

What School Psychologists Need to Know About *DSM-5*

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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

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Overview

This session will:

- provide an overview of the macro-changes & controversies associated with *DSM-5*
- discuss the relevance of these global changes to school-based mental health professionals
- explore how diagnosis fits into a school psychologist's role
- discuss three specific neurodevelopmental disorders:
 - Intellectual Disabilities (ID),
 - Learning Disabilities (LD), and
 - Attention-Deficit/Hyperactivity Disorder (ADHD).

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Learner Objectives

1. Recognize major changes that have occurred within the macrostructure of the new DSM and how those changes impact school psychology.
2. Identify specific changes to ID, LD, and ADHD diagnoses.
3. Recognize the impact of these changes on the school community.

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Introduction

- What is diagnosis?
- 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)

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Introduction

- How is “it” used by schools?
 - May direct the attention of school psychologists, but NEVER (in an of itself) dictates special education eligibility or the actions of IEP/504 teams
 - Can help inform interventions in the schools/counseling framework
 - Can help direct assessment from inception through IEP
 - 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

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Workshop Outline

- Changes to the Classification System
- Controversies associated with *DSM-5*
- Changes to Specific Criteria

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Changes to DSM Over Time

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

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Changes to DSM Over Time

Source	Sets of Criteria	Document Length
2013 <i>DSM-5</i>	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

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Changes to Over Time

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.

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Changes to DSM-5

- Current revision guided by 4 principles
 1. Clinical utility
 2. Research evidence
 3. Maintaining continuity
 4. No a priori restraints
- 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

APA 2012; 2013b

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Changes to DSM-5

- 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 allow 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)

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Changes to DSM-5

- 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)

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Changes to DSM-5

- 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

From APA (2013b)

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Changes to DSM-5

- Where did the Roman Numerals go?
 - Roman numerals are limiting.
 - Research advances will continue to require text revisions (which can be done only once given the previous labeling).
 - Future changes to *DSM-5* (prior to *DSM-6*) will be signified as *DSM-5.1*, *DSM-5.2*, etc.

From APA (2012)

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Workshop Outline

- Changes to the Classification System
- Controversies associated with *DSM-5*
- Changes to Specific Criteria

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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)

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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)

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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)

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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)

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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 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)

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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)

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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)

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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); Frances (2013b)

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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); Frances (2013, May); Greenberg (2010)

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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 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)

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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)


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Workshop Outline

- Controversies associated with *DSM-5*
- Changes to the Classification System
- Changes to Specific Neurodevelopmental Disorders Criteria

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Neurodevelopmental Disorders



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

Source: APA (2013b)

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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)

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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
 - Severity level specifiers “mild,” “moderate,” “severe,” “profound” (see pp. 34-36)

Source: APA (2013b)

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Intellectual Disabilities

- Rationale for *DSM-5* Changes
 - Intellectual disabilities is now the more common (preferred) term
 - PL 111-256, Rosa’s Law
 - ID is quite literally PC
 - Need for comprehensive assessment
 - Emphasizes clinical assessment AND standardized cognitive testing

Source: APA (2013b)

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Intellectual Disabilities

- Consequences of *DSM-5* Changes
 - Less reliance on the IQ score
 - Ensures IQ tests are not over-emphasized
 - Greater emphasis on adaptive functioning
 - Severity levels (mild, moderate, severe, profound) based on conceptual, social, and practical behaviors

Source: APA (2013b)

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Intellectual Disabilities

- Implications for School Psychologists
 - Same terminology as IDEA
 - Can be more certain that clinical assessments have given adequate consideration to adaptive behavior

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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) 35

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) 36

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 & Hart (2013)

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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*

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

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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 & Hart (2013)

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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 & Hart (2013)

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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 & Hart (in press); Frances (2013b)

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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 & Hart (2013)

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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) 43

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 signs 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) 44

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) 45

Specific Learning Disorder

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

Source: APA (2013b)

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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)

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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

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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) 49

Autism Spectrum Disorder

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

Source: APA (2013b, p. 68) 50

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. See Handout 3

<i>DSM-IV-TR</i>	<i>DSM-5</i>
Autistic Disorder Asperger's Disorder Rett's Disorder Childhood Disintegrative Disorder PDD Not Otherwise Specified	Autism Spectrum Disorder Social Communication Disorder

Sources: APA (2013b); Brock & Hart (2013) 51

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.

[Handout 3: DSM 5 Autism Criteria A & B](#)

Sources: APA (2013b); Brock & Hart (2013)

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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 (2013)

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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 (2013)

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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

Source: Brock & Hart (2013)

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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

Sources: Brock & Hart (2013)

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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)

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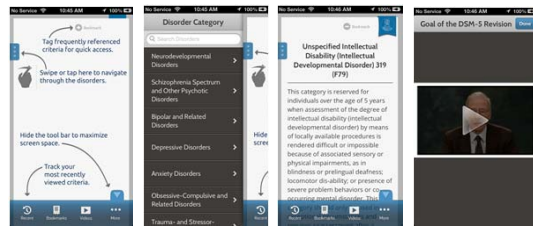
Other Conditions That May Be a Focus of Clinical Attention

- 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)

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DSM-5 Mobile (APA, 2013)



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

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