

DSM-5 - Overview and Substance Abuse

Table of Contents

Introduction	2
Changes in the DSM-5.....	2
Changes in Organizational Structure.....	2
Changes in Terminology	3
Change in Title.....	3
Organization of the Manual.....	3
Section 1: DSM-5 Basics	3
Section II: Diagnostic Criteria and Codes	4
Section III: Emerging Measures and Models.....	4
Assessment Measures.....	4
Cultural Formulation	5
Appendix	7
Coding of Disorders.....	7
Diagnostic Recording Procedures	7
Coding Differences between a Multiaxial System and a Nonaxial System.....	8
Changes in Disorders.....	9
Substance Use Disorders	11
Diagnostic Criteria	12
Major Changes in the Substance Related Disorders Chapter.....	14
Items that have been changed.....	14
Items that have been eliminated from the DSM-5.....	14
Items that have been added	15
Non-Substance Related [Addictive] Disorders.....	15
An example of how to diagnose including using the new assessments / measures.....	16
APA provides these Instructions to Clinicians.....	17
Scoring and Interpretation	17
Suggested Steps in Writing a Diagnosis	18
Culture and DSM-5	18
Conclusion.....	19
References	20

Introduction

The American Psychiatric Association (APA) developed the original Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952 to create a uniform way to define mental health disorders. The DSM publications have been the industry standard for clinicians, researchers, and insurance companies, since the first version was originally published in the early 1950s. The latest edition, the DSM-5 was published in 2013.

The purpose of the DSM is to provide the criteria for the diagnosis and treatment of mental disorders and it is used by mental health and healthcare professionals throughout the world. In addition, DSM criteria are utilized for billing purposes by major insurance companies in the US. Lastly, since treatment planning stems from diagnosis, the impact of the DSM manual is quite significant. The manual does not include guidelines for the treatment of identified disorders (Kraemer, 2007).

Despite the fact that the DSM is the standard for the diagnosis of mental disorders, each revision has had criticism (Kawa & Giordano, 2012). The publication of the DSM-5 was more controversial than other revisions, and quite a bit was written about it even before the manual was published. Concern regarding proposed changes to specific disorders, along with the inclusion of others which were not previously classified as mental disorders, led to numerous appeals to the APA to consider the impact the revisions would have in the field (Wakefield, 2013). Although clinicians may disagree about the utility of the DSM, any clinician who wishes to be licensed, whether in psychology, social work, counseling or other behavioral health professions, will have to master the manual.

Changes in the DSM-5

Changes in Organizational Structure

The DSM-5 has been restructured and reorganized in an effort to better reflect the interrelationships, within and across diagnostic categories. This was done because the DSM-IV's organizational structure failed to reflect shared features or symptoms of related disorders and diagnostic groups (like psychotic disorders with bipolar disorders, or internalizing (depressive, anxiety, somatic) and externalizing (impulse control, conduct, substance use) disorders.

The DSM-5's chapter structure, criteria revisions, and text outline now actively address age and development as part of diagnosis and classification. In addition, culture is similarly discussed more explicitly to bring greater attention to cultural variations in symptom presentations. These changes were made because the DSM-IV did not adequately address the lifespan perspective, including variations of symptom presentations across the developmental trajectory, or cultural perspectives. Current

consensus in the field is that both the lifespan and cultural perspectives are viewed as having a significant impact in the presentation of symptoms and diagnosis of mental illness.

Changes in Terminology

The DSM-5 includes a few changes in terminology as well. One of the most commonly used terms which is no longer in use is *Not Otherwise Specified (NOS)*, which has been used as a catch-all for clients who didn't fit into the more specific categories. NOS is eliminated in DSM-5. Instead, there the designation *Not Elsewhere Classified (NEC)* may be used. It will typically include a list of specifiers as to why the client's clinical condition doesn't meet a more specific disorder. Lastly, the phrase "*general medical condition*" is replaced in DSM-5 with "*another medical condition*" where relevant across all disorders.

Change in Title

In previous versions of the DSM, a roman numeral was used to indicate the edition. However, this version uses a standard number 5 to indicate the edition. This change was instituted so that future versions of the same edition will include a version number after the decimal point, much like the updates in operating software for cellular phones and computer systems. Under this system, the next revision of the DSM will be DSM 5.1 (APA, 2013⁴).

Organization of the Manual

The structure of the DSM-5 manual is significantly different than that of the DSM –IV-TR. The DSM-5 is organized into the following sections, a detailed discussion for each follows:

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

Section 1: DSM-5 Basics

The first section of the DSM-5 provides information on the basics of the DSM and instructions for how to use the manual. The APA also included a cautionary statement about the use of the DSM-5 for forensic purposes. Previous editions of the DSM did not include a section with instructions for use or cautions for forensic use of the manual

(APA, 2013²). The APA also stresses that the symptoms included in the manual are not comprehensive definitions of underlying disorders, but rather they summarize characteristic syndromes of signs and syndromes that indicate an underlying disorder (APA, 2013).

Section II: Diagnostic Criteria and Codes

The second section of the DSM-5 provides the descriptions and criteria for each of the diagnosable disorders. This section also provides coding information. Section II contains the diagnostic criteria approved for routine clinical use along with the ICD-9-CM codes (ICD-10 codes are shown parenthetically). For each mental disorder, the diagnostic criteria are followed by descriptive text to assist in diagnostic decision making. In some diagnostic categories specific recording procedures are presented with the diagnostic criteria to provide guidance in selecting the most appropriate code. In some cases, separate recording procedures for ICD-9-CM and ICD-10-CM are provided

Section III: Emerging Measures and Models

This is a new section in the DSM-5. This section provides information on types of assessments available as well as potential future revisions and conditions for further study (APA, 2013⁶). This section contains tools to improve the clinical decision making process, explore the cultural context of mental disorders. It also contains tools to gather information for emerging diagnoses for further study. It provides strategies to enhance clinical practice and new criteria to stimulate future research, representing a dynamic version of the DSM that is intended to evolve with advances in the field.

The tools in this section include:

- [Level 1 Cross-Cutting Symptom Measures](#)
- [Level 2 Cross-Cutting Symptom Measures](#)
- [Disorder-Specific Severity Measures](#)
- [Disability Measures](#)
- [Personality Inventories](#)
- [Early Development and Home Background](#)
- [Cultural Formulation Interviews](#)

Assessment Measures

Cross-cutting symptom measures are to be used in a comprehensive mental status assessment by drawing attention to symptoms that are important across diagnoses. They are designed to identify areas of inquiry that may guide

treatment and prognosis. Cross-cutting assessments focus on areas of functioning likely to “cut across” diagnostic boundaries (e.g., mood, anxiety, cognitive status, sleep, psychotic symptoms, and suicidal ideation) which may be of clinical relevance. All of these assessments are intended to provide a more dimensional approach to the diagnosis of mental disorders. The assessment measures enable practitioners to better identify and diagnose different aspects of mental disorders, including the level of severity, symptom intensity and type and duration of the symptoms.

Cross Cutting symptom measures provide two levels for diagnosis: Level I and Level II. The first level provides a general assessment and includes 13 symptom domains for adult patients and 12 domains for children. The use of Level 1 measures in intake ensures a comprehensive assessment. The second level is a more in-depth assessment of the domains. The Cross Cutting symptom measures are intended for use during an initial screening as well as throughout the duration of treatment.

The severity measures are disorder-specific, and the questions parallel the criteria that constitute the disorder. Some of the assessments are self-completed, whereas others require a clinician to complete.

The World Health Organization Disability Assessment Schedule, Version 2.0 (WHODAS 2.0) assesses a patient’s ability to perform activities in six areas of functioning and daily living and is informant-administered.

The Personality Inventories for DSM-5 measure maladaptive personality traits in five domains. There are brief forms (25 items) for adults and children ages 11 and older as well as full versions with 220 items.

The DSM-5 website provides electronic links to all of the assessment forms that are used during patient diagnosis and treatment. The forms can be accessed at the following website:

<http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>

Cultural Formulation

The addition of this section to the DSM-5 is an important revision that will enable practitioners to better assess and address cultural issues related to patient diagnosis and care (APA, 2013 ⁶). In the DSM-5, Cultural Formulation is included in the section entitled *Emerging Measures and Models* and includes descriptive information as well as

the Cultural Formulation Interview (CFI), which is a sixteen question tool that is administered during a patient's initial visit (APA, 2013).

This section continues with an Outline for Cultural Formulation. This outline provides guidelines for the assessment of cultural features related to a patient's mental disorder. The Outline for Cultural Formulation is broken into the following categories:

- Cultural Identity of the Individual
- Cultural conceptualization of distress
- Psychosocial stressors and cultural features of vulnerability and resilience
- Cultural features of the relationship between the individual and the clinician
- Overall cultural assessment (APA, 2013)

The Cultural Formulation Interview (CFI) is a sixteen item questionnaire that is practitioner administered. Many of the questions can be found in typical intake forms. Clinical supervisors and administrators should consider reviewing the CFI to ensure that their agency current intake includes all of the items in the questionnaire. The CFI is client-centered and relies on the client's perspective to assess the cultural factors that influence their participation in care (APA, 2013²).

The CFI also has Supplemental Modules that can be found at the following website:

<http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level1>

The final component of the Cultural Formulation section focuses on cultural concepts of distress. According to the APA, cultural concepts of distress "refers to ways that cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions (APA, 2013).

There are three main types of cultural concepts:

- Cultural syndromes
- Cultural idioms of distress
- Cultural explanations or perceived causes

There is widely held consensus in the field that culturally sensitive practice is essential for effective and ethical treatment. As a result, it is critical that culture is included in the assessment, diagnosis and treatment planning of all clients with mental health issues.

Appendix

The appendix, the final section of the DSM-5, includes important information for the reader and serves as a reference for information that clinicians are likely to need. The appendix is broken down into the following sections:

- Highlights of Changes from DSM-IV to DSM-5
- Glossary of Technical Terms
- Glossary of Cultural Concepts of Distress
- Alphabetical Listing of DSM Diagnoses and Codes (ICD-9-CM and ICD-10-CM)
- Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)
- Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM)
- DSM-5 Advisors and Other Contributors (APA, 2013)

Coding of Disorders

The coding system used in the DSM-5 is consistent with the current ICD-9. All new and revised DSM 5 diagnoses had to be mapped to an existing ICD 9 code. As a result, some disorders must share codes for recording and billing purposes. Because there may be several disorders associated with a DSM 5/ICD 9 code, the DSM-5 diagnosis description should always be recorded by name in the medical record in addition to listing the code.

Diagnostic Recording Procedures

One of the most significant changes in the DSM-5 system of categorization is the shift from a multiaxial coding system to a documentation system that does not use the Axis codes. The multiaxial system, which was utilized in previous editions of the manual, included Axis I, II, and III, IV and V.

In the DSM-5, Axis I, II and III have been combined into one category that contains all mental and other medical diagnoses. Doing so removes artificial distinctions among conditions, benefitting both clinical practice and research use.

The DSM-5 also includes separate psychosocial and contextual factors as well as disability factors. These were axis IV and V in previous versions (APA, 2013). With the new assessment system, clinicians will still take note of the same mental, physical, and social considerations as under the multiaxial system to provide comprehensive assessments. These components are just documented differently.

The purpose is to have precise measures that confirm the appropriate identification and diagnosis of mental disorders. In addition, the fourth axis, which described contributing stressors, is now represented through an expanded selected set of ICD-9-CM V codes (and from the forthcoming ICD-10-CM, Z codes). These V and Z codes provide ways for clinicians to indicate other conditions or problems that may be a focus of clinical attention or otherwise affect the diagnosis or treatment of a mental disorder.

Finally, DSM-IV's fifth axis, the GAF, which provided an assessment of functioning scale, was removed from DSM-5. Instead, the World Health Organization's Disability Assessment Schedule, in which disorders and their associated disabilities are conceptually distinct and assessed separately, is recommended as the best current alternative as a global measure of disability. This measure is based on an international classification of functioning and disability that is currently used throughout the rest of medicine, thereby bringing DSM-5 into greater alignment with other medical disciplines. The DSM-5 provides the instrument in Section 3, Assessment Measures, as a free download from the APA website,

<http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>

Coding Differences between a Multiaxial System and a Nonaxial System

Multiaxial	Nonaxial
Example 1: Axis I 304.00 Opioid Dependency Axis II 301.6 Dependent Personality Disorder Frequent use of denial Axis III None Axis IV Threat of job loss Axis V GAF = 35 (current)	Example 1: 304.00 (F11.20) Severe Opioid Use Disorder 301.6 Dependent Personality Disorder

Changes in Disorders

The DSM-5 includes numerous changes to specific disorders. An annotated list of some of the changes is provided. Please note that not all of the changes are included here – only those most relevant to substance abuse are listed:

Bipolar and Related Disorders

- *Hypomanic Episode*
 - *Criterion A revised to include increased energy/activity as a core symptom*
- *Manic Episode*
 - *Criterion A revised to include increased energy/activity as a core symptom*

Depressive Disorders

- *Mixed Anxiety/Depression*
 - *proposed for Section III, a section in DSM-5 in which conditions that require further research will be included*
- *Major Depressive Episode*
 - *removal of the bereavement exclusion*
 - *added a footnote to clarify for clinicians how to differentiate bereavement and other loss reactions from Major Depression*
- *Disruptive Mood Dysregulation Disorder*
 - *additional information provided to assist in differentiation from Oppositional Defiant Disorder.*

Anxiety Disorders

- *Adjustment Disorder*
 - *addition of a 6-month requirement for children for the bereavement related subtype*
- *Specific Phobia*
 - *duration criterion changed (from “The duration is at least 6 months” to “The fear, anxiety, or avoidance is persistent, typically lasting 6 or more months”) and minor wording changes*
- *Social Anxiety Disorder (Social Phobia)*
 - *duration criterion changed (from “The duration is at least 6 months” to “The fear, anxiety, or avoidance is persistent, typically lasting 6 or more months”) and minor wording changes*
- *Generalized Anxiety Disorder*
 - *the number of associated physical symptoms has been reduced from six to two;*
- *Panic Attack*
 - *minor wording changes*

- *Panic Disorder*
 - *wording changes*
- *Agoraphobia*
 - *duration criterion changed (from “The duration is at least 6 months” to “The fear, anxiety, or avoidance is persistent, typically lasting 6 or more months”)*
- *Separation Anxiety Disorder*
 - *duration criterion changed (from “The duration is at least 6 months” to “The fear, anxiety, or avoidance is persistent, typically lasting 6 or more months”)*
 - *age of onset requirement has been dropped; and minor wording changes*
- *Addition of criteria for Substance-Induced Anxiety Disorder*
- *Addition of criteria for Anxiety Disorder Attributable to Another Medical Condition*
- *Addition of criteria for Anxiety Disorder Not Elsewhere Classified*

Trauma and Stressor Related Disorders

- *Posttraumatic Stress Disorder - wording changes (e.g., adding “directly” in criterion A1); PTSD in preschool children proposed as a subtype of PTSD instead of a separate diagnosis; and proposal of a dissociative symptoms subtype*
- *Acute Stress Disorder - minor wording changes*
- *Addition of criteria for Persistent Complex Bereavement Disorder - this is being proposed for Section III, a section of DSM-5 in which conditions that require further research will be included*
- *Addition of criteria for Trauma- or Stressor- Related Disorder Not Elsewhere Classified*

Substance Use and Addictive Disorders see section [7] for detailed discussion

Personality Disorders

- *Addition of more extensive rationale for proposed changes in the diagnosis and classification of Personality Disorders*
- *Minor wording changes to all diagnostic criteria*

Substance Use Disorders

From the DSM-5:

“The essential feature of substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.”

There are 3 Basic Substance-Related Categories

1. **Substance use disorder.** The user has taken a substance frequently enough to produce clinically significant distress and/or impaired functioning
2. **Substance intoxication.** This is an acute condition resulting from a recent overuse of a substance.
3. **Substance withdrawal.** The user experiences a collection of symptoms which occur when the user has frequently used a substance discontinues or markedly reduces the amount used.

Nearly all substances are diagnosed based on the same overarching criteria. In this overarching categorization of substance abuse disorders, the criteria have not only been combined, but strengthened. Whereas a diagnosis of substance abuse previously required only one symptom, mild substance use disorder in DSM-5 requires two to three symptoms from a list of eleven. Drug craving has been added to the list, and problems with law enforcement have been eliminated due to cultural considerations that make the criteria difficult to apply internationally.

The DSM-5 uses ten groupings of individual disorders. The ten specific disorders are:

1. Alcohol
2. Caffeine
3. Cannabis
4. Hallucinogen Related Disorders
5. Inhalant Related Disorders
6. Opioid Related Disorders
7. Sedative, Hypnotic, or Anxiolytic Disorders
8. Stimulant Related Disorders
9. Tobacco Related Disorders
10. Other (or Unknown) Substance Related Disorders

Generally speaking, the substance related categories are the same for the majority of the categories. An example is Opioid Related Disorders:

- Opioid Related Disorders:
 - Opioid use disorder
 - Opioid intoxication

- Opioid withdrawal
- Unspecified opioid related disorder

Diagnostic Criteria

The essential features are the same for the majority of the categories.

A problematic pattern of opioid ***[any substance category could be substituted here]*** use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of an opioid.
Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
11. Withdrawal, as manifested by either of the following:
 - a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).
 - b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

A Comparison Between DSM-IV and DSM-5

DSM-IV		DSM-5		
Any 1 = ALCOHOL ABUSE	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household).	1	Alcohol is often taken in larger amounts or over a longer period than was intended. (See DSM-IV, criterion 7.)	
	Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol abuse).	2	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. (See DSM-IV, criterion 8.)	
	Recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct). **This is not included in DSM-5**	3	A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. (See DSM-IV, criterion 9.)	
	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about the consequences of intoxication, physical fights).	4	Craving, or a strong desire or urge to use alcohol. **This is new to DSM-5**	
Any 3 = ALCOHOL DEPENDENCE	Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect b) Markedly diminished effect with continued use of the same amount of alcohol	5	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. (See DSM-IV, criterion 1.)	
	Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol b) Alcohol is taken to relieve or avoid withdrawal symptoms	6	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. (See DSM-IV, criterion 4.)	
	Alcohol is often taken in larger amounts or over a longer period than was intended.	7	Important social, occupational, or recreational activities are given up or reduced because of alcohol use. (See DSM-IV, criterion 10.)	
	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.	8	Recurrent alcohol use in situations in which it is physically hazardous. (See DSM-IV, criterion 2.)	
	A great deal of time is spent in activities necessary to obtain alcohol (e.g., driving long distances), use alcohol, or recover from its effects.	9	Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol. (See DSM-IV, criterion 11.)	
	Important social, occupational, or recreational activities are given up or reduced because of alcohol use.	10	Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect b) A markedly diminished effect with continued use of the same amount of alcohol (See DSM-IV, criterion 5.)	
	Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).	11	Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal) b) Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms. (See DSM-IV, criterion 8.)	
				The presence of at least 2 of these symptoms indicates an Alcohol Use Disorder (AUD) .
				The severity of the AUD is defined as: Mild: The presence of 2 to 3 symptoms
				Moderate: The presence of 4 to 5 symptoms
				Severe: The presence of 6 or more symptoms



Major Changes in the Substance Related Disorders Chapter

The most significant change to substance use disorder is the diagnoses of substance abuse and dependence have been eliminated. The current view is that substance use exists in a continuum, from mild to severe. In addition, the threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria. The criteria are very similar to those outlined in DSM-IV for abuse and dependence combined. The diagnosis has subtypes that occur with a range of severity from mild to moderate to severe. The severity of the subtype is based on the number of symptoms presented.

- **Mild** is suggested by the presence of two to three symptoms
- **Moderate** is suggested by the presence of four to five symptoms.
- **Severe** is suggested by the presence of six or more symptoms.

In addition, criteria are provided for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant.

Another significant change is the reclassification of some substance disorders, for example Amphetamine and Cocaine Disorders are now reclassified into Stimulant Disorders.

Items that have been changed

- Amphetamine and Cocaine Disorders are now reclassified into Stimulant Disorders
- Sedative/Hypnotic-Related Disorders renamed from Sedative, Hypnotic, or Anxiolytic Disorders
- Chapter order and numbering designations have been reorganized according to substance, previously they were organized according to the diagnosis i.e., intoxication, and withdrawal
- Hallucinogen Disorders now include Phencyclidine (PCP) Disorders

Items that have been eliminated from the DSM-5

- The DSM-IV recurrent legal problems criterion for substance abuse is no longer valid
- The DSM-IV specifier for a physiological subtype has been eliminated
- The DSM-IV diagnosis of polysubstance dependence
- Substance-Induced Dissociative Disorder

Items that have been added

- Craving or a strong desire or urge to use a substance is now one of the 11 criteria that can be used to diagnose
- Cannabis withdrawal is new
- Caffeine withdrawal
- All the criteria for DSM-5 tobacco use disorder are the same as those for other substance use disorders
- Early remission is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and . . .
- Sustained remission is defined as at least 12 months without criteria (except craving). Additional new DSM-5 specifiers include “in a controlled environment” and “on maintenance therapy” as the situation warrants
- New criteria for Hallucinogen Persisting Perception Disorder
- Criteria for Caffeine Use Disorder – is now proposed in Section III, a section of DSM-5 in which conditions that require further research will be included.
- Criteria for Internet Use Disorder – is now proposed in Section III, a section of DSM-5 in which conditions that require further research will be included
- Criteria for Drug Specific "Not Elsewhere Classified" diagnoses

Non-Substance Related [Addictive] Disorders

The chapter also includes gambling disorder as the sole condition in a new category on behavioral addictions. DSM-IV listed pathological gambling but in a different chapter. This new term and its location in the new manual reflect research findings that gambling disorder is similar to substance-related disorders in clinical expression, brain origin, comorbidity, physiology, and treatment.

Recognition of these commonalities will help people with gambling disorder get the treatment and services they need, and others may better understand the challenges that individuals face in overcoming this disorder.

While gambling disorder is the only addictive disorder included in DSM-5 as a diagnosable condition, Internet gaming disorder has been included in Section III of the manual. (Disorders listed there require further research before their consideration as formal disorders.) This condition is included to reflect the scientific literature on persistent and recurrent use of Internet games, and a preoccupation with them, can result in clinically significant impairment or distress. The condition’s criteria do not include general use of the Internet, gambling, or social media at this time.

An example of how to diagnose including using the new assessments / measures

Much like the checklist that pilots use before takeoff, the additional assessments have been designed so that clinicians review the problems a client may be experiencing without forgetting an important area. The assessment is designed to help clinicians identify psychiatric symptoms that may need to be addressed in treatment.

The American Psychiatric Associations (APA) offers a number of “emerging measures” for further research and clinical evaluation. These patient assessment measures were developed to be administered at the initial patient interview and to monitor treatment progress. They should be used in evaluation (and research) as potentially useful tools to enhance clinical decision-making. They are not to be used as the sole basis for making a clinical diagnosis. The assessment tools are used in a similar fashion. To illustrate how to use them, let’s examine the Level 1 Cross-Cutting Symptom Measures (see hyperlink to measures below for complete measure).

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	

[Level 1 Cross-Cutting Symptom Measures](#)

APA provides these Instructions to Clinicians

The DSM-5 Level 1 Cross-Cutting Symptom Measure is a self- or informant-rated measure that assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the individual's treatment and prognosis. In addition, the measure may be used to track changes in the individual's symptom presentation over time.

This adult version of the measure consists of 23 questions that assess 13 psychiatric domains, including:

1. Depression
2. Anger
3. Mania
4. Anxiety
5. Somatic Symptoms
6. Suicidal Ideation
7. Psychosis
8. Sleep Problems
9. Memory
10. Repetitive Thoughts And Behaviors
11. Dissociation
12. Personality Functioning
13. Substance Use.

Each of the psychiatric domains have one to three questions in the measuring tool. Each item inquires about how much (or how often) the individual has been bothered by the specific symptom during the past 2 weeks. If the individual is of impaired capacity and unable to complete the form (e.g., an individual with dementia), a knowledgeable adult informant may complete the measure. The measure was found to be clinically useful and to have good test-retest reliability in the DSM-5 Field Trials that were conducted in adult clinical samples across the United States and in Canada.

Scoring and Interpretation

Each item on the measure is rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day). The score on each item within a domain should be reviewed. Because additional inquiry is based on the highest score on any item within a domain, the clinician is asked to indicate that score in the "Highest Domain Score" column. A rating of mild (i.e., 2) or greater on any item within a domain (except for substance use, suicidal ideation, and psychosis) may serve as a guide for additional inquiry and follow up to determine if a more detailed assessment for that domain is necessary. For substance use, suicidal ideation, and psychosis, a rating of slight (i.e., 1)

or greater on any item within the domain may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment is needed. The DSM-5 Level 2 Cross-Cutting Symptom Measures may be used to provide more detailed information on the symptoms associated with some of the Level 1 domains (see Table 1 below).

Suggested Steps in Writing a Diagnosis

1. Complete the information gathering via the Bio-Psycho-Social Assessment
2. Have the client complete the Level 1 Cross-Cutting Measure (Assist as needed)
3. Score the Level 1 Cross-Cutting Measure
4. If needed, have the client complete any Level 2 Cross-Cutting Measures that apply
5. Locate in the DSM-5 the disorder that meets criteria for the symptoms presented
6. Write out the name of the disorder:
 - a. Ex.: Posttraumatic Stress Disorder
7. Now add any subtype or specifiers that fit the presentation:
 - a. Ex.: Posttraumatic Stress Disorder, with dissociative symptoms, with delayed expression
8. Add the code number (located either at the top of the criteria set or within the subtypes or specifiers):
 - a. Two code numbers are listed, one in **bold** (ICD-9) and one in parentheses (ICD- 10), Example, **309.81** (F43.10) DSM 5 Criteria Sets\PTSD.docx or...
 - b. **309.81** (F43.10) Posttraumatic Stress Disorder, with dissociative symptoms, with delayed expression
9. Order of multiple diagnoses: The focus of treatment or reason for visit is listed first (principal diagnosis), followed by the other diagnoses in descending order of clinical importance

Culture and DSM-5

The previous edition of the DSM, the DSM-IV-TR included a section on the role of culture in diagnosing mental illness. This section was part of the appendix and included a Glossary of Cultural Bound Syndromes and an Outline of Cultural Formulation (APA, 2013 ⁵). While the appendix provided a means for understanding cultural implications in mental disorders, it did not align well with many of the DSM disorders (APA, 2013 ⁶). It also did not emphasize the role of culture in mental illness or how it may impact diagnosis.

In the DSM-5, Cultural Formulation is included in the section entitled *Emerging Measures and Models*. This section includes descriptive information and the Cultural Formulation Interview (CFI), a sixteen-question tool that is administered during the client's initial visit (APA, 2013).

Conclusion

The DSM-5 revision process took over a decade and culminated with the release of a comprehensive manual that is intended to be used to properly identify and diagnose mental disorders. The APA utilized task forces and work groups comprised of experts in the field and relied on current scientific knowledge and research findings to develop the diagnostic criteria for mental disorders. The result is a manual that is comprised of numerous new mental disorders, as well as many others that have been changed drastically. In addition, the manual features an expanded section focused on cultural awareness and assessment, as well as information regarding disorders that are still undergoing research.

The intent is for the DSM-5 to serve as the standard guidebook for mental health professionals to use in the identification and diagnosis of mental disorders. However, the revision process and the changes that have been made to the manual have created both controversy and divisions within the field of behavioral health. Critics of the DSM-5 manual take the position that it was not developed using best practices in research or empirical evidence. They have also pointed out that the manual contains disorders that are not truly mental disorders, thereby increasing the number of mentally and emotionally normal or healthy people who will be diagnosed with a mental disorder. The criticism against the DSM-5 extends beyond professionals in the field to advocates for the mentally ill, including families and individuals with mental disorders. Their concerns center around how the changes made to the manual will impact those with mental illness with regards to treatment options and insurance coverage.

The DSM has served as the standard guide for mental health diagnosis for several decades, however, there is currently less of a consensus on the utility and accuracy of the system of diagnosis and criteria. In fact, the National Institute on Mental Health has publicly stated that they will begin developing a new standard for the diagnosis of mental disorders rather than rely on the DSM-5. Therefore, the future of the DSM is not currently known.

References

- (1) American Psychiatric Association; 2013. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. DSM-5. Washington, DC:
 - (2) American Psychiatric Association. DSM-5 Overview: the future manual. Last Accessed July 18, 2013. <http://www.dsm5.org/about/pages/dsmvoverview.aspx>(2)
 - (3) American Psychiatric Association. (2013). Professional News: Insurance Implications of DSM-5. May 03, 2013.
 - (4) American Psychiatric Association. (2013). DSM-5 Development: Frequently Asked Questions. Last Accessed June 20, 2013. <http://www.dsm5.org/about/pages/faq.aspx>
 - (5) American Psychiatric Association (2013) American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. DSM-IV. Washington, DC; 1994.
 - (6) American Psychiatric Association. (2013). DSM-5 Development: Recent Updates to Proposed Revisions for DSM-5. Last Accessed June 15, 2013. <http://www.dsm5.org/Pages/RecentUpdates.aspx>
 - (7) American Psychiatric Association. (2013). Major Depressive Disorder and the “Bereavement Exclusion” Fact Sheet. Last Accessed June 16, 2013. <http://www.dsm5.org/Documents/Bereavement%20Exclusion%20Fact%20Sheet.pdf>
- Bradley D. The Proposed DSM-5: Alterations and Altercations. Last Accessed June 14, 2013. http://www.nami.org/Template.cfm?Section=Top_Story&template=/ContentManagement/ContentDisplay.cfm&ContentID=143362
- Diagnostic and Statistical Manual of Mental Disorders: Nature and Purposes. Encyclopedia of Mental Disorders. Last Accessed June 12, 2013. <http://www.minddisorders.com/Del-Fi/Diagnostic-and-Statistical-Manual-of-Mental-Disorders.html#b>
- Fox J, Jones KD. (2013). DSM-5 and Bereavement: The Loss of Normal Grief? Journal of Counseling & Development; 91: 113–119
- Frances A. A (2009). Warning Sign on the Road to DSM-V: Beware of Its Unintended Consequences. Psychiatric Times. 26:1,4.
- Friedman RA. (2012). Grief, Depression, and the DSM-5. New England Journal of Medicine; 366:1855-1857

Halter MJ, Rolin-Kenny D, Dzurec LC. (2013). An overview of the DSM-5: changes, controversy, and implications for psychiatric nursing. *Journal of Psychosocial Nursing in Mental Health Services*. Apr;51(4):30-9.

Jones DK. (2012). The Risk That DSM-5 Will Reduce the Credibility of Psychiatric Diagnosis. *Curr Psy Rev*; 8(4): 277-280

Kawa S and Giordano J. A (2012). brief historicity of the Diagnostic and Statistical Manual of Mental Disorders: Issues and implications for the future of psychiatric canon and practice. *Phil Eth and Hum in Med* ; 7:2

Kraemer HC (2007). DSM categories and dimensions in clinical and research contexts. *International Journal of Method in Psychiatric Research*; 16(suppl 1):S8–S15

Parker, G. Opening Pandora's box: how DSM-5 is coming to grief. *Acta Psychiatrica Scandinavica*; 128: 88–91.

Phoenix BJ, Tierney MJ. Bethany J. (2012). A Nursing Diagnostic Perspective on Proposed Criteria for Substance Use Disorders: What the DSM-5 is Leaving Out. *Issues in Mental Health Nursing* ; 33(9):613-617

Wakefield JC. DSM-5: An Overview of Changes and Controversies. (2013). *Clinical Social Work Journal*; 41(2):139-154

Zisook, S., Corruble, E., Duan, N., Iglewicz, A., Karam, E. G., Lanuette, N., Lebowitz, B., Pies, R., Reynolds, C., Seay, K., Katherine Shear, M., Simon, N. and Young, I. T. (2012), The Bereavement Exclusion And DSM-5. *Depression and Anxiety*, 29: 425–443.