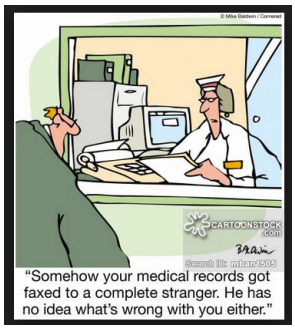
II. DSM-5 TRAINING

For: Yolo County

Key Constructs in DSM-5

Behavioral Health Solutions
March 7-8, 2017

Where did you learn how to diagnose?



JUST A LITTLE SIDETRACK

What Medi-Cal Says Regarding Use of DSM vs. ICD

Medi-Cal Guidance/Directives Regarding Use of DSM vs. ICD: MHSUDS Information Notices

Number	Date	Description
16-051	10/7/2016	Directs MHPs to use the APA DSM-5 to make diagnostic determinations for the purposes of determining if beneficiaries meet medical necessity criteria for Medi-Cal specialty mental health services (SMHS)
15-030	7/31/2015	Informs counties, direct providers, and MHPs of the release of the ICD-10 Test Plan, and provides a list of included ICD-10 diagnosis codes for SUD Services, and ICD-10 procedural and diagnosis crosswalk documents for SMHS
15-003	1/7/2015	Informs counties of the requirement to submit ICD-10 codes for diagnoses Client and Services Information (CSI) reporting effective October 1, 2015
14-040	12/16/2014	Informs counties, direct providers, and MHPs of the transition from ICD-9 to ICD-10 effective October 1, 2015
13-22	12/3/2013	Preliminary information concerning issuance of the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association

Current Medi-Cal Guidance/Directives Regarding Use of DSM vs. ICD

- MHSUDS Information Notice 16-051 (October 7, 2016):
  - Effective no later than April 1, 2017, Department of Health Care Services directs MHPs to use DSM-5 to make diagnostic determinations for the purposes of determining if beneficiaries meet medical necessity criteria for Medi-Cal specialty mental health services (SMHS).
  - MHPs are to continue to report only ICD-10 codes for claiming and diagnoses reporting purposes and provide ICD-10 procedural and diagnosis crosswalk documents for SMHS

Concepts in the DSM-5

- Cross-Cutting Symptom Measures
- Cultural Formation
- WHODAS 2.0
- The Three S's: Subtypes, Specifiers, and Severity
- Diagnosing Personality Disorders

What Are Cross-Cutting Symptom Measures?

- Cross-cutting symptom measures (CCSMs) are included in DSM-5 as one of four new "emerging measures" (DSM-5, pp. 734-748)
  - DSM-5 includes only a few CCSMs, but the APA's website has a complete list of links to others
- CCSMs screen for important symptoms — not specific diagnoses
  - Developed for use at the initial patient interview and to monitor progress
  - Designed as self- or informant-assessments
  - Intended as supplementary tools to be used by clinicians to enhance the accuracy of the diagnostic process and monitor treatment progress

Why Are CCSMs Included In DSM-5?

- DSM-5 Task Force and Work Groups developed CCSMs to introduce a more dimensional approach to the DSM's categorical approach to diagnosis
  - Issue: Categorical diagnoses can miss sub-threshold symptoms that cause or exacerbate impairment and distress (for example, a diagnosis of major depressive disorder may not account for sub-threshold anxiety or psychotic symptoms)
    - May lead clinician to diagnose 2 or 3 separate disorders as "not otherwise specified" in order to facilitate treatment

Categorical approach to diagnosis classifies a diagnosis as either present or absent, but a *dimensional approach* to diagnosis evaluates the extent to which symptoms exist

Cross-Cutting Symptom Measures: Two Levels

Level 1	• Assesses symptoms relevant to most psychiatric disorders
Level 2	• Provides a follow-up assessment when corresponding Level 1 assessment ranks as mild or greater

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Level 1 Cross-Cutting Symptom Measures

- Self- or informant-rated survey
- 1-3 questions about how much (or often) the individual has been bothered by a specific symptom during the past 2 weeks
- Rated on 5-point scale with the exception of Yes/No scoring for suicide ideation, suicide attempts, and substance use in children/adolescents
- Symptom domains cut across diagnostic boundaries

Adult Domains (13)	Children / Adolescent Domains (12)
• Depression, Anger, Mania, Anxiety, Somatic symptoms, Suicidal ideation, Psychosis, Sleep problems, Memory, Repetitive thoughts and behaviors, Dissociation, Personality functioning, and Substance use	• Same as adults with a few changes: • Excludes Memory, Dissociation, and Personality functioning • Adds Inattention • Adds Irritability

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

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____ **SAMPLE**

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

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

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no	0	1	2	3	4	

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Level 2 Cross-Cutting Symptom Measures

- Self- or informant-rated survey
- More detailed follow-up assessment to Level 1 when a corresponding Level 1 assessment ranks as mild or greater (any items scored as a '2' or greater, or with a "yes")
- Focus is on presence and severity of symptoms within specific psychiatric domains during past 7 days

Adult Domains (8)	Parents of Children, Ages 6-17, Domains (9)	Children, Ages 11-17, Domains (9)
• Depression, Anger, Mania, Anxiety, Somatic symptom, Sleep disturbance, Repetitive thoughts and behaviors, and Substance use	• Somatic symptom, Sleep disturbance, Inattention, Depression, Anger, Irritability, Mania, Anxiety, and Substance use	• Somatic symptom, Sleep disturbance, Depression, Anger, Irritability, Mania, Anxiety, Repetitive thoughts and behaviors, and Substance use

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LEVEL 2—Depression—Adult*

*PROMIS Emotional Distress—Depression—Short Form

SAMPLE

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

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "no interest or pleasure in doing things" and/or "feeling down, depressed, or hopeless" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							Item Score
		Never	Rarely	Sometimes	Often	Always	
1.	I felt worthless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt that I had nothing to look forward to.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt helpless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I felt sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt like a failure.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt depressed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt unhappy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	

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DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ❑ Male ❑ Female **Date:** _____

Relationship with the child: _____

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

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	

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Rationale For Introducing Cross Cutting Symptom Measures As "Emerging Measure"

Dimensional	• Helps address issue of co-occurring symptoms cross mental disorders
Patient-Centered	• Aligns with a more patient-centered approach to assessment and care
Further Study Needed	• APA requests feedback from clinicians on clinical utility • Field testing found CCSMs less reliable for children respondents than adults and parents

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The Case For Cultural Formulation

- Compared to whites, minorities are:
  - 20-50% less likely to initiate treatment
  - More likely to have shorter psychiatric visits
  - 40-60% less likely to fill prescriptions
  - 40-80% more likely to end treatment prematurely for axis I disorders
- Introduction of clinicians to patient cultural views can increase:
  - Patient participation throughout the interview
  - Clinician-patient information exchange
  - Interpersonal rapport
  - Overall patient satisfaction

Cultural formulation includes forms of expression, styles, values, and habits of reception

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Cultural Formulation & DSM-5

- Cultural formulation included in DSM-IV as the "Outline for Cultural Formulation" or OCF
  - Intent to improve the cultural validity of a clinician's interpretation of patient-clinician communications
  - Criticized for not providing clinicians with sufficient guidance on how to use
- DSM-5 Cultural Issues Subgroup revised and converted the OCF into the Cultural Formulation Interview (CFI) (DSM-5, p. 749-759)

Cultural formulation is included as an "emerging measure" in DSM-5

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What Is The Cultural Formulation Interview?

- CFI is a semi-structured 16-item questionnaire for use by any clinician with any patient in any clinical setting
  - 12 supplemental modules available online for further assessment
  - Informant version available to obtain material from care-givers
- Organizes information obtained during a mental health assessment about the impact of a patient's culture on key aspects of care

Cultural Formulation Interview (CFI) **SAMPLE**

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED***.
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.
CULTURAL DEFINITION OF THE PROBLEM	
CULTURAL DEFINITION OF THE PROBLEM (Explanatory Model, Level of Functioning)	
Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?
Ask how individual frames the problem for members of the social network.	2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
Focus on the aspects of the problem that matter most to the individual.	3. What troubles you most about your problem?

Additional Enhancements To Treatment Of Culture In DSM-5

- Classification system:
  - Disorders are defined in relation to cultural social and familial norms
  - Experience and expression of symptoms, signs and behaviors are viewed through the interpretative framework of culture
  - The decision that a given behavior is abnormal requires intervention and/or treatment is dependent upon cultural norms
- Cultural concepts:
  - Cultural syndrome: A cluster of group of symptoms not viewed by the native culture as an illness but recognized by external observers
  - Cultural idiom of distress: A linguistic term, phrase or way of talking about distress in a culture independent of an illness or disorder
  - Cultural explanation of perceived cause: A label, attribution of feature that provides a culturally conceived cause for an illness
- Inclusion of new appendix: "Glossary of Cultural Concepts of Distress" (DSM-5, pp. 833-837)

Treatment Of Culture in DSM-5 Example: Dissociative Identify Disorder

- DSM-5 adds a new exclusion based on cultural or religious practices for a diagnosis of Dissociative Identify Disorder (Criterion D):
  - *"The disturbance is not a normal part of a broadly accepted cultural or religious practice…"*
- Rationale:
  - This acknowledges that possession states are commonly recognized in cultures around the world and do not necessarily indicate presence of Dissociative Identify Disorder (DID) or any other mental disorder
  - In contrast, possession-form DID is recurrent and unwanted, leads to distress or impairment, and is not part of a broadly accepted cultural or religious practice

Cultural Formulation & DSM-5: Bigger Picture

- CFI Interview tool was designed to increase cultural validity of diagnostic assessments, facilitate treatment planning, and *promote patient engagement and satisfaction (hint: metric for value-based pay!)*
- Validation continues
  - CFI field trial took place in 6 countries, 14 sites, and with 321 patients to explore its feasibility, acceptability, and clinical utility with patients and clinicians
- Research needed to demonstrate impact of cultural interviews on outcomes, including:
  - Medication adherence
  - Appointment retention
  - Health conditions

Cultural Concepts of Distress

Koro—Koro was one of the first cultural concepts discussed in transcultural psychiatry literature.16 Koro epidemics have been reported in South Asia, and case reports have been reported throughout the world. Fear of the penis retracting into the body among men and retraction of breasts among women is a central feature. The majority of reported cases are among men.

Brain fag—Brain fag has been studied for a half-century in Western Africa. The condition is characterized by distress from thinking too much, with students being a vulnerable population.86 The experience includes headaches and an experience of a worm crawling in the head. This is similar to the Nigerian cultural concept of distress, ode ori:84 the disorder ode ori (hunter in the head) affects the brain under the anterior fontanelle where the iye (senses) control mental functions through okun (strings) that project throughout the body and provide direct linkages among the brain, eyes, ears and heart.

Khyal attacks and 'wind'-related illnesses—The substance qi, (cf chi, chi'i, khí, khii, rlung, khyal) is associated with wind flow and wind balance. Wind-related illnesses are commonly described in East Asian populations including Tibetans, Cambodians, Vietnamese, Chinese and Mongolians.73·77·78·129·130 Shenjing shuairuo (neurological weakness, neurasthenia), studied by Kleinman in the 1970s and 80s, is associated with weakness, fatigue and social distress mediated by an alteration in qi.77 Yadargaa, a nervous fatigue described in Mongolia, is similarly viewed as an alteration in khii flow and balance.78 In the Vietnamese CCD 'hit by wind', shifts in ambient temperature, especially gusts of cold air, are associated with a range of physical complaints, traumatic memories,

THE MOVE AWAY FROM THE GAF

World Health Organization Disability Assessment Schedule 2.0, AKA "WHODAS 2.0"

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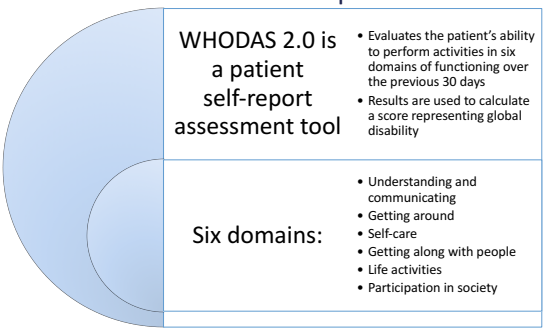
DSM-5 Replaces GAF With WHODAS 2.0 For Assessment Of Functional Impairment



WHODAS 2.0 is a patient self-report assessment tool

- Evaluates the patient's ability to perform activities in six domains of functioning over the previous 30 days
- Results are used to calculate a score representing global disability

Six domains:

- Understanding and communicating
- Getting around
- Self-care
- Getting along with people
- Life activities
- Participation in society

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What Is WHODAS 2.0?

- WHODAS stands for World Health Organization Disability Assessment Schedule
  - Version 2.0 released by World Health Organization (WHO) in 2010
  - WHODAS 2.0 field tested by DSM-5
- WHODAS assesses impairment and disability separately from diagnostic considerations and is based on two WHO classification systems:
  - International Classification of Diseases (ICD): Lists diagnoses of both physical and mental disorders
  - International Classification of Functioning, Disability, and Health (ICF): Defines impairment and disability and their assessments in relation to illness

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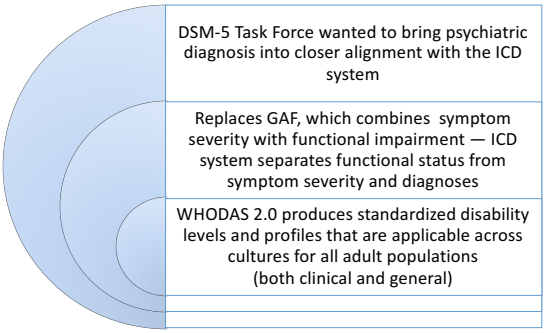
Why WHODAS 2.0?



DSM-5 Task Force wanted to bring psychiatric diagnosis into closer alignment with the ICD system

Replaces GAF, which combines symptom severity with functional impairment — ICD system separates functional status from symptom severity and diagnoses

WHODAS 2.0 produces standardized disability levels and profiles that are applicable across cultures for all adult populations (both clinical and general)

WHODAS 2.0 Specifics (As Recommended In DSM-5, PP. 745)

Assessment Tool	• Includes the 36-question self-administered WHODAS 2.0 assessment — which it recommends combining with a clinical social work interview — under "emerging measures"
Target clients	• Adults • Child version developed by DSM-5 Taskforce is pending WHO approval
Scoring	• Scores assigned to each question — None (1), Mild (2), Moderate (3), Severe (4), and Extreme or Cannot Do (5) • Calculate average scores by domain and overall
Frequency of Use	• Can repeat at regular intervals based on symptom stability to track changes in level of disability over time

WHODAS 2.0
World Health Organization Disability Assessment Schedule 2.0
36-item version, self-administered

SAMPLE

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

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the past 30 days and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

Numeric scores assigned to each of the items:		1	2	3	4	5	Clinician Use Only: Raw Item Score	Raw Domain Score	Average Domain Score
In the last 30 days, how much difficulty did you have in:									
Understanding and communicating									
D1.1	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.2	Remembering to do important things?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.3	Analyzing and finding solutions to problems in day-to-day life?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.4	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do		___ 30	___ 5
D1.5	Generally understanding what people say?	None	Mild	Moderate	Severe	Extreme or cannot do			
D1.6	Starting and maintaining a conversation?	None	Mild	Moderate	Severe	Extreme or cannot do			
Getting around									
D2.1	Standing for long periods, such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.2	Standing up from sitting down?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.3	Moving around inside your home?	None	Mild	Moderate	Severe	Extreme or cannot do		___ 25	___ 5
D2.4	Getting out of your home?	None	Mild	Moderate	Severe	Extreme or cannot do			
D2.5	Walking a long distance, such as a kilometer (or equivalent)?	None	Mild	Moderate	Severe	Extreme or cannot do			
Self-care									
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do			
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do		___ 20	___ 5

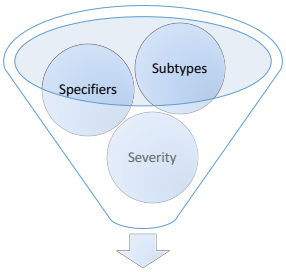
DSM-5: Tentative Endorsement Of WHODAS 2.0

- WHODAS 2.0 is included in DSM-5 as an emerging measure
- Functional assessment is not required when providing a mental health diagnosis
- DSM-5 calls for further study

SOME DEFINITIONS IN THE DSM-5

Subtypes, Specifiers, and Severity

The Three S's



WHICH ONE??

Subtypes and Specifiers (p.21)

- Subtypes Defined: mutually exclusive and jointly exhaustive phenomenological subgroupings with a diagnosis
  - You will see terms: "***Specify*** whether…." in the criteria set
- Specifiers: NOT mutually exclusive or exhaustive therefore more than one can be given. Provides an opportunity to define a more homogeneous subgrouping of individuals with the disorder
  - You will see terms: "Specify" or "Specify if"
  - Not always used as a digit; rather, some specifiers are indicated by writing down the description of the specifier in the diagnosis ("with mixed features")
- Can be coded in the 4th, 5th, and 6th digits and used for increased specificity

Subtypes

The Key words: *"specify whether"* and pick ONE

Defined:

Intent to community greater specificity/clarity

Text will indicate *"specify whether"*

Represents mutually exclusive groupings of symptoms

Can only choose ONE

Example:

ADHD has 3 different subtypes: (predominantly hyperactive, predominantly hyperactive/impulsive, combined)

Specifiers

The Key words: *"Specify if" and* more than one can be used

Defined:

Specifiers typically indicate clinical state or severity

Only choose specifiers if they apply

Example:

Autism Spectrum Diagnoses can be further specified by utilizing the Table 2 Severity Levels: "requiring support," "requiring substantial support," & "requiring very substantial support."

DSM-5 Statement on Subtypes and Specifiers

- "The majority of subtypes and specifiers included in DSM-5 cannot be coded within the ICD-9 CM and ICD-10 CM systems and indicated only by including the subtype or specifier after the name of the disorder. (e.g., social anxiety disorder (social phobia), *performance type*." (p.22)
- In other words, we must WRITE IT DOWN in the record if there are NO code numbers available

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Schizophrenia Specifiers in the DSM-5

Instructed to use the "Clinician-Rated Dimensions of Psychosis Symptom Severity" chart

Rate symptoms on a 5-point Likert scale

F20.9: Schizophrenia, Unspecified

- The only way to determine what flavor of schizophrenia someone has when using strictly the DSM-5 is in the narrative portion of the record.

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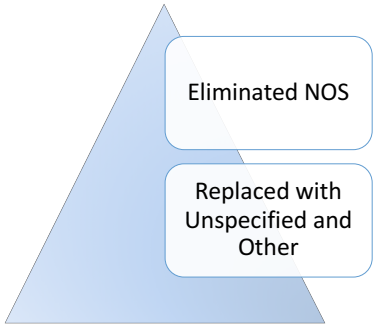
Narratives versus Diagnoses

- DSM-5 Subtypes, Specifiers and Severity, in many cases, does not map to ICD-10
- How then is the qualifier communicated? By the narrative text portion of the chart notes
- Many diagnoses, therefore, "map" to an ICD-10 Unspecified code, which may contradict the narrative portion
- How might this be problematic? How will you handle this?

DSM-5 ON THE USE OF OTHER SPECIFIED AND UNSPECIFIED

A Reminder of the ICD-10 Coding Rules

Alignment of the DSM-5 with the ICD System



"But Our Favorite Diagnosis Is….."

- Bipolar UNSPECIFIED
- Schizoaffective UNSPECIFIED
- PTSD UNSPECIFIED

ICD-10 Rules About "Other" And "Unspecified"

"Unspecified" Codes:

- Use these when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified.

"Other" Codes:

- Codes titled "other" or "other specified" for use when the information in the medical record provides detail for which a specific code does not exist.

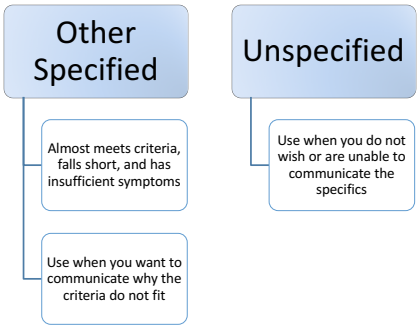
Unspecified in DSM-5

- Use of this category is based on a clinician's judgment and decision
- Clinicians do not have to differentiate between other specified and unspecified disorders based on some feature of the presentation itself. When the clinician determines that there is evidence to specify the nature of the clinical presentation, the other specified diagnosis can be given.
- When the clinician is not able to further specify and describe the clinical presentation, the unspecified diagnosis can be given. This is left entirely up to clinical judgment.

Other Specified in DSM-5

- Other Specified:
  - This category is provided to allow the clinician to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class.
  - This is done by recording the name of the category, followed by the specific reason. If the clinician chooses not to specify the reason, then they should use "Unspecified Depressive Disorder"
    - Example: Other Specified Depressive Disorder, depressive episode with insufficient symptoms

The DSM-5's Interpretation of Other and Unspecified



Diagnosing Personality Disorders in the DSM-5

- For diagnosing, the categorical approach remains dominant
- Section III, "Alternative DSM-5 Model for Personality Disorders" is introduced
  - Rationale: preserve continuity with current clinical practice, while also introducing a new approach that aims to address numerous shortcomings of the current approach.
- 2 determinations must be made to diagnose a PD in this model:
  - Levels of impairment of personality functioning
  - Pathological personality traits
- Impairment in personality functioning and trait expression are relatively inflexible & pervasive across a broad range of personal and social situations

Level of Personality Functioning

- Disturbances in self and interpersonal functioning are key
- Measured by: "Level of Personality Functioning Scale" (LPFS) that has 5 different levels of impairment
  - Level 0: little to no impairment, healthy adaptive functioning
  - Level 1: some
  - Level 2: moderate
  - Level 3: severe
  - Level 4: extreme

Elements of Personality Function Measures: Interpersonal

Empathy: comprehension and appreciation of others motivations and experiences, tolerance of differing perspectives, understanding the effects of one's own behavior on others

Intimacy: Depth and duration of connection with others, desire and capacity for closeness, mutuality of regard reflected in interpersonal behavior

Elements of Personality Function Measures: Self

Identity: Experience of oneself as unique, with clear boundaries between self/others; stability of self-esteem, accuracy of self-appraisal, ability to regulate

Self-direction: pursuit of coherent and meaningful short/long term goals, constructive and prosocial internal standards of behavior, self-reflection

TABLE 2 Level of Personality Functioning Scale

	SELF		INTERPERSONAL	
Level of impairment	Identity	Self-direction	Empathy	Intimacy
0—Little or no impairment	Has ongoing awareness of a unique self; maintains role-appropriate boundaries. Has consistent and self-regulated positive self-esteem, with accurate self-appraisal. Is capable of experiencing, tolerating, and regulating a full range of emotions.	Sets and aspires to reasonable goals based on a realistic assessment of personal capacities. Utilizes appropriate standards of behavior, attaining fulfillment in multiple realms. Can reflect on, and make constructive meaning of, internal experience.	Is capable of accurately understanding others' experiences and motivations in most situations. Comprehends and appreciates others' perspectives, even if disagreeing. Is aware of the effect of own actions on others.	Maintains multiple satisfying and enduring relationships in personal and community life. Desires and engages in a number of caring, close, and reciprocal relationships. Strives for cooperation and mutual benefit and flexibly responds to a range of others' ideas, emotions, and behaviors.
1—Some impairment	Has relatively intact sense of self, with some decrease in clarity of boundaries when strong emotions and mental distress are experienced. Self-esteem diminished at times, with overly critical or somewhat distorted self-appraisal. Strong emotions may be distressing, associated with a restriction in range of emotional	Is excessively goal-directed, somewhat goal-inhibited, or conflicted about goals. May have an unrealistic or socially inappropriate set of personal standards, limiting some aspects of fulfillment. Is able to reflect on internal experiences, but may overemphasize a single (e.g., intellectual, emotional) type	Is somewhat compromised in ability to appreciate and understand others' experiences; may tend to see others as having unreasonable expectations or a wish for control. Although capable of considering and understanding different perspectives, resists doing so. Has inconsistent awareness of	Is able to establish enduring relationships in personal and community life, with some limitations on degree of depth and satisfaction. Is capable of forming and desires to form intimate and reciprocal relationships, but may be inhibited in meaningful expression and sometimes constrained if intense emotions or conflicts arise. Cooperation may be inhibited by unrealistic standards; somewhat

...ersonality Disorders

TABLE 3 Definitions of DSM-5 personality disorder tra... and facets

DOMAINS (Polar Opposites) and Facets	Definitions
NEGATIVE AFFECTIVITY (vs. Emotional Stability)	Frequent and intense experiences of ... negative emotions (e.g., anxiety, de... anger) and their behavioral (e.g., self... dependency) manifestations.
Emotional lability	Instability of emotional experiences a... easily aroused, intense, and/or out ... cumstances.
Anxiousness	Feelings of nervousness, tenseness, or p... tions; frequent worry about the negati... experiences and future negative possi... apprehensive about uncertainty; expe...
Separation insecurity	Fears of being alone due to rejection b... significant others, based in a lack of ... care for oneself, both physically and ...
Submissiveness	Adaptation of one's behavior to the act... desires of others even when doing so ... interests, needs, or desires.
Hostility	Persistent or frequent angry feelings; a... to minor slights and insults; mean, na... *also* Antagonism.
Perseveration	Persistence at tasks or in a particular way ... behavior has ceased to be functional or ... behavior despite repeated failure

Speaking of Assessment Measures…..

- DSM5.Org and APA have a number of easy, quick, online tools and assessments you can use to help formulae your diagnoses:
- https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures
- Online Assessment Measures
  - Adults and Children
  - Cross-Cutting Measures
  - Personality Assessments

The Personality Inventory for DSM-5—Brief Form (PID-5-BF)—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

	Instructions: This is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no right or wrong answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We'd like you to take your time and read each statement carefully, selecting the response that best describes you.					**Clinician Use**
		Very False or Often False	**Sometimes or Somewhat False**	**Sometimes or Somewhat True**	**Very True or Often True**	**Item score**
1	People would describe me as reckless.	0	1	2	3	
2	I feel like I act totally on impulse.	0	1	2	3	
3	Even though I know better, I can't stop making rash decisions.	0	1	2	3	
4	I often feel like nothing I do really matters.	0	1	2	3	
5	Others see me as irresponsible.	0	1	2	3	
6	I'm not good at planning ahead.	0	1	2	3	
7	My thoughts often don't make sense to others.	0	1	2	3	
8	I worry about almost everything.	0	1	2	3	
9	I get emotional easily, often for very little reason.	0	1	2	3	
10	I fear being alone in life more than anything else.	0	1	2	3	

UP NEXT: CLINICAL DIAGNOSES IN THE DSM-5