Handout for the Neuroscience Education Institute (NEI) online activity:

DSM-5 Has Arrived
Learning Objectives

• Describe the major changes made to the DSM between DSM-IV and DSM-5, including manual-wide changes and diagnosis-specific changes

• Explain the rationale for the changes to the chapter structure in DSM-5

• Explain how changes made in DSM-5 might affect clinical practice

• Explain how changes made in DSM-5 might affect research outcomes
Pretest Question 1

In DSM-5:

1. The DSM-IV multiaxial system was fully retained
2. The DSM-IV multiaxial system was modified
3. The DSM-IV multiaxial system was replaced with a new multiaxial system
4. The multiaxial system was removed
Pretest Question 2

The chapter organization of DSM-5

1. Retains that of DSM-IV
2. Replaces that of DSM-IV with an alphabetical one
3. Replaces that of DSM-IV with a developmentally-informed one
4. Was entirely determined by the World Health Organization
DSM-5 – The Future Arrived

David J. Kupfer, MD
Emily A. Kuhl, PhD
Darrel A. Regier, MD, MPH

Strategies for Improving DSM

• Incorporate research into the revision and evolution of the classification

• Move beyond a process of clinical consensus and build diagnoses on a foundation of empirical findings from scientific disciplines

• Seek multidisciplinary, international, scientific participation in the task of planning the DSM-5 revision
APA/WHO/NIH Diagnosis Research Planning Conferences: Participant Distribution

- 397 Participants
- 39 Countries
- 16 Developing Nations
- 51% Non-US Participants
- 10% Developing Nation Participants

**Africa**
- Kenya, 2
- Nigeria, 3
- South Africa, 4

**Latin America**
- Argentina, 2
- Brazil, 4
- Chile, 3
- Mexico, 5
- Puerto Rico, 2

**Eastern Mediterranean**
- Bahrain, 1
- Israel, 3
- Lebanon, 1

**Europe (Cont)**
- Greece, 1
- Hungary, 1
- Italy, 5
- Luxembourg, 1
- Netherlands, 12
- Norway, 2
- Russia, 4
- Spain, 5
- Sweden, 4
- Switzerland, 21
- UK, 41

**Europe**
- Belarus, 1
- Belgium, 2
- Denmark, 4
- Estonia, 1
- France, 3
- Germany, 11

**South Asia**
- India, 5
- Pakistan, 2
- Sri Lanka, 1
- Thailand, 2

**Western Pacific**
- Australia, 9
- China, 9
- Japan, 8
- Korea, 3
- New Zealand, 3
DSM-5 Conference Output

• 13 conferences (2003-2008)
• 10 monographs published
  - Dimensional Models of Personality Disorders
  - Diagnostic Issues in Substance Use Disorders
  - Diagnostic Issues in Dementia
  - Dimensional Approaches in Diagnostic Classification
  - Stress-Induced and Fear Circuitry Disorders
  - Somatic Presentations of Mental Disorders
  - Deconstructing Psychosis
  - Depression and GAD
  - Obsessive-Compulsive Behavior Spectrum Disorders
  - Public Health Aspects of Psychiatric Diagnosis
• More than 200 journal articles published
DSM-5 Work Groups and Chairs

- ADHD and Disruptive Behavior Disorders (David Shaffer, MD)
- Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders (Katharine Phillips, MD)
- Disorders in Childhood and Adolescence (Daniel Pine, MD)
- Eating Disorders (Timothy Walsh, MD)
- Mood Disorders (Jan Fawcett, MD)
- Neurocognitive Disorders (Dilip Jeste, MD)
- Neurodevelopmental Disorders (Susan Swedo, MD)
- Personality Disorders (Andrew Skodol, MD)
- Psychotic Disorders (William Carpenter, MD)
- Sexual and Gender Identity Disorders (Kenneth Zucker, PhD)
- Sleep–Wake Disorders (Charles Reynolds, MD)
- Somatic Distress Disorders (JoelDimsdale, MD)
- Substance-Related Disorders (Charles O'Brien, MD, PhD)
DSM-5 Revisions: Rationales
DSM-5 Revisions: Rationales

• DSM-IV's organizational structure failed to reflect shared features or symptoms of related disorders and diagnostic groups (e.g., psychotic disorders and bipolar disorders; internalizing (depressive, anxiety, somatic) and externalizing (impulse control, conduct, substance use) disorders)

• DSM-5 restructuring better reflects these interrelationships within and across diagnostic chapters
DSM-5 Revisions: Rationales

- DSM-IV does not adequately address the lifespan perspective, including variations in symptom presentations across the developmental trajectory, or cultural perspectives.

- DSM-5's chapter structure, criteria revisions, and text outline actively address age and development as part of diagnosis and classification.

- Culture is discussed more explicitly to bring greater attention to cultural variations in symptom presentations.
DSM-5 Revisions: Rationales

• DSM-5 represents an opportunity to better integrate **neuroscience** and the wealth of findings from neuroimaging, genetics, cognitive research, etc. that have emerged over the past several decades, all of which are vital to diagnosis and treatment development

• DSM-5 will be more amenable to updates in psychiatry and neuroscience, making it a living document and less susceptible to becoming outdated
DSM-5 Revisions: Rationales

• The **multiaxial** system in DSM-IV is not required to make a mental disorder diagnosis and has not been universally used

• DSM-5 has moved to a nonaxial documentation of diagnosis (formerly Axes I, II, and III), with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V)

• This approach is consistent with established WHO and ICD guidance to consider the individual's functional status separately from his or her diagnosis or symptom status
DSM-5 Revisions: Highlights of Changes
DSM-5 Structure

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

• Brief DSM-5 developmental history
• Guidance on use of the manual
• Definition of a mental disorder
• Cautionary forensic statement
• Brief DSM-5 classification summary
Use of the Manual

• Approach to Clinical Case Formulation
• Definition of a Mental Disorder
• Criterion for Clinical Significance
• Elements of a Diagnosis
  – Diagnostic Criteria and Descriptors
  – Subtypes and Specifiers
Section II

Revised DSM-5 Chapter Structure
Clustering of Chapters

• Neurodevelopmental Disorders
• Emotional (Internalizing) Disorders
• Somatic Disorders
• Externalizing Disorders
• Neurocognitive Disorders
• Personality Disorders
Section II: Chapter Structure

A. Neurodevelopmental Disorders
B. Schizophrenia Spectrum and Other Psychotic Disorders
C. Bipolar and Related Disorders
D. Depressive Disorders
E. Anxiety Disorders
F. Obsessive-Compulsive and Related Disorders
G. Trauma- and Stress-Related Disorders
H. Dissociative Disorders
Section II: Chapter Structure

I. Somatic Symptom and Related Disorders
J. Feeding and Eating Disorders
K. Elimination Disorders
L. Sleep–Wake Disorders
M. Sexual Dysfunction
N. Gender Dysphoria
Section II: Chapter Structure

O. Disruptive, Impulse Control, and Conduct Disorders
P. Substance-Related and Addictive Disorders
Q. Neurocognitive Disorders
R. Personality Disorders
S. Paraphilic Disorders
T. Other Disorders
U. Medication-Induced Movement Disorders and Other Adverse Effects of Medication
V. Other Conditions That May Be a Focus of Clinical Attention
Changes in Specific DSM Disorder Numbers: Combination of New, Eliminated, and Combined Disorders (Net Difference = -15)

<table>
<thead>
<tr>
<th>Specific Mental Disorders*</th>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>172</td>
<td>157</td>
</tr>
</tbody>
</table>

*NOS (DSM-IV) and Other Specified/Unspecified (DSM-5) conditions are counted separately
New and Eliminated Disorders in DSM-5
(Net Difference = +13)

New Disorders
1. Social (Pragmatic) Communication Disorder
2. Disruptive Mood Dysregulation Disorder
3. Premenstrual Dysphoric Disorder (DSM-IV appendix)
4. Hoarding Disorder
5. Excoriation (Skin-Picking) Disorder
6. Disinhibited Social Engagement Disorder (split from Reactive Attachment Disorder)
7. Binge Eating Disorder (DSM-IV appendix)
8. Central Sleep Apnea (split from Breathing-Related Sleep Disorder)
9. Sleep-Related Hypoventilation (split from Breathing-Related Sleep Disorder)
10. Rapid Eye Movement Sleep Behavior Disorder (Parasomnia NOS)
11. Restless Legs Syndrome (Dyssomnia NOS)
12. Caffeine Withdrawal (DSM-IV Appendix)
13. Cannabis Withdrawal
14. Major Neurocognitive Disorder With Lewy Body Disease (Dementia Due to Other Medical Conditions)
15. Mild Neurocognitive Disorder (DSM-IV Appendix)

Eliminated Disorders
1. Sexual Aversion Disorder
2. Polysubstance-Related Disorder
Combined Specific Disorders in DSM-5
(Net Difference = -28)

1. **Language Disorder** (Expressive Language Disorder and Mixed Receptive-Expressive Language Disorder)

2. **Autism Spectrum Disorder** (Autistic Disorder, Asperger’s Disorder, Childhood Disintegrative Disorder, and Rett's Disorder; PDD-NOS is in the NOS count)

3. **Specific Learning Disorder** (Reading Disorder, Math Disorder, and Disorder of Written Expression)

4. **Delusional Disorder** (Shared Psychotic Disorder and Delusional Disorder)

5. **Panic Disorder** (Panic Disorder Without Agoraphobia and Panic Disorder With Agoraphobia)

6. **Dissociative Amnesia** (Dissociative Fugue and Dissociative Amnesia)

7. **Somatic Symptom Disorder** (Somatization Disorder, Undifferentiated Somatoform Disorder, and Pain Disorder)

8. **Insomnia Disorder** (Primary Insomnia and Insomnia Related to Another Mental Disorder)

9. **Hypersomnolence Disorder** (Primary Hypersomnia and Hypersomnia Related to Another Mental Disorder)

10. **Non-rapid Eye Movement Sleep Arousal Disorders** (Sleepwalking Disorder and Sleep Terror Disorder)

Combined Specific Disorders in DSM-5 (cont.)
(Net Difference = -28)

11. Genito-Pelvic Pain/Penetration Disorder (Vaginismus and Dyspareunia)
12. Alcohol Use Disorder (Alcohol Abuse and Alcohol Dependence)
13. Cannabis Use Disorder (Cannabis Abuse and Cannabis Dependence)
14. Phencyclidine Use Disorder (Phencyclidine Abuse and Phencyclidine Dependence)
15. Other Hallucinogen Use Disorder (Hallucinogen Abuse and Hallucinogen Dependence)
16. Inhalant Use Disorder (Inhalant Abuse and Inhalant Dependence)
17. Opioid Use Disorder (Opioid Abuse and Opioid Dependence)
18. Sedative, Hypnotic, or Anxiolytic Use Disorder (Sedative, Hypnotic, or Anxiolytic Abuse and Sedative, Hypnotic, or Anxiolytic Dependence)
19. Stimulant Use Disorder (Amphetamine Abuse, Amphetamine Dependence, Cocaine Abuse, and Cocaine Dependence)
20. Stimulant Intoxication (Amphetamine Intoxication and Cocaine Intoxication)
22. Substance/Medication-Induced Disorders (aggregate of Mood (+1), Anxiety (+1), and Neurocognitive (-3) Disorders)
### Changes From NOS to Other Specified/Unspecified (Net Difference = +24)

<table>
<thead>
<tr>
<th></th>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOS (DSM-IV) and Other Specified/Unspecified (DSM-5)</td>
<td>41</td>
<td>65</td>
</tr>
</tbody>
</table>

Other Specified/Unspecified Disorders in DSM-5 replaced the Not Otherwise Specified (NOS) conditions in DSM-IV to maintain greater concordance with the official International Classification of Diseases (ICD) coding system. This statistical accounting change does not signify any new specific mental disorders.
Highlights of Specific Disorder Revisions and Rationales
Autism Spectrum Disorder (ASD) (Neurodevelopmental Disorders)

- ASD replaces DSM-IV's autistic disorder, Asperger's disorder, childhood disintegration disorder, and pervasive developmental disorder NOS
  - Rationale: Clinicians had been applying the DSM-IV criteria for these disorders inconsistently and incorrectly. Subsequently, reliability data to support their continued separation was very poor.
  - Specifiers can be used to describe variants of ASD (e.g., the former diagnosis of Asperger's can now be diagnosed as autism spectrum disorder, without intellectual impairment and without structural language impairment).
Autism Spectrum Disorder

• The criteria from DSM-IV's autistic disorder, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder NOS have been combined into a single diagnosis of autism spectrum disorder

• The aim is to more accurately characterize children with social communication and interaction deficits as well as restrictive, repetitive behaviors, activities, or interests
Autism Spectrum Disorder (2)

• This revision is not expected to significantly alter prevalence rates

• The criteria were developed with enough sensitivity and specificity that most children (91%) previously diagnosed with a pervasive developmental disorder under DSM-IV will meet criteria for autism spectrum disorder, allowing them to retain a diagnosis and continue receiving treatment and educational services.
Intellectual Disability
(Intellectual Developmental Disorder)

• Mental retardation was renamed intellectual disability (intellectual developmental disorder)

  – Rationale: The term *intellectual disability* reflects the wording adopted into US law in 2010 (Rosa's Law), in use in professional journals, and endorsed by certain patient advocacy groups. The term *intellectual developmental disorder* is consistent with the language proposed for ICD-11.

• Greater emphasis on adaptive functioning deficits rather than IQ scores alone

  – Rationale: Standardized IQ test scores were overemphasized as the determining factor of abilities in DSM-IV. Consideration of functioning provides a more comprehensive assessment of the individual.
Attention-Deficit/Hyperactivity Disorder

• Age of onset was raised from 7 to 12 years
  - Rationale: Numerous large-scale studies indicate that in many cases, onset is not identified until after age 7, when a child is challenged by school requirements. Recall of onset is more accurate at 12 years.

• The symptom threshold for adults aged 17 years and older was reduced to 5
  – Rationale: The reduction in symptom threshold was for adults only and was made based on longitudinal studies showing that patients tend to have fewer symptoms in adulthood than in childhood. This should result in a minimal increase in the prevalence of adult ADHD.
Specific Learning Disorder

• Now presented as a single disorder with coded specifiers for specific deficits in reading, writing, and mathematics

  – Rationale: There was widespread concern among clinicians and researchers that clinical reality did not support DSM-IV's 3 independent learning disorders. This is particularly important given that most children with specific learning disorder manifest deficits in more than 1 area.

  – By reclassifying these as a single disorder, separate specifiers can be used to code the level of deficits present in each of the 3 areas for any person.
Schizophrenia
(Schizophrenia Spectrum and Other Psychotic Disorders)

• Elimination of special treatment of bizarre delusions and "special" hallucinations in Criterion A (characteristic symptoms)
  – Rationale: This was removed due to poor reliability in distinguishing bizarre from non-bizarre delusions.

• At least 1 of the 2 symptoms required to meet Criterion A must be delusions, hallucinations, or disorganized speech
  – Rationale: This will improve reliability and prevent individuals with only negative symptoms and catatonia from being diagnosed with schizophrenia.
Schizophrenia (cont.)

• Deletion of specific subtypes
  – Rationale: DSM-IV's subtypes were shown to have very poor reliability and validity. They also failed to differentiate from one another based on treatment response and course.
Schizoaffective Disorder

• Now based on lifetime (rather than episodic) duration of illness in which the mood and psychotic symptoms described in Criterion A occur

  – Rationale: The criteria in DSM-IV have demonstrated poor reliability and clinical utility, in part because the language in DSM-IV regarding the duration of illness is ambiguous. This revision is consistent with the schizophrenia and mood episodes language, which explicitly describes a longitudinal rather than an episodic course. Applying a longitudinal course to schizoaffective disorder will aid in its differential diagnosis from these related disorders.
Catatonia

• Now exists as a **specifier** for neurodevelopmental, psychotic, mood, and other mental disorders as well as other medical disorders (catatonia due to another medical condition)

  – Rationale: As represented in DSM-IV, catatonia was under-recognized, particularly in psychiatric disorders other than schizophrenia and psychotic mood disorders as well as in other medical disorders. It was also apparent that the inclusion of catatonia as a specific condition that can apply more broadly across the manual may help address gaps in the treatment of catatonia.
Anxiety Disorders

• Relocated to own chapter, separate from other anxiety-related disorders

• "With panic attacks": specifier for any mental disorder

• Panic disorder and agoraphobia unlinked

• Inclusion of separation anxiety disorder and selective mutism in this chapter rather than in a chapter on child/adolescent disorders
Obsessive-Compulsive and Related Disorders

• Relocated to own chapter, separate from other anxiety disorders

• New or renamed disorders
  – Hoarding disorder
  – Excoriation (skin-picking) disorder
  – Trichotillomania (hair-pulling disorder)

• Expansion of insight specifiers for OCD and BDD (i.e., "good or fair," "poor," "absent/delusional")
Trauma- and Stress-Related Disorders

• Relocated to own chapter, separate from other anxiety disorders

• PTSD criteria revised
  – Stressor criterion (Criterion A) more explicit; elimination of subjective reaction (Criterion A2)
  – Expansion to 4 symptom clusters, with avoidance/numbing cluster divided into 2 distinct clusters: avoidance and persistent negative alterations in cognitions and mood
• By including an additional criteria set focused solely on symptoms in children aged 6 and younger, diagnosis will be more developmentally sensitive and will call attention to differences in presentation among young children vs. adults (e.g., the re-experiencing of traumatic events through play or storytelling)
Trauma- and Stress-Related Disorders (3)

• Subtypes of reactive attachment disorder are now 2 distinct disorders
  – Reactive attachment disorder
  – Disinhibited social engagement disorder
Feeding and Eating Disorders

- Binge eating disorder elevated to the main body of the manual
- Inclusion of pica and rumination disorder in this chapter rather than in a chapter on child/adolescent disorders
- Anorexia nervosa: elimination of amenorrhea requirement
- Feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder
Sleep–Wake Disorders

- Primary insomnia renamed insomnia disorder
- Subtypes of circadian rhythm sleep disorders expanded to include advanced sleep phase syndrome, irregular sleep–wake type, and free-running type
- Rapid eye movement sleep behavior disorder and restless legs syndrome both elevated to the main body of the manual
- Age and development more explicitly addressed in criteria and text
Gender Dysphoria

- New diagnostic class to reflect a change in the conceptualization of the disorder's defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification, as in DSM-IV

- Gender identity disorder now named gender dysphoria
  - Includes 2 separate sets of criteria for children and adults and adolescents
  - Subtyping on the basis of sexual orientation is eliminated
Disruptive, Impulse Control, and Conduct Disorders

• Conduct disorder
  – Addition of specifier: "with limited prosocial emotions"
    • Lack of remorse
    • Callous or lack of empathy
    • Unconcerned about performance in school/work
    • Shallow or deficient affect

• Cross-listing of antisocial personality disorder here and in personality disorders
Substance-Related and Addictive Disorders

• Consolidate substance abuse and substance dependence into a single disorder called substance use disorder
  – Create a continuum that includes mild, moderate, and severe substance use

• Removal of one of the DSM-IV abuse criteria; addition of a new criterion to the new substance use disorder diagnosis
  – Removal of legal consequences (e.g., multiple arrests)
  – Addition of craving
Neurocognitive Disorders (NCD)

• Use of the term major neurocognitive disorder rather than dementia

  − Rationale: The term dementia is usually associated with neurodegenerative conditions occurring in older populations, as in Alzheimer's disease and Lewy Body dementia. However, DSM-5's major NCD refers to a broad range of possible etiologies that can occur even in young adults, such as major NCD due to traumatic brain injury or HIV infection.
Mild NCD

- Newly added to DSM-5
  - Rationale: Patients with mild NCD are frequently seen in clinics and research settings, and there is widespread consensus throughout the field that this population can benefit from diagnosis and treatment. The clinical utility of such a diagnosis is also highly supported in the literature.
Select Changes in Diagnoses: Personality Disorders

• All 10 DSM-IV personality disorders will remain intact and located in Section II of DSM-5

• Section III contains an alternative, trait-based diagnostic approach to personality disorders that separates functional impairment (A Criteria) and the expression of characteristic traits (B Criteria) for 6 personality disorders
  – Personality disorder – trait specified
  – A direct mapping to existing criteria for DSM-IV personality disorders will assist clinicians in learning the new approach
Section III: Purpose

- Section III serves as a designated location, separate from diagnostic criteria, text, and clinical codes, for items that appear to have initial support in terms of clinical use but require further research before being officially recommended as part of the main body of the manual.

  - This separation clearly conveys to readers that the content may be clinically useful and warrants review but is not a part of an official diagnosis of a mental disorder and cannot be used as such.
Section III: Content

• Section III: Emerging Measures and Models
  – Assessment Measures
  – Cultural Formulation
  – Alternative DSM-5 Model for Personality Disorders
  – Conditions for Further Study
Optional Section III: Measures Recommended for Further Study and Evaluation
Optional Measurements in DSM-5

• Assess patient characteristics not necessarily included in diagnostic criteria but of high relevance to prognosis, treatment planning, and outcome for most patients

• In DSM-5, these include:
  – Level 1 and Level 2 Cross-Cutting Symptom assessments
  – Diagnosis-specific severity ratings
  – Disability assessment

• May be patient, informant, or clinician completed, depending on the measure

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Level 1 Cross-Cutting Symptom Measure

• Referred to as "cross-cutting" because it calls attention to symptoms relevant to most if not all psychiatric disorders (e.g., mood, anxiety, sleep disturbance, substance use, suicide)
  – Self-administered by patient
  – 13 symptom domains for adults
  – 12 symptom domains for children 11+ and parents of children 6+
  – Brief; 1-3 questions per symptom domain
  – Screen for important symptoms, not for specific diagnoses (i.e., "cross-cutting")
### Patient-Related Level 1 Cross-Cutting Measures

**Note:** The following questions inquire about how you have been feeling over the past two weeks.

<table>
<thead>
<tr>
<th>During the past 2 weeks, how much have you been bothered by the following problems:</th>
<th>None Not at all</th>
<th>Slight Rare, less than a day or two</th>
<th>Mild Several days</th>
<th>Moderate More than half the days</th>
<th>Severe Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Feeling irritated, grouchy, angry?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Sleeping less but still having a lot of energy?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Starting lots of projects or doing more risky things?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Feeling nervous, anxious, frightened, worried, or on edge?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Feeling panic or being frightened?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Avoiding situations that make you anxious?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Having unexplained aches and pains (e.g. head, back, joints, abdomen, legs)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Feeling that your illnesses are not being taken seriously enough?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Patient-Related Level 1 Cross-Cutting Measures

*Note:* The following questions inquire about how you have been feeling over the past two weeks.

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<th>Mild Several days</th>
<th>Moderate More than half the days</th>
<th>Severe Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the <strong>past 2 weeks</strong>, how much have you been bothered by the following problems?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Having thoughts of actually hurting yourself?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Hearing things other people couldn’t hear, such as voices even when no one was around?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Feeling that someone could hear your thoughts or that you could hear what another person was thinking?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. Having problems with sleep that affected your sleep quality over all?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. Having problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. Having unpleasant thoughts, images, or urges that repeatedly enter your mind?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. Feeling driven to perform certain acts over and over again?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. Not knowing who you really are or what you want out of life?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. Not feeling close to other people or enjoying your relationships with them?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. Drinking at least 4 drinks of any kind of alcohol in a single day?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. Smoking any cigarettes, a cigar, or pipe or using snuff or chewing tobacco?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22. Using any of the following medicines ON YOUR OWN, that is, without a doctor’s prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]]</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Level 2 Cross-Cutting Measure

- Completed when the corresponding Level 1 item is endorsed at the level of "mild" or greater (for most but not all items; e.g., psychosis, inattention)
  - Gives a more detailed assessment of the symptom domain
  - Largely based on pre-existing, well-validated measures, including the SNAP-IV (inattention); NIDA-modified ASSIST (substance use); and PROMIS® forms (anger, sleep disturbance, emotional distress)
### Example of a Level 2 Cross-Cutting Assessment: Sleep

Please respond to each item by choosing one option per question.

<table>
<thead>
<tr>
<th>In the past SEVEN (7) DAYS....</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>My sleep was restless.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was satisfied with my sleep.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My sleep was refreshing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I had difficulty falling asleep.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the past SEVEN (7) DAYS....</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometime</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I had trouble staying asleep.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I had trouble sleeping.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I got enough sleep.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the past SEVEN (7) DAYS....</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>My sleep quality was...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Diagnosis-Specific Severity Measures

• For documenting the severity of a specific disorder using, for example, the frequency and intensity of its component symptoms

• Can be administered to individuals with:
  – A diagnosis meeting full criteria
  – An "other specified" diagnosis, especially a clinically significant syndrome that does not meet diagnostic threshold

• Some clinician rated, some patient rated
Diagnosis-Specific Severity Assessment: Symptom Domains for Schizophrenia

- Hallucinations
- Delusions
- Disorganized Speech
- Abnormal Psychomotor Behavior
- Negative Symptoms (Restricted Emotional Expression or Avolition)
- Impaired Cognition
- Depression
- Mania

0 = Not Present
1 = Equivocal
2 = Present, but mild
3 = Present and moderate
4 = Present and severe
World Health Organization Disability Assessment Schedule (WHODAS 2.0)

- WHODAS 2.0 is the recommended but not required assessment for disability
- Corresponds to disability domains of ICF
- Developed for use in all clinical and general population groups
- Tested worldwide and in DSM-5 Field Trials
- 36 questions, self-administered with clinician review
- For adult patients
  - Child version developed by DSM-5, not yet approved by WHO
Section III: Content

• Section III: **Conditions for Further Study**
  
  – Attenuated Psychosis Syndrome
  – Depressive Episodes With Short-Duration Hypomania
  – Persistent Complex Bereavement Disorder
  – Caffeine Use Disorder
  – Internet Gaming Disorder
  – Neurobehavioral Disorder Due to Prenatal Alcohol Exposure
  – Suicidal Behavior Disorder
  – Non-suicidal Self-Injury
Appendix: Content

• Separate from Section III will be an Appendix including:
  – Highlights of Changes From DSM-IV to DSM-5
  – Glossary of Technical Terms
  – Glossary of Cultural Concepts of Distress
  – Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)
  – Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)
  – Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM)
  – DSM-5 Advisors and Other Contributors