder	No prominent delusions or hallucinations
Malingering	Is something to be gained by "faking crazy?"
Political or Religious Zealotry	Bizarre beliefs shared by others

Source: Francis (2013a)

86

Bipolar and Related Disorders

- Bipolar I
- Bipolar II
- Cyclothymic

Source: APA (2013b)

87

Bipolar and Related Disorders

Definition

- Distinct mood phases ranging from mania or hypomania to depression.
  - Bipolar I Disorder
    - Criteria have been met for at least 1 manic episode
      - May have been preceded by and followed by hypomanic OR major depressive episodes
  - Bipolar II Disorder
    - Criteria have been met for a current or past hypomanic episode AND a past major depressive episode
      - There has never been a manic episode
  - Cyclothymic
    - Alternating hypomanic and depressive symptoms but not severe enough for Bipolar I or Bipolar II

Source: APA (2013b); Frances (2013a)

88

Bipolar and Related Disorders

Changes from *DSM-IV-TR*

- No longer classified as a "mood disorder" – has own category
- Placed between the chapters on schizophrenia and depressive disorders
  - Consistent with their place between the two diagnostic classes in terms of symptomatology, family history, and genetics.
- Bipolar I criteria have not changed
- Bipolar II must have hypomanic as well as history of major depression and have clinically significant
  - can now include episodes with mixed ***features.***
  - past editions, a person who had mixed *episodes* would not be diagnosed with bipolar II
  - diagnosis of hypomania or mania will now require a finding of increased energy, not just change in mood

Source: APA (2013b)

89

Bipolar and Related Disorders

- Rationale for *DSM-5* Changes
  - pinpoint the predominant mood ("features")
- a person must now exhibit changes in mood as well as energy
  - For example, a person would have to be highly irritable and impulsive in addition to not having a need for sleep
  - helps to separate bipolar disorders from other illnesses that may have similar symptoms.
  - intention is to cut down on misdiagnosis, resulting in more effective bipolar disorder treatment. -

90

Bipolar and Related Disorders

- Possible Consequences of *DSM-5* Changes
  - Still does not address potential bipolar children and adolescents
  - Could miss bipolar in children and then prescribe medication that make symptoms worse
  - Hopefully will increased accuracy with diagnosis

91

Bipolar and Related Disorders

- Implications for School Psychologists
  - Children who experience bipolar-like phenomena that do not meet criteria for bipolar I, bipolar II, or cyclothymic disorder would be diagnosed "other specified bipolar and related disorder"
  - If they have explosive tendencies may be (mis)diagnosed with Disruptive Mood Dysregulation Disorder
    - focus too much on externalizing behaviors and ignore possible underlying depressive symptoms

92

Bipolar I

Alternative Diagnosis	Differential Consideration
Major Depressive Disorder	Person with depressive Sx never had Manic/Hypomanic episodes
Bipolar II	Hypomanic episodes, w/o a full Manic episode
Cyclothymic Disorder	Lesser mood swings of alternating depression - hypomania (never meeting depressive or manic criteria) cause clinically significant distress/impairment
Normal Mood Swings	Alternating periods of sadness and elevated mood, without clinically significant distress/impairment
Schizoaffective Disorder	Sx resemble Bipolar I, severe with psychotic features but psychotic Sx occur absent mood Sx
Schizophrenia or Delusional Disorder	Psychotic symptoms dominate. Cccur without prominent mood episodes
Substance Induced Bipolar Disorder	Stimulant drugs can produce bipolar Sx

Source: Francis (2013a)

93

Bipolar II

Alternative Diagnosis	Differential Consideration
Major Depressive Disorder	No Hx of hypomanic (or manic) episodes
Bipolar I	At least 1 manic episode
Cyclothymic Disorder	Mood swings (hypomania to mild depression) cause clinically significant distress/impairment; no history of any Major Depressive Episode
Normal Mood Swings	Alternately feels a bit high and a bit low, but with no clinically significant distress/impairment
Substance Induced Bipolar Disorder	Hypomanic episode caused by antidepressant medication or cocaine
ADHD	Common Sx presentation, but ADHD onset is in early childhood. Course chronic rather than episodic. Does not include features of elevated mood.

Source: Francis (2013b)

94

Cyclothymic Disorder

Alternative Diagnosis	Differential Consideration
Normal Mood Swings	Ups &downs without clinically significant distress/impairment
Major Depressive Disorder	Had a major depressive episode
Bipolar I	At least one Manic episode
Bipolar II	At least one clear Major Depressive episode
Substance Induced Bipolar Disorder	Mood swings caused by antidepressant medication or cocaine. Stimulant drugs can produce bipolar symptoms

Source: Francis (2013a)

95

Depressive Disorders

- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)

Source: APA (2013b)

96

Disruptive Mood Dysregulation Disorder

- Definition
  - Characterized by chronic, severe and persistent irritability and generally, was introduced in the hopes of helping to address challenges and disagreements regarding the diagnosis of bipolar disorder in youth.

Sources: APA (2013b), Hart (2014)

97

Disruptive Mood Dysregulation Disorder

- DSM-5 Criteria
  - A. Severe recurrent temper outbursts grossly out of proportion to situation or provocation
  - B. Inconsistent with developmental level
  - C. Occur, on average, three or more times per week
  - D. Mood between outbursts is persistently irritable or angry
  - E. Criteria A–D present for 12 or more months.
  - F. Criteria A and D present in at least 2 of 3 settings (home, school, with peers) and severe in at least one
  - G. Diagnosis not made before age 6 years or after age 18 years
  - H. Age at onset of Criteria A–E before 10 year
  - I. Never been a period lasting more than 1 day during which the full criteria, except duration, for a manic or hypomanic episode been met
  - J. Behaviors do not occur exclusively during an episode of major depressive disorder and not better explained by another mental disorder
  - K. Symptoms not attributable to the physiological effects of a substance or to another medical or neurological condition

Sources: APA (2013b), Hart (2014)

98

Disruptive Mood Dysregulation Disorder

- Changes from *DSM-IV-TR*
  - A new diagnosis
  - Not found in *DSM-IV-TR*

Source: Hart (2014)

99

Disruptive Mood Dysregulation Disorder

- Rationale for *DSM-5* Changes
  - Address alarming increases in the diagnosis of bipolar disorder youth
    - Many of whom did not be bipolar criteria in the strictest sense
  - Youth better served by emphasizing the mood dysregulation difficulties and chronic irritability
    - vs. giving them a bipolar Dx
  - Research supported the distinction between this group and those with a more classic bipolar presentation
    - Relative to bipolar, those with Severe Mood and Behavioral Dysregulation phenotype
      - more likely to develop anxiety or unipolar depression in adulthood
      - more likely to be male
      - Have different family histories

Source: Hart (2014)

100

Disruptive Mood Dysregulation Disorder

- Possible Consequences of *DSM-5* Changes
  - Reduce rates of bipolar disorder
  - Might be lacking in diagnostic utility
    - Over ½ of youth diagnosed only met criteria at one assessment wave
    - Those with DMDD did not differ in rates of mood, anxiety, or ADHD disorders, functional impairment or parental history from those without DMDD.
  - Uncommon after early childhood, has high comorbidity, and captures children with significant functional impairment and increased service use.
    - Substantial overlap with ODD.
    - Youth diagnosed with DMDD were significantly more likely to be from low SES homes.

Source: Hart (2014)

101

Disruptive Mood Dysregulation Disorder

- Implications for School Psychologists
  - It will be intriguing to see how quickly the assignment of DMDD "catches on."
    - There will likely be a lag in community-based clinicians becoming aware of, accepting, and diagnosing this disorder
    - It might be up to knowledgeable school-employed mental health practitioners to bring awareness of these children to clinical entities.
  - While it may direct our attention toward students who might require support, diagnostic labels do not automatically result in special education eligibility or services.

Source: Hart (2014)

102

Major Depressive Disorder

Definition

- 5 of 9 criteria (one must be #1 or #2)
  1. depressed mood most of the day, early everyday (children: irritable)
  2. diminished interest or pleasure in almost all activities
  3. significant weight loss/gain or decreased/increased appetite (children: failure weight gain)
  4. insomnia or hypersomnia
  5. psychomotor retardation or agitation
  6. fatigue, loss of energy
  7. feelings of worthlessness or excessive/inappropriate guilt
  8. Diminished ability to think/concentrate or indecisiveness
  9. Recurrent thoughts of death, recurrent suicide ideation, plan and/or attempt
- The feelings are pervasive and symptoms are intense.
  - Marked impairment in occupational functioning or in usual social activities or relationships
  - Not due to bereavement, substance use, medical condition
- Specifiers: anxious distress, mixed features, melancholic features, atypical features, mood-congruent psychotic features, mood incongruent psychotic features, catatonia, peripartum onset, seasonal pattern

APA (2013b)

103

Major Depressive Disorder

- Changes from *DSM-IV-TR*
  - Relatively little changes
  - Added a "mixed features" specifier
    - Applicable to manic, hypomanic, depressive episodes
    - Can score subthreshold symptoms
  - Removed "bereavement exclusion"
  - Option of scoring severity dimensions (mild, moderate, severe; single/recurrent episodes; partial/full remission)
  - Specifiers for Depressive Disorders

Source: APA (2013b); Paris (2013)

104

Major Depressive Disorder

- Rationale for *DSM-5* Changes
  - Research did not support bereavement exclusion
    - Symptoms for diagnosis of major depressive disorder did not change if a loss was involved

Source: APA (2013b)

105

Major Depressive Disorder

- Possible Consequences of *DSM-5* Changes
  - More likely to identify mixed episodes ("mixed features")
  - Very broad – almost anyone can meet criteria at some point in life
  - Blurs line between normal grief and depression
    - Could lead to over diagnosis of those who have experienced a significant loss
  - Removing the bereavement exclusion helps prevent major depression from being overlooked
    - facilitates the possibility of appropriate treatment including therapy or other interventions.

Source: APA (2013b)

106

Major Depressive Disorder

- Implications for School Psychologists
  - Easy to miss and easy to overdiagnose
  - If person experiences a loss, reserve diagnosis for those had previously experiences major depressive episodes and/or are now having server and prolonged symptoms

107

Major Depressive Disorder

Grief	Major Depressive Episode
Feelings of emptiness and loss	Persistent depressed mood; inability to anticipate happiness or pleasure
Dysphoria likely decreases in intensity and over days/weeks. Occurs in waves (associated with thoughts/reminders of loss)	Depressed mood is more persistent and not tied to specific thoughts or preoccupations
Pain accompanied by positive emotions/humor	Pervasive unhappiness and misery
Preoccupation with thoughts and memories of loss	Self-critical or pessimistic ruminations
Self-esteem preserved	Feeling worthlessness and self-loathing
Perceived failings connected to deceased	Perceived failing in many situations
Thoughts of death (if present) focused on joining the deceased	Thoughts of death focused on ending own life because not deserving, feel worthless, or unable to cope with pain

Source: APA(2013b)

108

Major Depressive Disorder

Alternative Diagnosis	Differential Consideration
Bipolar Disorders	Current or previous Sx of mania or hypomania
Uncomplicated Bereavement	Depressive Sx better understood as expectable manifestation of normal grief
Substance-Induced Mood Disorder	Sx are caused by drug abuse or medications
Chronic Depressive Disorder (Dysthymic Disorder)	Depressive Sx milder and persist for years
Schizophrenia, Schizoaffective Disorder, or Delusional Disorder	Delusions & hallucinations occur during periods absent of mood Sx
Brief Psychotic Disorder	Sx occur without an episode of depression, resolve quickly, and sometimes arise in response to stress

Source: Francis (2013a)

109

Persistent Depressive Disorder (Dysthymia)

A. A depressed mood for most of the day, for more days than not….for at least 2 years (at least one year in children and can be irritable)

B. Depression is accompanied by at least two:
   A. Poor appetite or overeating, insomnia or hyperinsomia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, feelings of hopelessness

C. During the course of 2 years (1 year children), there has not been symptom relief of A and B for more than 2 months

D. Major Depressive Disorder can be continuously present for 2 years. Etc….

- Specifiers: anxious distress, mixed features, melancholic features, atypical features, mood-congruent psychotic features, mood incongruent psychotic features, peripartum onset, seasonal pattern; partial or full remission, early or late onset…

Severity: mild, moderate, severe (DSM 5, p. 188)

APA (2013b)

110

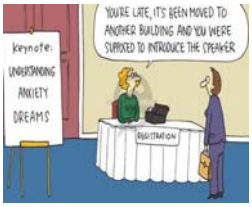
Persistent Depressive Disorder (Dysthymia)

Alternative Diagnosis	Differential Consideration
Normal Existential Sadness	Persistent sadness can be normal, especially in people who cope with chronic stress/disappointment
Bipolar Disorders	Have been manic or hypomanic episodes
Chronic Major Depressive Disorder	Sx are severe
Depressive Disorder Due to Another Medical Condition	Physiological aspects of an illness cause long-term depressive Sx
Substance-Induced Mood Disorder	Substance use is also chronic
Chronic Psychotic Disorders	Chronic depression is an associated feature, but not diagnosed separately

Source: Francis (2013a)

111

Anxiety Disorders



- Separation Anxiety Disorders
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder

Source: APA (2013b)

112

Anxiety Disorders

- Definition
  - Include features of excessive fear and anxiety and related behavioral disturbances.
  - *Generalized Anxiety Disorder* has greater emphasis on "worry" (difficult to control, apprehensive expectation…) in addition to the anxiety
  - *Social Anxiety Disorder* – more emphasis on the fear of being negatively evaluated
    - Purposeful avoidance of social situations
    - Fear must occur also in peer settings
  - *Selective Mutism* – recognizes anxiety underlying fear of speaking in some situations
  - *Agoraphobia* - endorsement of fears from two or more agoraphobia situations is now required

Source: APA (2013b, p. 189)

113

Anxiety Disorders

- Changes from *DSM-IV-TR*
  - No longer includes obsessive-compulsive disorder
  - No longer includes posttraumatic and acute stress disorders
    - The close relationship between OCD, PTSD and anxiety disorders is found in the fact that these sections immediately follow anxiety disorders
  - Now includes Separation Anxiety Disorder and Selective Mutism
  - Panic disorder and agoraphobia are now coded as separate diagnoses.
    - This change recognizes that a substantial number of individuals with agoraphobia do not experience panic symptoms
  - Panic Attacks are now a specifier that is applicable to all *DSM-5* disorders
  - **See Handout 4 for a listing of changes**

Sources: APA (2013b), Kraynak & Hart (2014)

114

Anxiety Disorders

- Changes from *DSM-IV-TR*
  - Phobias – no longer have to self-recognize the phobia is irrational
  - Social phobia now known as social anxiety disorder
    - Individual does not have to have insight that the fear is excessive or unreasonable
    - General specifier replaced with "performance only" specifier

Sources: APA (2013b), Kraynak & Hart (2014)

115

Anxiety Disorders

- Rationale for *DSM-5* Changes
  - Agoraphobia, specific phobia, and social anxiety disorder often overestimate danger in public situations
  - 6 month duration that was limited to individuals under 18 years old is now extended to all ages
    - Minimize diagnosis of transient fears
  - Panic disorder and agoraphobia separated
    - a substantial number of individuals with agoraphobia do not experience panic symptoms
- Agoraphobia – requiring two distinguishes from specific phobias
- Social Anxiety Disorder - performance specifier

Source: Kraynak & Hart (2014)

116

Anxiety Disorders

- Possible Consequences of *DSM-5* Changes
  - Social anxiety disorder too broadly define
    - e.g., fear of public speaking could meet requirements
  - Lead to overdiagnosis, especially with Generalized Anxiety Disorder
    - Possible and overuse of anxiety medications
    - No empirical findings to support that this is happening.

Source: Kraynak & Hart (2014)

117

Anxiety Disorders

- Implications for School Psychologists
  - More clearly defines various anxiety disorders
  - Selective Mutism acknowledged
    - hopefully lead to better research and professional agreement
  - Not having to be able to recognize phobia is irrational allows us better identify given age groups we work with
  - May be an element of OHI and ED eligibility determinations

Source: Kraynak & Hart (2014)

118

Anxiety Disorders (Agoraphobia)

Alternative Diagnosis	Differential Consideration
Social Anxiety Disorder (Social Phobia)	Only specific situations are avoided
Specific Phobia	Only a specific situation/object is avoided
PTSD or Acute Stress Disorder	Avoids reminders of the traumatic event
Separation Anxiety Disorder	Avoidance motivated by fear of separation from caregiver
OCD	Avoidance focused on things that trigger compulsive rituals
Major Depressive Disorder	Withdrawal caused by loss of interest, pleasure, & energy rather than fears
Psychotic Disorder	Fears motivating avoidance are delusional
Substance Dependence	Intoxication and lack of motivation make person housebound

Source: Francis (2013a)

119

Anxiety Disorders (Social Anxiety Disorder)

Alternative Diagnosis	Differential Consideration
Normal Shyness	Fears is going to a party where don't know anyone
Agoraphobia	Avoidance generalized, not restricted to social situations
Specific Phobia	A specific object/nonsocial situation is avoided
PTSD or Acute Stress Disorder	Avoids reminders of the traumatic event
Separation Anxiety Disorder	Avoidance motivated by fear of caregiver separation
OCD	Avoidance focused compulsive rituals triggers
Autism Spectrum Disorder or Schizotypal, or Schizoid Personality Disorder	Lacks interest others
Avoidance Personality Disorder	Avoidance of social situations has early onset, long-standing, and a pervasive pattern of behavior
Major Depressive Disorder	Social withdrawal caused by loss of interest, pleasure, & energy
Psychotic Disorder	Fears motivating avoidance are delusional
Substance Dependence	Intoxication & lack of motivation cause social avoidance
Medical Illness	Avoids embarrassment of showing illness

Source: Francis (2013a)

120

Anxiety Disorders (Generalized Anxiety Disorder)

Alternative Diagnosis	Differential Consideration
Realistic Worries	Require no diagnosis
Adjustment Disorder	Worries are exaggerated/impairing, but usually transient and related to a specific realistic stress
Panic Disorder	Worry is focused on having a panic attack
Social Anxiety Disorder	Worry is confined to embarrassment in social situations
OCD	Worry is about an obsession
Separation Anxiety Disorder	Worry is about separation from caregivers
Anorexia Nervosa	Worry is about gaining weight
Body Dysmorphic Disorder	Worry is about perceived defect in physical appearance
Somatic Symptom Disorder	Worried are focused on bodily symptoms
PTSD and Acute Distress	Worry is focused on reminders of a traumatic event
Major Depressive Disorder	Worry has a desperate theme
Psychotic Disorders	Worries that are not reality-tests become delusional
Substance-Induced Anxiety Disorder	Anxiety comes from substance intoxication or withdrawal

Source: Francis (2013a)

121

Obsessive-Compulsive and Related Disorders

- Obsessive Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania
- Excoriation Disorder (Skin-Picking

Source: APA (2013b)

122

Obsessive-Compulsive and Related Disorders

- Definition
  - OCD: Obsessions, Compulsions – has not changed from *DSM-IV*
    - Particular obsessions tend to be paired with particular compulsions
  - Body Dysphoric Disorder: disproportionate concerns about real or imagined flaw in way they look
  - Hoarding Disorder: persistent difficulty discarding or parting with possessions, regardless of value
  - Trichotillomania: pull out hair – sense of relief accompanied by anxiety – largely unchanged
  - Excoriation Disorder (Skin-Picking): skin picking results in lesions
  - Substance/Medication-Induced OCD

Source: APA (2013b)

123

Obsessive-Compulsive and Related Disorders

- Changes from *DSM-IV-TR*
  - Organized from least to most severe
  - Need at least two specified symptoms
  - No longer identifies subtypes
  - *DSM-IV* specifier *with poor insight* has been modified to allow a spectrum of insight:
    - Good or fair insight
    - Poor insight
    - Absent insight/delusional obsessive-compulsive disorder beliefs (i.e., complete conviction that obsessive-compulsive disorder beliefs are true)
- Added Hoarding - some controversy as separate diagnosis

Source: APA (2013b); Paris (2013).

124

Obsessive-Compulsive and Related Disorders

- Rationale for *DSM-5* Changes
  - Research showed Hoarding Disorder and Skin Picking Disorders are both distinct disorders with distinct treatment
  - No significant changes to OCD were warranted

Source: APA (2013d)

125

Obsessive-Compulsive and Related Disorders

- Possible Consequences of *DSM-5* Changes
  - Possible over-identification of short-term behaviors

126

Obsessive-Compulsive and Related Disorders

- Implications for School Psychologists
  - Some symptoms can overlap with developmental disorders (e.g. Autism)
  - Treatment can be very complex and difficult for a school setting

127

Obsessive-Compulsive and Related Disorders

Alternative Diagnosis	Differential Consideration
Major Depressive Disorder	Depressive occupations
Body Dysmorphic Disorder	Intrusive thoughts of a body part that is horribly ugly
Generalized Anxiety Disorder	Excessive but realistic worries about everyday things
PTSD or Acute Stress Disorder	Repetitive memories of the terrible event
Anorexia Nervosa	Preoccupations with being fat
Delusional Disorder	Obsessions that have turned into delusions (i.e. I will die because of the contamination)
Schizotypal Personality Disorder	Odd, eccentric thoughts, but not experienced as externally driven and intrusive
Somatic Symptom Disorder	Intrusive worries about having a serious illness

Source: Francis (2013a)

128

Trauma- and Stressor-Related Disorders

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders

Source: APA (2013b)

129

Reactive Attachment Disorder

- Definition
  - Pattern of inhibited, emotionally withdrawn behavior
  - Persistent social and emotional disturbance
  - Patterns of extreme insufficient care
  - Lack of care is presumed to be responsible for emotionally withdrawn behavior
  - Evident before age 5
  - Has developmental age of at least nine months
  - Specifier: Persistent= present more than 12 months
    Severe = high levels of all symptoms

Source: APA (2013b)

130

Reactive Attachment Disorder

- Changes from *DSM-IV-TR*
  - Criteria split between RAD and new Disinhibited Social Engagement Disorder
  - Now falls under "Trauma and Stressor Related Disorders" as opposed to "Disorders of Infancy, Childhood, Adolescence."

Sources: APA (2013b), Leveille (2014)

131

Reactive Attachment Disorder

- Rationale for *DSM-5* Changes*
  - Future path can be very different between RAD and Disinhibited Social Engagement Disorder

Sources: APA (2013b), Leveille (2014); NOTE *Applies also to Disinhibited Social Engagement Disorder

132

Reactive Attachment Disorder

- Possible Consequences of *DSM-5* Changes
  - Due to very low prevalence rate will be hard to study the criteria
  - May increase psychiatric labeling of youth raised in orphanages or foster care

Sources: APA (2013b), Leveille (2014)

133

Reactive Attachment Disorder

- Implications for School Psychologists
  - Developmental history is critical
  - Use caution if diagnosis is made after the age of 5
  - Can see functional impairment in all areas of schools

Source: Leveille (2014)

134

Disinhibited Social Engagement Disorder

- Definition
  - A pattern of behavior wherein a child actively approaches and interacts with unfamiliar adults (2 of following)
    - Reduced/absent reticence in approach
    - Overly familiar behavior
    - Diminished/absent checking back in with caregiver
    - Willingness to to with unfamiliar adult with little/no hesitation
  - Patterns of extremes of insufficient care
  - Present for more than 12 months

Sources: APA (2013b), Leveille (2014)

135

Disinhibited Social Engagement Disorder

- Changes from *DSM-IV-TR*
  - A new diagnosis
  - Not found in *DSM-IV-TR*

Sources: APA (2013b), Leveille (2014)

136

Disinhibited Social Engagement Disorder

- Possible Consequences of *DSM-5* Changes
  - Increased accuracy in diagnosis
  - Yet since new there is minimal research

Sources: APA (2013b), Leveille (2014)

137

Disinhibited Social Engagement Disorder

- Implications for School Psychologists
  - Preschool:
    - Attention seeking behaviors due to indiscriminant social behaviors
  - Middle Childhood:
    - Verbal and physical overfamiliarity; inauthentic expression of emotions (especially with adults)
  - Adolescents:
    - Indiscriminate behavior and conflicts
  - Neglect begins before age 2 – dev hx is critical!

Source: Leveille (2014)

138

Posttraumatic Stress Disorder

- Definition
  - Exposure
    - Indirect exposure is limited to close relatives, friends, or violent or accidental death (exposure via social networking or death by natural cause does not count)
  - Intrusion symptoms
  - Avoidance of stimuli
  - Negative alterations in cognitions and mood
  - Marked alterations in arousal and reactivity
  - Duration longer than a month
  - Clinical distress
  - Specifier: with dissociative symptoms
    - Depersonalization
    - Derealization

Source: APA (2013b)

139

Posttraumatic Stress Disorder

- Changes from *DSM-IV-TR*
  - Requirement of fear, helplessness or horror immediately following the trauma **removed**
  - Exposure to threatened death, serious injury, or sexual violence can be via learning the traumatic event occurred to a close family member or friend OR repeated exposure to aversive details of traumatic event (e.g., 1st responders, police)
  - 4 symptom clusters
    - Intrusion Sx
    - Avoidance Sx
    - Negative alterations in moods/cognitions
    - Arousal/reactivity Sx
  - PTSD Sx for Children 6 and Younger

Source: APA (2013b)

140

Posttraumatic Stress Disorder

- Rationale for *DSM-5* Changes
  - Better describe the cognitive, emotional, behavioral, and functional implications of PTSD
  - Address the different symptomology with younger children
  - Gives more specific examples to clarify and also make more culturally appropriate

Source: APA (2013b)

141

Posttraumatic Stress Disorder

- Possible Consequences of *DSM-5* Changes
  - Opens the door to attributing one's symptoms to a past event
  - May receive diagnosis where or not symptoms are actually related to event
  - Focuses on reaction to trauma rather than uncovering temperamental vulnerability to stress
    - Oversimplifies that the trauma is the sole or main cause
  - Boundary with normality is blurred
  - Much heterogeneity so makes research challenging

Source: APA (2013b); Paris (2013)

142

Posttraumatic Stress Disorder

- Implications for School Psychologists
  - Still no clear definition of a traumatic event
  - Still using adult criteria for elementary and secondary age students
  - Really should be reserved for those with traumatic memories and avoidance many months after
  - Can provide validation for reactions to adversity/traumatic event
  - Has led to school-based interventions that help minimize PTSD symptomology (e.g., CBITS)
  - For preschoolers has allowed for more age and developmentally sensitive diagnostic criteria
  - Need to be well-informed of proven therapies to help if a referral is needed

Source: Paris (2013)

143

PTSD in Preschool

A. The child (≤6 years old) exposure to actual/threatened death, serious injury, or sexual violation, in one or more of the following ways:
   1. Direct exposure
   2. Witnessing (does not include exposure via electronic media)
   3. Learning that the event(s) occurred (to close relative/close friend)

B. Intrusion Sx associated w/ traumatic event (began after the event), evidenced by 1+ of the following:
   1. Recurrent, involuntary, intrusive distressing memories
      Note: spontaneous/intrusive memories don't necessarily appear distressing, may be expressed as play reenactment
   2. Recurrent distressing dreams
      Note: may not be possible to connect content to the event
   3. Dissociative reactions wherein the child feels/acts as if the event(s) were recurring
      Note: reactions occur on a continuum w/most extreme being complete loss of awareness of surroundings
   3. Intense/prolonged psychological distress with exposure to internal/external cues that symbolize/resemble the event
   4. Marked physiological reactions to reminders

Source: APA (2013b)

144

PTSD in Preschool

One item from C or D below:

C. Persistent avoidance of stimuli associated with the event (began after the event), evidenced by efforts to avoid:
   1. Activities, places or physical reminders, that arouse recollections of the event
   2. People, conversations, or interpersonal situations that arouse recollections of the event

   Negative alterations in cognitions & mood associated with the event (began or worsened after the event), as evidenced by 1+ of the following:
   1. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame or confusion)
   2. Markedly diminished interest/participation in significant activities (e.g., constriction of play)
   3. Socially withdraw
   4. Reduction in expression of positive emotions

Source: APA (2013b)

145

PTSD in Preschool

D. Alterations in arousal/reactivity associated w/ event (began or worsened after the event), as evidenced by 2+ of the following:
   1. Irritable/angry/aggressive behavior (e.g., extreme temper tantrums)
   2. Hypervigilance
   3. Exaggerated startle response
   4. Problems with concentration
   5. Sleep disturbance (e.g., difficulty falling or staying asleep, or restless sleep)

E. Duration (Sx Criteria B, C, D and E) 1+ month

F. Disturbance causes clinically significant distress or impairment in relationships w/ sibs, peers or caregivers, or school behavior

Specifier: with dissociative symptoms: Depersonalization or Derealization

Specify if with delayed expression: full diagnostic criteria not met until 6 months after event (although onset & expression of some Sx may be immediate)

Source: APA (2013b)

146

Posttraumatic Stress Disorder

Alternative Diagnosis	Differential Consideration
PTSD Sx w/out PTSD	Typical PTSD Sx are present, but not at a level to cause clinically significant distress/impairment
Acute Stress Disorder	Sx confined to the first month after trauma exposure
Adjustment Disorder	Reaction to stress. but symptomatic reaction is subthreshold
Other causes of flashbacks	Perceptual distortions come from substance use, head injury, Bipolar or Depressive Disorder, or Psychotic Disorder
Malingering	When stressor is marginal and/or there is financial or other gain from having diagnosis of PTSD

Source: Francis (2013a)

147

Acute Stress Disorder

Definition
- Exposure
  - Indirect exposure is limited to close relatives, friends, or violent or accidental death (exposure via social networking, media, or death by natural cause does not count unless part of your job)
- Intrusion symptoms
- Negative Mood
- Dissociative Symptoms
- Avoidance symptoms
- Arousal symptoms
- Duration: 3 days to one month
- Clinical distress

Source: APA (2013b)

148

Acute Stress Disorder

- Changes from *DSM-IV-TR*
  - Must be explicit if experienced directly, witnessed or experienced indirectly
  - Minimized emphasis on dissociative disorders

Source: APA (2013b)

149

Acute Stress Disorder

- Rationale for *DSM-5* Changes
  - Better describe the cognitive, emotional, behavioral, and functional implications of PTSD
  - Gives more specific examples to clarify and also make more culturally appropriate

150

Acute Stress Disorder

- Possible Consequences of *DSM-5* Changes
  - provided better examples for each of the criteria to clarify

151

Acute Stress Disorder

- Implications for School Psychologists
  - Understand the difference between ASD and PTSD
  - Need to be well-informed of proven therapies to help if a referral is needed
  - Does ASD develop into PTSD?

152

Adjustment Disorders

- Definition
  - Response to an identifiable stressor occurring within 3 months of onset
  - Marked distress out of proportion
  - Significant impairment
  - Specifiers- with:
    - Depressed mood
    - Anxiety
    - Mixed anxiety and depressed
    - Disturbance of conduct
    - Mixed disturbance of emotions and conduct
    - Unspecified

Source: APA (2013b)

153

Adjustment Disorders

- Changes from *DSM-IV-TR*
  - No longer own category, now falls under Trauma and Stressor Related Disorders
  - No substantial changes to criteria
  - Moved to this new section and reconceptualized as heterogeneous stress-response syndromes

Source: APA (2013b)

154

Dissociative Disorders

- Dissociative Identity Disorder
- Dissociative Amnesia
- Depersonalization/Derealization Disorder

Source: APA (2013b)

155

Somatic Symptom and Related Disorders

- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder
- Factitious Disorder

Source: APA (2013b)
NOTE: Dx should be made with caution in individuals whose cultural beliefs sanction such thinking

156

Feeding and Eating Disorders

- Pica*
- Rumination Disorder*
- Avoidant/Restrictive Food Intake Disorder*
- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder*

Source: APA (2013b) NOTE: * = New to this classification

157

Elimination Disorders

- Enuresis
- Encopresis

Source: APA (2013b) NOTE: No significant changes made

158

Sleep-Wake Disorders

- Insomnia Disorder
- Hypersomnolence Disorder
- Narcolepsy
- Breathing-Related Sleep Disorders
- Circadian Rhythm Sleep-Wake Disorders
- Parasomnias

Source: APA (2013b)

159

Sexual Dysfunctions

Overview not necessarily needed for school-age population

160

Gender ~~Disorder~~ Dysphoria

- Gender Dysphoria
  - in Children
  - in Adolescents and Adults

Sources: APA (2013b), Dickey, Fedewa, Hirsch (2014)

161

Disruptive, Impulse-Control, and Conduct Disorders

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorder
- Pyromania
- Kleptomania

Source: APA (2013b)

162

Oppositional Defiant Disorder

Definition

- A persistent pattern of angry and irritable mood along with defiant and vindictive behavior as evidenced by four (or more) of the following symptoms

Angry/Irritable Mood

1. Loses temper
2. Is touchy or easily annoyed by others.
3. Is angry and resentful

Defiant/Headstrong Behavior

4. Argues with adults
5. Actively defies or refuses to comply with adults' request or rules
6. Deliberately annoys people
7. Blames others for his or her mistakes or misbehavior

Vindictiveness

8. Has been spiteful or vindictive at least twice within the past six months

Sources: APA (2013b), Twyford (in press)

163

Oppositional Defiant Disorder

Changes from *DSM-IV-TR*

- Organized symptoms in the criteria for ODD to distinguish emotional and behavioral symptoms.
- 4 Refinements:
  1) Symptoms are now grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness.
  2) Exclusion criterion for conduct disorder has been removed.
  3) Guidance on the frequency typically needed for a behavior to be considered symptomatic of the disorder.
     - For children under 5 years of age, the behavior must occur on most days for a period of at least six months unless otherwise noted
     - For individuals 5 years or older, the behavior must occur at least once per week for at least six months, unless otherwise noted
  4) Severity rating: mild, moderate, severe

Sources: APA (2013b); APA (2012), Twyford (2014)

164

Oppositional Defiant Disorder

Rationale for *DSM-5* Changes

- Better guidance on time frame to distinguish between normal and problem behaviors
- Severity rating: showing that the degree of pervasiveness of symptoms across settings is an important indicator of severity.

Source: Twyford (in press)

165

Oppositional Defiant Disorder

- Possible Consequences of *DSM-5* Changes
  - More descriptive criteria allows clinicians to look more in-depth at emotional and behavioral variable
  - Focus is also on underlying emotional issues, not just externalizing behaviors

Source: Twyford (in press)

166

Oppositional Defiant Disorder

- Implications for School Psychology
  - Possible that a student whose learning is adversely impacted and has ODD symptoms would qualify for special education eligibility criteria under the Emotional Disturbance (ED) category.
  - Additions of frequency guidelines, specifiers, and three facets of symptoms will aid IEP teams to determine special education ED eligibility
  - Organizing ODD symptoms by different facets will assist school psychologists and researchers to clearly identify the appropriate prognosis and probabilities for co-morbid conditions, such as internalizing problems (e.g., depression, anxiety), attention-deficit/hyperactivity disorder (ADHD), substance abuse, and CD.

Source: Twyford (in press)

167

Oppositional Defiant Disorder

Alternative Diagnosis	Differential Consideration
Developmentally normal willfulness	Part of growing up is establishing independence and separate identity
Parent-Child Relational Problem	Not considered a mental disorder
Adjustment Disorder	Defiance is in reaction to a life stressor (e.g. divorce, birth of sibling)
Conduct Disorder	Misbehavior is more severe and pervasive
ADHD	Also has hyperactivity, impulsivity, and/or inattentiveness
Bipolar or Depressive	Irritability arises from clear depressive or manic symptoms
Separation Anxiety Disorder	Opposition is focused on resisting separations

Source: Francis (2013a)

168

Intermittent Explosive Disorder

Alternative Diagnosis	Differential Consideration
Another mental condition	Intermittent Explosive Disorder is only a residual category; it is not meant to be used if the aggressive behavior is an associated feature of any other mental disorder diagnosis
A Neurological Disorder	Refer the patient for evaluation and testing
Simple Criminal Behavior	Unrelated to medical or psychiatric disorder
Purposeful Aggression	Person is motivated by revenge or honor killing
Normal anger of everyday life	Outbursts do not cause clinically significant distress or impairment
Malingering	Person is trying to avoid facing the consequences of his/her actions

Source: Francis (2013a)

169

Conduct Disorder

Definition

- Repetitive and persistent pattern in which basic rights of others or age-appropriate societal norms or rules are violated
- Need 3 of 15 criteria in past 12 months, with at least one in past 6 months
- 4 areas:
  - Aggression to people and animals
  - Destruction or property
  - Deceitfulness or theft
  - Serious violation of rules
- Childhood, Adolescent, or unspecified onset
- Severity: Mild, Moderate or Sever
- Specifier: with limited prosocial emotions
  - lack of remorse or guilt; callous – lack of empathy; unconcerned about performance, shallow or deficient effect

170

Conduct Disorder

CD Specifier: with Limited Prosocial Emotions

1. Meets full criteria for Conduct Disorder.
2. Shows 2 or more of the following characteristics persistently over at least 12 months and in more than multiple relationships and settings.

Lack of Remorse or Guilt: Does not feel bad or guilty when he/she does something wrong (except if expressing remorse when caught and/or facing punishment).

Callous-Lack of Empathy: Disregards and is unconcerned about the feelings of others.

Unconcerned about Performance: Does not show concern about poor/problematic performance at school, work, or in other important activities.

Shallow or Deficient Affect: Does not express feelings or show emotions to others, except in ways that seem shallow or superficial (e.g., emotions are not consistent with actions; can turn emotions "on" or "off" quickly) or when they are used for gain (e.g., to manipulate or intimidate others).

Source: APA (2012)

171

Conduct Disorder

Changes from *DSM-IV-TR*

- Minimal changes
- Prosocial specifier is new – applies to those with more serious pattern of behavior (callous and unemotional)
- Criteria are more descriptive

Source: APA (2013b)

172

Conduct Disorder

Rationale for *DSM-5* Changes

Specifier:

- Allows clinicians to more accurately identify and diagnosis individuals who need more intensive and individualized treatment.
- Attempts to avoid stigmatizing language and focuses on a limited display of prosocial emotions such as empathy and guilt.
- Encourage treatment research to refine what does and does not work for this group of individuals.
- Will impact the research on persons with conduct disorder by designating groups of patients with more similar causal factors

Source: APA (2013c)

173

Conduct Disorder

Implications for School Psychologists

- Clearer criteria
- Time frames allow for better consistency with diagnosis
- Specifiers and severity ratings better reflect behavior on a continuum
- Better reflects underlying emotional issues
- Hopefully will lead to better research and treatment options

174

Conduct Disorder

Alternative Diagnosis	Differential Consideration
No mental disorder	Misbehaviors are not severe & don't cause clinically significant impairment
Adjustment Disorder	Bad conduct doesn't exceed environmental cultural norms or he/she is responding to chaotic/abusive situation
Oppositional Defiant Disorder	Has pattern of defiance to authority, but without severe/pervasive lack of respect for law and others rights
Substance Use Disorders	Misbehaviors occur only in relation to Intoxication/Dependence
ADHD	Causes behavioral scrapes, but not the same magnitude/pervasiveness
Bipolar or Depressive	Misbehavior occurs in the context of clear depressive/manic symptoms
Child or Adolescent Antisocial Behavior	One isolated act of misbehavior, however severe, does not constitute a mental disorder

Source: Francis (2013a)

175

Substance-Related and Addictive Disorders

- Substance Relate Disorders
  - Alcohol-Related Disorders
  - Caffeine-Related Disorders
  - Cannabis-Related Disorders
  - Hallucinogen-Related Disorders
  - Inhalant-Related Disorders
  - Opioid-Related Disorders
  - Sedative-, Hypnotic-, Anxiolytic- Related Disorders
  - Stimulant-Related Disorders
  - Tobacco-Related Disorders
  - Other (or Unknown) Substance-Related Disorders
- Non-Substance-Related Disorders
  - Gambling Disorder

Source: APA (2013b)

176

Neurocognitive Disorders

- Overview not necessarily needed for school-age population
  - Controversy around Mild Neurocognitive Disorder
    - Over dx of dementia like sx
    - May be normal aging
    - Pathologizing typical decline
    - No treatment for this
    - May cause mislabeling and panic

Source: APA (2013b)

177

Personality Disorders

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder

Source: APA (2013b)

178

Paraphilic Disorders

Overview not necessarily needed for school-age population

Source: APA (2013b)

179

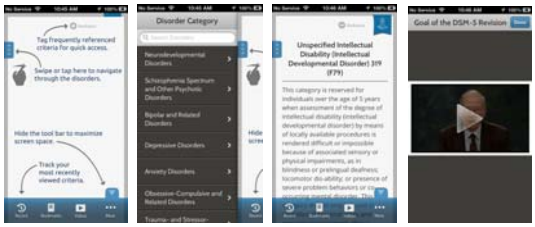
Other Conditions That May Be a Focus of Clinical Attention

- Not mental disorders, just to draw attention to other factors that may be involved
  - Problems Related to Family Upbringing
  - Other Problems Related to Primary Support Group
  - Child Maltreatment and Neglect Problems
  - Child Sexual Abuse
  - Child Neglect
  - Child Psychological Abuse
  - Educational Problems
  - Housing Problems
  - Economic Problems

Source: APA (2013b)

180

DSM-5 Mobile (APA, 2013)



http://www.appi.org/Pages/DSM5Mobile.aspx

181

References

American Psychiatric Association. (1952). *Diagnostic and statistical manual: Mental Disorders.* Washington, DC: Author. Retrieved from http://www.turkpsikiyatri.org/arsiv/dsm-1952.pdf

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed., DSM-II). Washington, DC: Author. Retrieved from http://www.scribd.com/doc/14532307/dsmii

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed., DSM-III). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., Rev., DSM-III-R). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed., DSM-IV). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Rev., DSM-IV-TR). Washington, DC: Author.

American Psychiatric Association. (2012). *DSM-5 overview: The future manual. Retrieved* from http://www.dsm5.org/ABOUT/Pages/DSMVOverview.aspx

American Psychiatric Association. (2013a). *Autism spectrum disorder*. Retrieved from http://www.dsm5.org/Documents/Autism%20Spectrum%20Disorder%20Fact%20Sheet.pdf

American Psychiatric Association. (2013b). *Diagnostic and statistical manual of mental disorders* (5th ed., DSM-5). Washington, DC: Author.

182

References

American Psychiatric Association. (2013c) *Conduct disorder.* Retrieved from http://www.dsm5.org/Documents/Conduct%20Disorder%20Fact%20Sheet.pdf

American Psychiatric Association. (2013d) *Obsessive compulsive disorder.* Retrieved from http://www.dsm5.org/Documents/Obsessive%20Compulsive%20Disorders%20Fact%20Sheet.pdf

American Psychiatric Association. (2013e). Schizophrenia. Retrieved from http://www.dsm5.org/Documents/Schizophrenia%20Fact%20Sheet.pdf

Brock, S. E., & Hart, S. R. (2013, September). DSM-5 and school psychology: Controversy surrounds release of DSM-5. *Communiqué: Newspaper of the National Association of School Psychologists, 42*(1), 1, 30-31. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

Brock, S. E., & Hart, S. R. (2013a, October). 5 and school psychology: Changes to ASD diagnosis. *Communiqué: Newspaper of the National Association of School Psychologists, 42*(2), 1, 34-35. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

Brock, S. E., & Hart, S. R. (2013b, September). Diagnostic inflation. *Communiqué: Newspaper of the National Association of School Psychologists, 42*(2), 1, 35. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

Committee on Statistics of the American Medico-Psychological & Bureau of Statistics, National Committee for Mental Hygiene. (1918). *Statistical manual for the use of institutions for the insane.* New York, NY: Author. Retrieved from http://archive.org/stream/statisticalmanu00assogoog#page/n10/mode/2up

183

References

Dickey, L. M., Fedewa, A., & Hirsch, A. (2014, May). DSM-5 and school Psychology. Diagnostic changes: Gender dysphoria. *Communiqué: Newspaper of the National Association of School Psychologists, 42*(7), 1, 16. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

Douglas, M., & Yates, M. (1981, October) New York State census records, 1790-1925: Bibliography Bulletin 88. Albany, NY: The University of the State of New York, The State Education Department. Retrieved from http://128.121.13.244/awweb/main.jsp?flag=browse&smd=1&awdid=1

Francis, A. (2013a). *Essentials of psychiatric diagnosis: Responding to the challenge of DSM-5.* New York, NY: Guilford Press.

Francis, A. (2013b). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma, and the medicalization of ordinary life*. New York, NU: HarperCollins.

Frances, A. (2013, May 17). The new crisis in confidence in psychiatric diagnosis. *Annals of Internal Medicine* Advance online publication. doi:10.7326/0003-4819-159-3-201308060-00655

Gibbons, E. (2013, November). DSM-5 and school psychology: Changes toDSM-5 ADHD diagnosis. *Communiqué: Newspaper of the National Association of School Psychologists, 42*(3), 1, 30-31. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

Greenberg, G. (2010, December 27). Inside the battle to define mental illness. *Wired Magazine.* Retrieved from http://www.wired.com/magazine/2010/12/ff_dsmv/

Gibbons, E., & Hart, S. R. (in preparation). DSM-5 and school psychology: Disruptive mood dysregulation disorder. *Communiqué: Newspaper of the National Association of School Psychologists.*

184

References

Gubi, A. A., McDonnel, C., & Bocanegra, J. O. (2014, December). DSM-5 and school Psychology: Changes to DSM-5 Schizophrenia diagnosis. *Communiqué: Newspaper of the National Association of School Psychologists, 43*(4), 1, 23. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

Hart, S. R. (2014, September). DSM-5 and school Psychology: Disruptive mood dysregulation disorder. *Communiqué: Newspaper of the National Association of School Psychologists, 43*(1), 1, 20-22. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

Hart, S. R., Pate, C. M., & Brock, S. E. (Ed.). (2013, January/February). Meet the new (and improved?) DSM-5. *Communiqué: Newspaper of the National Association of School Psychologists, 41*(5), 1, 15. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

Kraynak, A. R., & Hart, S. R. (2014, March/April). DSM-5 and school Psychology: Changes to intellectual disability diagnosis. *Communiqué: Newspaper of the National Association of School Psychologists, 42*(6), 12-13. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

Kulage, K. M., Smaldone, A. M., & Cohn, E. G. (2014). How will DSM-5 affect autism diagnosis? A systematic literature review and meta-analysis. *Journal Of Autism And Developmental Disorders*, *44*(8), 1918-1932. doi:10.1007/s10803-014-2065-2

Leveille, M., A. R. (2014, June). DSM-5 and school Psychology: Reactive attachment disorder and disinhibited social engagement disorder. *Communiqué: Newspaper of the National Association of School Psychologists, 42*(8), 1, 21, 23. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

185

References

Morera, C. C. (2014, January/February). DSM-5 and school Psychology: Changes to DSM-5 anxiety disorder diagnosis. *Communiqué: Newspaper of the National Association of School Psychologists, 42*(5), 1, 14-15. Retrieved from http://www.nasponline.org/publications/cq/index-list.aspx

National Conference on Nomenclature of Disease, & Logie, H. B. (1938). *Standard classified nomenclature of disease.* Chicago, IL: American Medical Association. Retrieved from http://babel.hathitrust.org/cgi/pt?id=uc1.b3958532;view=1up;seq=7

Paris, J. (2013). *The intelligent clinician's guide to the DSM -5.* New York: NY: Oxford University Press.

Tsai, L. Y. (2014). Impact of DSM-5 on epidemiology of autism spectrum disorder. *Research In Autism Spectrum Disorders*, *8*(11), 1454-1470. doi:10.1016/j.rasd.2014.07.016

Twyford, J. M. (in press). DSM-5 and school Psychology: Oppositional defiant disorder. *Communiqué: Newspaper of the National Association of School Psychologists.*

Wines, F. H. (1888). *Report on the defective, dependent, and delinquent classes of the population of the United Sates, as returned at the tenth census (June 1, 1800).* Washington, DC: Government Printing Office. Retrieved from http://www2.census.gov/prod2/decennial/documents/1880a_v21-01.pdf

186

What School Psychologists Need to Know about DSM-5

Stephen E. Brock, PhD, NCSP
&
Melissa Holland, PhD, NCSP
California State University, Sacramento