DSM-5-TR Updates:

What Providers Need to Know

Friday, May 20, 2022
9AM- 2PM CT | 8AM- 1PM MT

BHECN
BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

NCA
Nebraska Counseling Association

1

DSM-5-TR Updates:
What Providers Need to Know

Dr. Arden Szepe – Assistant Professor
Master of Arts in Counseling Program
Doane University

Dr. Krista Fritson -- Licensed Clinical Psychologist
UNK Undergraduate Psych Professor
Director, BHECN – Kearney
Clinical Director, Central NE LOSS

2

Webinar Summary

- DSM-5-TR Organization Summary
- Wording and Coding
- Suicidal Behavior
- Diagnostic Changes
- 50 Coding Updates
- Updated Re-design
- Future Considerations

3

DSM-5-TR Organizational Summary

- Primary goals:
  - Help clinicians make more accurate and consistent diagnoses
  - Help researchers better study how disorders relate to one another, which can lead to better treatment for patients.
  - Lifespan approach in Section II
  - Section III now includes "Conditions for Further Study" section p. 20
  - Color organization of sections within section II

4

DSM-5-TR Organizational Summary
Same Structure as the DSM-5

- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Elimination Disorders
- Other Mental Disorders and Additional Codes
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders

5

DSM-5-TR Organizational Summary

Same Structure as the DSM-5

- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders Feeding and Eating Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Substance-Related and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorder
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication
- Other Conditions That May Be a Focus of Clinical Attention

6

History

DSM Edition	Year of Publication	Disorders Listed
DSM-I	1952	106 Disorders
DSM-II	1968	182 Disorders
DSM-III	1980	265 Disorders
DSM-III-TR	1987	292 Disorders
DSM-IV	1994	297 Disorders
DSM-IV-TR	2000	297 Disorders
DSM-5	2013	298 Disorders
DSM-5-TR	2022	299 Disorder

7

Wording and Coding

Wording/Terminology

Culture

- Section III Assessments
- ICD-10–Only: NO DSM code

8

Changes in Wording/ Terminology

- 'Racialized' instead of 'race/racial'
- 'Ethnoracial' used to denote U.S. Census categories (i.e., Hispanic, White, or African American) that combine ethnic and racialized identifiers
- Removed terms 'Minority' and 'non-White'
- 'Caucasian'
  - Now becoming larger population
  - Prevents term designating as less than
- 'Latinx' used to promote gender-inclusive terminology rather than "Latino(a)"
  - Some information/articles suggesting not ALL in this culture/ethnocial group are embracing this idea (https://www.pewresearch.org/hispanic/2020/08/11/about-one-in-four-u-s-hispanics-have-heard-of-latinx-but-just-3-use-it/)
  - https://www.nbcnews.com/think/opinion/many-latinos-say-latinx-offends-or-bothers-them-here-s-ncna1284916
  - https://www.wsj.com/articles/does-latinx-rhyme-kleenex-latino-latina-hispanic-woke-gender-lgbtqia-colonialism-progressives-11639930248

(APA, 2022a)

9

Recognizing Cultural Differences

(DSM-5-TR Manual, p. 18-19)

- Added disclaimers/notes to inform reader of higher incidence of diagnosis in certain cultural groups
  - Attention to cultural norms
- Attention to risk of misdiagnosis when evaluating individuals from socially oppressed ethnoracial groups
- Terms: "Cultural contexts" or "Cultural backgrounds" to avoid overgeneralization
- Identifies specific "Concepts of Distress"

10

Cultural Context

(DSM-5-TR, p. 859-871)

- Cultural Context Section
  - Addresses cultural context of mental illness and the Cultural Formulation Interview (CFI) (p. 864-871)
  - Addresses stigmatization or use of generalized language
  - Revised examples of cultural concepts of distress and describes ways distress/illness is expressed, reported, and interpreted (p. 871)
  - Includes outline for systematic person-centered cultural assessment in cultural formulation section (p. 862-871)

(APA, 2022a)

11

Cultural Concepts of Distress

(DSM-5-TR, p. 871)

- *Cultural Concepts of Distress*
  - "refers to ways that individuals experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions." (p. 871)
- 3 main types of *Concepts of Distress*
  - ***Cultural Idioms of Distress*** - ways of expressing distress that may not involve specific symptoms or syndromes (e.g., "nerves" "depressed" "worried"
  - ***Cultural Explanations*** - (perceived causes) are labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress.
  - ***Cultural Syndromes*** - clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities or contexts and that are recognized locally as coherent patterns of experience.

(APA, 2022a)

12

Cultural Concepts of Distress

(DSM-5-TR, p. 871-872)

- *Cultural Concepts of Distress*
  - Replaces former formulation *Culture-bound Syndrome*.
  - Change made to clarify to emphasize clinically important cultural differences often involve explanations or experience of distress rather than culturally distinctive configurations of symptoms.
  - *Culture bound* overemphasizes the ext to which cultural concepts of distress are characterized by highly idiosyncratic experiences that are restricted to specific geographic regions.

(APA, 2022a)

13

Cultural Concepts of Distress

(DSM-5-TR, p. 874-879)

- Examples

Attaque de nervios	Dhat syndrome
Hikikomori	Khyal cap
Kufungisisa	Maladi dyab
Nervios	Shenjing shuairuo
Susto	Taijin kyofusho

(APA, 2022a)

14

Sex / Gender Differences

(DSM-5-TR, p. 19)

- **Sex:** "refers to factors attributable to an individual's reproductive organs and XX or XY chromosomal implement"
- **Gender:** "is a result of reproductive organs as well as an individual's self-representation and includes the psychological, behavioral, and social consequences of the individual's perceived gender.
- **Common Terms:** "gender differences" or "women/men" or "girls/boys" vs "sex differences" or "male/female"
- **Exceptions:** use "sex" ("male/female") when information is pertinent to sex.
  - Metabolism of substances
  - life stage restrictions to one sex - pregnancy, menopause

(APA, 2022b)

15

Gender

(DSM-5-TR, p. 511)

- Removed binary classifications of male/female
- Natal male/natal female is now individual "assigned male/female at birth" ("birth-assigned sex")
- Desired gender is now "experienced gender"
- Cross-sex medical procedure is now "gender-affirming medical procedure"

(APA, 2022b)

16

Section III Assessments

(DSM-5-TR, p. 841-857)

- Clinical Sequence: (p. 847-850)
  - Level 1 cross-cutting/self informant-rated measures
  - Level 2 cross-cutting symptoms measures
- Clinician-Rated Dimensions of Psychosis Symptom Severity (p. 852)
  - Measure for schizophrenia spectrum and other psychotic disorders
  - Updated to keep with criteria (severity specifiers)
- World Health Organization Disability Assessment Schedule 2.0 (p. 856)
  - Updated to include clarifications to instructions for calculating summary scores

(APA, 2022c)

17

Section III Assessments

Self-Rated Level 1…
(DSM-5-TR, p. 847-848)

Adult Version

Adult Online Version (23 Questions):

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

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

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

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

	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	

18

Section III

Assessments

Self-Rated Level 1…
(DSM-5-TR, p. 849-850)

Child Version

Child Online Version (25 Questions):

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

Child's Name: _____ **Age:** ____ **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. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	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	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	

19

Section III

Assessments

Psychosis Symptoms Severity
(DSM-5-TR, p. 851-853)

Online Scale Psychosis Symptoms Severity: (8 Domains)

Clinician-Rated Dimensions of Psychosis Symptom Severity

Name:_____ **Age:** _____ **Sex:** [ ] Male [ ] Female **Date:**_____

Instructions: Based on all the information you have on the individual and using your clinical judgment, please rate (with checkmark) the presence and severity of the following symptoms as experienced by the individual in the past seven (7) days.

Domain	0	1	2	3	4	Score
I. Hallucinations	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered psychosis)	❑ Present, but mild (little pressure to act upon voices, not very bothered by voices)	❑ Present and moderate (some pressure to respond to voices, or is somewhat bothered by voices)	❑ Present and severe (severe pressure to respond to voices, or is very bothered by voices)	
II. Delusions	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered psychosis)	❑ Present, but mild (little pressure to act upon delusional beliefs, not very bothered by beliefs)	❑ Present and moderate (some pressure to act upon beliefs, or is somewhat bothered by beliefs)	❑ Present and severe (severe pressure to act upon beliefs, or is very bothered by beliefs)	
III. Disorganized speech	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered disorganization)	❑ Present, but mild (some difficulty following speech)	❑ Present and moderate (speech often difficult to follow)	❑ Present and severe (speech almost impossible to follow)	
IV. Abnormal psychomotor behavior	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered abnormal psychomotor behavior)	❑ Present, but mild (occasional abnormal or bizarre motor behavior or catatonia)	❑ Present and moderate (frequent abnormal or bizarre motor behavior or catatonia)	❑ Present and severe (abnormal or bizarre motor behavior or catatonia almost constant)	
V. Negative symptoms (restricted emotional	❑ Not present	❑ Equivocal decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present, but mild decrease in facial expressivity, prosody, gestures, or	❑ Present and moderate decrease in facial expressivity, prosody, gestures, or self-initiated	❑ Present and severe decrease in facial expressivity, prosody, gestures, or	

20

Section III

Assessments

Disability Assessment
(DSM-5-TR, p 854-855)

Online WHODAS 2.0 (36 Items):

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

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*		
In the last 30 days, how much difficulty did you have in:							Item Score	Raw Domain Score	Domain Score
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			

21

ICD-10

- Only ICD-10-CM codes used to match current version of ICD in effect in the U.S.
- Based on WHO's ICD-10 codes but modified for clinical use by CDC's National Center for Health Statistics
- ICD-10 is ONLY permissible clinical diagnostic codes for mental disorders in the U.S. (ICD-9 NO longer used; NO DSM codes)
- ICD-11 is likely to be released in 2025
- Most disorders in DSM-5-TR have an alphanumeric ICD-10-CM code that appears preceding the name of the disorder (or coded subtype or specifier). The text sections "recording procedures" or "coding notes" describe the appropriate coding procedure for the DSM diagnoses.
- The use of diagnostic codes is fundamental to medical record keeping. It facilitates data collection and retrieval and compilation of statistical information.

(APA, 2022d)

22

Suicidal and Nonsuicidal Self-Injury Behaviors

23

Suicidal Behavior

(DSM-5-TR, p. 822)

Coding

May be used for individuals who have engaged in potentially self-injurious behavior with at least some intent to die as a result of the act. Evidence of intent to end one's life can be explicit or inferred from the behavior or circumstances. A suicide attempt may or may not result in actual self-injury. **If the individual is dissuaded by another person or changes his or her mind before initiating the behavior, this category does not apply.**

Current Suicidal Behavior

T14.91A Initial encounter: If suicidal behavior is part of the initial encounter with the clinical presentation

T14.91D Subsequent encounter: If suicidal behavior is part of subsequent encounters with the clinical presentation.

Z91.51 History of Suicidal Behavior

(APA, 2022e)

24

Suicidal Behavior
(DSM-5-TR, p. 822)

Additional Definitions of ICD-10 Coding for Suicidal Behavior

A (initial encounter)- use while individual is in active treatment for behavior (e.g., emergency department; evaluation and treatment by clinician)

D (subsequent encounter)- use after the individual has received active treatment for behavior and when they are receiving routine care

Use only for T codes

25

Nonsuicidal Self-Injury
(DSM-5-TR, p. 822-823)

Coding

Used for individuals who have engaged in intentional self-inflicted damage to their body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing) in the **absence** of suicidal intent.

R45.88 Current Nonsuicidal Self-Injury
*If behavior is part of clinical presentation

Z91.52 History of Nonsuicidal Self-Injury
* If behavior has occurred during the individual's lifetime

26

Proposed Suicidal Behavior Disorder
(DSM-5-TR, p. 920-923)

Proposed Diagnostic Criteria

A. Within the last 24 months, the individual has made a suicide attempt.
Note: A suicide attempt is a self-initiated sequence of beahviors by an individual who, at the time of initiation, exprected that the set of actions would lead to his or her own death. (The "time of initiation" is the time when a behavior took place hat involved applying the method.)
B. The act does not meet criteria for nonsuicidal self-injury- that is, it does not involve self-injury directed to the surface of the body undertaken to induce relief from a negative feeling/cognitive state or to achieve a positive mood state.
C. The diagnosis is not applied to suicidal ideation or to prepartory acts.
D. The act was not initiated during a state of delirium or confusion.
E. The act was not undertaken solely for a political or religious objective.

Specify if:
Current: Not more than 12 months since the last attempt.
In early remission: 12-24 months since the last attempt.

27

Proposed Nonsuicidal Self-Injury Disorder
(DSM-5-TR, p. 923-926)

Proposed Diagnostic Criteria:

A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain, with the expectation that the injury will lead to only minor or moderate physical harm
B. The individual engages in the self-injurious behavior with one or more of the following expectations:
   1. To obtain relief from a negative feeling or cognitive state.
   2. To resolve an interpersonal difficulty.
   3. To induce a positive feeling state.
C. The intentional self-injury is associated with at least one of the following:
   1. Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.
   2. Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control.
   3. Thinking about self-injury that occurs frequent, even when it is not acted upon.
D. The behavior is not socially sanctioned and is not restricted to picking a scab or nail biting.
E. The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.
F. The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypes. The behavior is not better explained by another mental disorder or medical condition.

28

Diagnostic Changes

Prolonged Grief Disorder
Updated Diagnoses
Diagnostic Updates for Children

29

Prolonged Grief Disorder (PGD)
(DSM-5-TR, p. 322)

Timeline:

- DSM5: Persistent Complicated Bereavement Disorder added to Section 3 (2013)
- Proposal submitted for Prolonged Grief Disorder to be included in Section II of the DSM (2018)
- Criteria finalized and approved by Steering Committee, and the APA's Assembly and Board of Trustees (2019)
- PGD added to "Trauma and Stress-Related Disorders" chapter in Section 2 of the DSM-5-TR (2022)

(APA, 2022f)

30

Prolonged Grief Disorder

(DSM-5-TR, p. 322)

Defined as: "Intense yearning or longing for the deceased (often with intense sorrow and emotional pain), and preoccupation with thoughts or memories of the deceased (in children adolescents, this preoccupation may focus on the circumstances of the death)" (APA, 2022f).

Prevalence:

- Prevalence in adults is unknown
- Meta-analysis demonstrated a pooled prevalence of 9.8%
  - Substantial heterogeneity across the 4 studies analyzed which affected findings (e.g., symptom definitions, measures, duration)

31

Prolonged Grief Disorder (F43.8)

(DSM-5-TR, p. 322)

Diagnostic Criteria

A. The death, at least 12 months ago, of a person who was close to the bereaved individual (for children and adolescents, at least 6 months ago).

B. Since the death, the development of a persistent grief response characterized by one or both of the following symptoms, which have been present most days to a clinically significant degree. In addition, the symptom(s) has occurred nearly every day for at least the last month:

   1. Intense yearning/longing for the deceased person
   2. Preoccupation with thoughts or memories of the deceased person (in children and adolescents, preoccupation may focus on the circumstances of the death).

32

Prolonged Grief Disorder

(DSM-5-TR, p. 322)

Diagnostic Criteria (cont.)

C. Since the death, at least three of the following symptoms have been present most days to a clinically significant degree. In addition, the symptoms have occurred nearly every day for at least the last month:

   1. Identity disruption (e.g., feeling as though part of oneself has died) since the death.
   2. Marked sense of disbelief about the death.
   3. Avoidance of reminders that the person is dead (in children and adolescents, may be characterized by efforts to avoid reminders).
   4. Intense emotional pain (e.g., anger, bitterness, sorrow) related to death.
   5. Difficulty reintegrating into one's relationships and activities after the death (e.g., problems engaging with friends, pursuing interests, or planning for the future).
   6. Emotional numbness (absence or marked reduction of emotional experience) as a result of the death.
   7. Feeling that life is meaningless as a result of the death.
   8. Intense loneliness as a result of the death.

33

Prolonged Grief Disorder

(DSM-5-TR, p. 322)

Diagnostic Criteria (cont.)

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The duration and severity of the bereavement reaction clearly exceed expected social, cultural, or religious norms for the individual's culture and context.

F. The symptoms are not better explained by another mental disorder, such as major depressive disorder or posttraumatic stress disorder, and are not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

34

Prolonged Grief Disorder

(DSM-5-TR, p. 322)

Considerations:

- Developmental
- Comorbidity with PTSD
- Environmental
- Cultural

Note:

Z63.4 Uncomplicated Bereavement

"Used when focus of clinical attention is a normal reaction to the death of a loved one. As part of their reaction to such a loss, some grieving individuals present with symptoms characteristic of a major depressive episode. The bereaved individual typically regards the depressed mood as "normal," although the individual may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of "normal" bereavement vary considerably among different cultural groups. Further guidance in distinguishing grief from a major depressive episode and from prolonged grief disorder is provided in their respective texts" (p. 834).

35

Prolonged Grief Disorder

(DSM-5-TR, p. 322)

Differential Diagnosis:

- Normal Grief
- Depressive Disorders
- Posttraumatic Stress Disorder
- Separation Anxiety Disorder
- Psychotic Disorder

Most Common Comorbidity:

- Posttraumatic Stress Disorder
- Major Depressive Disorder
- Substance Use Disorders

36

Prolonged Grief Disorder

Grief Assessments:

- PG-13-Revised Scale
- Inventory of Complicated Grief

Prolonged Grief Disorder (PG-13-Revised)

Q1. Have you lost someone significant to you? ○ Yes ○ No

Q2. How many months has it been since your significant other died? ☐ Months

For each item below, please indicate how you currently feel

Since the death, or as a result of the death...	Not at all	Slightly	Somewhat	Quite a bit	Overwhelmingly
Q3. Do you feel yourself longing or yearning for the person who died?	○	○	○	○	○
Q4. Do you have trouble doing the things you normally do because you are thinking so much about the person who died?	○	○	○	○	○
Q5. Do you feel confused about your role in life or feel like you don't know who you are anymore or feel dazed or like that a part of you has died?	○	○	○	○	○
Q6. Do you have trouble believing that the person who died is really gone?	○	○	○	○	○
Q7. Do you avoid reminders that the person who died is really gone?	○	○	○	○	○
Q8. Do you feel emotional pain (e.g., anger, bitterness, sorrow) related to the death?	○	○	○	○	○
Q9. Do you feel that you have trouble re-engaging in life (e.g., problems engaging with friends, pursuing interests, planning for the future)?	○	○	○	○	○
Q10. Do you feel emotionally numb or detached from others?	○	○	○	○	○
Q11. Do you feel that life is meaningless without the person who died?	○	○	○	○	○
Q12. Do you feel alone or lonely without the deceased?	○	○	○	○	○

Q13. Have the symptoms above caused significant impairment in social, occupational, or other important areas of functioning? ○ Yes ○ No

37

Prolonged Grief Disorder

Resources / Articles

Resources / Scholarly Articles

- *Complicated Grief: A Case Study*
  http://www.dralbertwong.com/complicated-grief-a-case-study/
- *Prevalence in Female Refugees*
  https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-019-2136-1
- *Tips for Understanding PGD*
  https://www.psychiatry.org/newsroom/news-releases/apa-offers-tips-for-understanding-prolonged-grief-disorder

38

Case Example

Sue, a 50-year-old woman, comes to your office stating she feels as if days pass by while she waits until she can sleep at night. Sue reports feeling 'numb' to almost everything around her in her day-to-day life. Sue's youngest son died unexpectedly in a car accident almost two years ago. She reports that she can't wait until she can finally go to sleep during the day because that is when she can experience some relief from the anguish of her loss. It is the one time she can relax her mind during the day. Sue reports she is currently taking prescribed sleeping medication to help her fall and stay asleep through the night. She was taking this medication prior to her son's death.

Sue is retired and enjoys helping her other four adult children during the day. Sue states she relives the phone call informing her of the accident daily. She describes feeling as if her life was placed on pause at that very moment. While she enjoys being with her children, Sue reports feeling preoccupied with how the accident occurred and is not able to fully enjoy these moments because she knows one piece of her family is missing. She feels as if her husband and children have been able to go back to their routines/roles while she has not been able to. Sue visits the cemetery daily as a way to connect with her son and states those visits help tremendously.

Sue states that no one around her understands the pain she experiences daily. She states that while people tell her how strong she is, she does not feel that way and does not feel like she can show her true feelings. Sue has closed off many of her support systems; as a result to maintain a 'strong' exterior. She states while she has forgiven the person that caused the accident, she is still very angry and does not understand why bad things continue to happen to her family.

39

Updated Diagnoses

- Attenuated Psychosis Syndrome
- Autism Spectrum Disorder
- Avoidant Restrictive Food Intake
- Bipolar and Related Disorders Due to Medical Conditions
- Bipolar I
- Bipolar II
- Delirium
- Depressive Disorder Due to Another Medical Condition
- Functional Neurological Symptom Disorder
- Gender Dysphoria
- Intellectual Disability
- Major Depressive Disorder
- Narcolepsy
- Olfactory Reference Disorder
- Other Specified Bipolar and Related Disorder
- Other Specified Delirium Disorder
- Other Specified Feeding Disorder
- Other Specified Schizophrenia
- Persistent Depressive Disorder
- Prolonged Grief Disorder
- PTSD
- Social Anxiety Disorder
- Substance Medication Induced Bipolar Disorder
- Unspecified Mood Disorder

40

Diagnostic Updates for Children

Updates include more precise criteria and descriptions

- **Autism Spectrum Disorder**
  - "as manifested by all of the following"
  - "all of the following"
- **Disruptive Mood Dysregulation Disorder**
  - Criterion G updated "6-18 years"
- **Posttraumatic Stress Disorder**
  - Criterion A2 removed to avoid repetitiveness
    - "Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures"
- **Prolonged Grief Disorder**
  - Language added to differentiate between children and adolescents versus adults
  - Highlights differences in reactions

(APA, 2022g)

41

Bipolar I Disorder & Bipolar II Disorder

(DSM-5oTR, p. 139)

- Placed between Schizophrenia Spectrum/Other Psychotic Disorders and Depressive Disorders
- Recognition of Bipolar Disorders as a bridge between the two diagnostic classes regarding symptomatology, family history, and genetics.
- **Note:** Bipolar II Disorder-No longer viewed as less severe than Bipolar I due to the burden of depressive symptoms and impairment in work and social functioning due to mood instability.

(APA, 2022h)

42

Bipolar I Disorder & Bipolar II Disorder

- Specifier Changes
- Mood-Congruent & Mood Incongruent Specifiers are dependent upon whether the current (most recent) episode is depressive or manic
- Severity Specifiers for Depression
  - Mild: Few, if any, symptoms in excess of those required to meet the diagnostic criteria are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.
  - Moderate: The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe."
  - Severe: The number of symptoms is substantially in excess of those required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.
- Severity Specifiers for Mania
  - Mild: Minimum symptom criteria are met for a manic episode.
  - Moderate: Very significant increase in activity or impairment in judgment.
  - Severe: Almost continual supervision is required in order to prevent physical harm to self or others.

(APA, 2022h)

43

Bipolar I Disorder

For Bipolar I Disorder

"B. At least one manic episode is not better explained by:

- schizoaffective disorder
- not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder."

(APA, 2022h)

44

Bipolar II Disorder

For Bipolar II Disorder

"C. At least one hypomanic episode and at least one major depressive episode are not better explained by:

- schizoaffective disorder
- not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder."

(APA, 2022h)

45

Persistent Depressive Disorder

Specifiers

- The criteria set for persistent depressive disorder in DSM-5 listed seven out of the eight specifiers that apply to major depressive disorder:
  - with anxious distress
  - with mixed features
  - with melancholic features
  - with atypical features
  - with mood-congruent psychotic features
  - with mood-incongruent psychotic features
  - and with peripartum onset
- However, per the definitions of these specifiers, only the anxious distress specifier and the atypical features specifier are explicitly applicable to persistent depressive disorder.
- In DSM-5-TR, the extraneous specifiers were eliminated, as approved by the DSM Steering Committee, and the APA Assembly and Board of Trustees.

(APA, 2022i)

46

Attenuated Psychosis Syndrome (APS)

- Criterion A of attenuated psychosis syndrome (APS) was modified to enhance its clarity.
- The DSM-5 definition of the attenuated psychosis syndrome (APS) included the phrase "with relatively intact reality testing."
  - This caused confusion and logical inconsistency in the criterion as it defined delusions and hallucinations, forms of reality distortion, with intact reality testing.
  - To avoid such confusion, the phrase "with relatively intact reality testing" has been removed and the three symptoms (i.e., attenuated forms of delusion, hallucination, and disorganized speech) have been defined more accurately, using a "gatekeeper" to distinguish the attenuated from the non-attenuated form.

(APA, 2022j)

47

Intellectual Developmental Disorder - (Intellectual Disability)

- The diagnosis of Intellectual Developmental Disorder (Intellectual Disability)
- The term "intellectual developmental disorder" is used to clarify the disorder's relationship with the World Health Organization's International Classification of Diseases, eleventh revision (ICD-11) Classification system, which uses the term "disorders of intellectual development."
- The equivalent term "intellectual disability" is placed in parentheses for continued use.

(APA, 2022k)

48

Social Anxiety Disorder

- Social Anxiety Disorder
- Social Phobia is NO longer acceptable for use

(APA, 2022l)

49

Functional Neurological Symptom Disorder (Conversion Disorder)

- Conversion Disorder is NO longer used
- Replaced by Functional Neurological Symptoms Disorder

(APA, 2022m)

50

Unspecified Mood Disorder

- Unspecified Mood Disorder reinstated in DSM-5-TR
  - Located in both depressive and bipolar disorder chapters in Section II
- **Applies to:**
  - Symptoms that are characteristic of depressive disorder
  - Cause clinically significant distress or impairment in social, occupational, or other areas of functioning
  - Symptoms do NOT meet criteria for any disorders in depressive disorders, adjustment disorder with depressed mood, or adjustment disorder with mixed anxiety and depressed mood.
- Intended to be used when the clinician chooses not to specific the reason that the criteria are not met for a specific depressive disorder and includes presentations where there is insufficient information to a make a more specific diagnosis.

(APA, 2022n)

51

Unspecified Mood Disorder (F39)

(DSM-5-TR, p 169, 210)

"This category applies to presentations in which symptoms are characteristic of a mood disorder that causes clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not at the time of the evaluation meet the full criteria for any of the disorders in either the bipolar or the depressive disorders diagnostic classes in which it is difficult to choose between unspecified bipolar and related disorder and unspecified depressive disorder (e.g., acute agitation)."

52

Unspecified Bipolar and Related Disorder v. Unspecified Depressive Disorder	
Unspecified Bipolar and Related Disorder (F31.9)	This category applies to presentations in which symptoms characteristics of a bipolar and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the bipolar and related disorders diagnostic class. The unspecified bipolar and related category is used in solutions in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific bipolar and related disorder and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings). (p. 169)
Unspecified Depressive Disorder (F32.A)	This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class and do not meet criteria for adjustment disorder with depressed mood or adjustment disorder with mixed anxiety and depressed mood. The unspecified depressive category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific depressive disorder and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings). (p.210)

53

Coding Updates - 50

- **Updates to ICD-10-CM Coding 2022**
- **ONLY ICD-10 Codes (Alphanumeric code): NO DSM Codes**
- The American Psychological Association (APA) announced coding updates to its DSM-5 diagnosis list based on the Centers for Medicare and Medicaid Services (CMS) ICD-10 diagnostic coding updates for 2022.
- Healthcare providers worldwide use the ICD-10-CM as a standardized system to share and compare health information. Each year, the CMC reviews and approves changes to the ICD-10-CM. Several code changes for 2022 pertain to diagnoses listed in the APA's DSM-5. These coding changes went into effect on October 1, 2021 and are already live in Valant's system.

54

Coding Updates - 50

- **Updated Codes - Examples**
- The updated codes break down several diagnoses into more specific subcategories.
- Homelessness previously fell under the Z59.0 code, but has been subdivided into two categories: sheltered homelessness (Z59.01) for patients who have access to homeless shelters, domestic violence shelters, or other temporary relief measures; and unsheltered homelessness (Z59.02) for those who lack access to any adequate housing situation.
- The new codes separate lack of access to adequate food and lack of access to safe drinking water. Previously grouped under Z59.4, they're now broken into the categories of food insecurity (Z59.41) and lack of safe drinking water (Z58.6)
- For identifying a patient's personal history of self-harm, the codes now differentiate between personal history of suicidal behavior (Z91.51) vs. personal history of non-suicidal self-injury (Z91.52).
- Other changes include a code change for unspecified depressive disorder (now F32.A) and the addition of non-suicidal self-injury (R45.88).

55

Future ICD-11

(DSM-5-TR, p. 13)

- Harmonization with ICD-11
- Overarching goal to harmonize the DSM & ICD classification systems as much as possible for the for the following reasons:
  - Data Collection/Tracking
    - National health statistics
    - Designing clinical trials for new treatments
    - Improve global applicability of results by international regulatory agencies
  - Improve replication of scientific results across national boundaries
  - Significant complications/inconsistencies evident when attempting to identify identical populations when using the DSM-IV and ICD-10

56

Updated Redesign

57

Enhancements in the DSM-5-TR Text

- Representation of developmental issues
- Integration of scientific findings from latest research in genetics and neuroimaging
- Consolidation of autistic disorder, Asperger's disorder, and pervasive developmental disorder into autism spectrum disorder
- Classification of bipolar and depressive disorders
- Restructuring of substance use disorders for consistency and clarity
- Enhanced specificity for major and mild neurocognitive disorders
- Transition in conceptualizing personality disorders
- Section III
- Online enhancements

58

Future Considerations

59

Further Study

(DSM-5-TR, p.903)

- Attenuated Psychosis Syndrome
- Depressive Episodes with Short-Duration Hypomania
- Caffeine Use Disorder
- Internet Gaming
- Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure
- Suicidal Behavior Disorder
- Nonsuicidal Self-Injury Disorder

60

Resources

- DSM-5-TR Fact Sheets
- *Facts About the DSM-5-TR*
- DSM-5-TR Online Assessment Measures

61

Uhhhuhqfhv

62

Uhhhuhqfhv

63

Uhhhuhqfhv

64

Uhhhuhqfhv

65

Thank you!

Connect with us on Social Media

BHECN
BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

unmc.edu/bhecn

66