What School Psychologists Need to Know about DSM-5

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Workshop 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 these changes might influence IDEA eligibility determinations

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 presentation.
• Neither of the presenters, Melissa Reeves or Stephen Brock, has a known financial interest related to this workshop presentation.

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.

Workshop 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

• 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)
The Classification of Mental Illness in the United States

### Source

- 1840 US Census
- 1888 US Census

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By the 1880s different categories of insanity were established:

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


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**Discussion:**

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

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### Source

- 1918 APA
- 1938 AMA

<table>
<thead>
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### Source

- Committee on Statistics (1918), National Conference on Nomenclature (1938)

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### Source

- 1952 DSM
- 1968 DSM-II
- 1980 DSM-III
- 1987 DSM-III-R
- 1994 DSM-IV
- 2000 DSM-IV-TR

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<tr>
<td>1980 DSM-III</td>
<td>210</td>
<td>505 pages</td>
</tr>
<tr>
<td>1987 DSM-III-R</td>
<td>235</td>
<td>582 pages</td>
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<td>1994 DSM-IV</td>
<td>322</td>
<td>914 pages</td>
</tr>
<tr>
<td>2000 DSM-IV-TR</td>
<td>324</td>
<td>980 pages</td>
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</tbody>
</table>

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

### Source

- Brock & Hart (2013b, October)

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### Source

- 2013 DSM-5

<table>
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</thead>
<tbody>
<tr>
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<td>392</td>
<td>1009 pages</td>
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</table>

- 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)
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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)

DSM-5 Development

- 2004 to 2008
  - 13 conferences held
    - Conference steering committee included representatives from APIRE, NIH, and WHOD
    - 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)

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)

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)

Melissa A. Reeves, PhD, NCSP
Stephen E, Brock, PhD, NCSP
**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.

**Workshop Outline**

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

**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
- 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
- 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
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, September)

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)

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)

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.”

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

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)
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 loosened further.”

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

Workshop Outline

• The Classification of Mental Illness in the United States
• Development of DSM-5
• Controversies associated with DSM-5

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

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

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)

From APA (2013b)
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)

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)

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)

Changes to the Classification System

An interpretation of DSM-5’s conceptualization of mental illness

- Genetic Vulnerability Interacts with Environmental Stress
- Cause
- Caused/Effect
- Cause
- Genetics
- Biology
- Environment
- Biology may cause mental illness
- Mental illness may affect biology
- Traumatic events may affect the environment and cause mental illness

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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)
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)

• 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)

• 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)

• 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)

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)

• Alternative Diagnosis

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

  Source: Francis (2013a)
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)

Social (Pragmatic) Communication Disorder

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

Source: Brock & Hart (2013a, October)

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)

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)

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)

Autism Spectrum Disorder (ASD)

• Definition
  – Impaired reciprocal social communication; and restricted, repetitive patterns of behaviors, interests or activities (RBB).

Source: APA (2013b, p. 53)
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)

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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 criteria 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)

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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
- Appears to have affected the epidemiology of ASD

Sources: Brock & Hart (2013a, October); Kulage, Smaldone, & Cohn (2014); Tsai (2014)
Autism Spectrum Disorder

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

Source: Francis (2013a)

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

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

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

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

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

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

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

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)
**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)

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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 (2013)

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**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)

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**Specific Learning Disorder**

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

**Source:** APA (2013b)
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!

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

Specific Learning Disorder

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Intellectual Disabilities</td>
<td>Learning problems no greater than what would be expected given IQ.</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>This is the primary cause of poor functioning. Both diagnoses can be given if a specific academic area is disproportionately impaired.</td>
</tr>
<tr>
<td>Sensory Deficit</td>
<td>Accounts for learning problems.</td>
</tr>
<tr>
<td>ADHD</td>
<td>Causes poor test taking. Both diagnoses can be given when appropriate.</td>
</tr>
</tbody>
</table>

Source: APA (2013b)

Schizophrenia Spectrum and Other Psychotic Disorders

- Delusional Disorder
- Brief Psychotic Disorder
- Schizoaffective Disorder
- Schizophrenia
- Schizoaffective Disorder
- Disorganizing Disorder
- Schizoaffective Disorder
- Substance/Drug-Induced Psychotic Disorder
- Disorganizing Disorder due to another medical condition
- Catatonia

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

Schizophrenia Spectrum

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

Source: APA (2013b)
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)

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)

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)

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

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

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)

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 year of identification
    - 32% meet diagnostic criteria for a psychotic disorder within 3 years of identification

Source: Trench (2013a)
Schizophrenia Spectrum

<table>
<thead>
<tr>
<th>Alternative Diagnosis</th>
<th>Differential Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizoaffective Disorder</td>
<td>Mood sx are prominent in presentation, but psychotic symptoms persist even absent mood episodes</td>
</tr>
<tr>
<td>Major Depressive Disorder, severe with psychotic features</td>
<td>Psychotic symptoms restricted to depressive episodes</td>
</tr>
<tr>
<td>Bipolar I, Severe with Psychotic Features</td>
<td>Psychotic symptoms restricted to manic or depressive episodes</td>
</tr>
<tr>
<td>Schizotypal Personality Disorder</td>
<td>No psychotic symptoms</td>
</tr>
<tr>
<td>Schizophreniform Disorder</td>
<td>Same sx as schizophrenia, but last for &gt;1 month and &lt;6 months</td>
</tr>
<tr>
<td>Brief Psychotic Disorder</td>
<td>Same sx as schizophrenia, but last for &lt;1 month</td>
</tr>
<tr>
<td>Delusional Disorder</td>
<td>Only delusions – no hallucinations, disorganization, or neg ( Source: Francis (2013a) )</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>No prominent delusions or hallucinations</td>
</tr>
<tr>
<td>Malingering</td>
<td>Is something to be gained by &quot;faking crazy?&quot;</td>
</tr>
<tr>
<td>Political or Religious Zealotry</td>
<td>Bizarre beliefs shared by others</td>
</tr>
</tbody>
</table>

Source: Francis (2013a)

Bipolar and Related Disorders

Definition

- Distinct mood phases ranging frommania 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)

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)

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

Source: APA (2013b)

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.
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 misdiagnosed with Disruptive Mood Dysregulation Disorder
  • focus too much on externalizing behaviors and ignore possible underlying depressive symptoms

Bipolar I

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

Source: Francis (2013a)

Bipolar II

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

Source: Francis (2013b)

Cyclothymic Disorder

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

Source: Francis (2013a)

Depressive Disorders

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

Source: APA (2013b)

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.

Source: APA (2013b), Hart (2014)
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 setting.
  G. Diagnosis not made before age 6 years or after age 18 years.
  H. Age at onset of Criteria A–E before 10 years.
  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)

Disruptive Mood Dysregulation Disorder

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

Source: Hart (2014)

Disruptive Mood Dysregulation Disorder

- **Rationale for DSM-5 Changes**
  - Address alarming increases in the diagnosis of bipolar disorder youth:
    - Many of whom did not have 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)

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 parent 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)

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

Source: Hart (2014)
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

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

Applicable to manic, hypomanic, depressive episodes

Can score subthreshold symptoms

Specifiers for Depressive Disorders

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

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)

Implications for School Psychologists

- Easy to miss and easy to overdiagnose
  - If person experiences a loss, reserve diagnosis for those who previously experienced major depressive episodes and/or are now having severe and prolonged symptoms

Grief

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

Alternative Diagnosis

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

Source: Francis (2013a)
**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:
   - Poor appetite or overeating, insomnia or hypersomnia, 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)

### Alternative Diagnosis

**Differential Consideration**

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

Source: Francis (2013a)

---

**Anxiety Disorders**

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

Source: APA (2013b)

---

**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 expectations...) 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)

---

**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 list of changes


---

**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

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

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

Anxiety Disorders (Social Anxiety Disorder)

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

Source: Francis (2013a)

Anxiety Disorders (Agoraphobia)

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

Source: Francis (2013a)
Obsessive-Compulsive and Related Disorders

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

Source: APA (2013b)

Definition
- OCD: Obsessions, Compulsions – has not changed from DSM-IV
- Particular obsessions tend to be paired with particular compulsions
- Body Dysmorphic 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)

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


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

Source: APA (2013b)
### Obsessive-Compulsive and Related Disorders

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

Source: Francis (2013a)

### Trauma- and Stressor-Related Disorders

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

Source: APA (2013b)

---

### 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)

**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

Source: APA (2013b); Leveille (2014)

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

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

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**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.”
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

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

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

Disinhibited Social Engagement Disorder

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

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

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)

Disinhibited Social Engagement Disorder

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

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

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)
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)

Posttraumatic Stress Disorder

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

Source: APA (2013b)

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)

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
  4. Intense/prolonged psychological distress with exposure to internal/external cues that symbolize/resemble the event

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
  3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame or confusion)
  4. Markedly diminished interest/participation in significant activities (e.g., constriction of play)
  5. Socially withdraw
  6. Reduction in expression of positive emotions

Source: APA (2013b)
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 (≥ 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)

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)

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)

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

Source: APA (2013b)

Acute Stress Disorder

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

Source: APA (2013b)
**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?

**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

**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

**Dissociative Disorders**

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

**Somatic Symptom and Related Disorders**

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

**Feeding and Eating Disorders**

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

- Enuresis
- Encopresis

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

Sleep-Wake Disorders

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

Source: APA (2013b)

Sexual Dysfunctions

Overview not necessarily needed for school-age population


Gender Dysphoria

- Gender Dysphoria
  - in Children
  - in Adolescents and Adults


Disruptive, Impulse-Control, and Conduct Disorders

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

Source: APA (2013b)

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

Source: APA (2013b), Taylor (in press)
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.

Changes from DSM-IV-TR

• 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.

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.

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.

Alternatives Diagnosis

| Developmentally normal self-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)

Intermittent Explosive Disorder

<table>
<thead>
<tr>
<th>Alternative Diagnosis</th>
<th>Differential Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Another mental condition</td>
<td>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.</td>
</tr>
<tr>
<td>A Neurological Disorder</td>
<td>Refer the patient for evaluation and testing</td>
</tr>
<tr>
<td>Simple Criminal Behavior</td>
<td>Unrelated to medical or psychiatric disorder</td>
</tr>
<tr>
<td>Purposeful Aggression</td>
<td>Person is motivated by revenge or honor killing</td>
</tr>
<tr>
<td>Normal anger of everyday life</td>
<td>Outbursts do not cause clinically significant distress or impairment</td>
</tr>
<tr>
<td>Malingerer</td>
<td>Person is trying to avoid facing the consequences of his/her actions</td>
</tr>
</tbody>
</table>

Source: Francis (2013a)
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
  - Deceitful or lies
  - 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

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

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

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

Conduct Disorder

Alternative Diagnosis

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

Source: APA (2013c)
Substance-Related and Addictive Disorders

- Substance-Related Disorders
- Alcohol-Related Disorders
- Caffeine-Related Disorders
- Cannabis-Related Disorders
- Hallucinogen-Related Disorders
- Inhaling-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)

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)

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)

Paraphilic Disorders

Overview not necessarily needed for school-age population

Source: APA (2013b)

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)

DSM-5 Mobile (APA, 2013)

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