Using DSM-5

in Case Formulation and Treatment Planning

Presented by Gary G. Gintner, PhD, LPC

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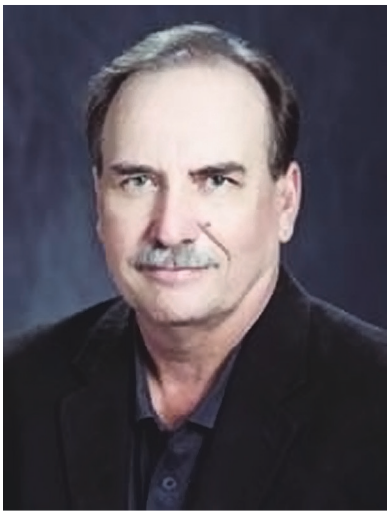

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Using DSM-5 in Case Formulation and Treatment Planning

Gary G. Gintner, Ph.D., LPC
Louisiana State University
gintner@lsu.edu

Disclosures

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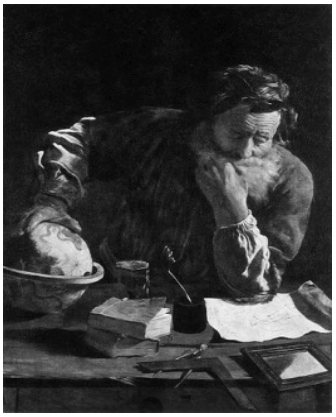
Role of the DSM-5

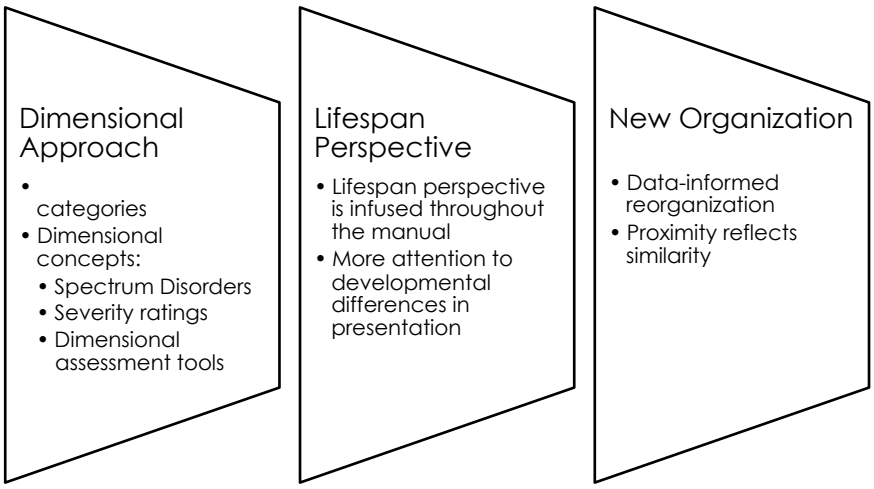
- A way of naming the problem
- Communication
- Provides surplus information:
  - Trajectory and course
  - Risk factors
  - Treatment options
  - *Informs* case formulation and treatment planning

Part I: Overview of DSM-5



- Fundamental changes
- DSM-5 organization
- Relationship between DSM and ICD
- How to write a DSM-5 diagnosis

Fundamental Changes in DSM-5



Greater Harmonization with ICD

- ICD's role in healthcare
- ICD vs. DSM
- DSM-5 harmonization efforts:
  - Discontinuation of the multiaxial system
  - Renaming disorders to be consistent with ICD
  - Harmonization with upcoming ICD-11

Sections of DSM-5

- **Section I: Basics (Introduction and Use of Manual)**
- **Section II: Diagnostic Criteria and Codes**
- **Section III: Emerging Measures and Models**
  - Assessment Measures
  - Cultural Formulation
  - Alternative DSM-5 Model for Personality Disorders
  - Conditions for Further Study
- **Appendix**
  - Highlights of changes from DSM-IV to DSM-5
  - Glossary of Cultural Concepts of Distress
  - ICD-9 and ICD-10 codes for DSM-5 disorders

Chapters in Section II

- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders

Section II (Cont.)

- Elimination Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse Control and Conduct Disorders
- Substance-Related and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders

Section II (Continued)

- Paraphilic Disorders
- Other Mental Disorders
- Medication Induced Movement Disorders and Other Adverse Effects of Medication
- Other Conditions that May be the Focus of Clinical Attention (e.g., V-codes)

DSM-5's Single Axis System

- There is one diagnostic axis on which all of the following can be coded:
  - All mental disorders (formerly on Axis I and II)
  - Other Conditions that May be the Focus of Treatment (V-codes; formerly Axis I)
  - Medical disorders (formerly Axis III)

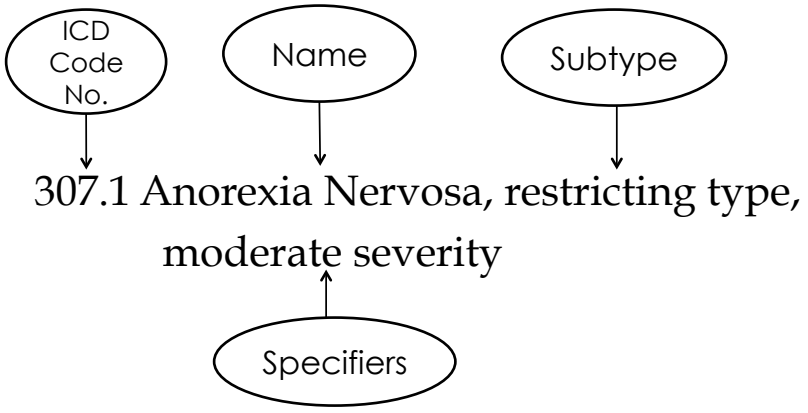
What about Axis IV and V Information?

- Contextual and situational factors can be noted by coding V codes (ICD-9) or forthcoming Z-codes (ICD-10)
  - Reason for visit
  - Important factor to note in the treatment plan
- What about noting impairment (Axis V)?
  - World Health Organization Disability Assessment Schedule 2.0 replaces GAF
  - What's different?

How Information for Each Disorder is Organized

- **Diagnostic criteria**
  - Criteria set
  - Coding information
- **Explanatory text information**
  - Diagnostic features
  - Associated features
  - Prevalence
  - Development and course
  - Risk and prognostic factors
  - Culture-related diagnostic issues
  - Gender-related diagnostic issues
  - Suicide risk
  - Functional consequences
  - Differential diagnosis
  - Comorbidity

Elements of a Diagnosis



Selecting Code Numbers

- Two code numbers are listed, one in **bold** (ICD-9) and one in parentheses (ICD-10)
  DSM 5 Criteria Sets\Bulimia Nervosa.docx
- **U.S. implementation of ICD-10 has been delayed until October 1, 2015**
- Code as follows:
  - Before October 1, **2015**, use the bolded ICD-9 code:

    307.51 Bulimia Nervosa, moderate severity
  - Starting October 1, **2015** use the ICD-10 code in parenthesis:

    F50.2 Bulimia Nervosa, moderate Severity

Order of Multiple Diagnoses

- The focus of treatment or reason for visit is listed first (principal diagnosis)
- Follow by the other diagnoses in descending order of clinical importance

Sample DSM-5 Diagnosis

Before October 1, **2015:**
296.42 Bipolar I Disorder, current episode manic, moderate severity, with mixed features
301.83 Borderline Personality Disorder
V62.29 Other Problem Related to Employment

October 1, **2015** and after
F31.12 Bipolar I Disorder, current episode manic, moderate severity, with mixed features
F60.3 Borderline Personality Disorder
Z56.9 Other Problem Related to Employment

A Critical Look at DSM-5

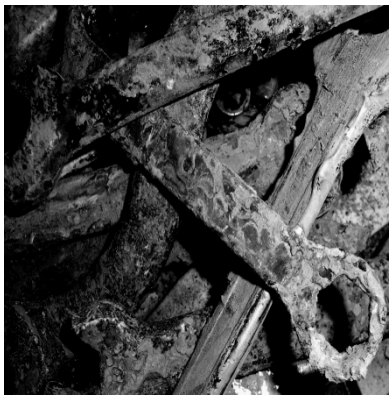
The Good

- Incorporates research over the last 20 years
- Organization informs differential diagnosis
- Does a better job of reflecting nature
- Provides additional diagnostic tools

The Not So Good

- The classification is simply descriptive
- Loss of the multiaxial system
- Some disorders were prematurely added
- Changes to criteria thresholds have calibration problems
  - Over diagnosis
  - Under diagnosis

Part II: DSM-5 Tools and Enhancements



- Clinical rating scales
- WHODAS 2.0
- Cultural Formulation Interview

Clinical Rating Scales

- Rationale for adding:
  - Measurement-informed care
  - Dimensional assessment of severity
  - Assessment of broad range of symptoms
  - Adjunct to clinical evaluation
- Types
  - Cross-Cutting Symptom Measures
  - Disorder-Specific Severity Measures
  - Disability Measures (WHODAS 2.0)
  - Personality Inventories
  - Early Development and Home Background Form

Link to Online Assessment Measures

- Assessment measures can be freely used by clinicians for use with clients
- They can be downloaded at:

http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

or

www.dsm5.org DSM-5 Online Measures.docx

Cross-Cutting Symptom Measures

- Assesses symptoms across the major domains of psychopathology
- Two types:
  - Level 1
  - Level 2
- Versions
  - Adult self-report
  - Parent/guardian-rated version (for children 6-17)
  - Youth self-report (11-17)

Level 1 Cross-Cutting Symptom Measure

- Description: Adult version measures 13 domains of symptoms DSM-5 level1 assessment.pdf
- Rate each item:
  - How much or how often "you have you been bothered by…in the past two weeks."
  - 5-point rating scale from 4 (severe, nearly everyday) to 0 (none or not at all)
- Scoring: Rating of 2 or higher (Mild, several days) should be followed up by further clinical assessment. On items for suicidal ideation, psychosis and substance use, a rating of 1 (Slight) or higher should be used.

Level 2 Assessment Measure

- Description: A brief rating scale for a particular symptom (e.g., anxiety, depression, substance use)
- Indications: When a Level 1 item is rated above the cut-off
- Can be readministered periodically to plot change
- Scoring instructions are available at the site
- DSM-5 Online Measures.docx

Disorder-Specific Rating Scales

- Description: Disorder-specific rating scales that correspond to the diagnostic criteria
- Indications: Used to confirm a diagnostic impression, assess severity, and monitor progress
- Versions: Adult, Youth and Clinician rated
- DSM-5 Online Measures.docx

WHODAS 2.0

- Description: A 36-item measure that assesses disability in adults 18 years and older
- Rating: "How much difficulty have you had doing the following activities in the past 30 days." Rated 1 (None) to 5 (Extreme or cannot do)
- Scoring: Calculate average score for each domain and overall
- Versions: Adult and proxy-administered
- DSM-5 whodas2selfadministered.pdf

Domains on the WHODAS 2.0

1. Understanding and communicating
2. Getting around
3. Self-care
4. Getting along with people
5. Life activities
6. Participation in society

DSM-5 whodas2selfadministered.pdf

Cultural Formulation Interview (CFI)

- Description: A 16-item semistructured interview to assess the impact of culture on key aspects of the clinical presentation and treatment plan
- Indications: Use as part of the initial assessment with *any* client but is especially indicated when there are significant differences in "cultural, religious or socioeconomic backgrounds of the clinician and the individual"(p. 751).

CFI Domains

- Cultural definition of the problem
- Causes of the problem, stressors and available supports
- Coping efforts and past help-seeking
- Current help-seeking and the clinician-client relationship DSM-5 Cultural Formulation Interview.pdf

Clinical Applications of DSM-5 Enhancements

- During initial assessment:
  - Administer Level 1 Cross-Cutting Symptom Measure
  - Complete intake including social history, mental status, and diagnostic assessment
  - Administer Level 2 measures as needed
  - WHODAS 2.0 can be administered as indicated
  - Use aspects of the CFI interview throughout
- Follow-up sessions
  - Administer disorder-specific measures
  - Re-administer periodically to assess progress

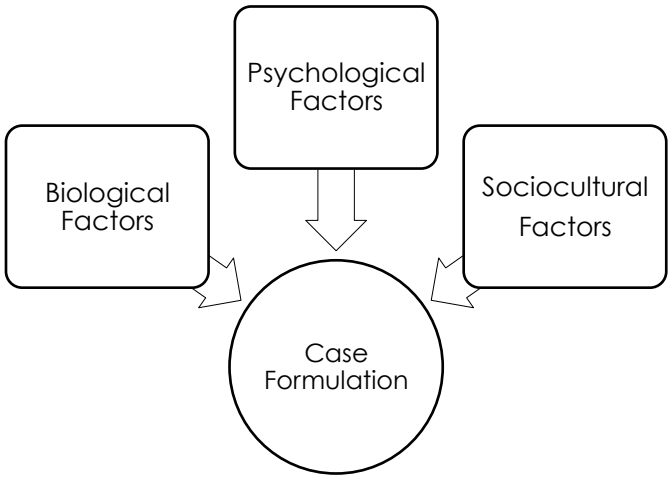
Part III: DSM-5 and Case Formulation

- The case formulation process
- Biopsychosocial model in case formulation
- The Five P's of Case Formulations

Case Formulation

- Case formulation is a core clinical skill that links assessment information and treatment planning
- It is a hypothesis about the mechanisms that cause and maintain the problem
- It answers the question, "Why is *this* person, having *this* type of problem, *now*?"

Biopsychosocial Model in Case Formulation

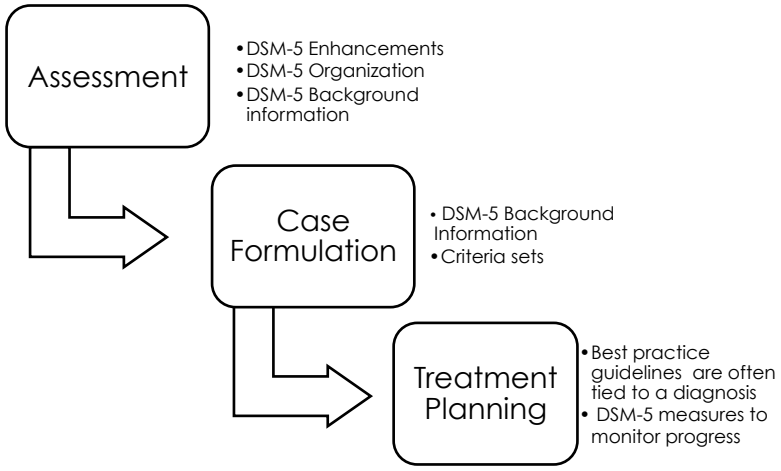


The Five P's of Case Formulation

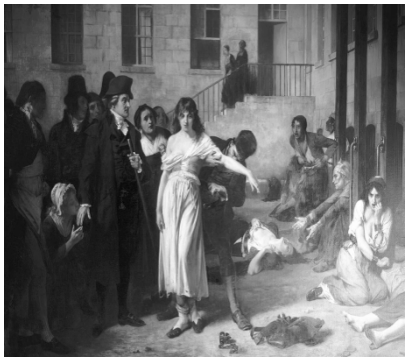
(Macneil et al., 2012)

- Presenting problem
- Predisposing factors
- Precipitants
- Perpetuating factors
- Protective/positive factors

DSM-5 Informed Case Formulation Process

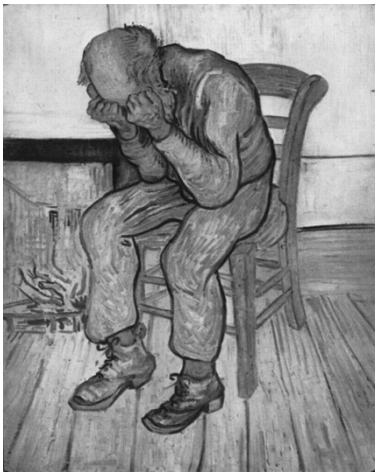


Part IV: Case Formulation and Treatments for Specific Disorders



- Major Depressive Disorder
- Bipolar Disorders
- ADHD
- Substance Use Disorders
- PTSD

Major Depressive Disorder



- Overview of the chapter on Depressive Disorders
- Diagnostic criteria for Major Depressive Disorder
- Diagnostic work-up and case formulation
- Overview of treatment guidelines

Depressive Disorders in DSM-5

- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder (MDD)
- Persistent Depressive Disorder
- Premenstrual Dysphoric Disorder
- Substance/Medication Induced Depressive Disorder
- Depressive Disorder Due to Another Medical Condition
- Other Specified and Unspecified Depressive Disorders

Major Depressive Episode

- *Essential features:* Either depressed mood *or* loss of interest or pleasure plus four other depressive symptoms for at least two weeks
- **Note**: Be careful about diagnosing major depression following a significant loss because normal grief "may resemble a depressive episode." DSM 5 Criteria Sets\Major Depressive Disorder.docx

Diagnosing MDD

Essential Diagnostic Criteria:

- Meets criteria for a Major Depressive Episode
- No history of a Manic or Hypomanic Episode

Coding Steps:

1. Start with noting whether it is:
   - Major Depressive Disorder, single episode
   - Major Depressive Disorder, recurrent episodes
2. State the severity/course specifier term after single or recurrent episode: Mild, moderate, severe, with psychotic features and in full or partial remission
3. Find the correct code number in table on page 162
4. Now add any of available specifiers (see next slide)

DSM 5 Criteria Sets\Major Depressive Disorder.docx

Available Specifiers

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

DSM 5 Criteria Sets\Major Depressive Disorder.docx

DSM-5 Background Information

- Development and course
- Predisposing factors
  - Genetics
  - Negative affectivity
  - Repeated adverse child experiences
  - Negative cognitive schema
- Precipitants
  - Stressful life event, especially loss events
  - Low levels of pleasant events
- Perpetuating:
  - Negative cognitive schemas
  - Low social support
  - Chronic or additional stressors
  - Low levels of pleasant events
- Protective factors

Differential Diagnosis

- DSM-5 Measures:
  - Level 1 (items for depression)
  - Level 2, Depression
  - Disorder-Specific: PHQ-9 Depression (Adult and Adolescent versions) DSM-5 PHQ 9.pdf
- Rule-outs
  - Medication, medical condition or substance use
  - Bipolar disorders
  - ADHD
  - Adjustment disorder with depressed mood
  - Normal sadness
  - Comorbidities to consider

Practice Guidelines for MDD
(APA, 2010)

- If the MDD is in the mild to moderate range, use *either* psychotherapy or meds.
  - Indications for psychotherapy:
    - Significant stressors
    - Interpersonal problems
    - Patient preference
    - Pregnant, lactating or wish to become pregnant
    - Personality Disorder traits
  - Indications for medication:
    - Prior positive response
    - Somatic symptoms
    - Patient preference
- If the MDD is in the moderate to severe range or is complicated by specifieres, use a combination.

Empirically Supported Psychotherapies

- Negative thinking?
  - Cognitive Therapy or CBT approaches
  - Monitor thinking
  - Activities to challenge distortions and build mastery
- Interpersonal problems contribute to depression?
  - Interpersonal Therapy
  - Target: Loss, Role Transition, Interpersonal Disputes, or Skill Problems
- Lifestyle factors contribute to depression?
  - Behavior Therapy
  - Increase weekly pleasant events
  - Regular exercise
  - Vocational counseling
- Depression due to conflicts or attachment issues from the past?
  - Psychodynamic therapy
  - Expressive-supportive continuum

Positive Mental Health Activities in the Treatment of MDD

- Ask client to monitor instances of well-being.
- Each night right down three good things that happened to you that day and why.
- Increase regular pleasant or meaningful events.
- Have the client make a conscious effort to respond positively to others (e.g., express gratitude, acknowledge other's positive events).
- Engage in volunteer or helping effort.
- Practice mindfulness.

Case of Helen

Helen was fired from her job one month ago because she started making numerous mistakes and had trouble concentrating. About three months ago she started feeling "down" after a break-up with a man she had been dating for a few months. She has trouble falling asleep and has noticed a significant decline in her appetite. She feels like a failure and believes that no one will want to hire her again.

Helen Continued

She has thoughts of committing suicide but admits, "I could never do it." The only thing that seems to help is when she participates in a bible-reading group every Tuesday night. She explains, "During that time I'm more like my old self and at least that night I can sleep." She also reports that her mood improves when she visits her friends. However, she reports such low energy throughout the day that she is unable to schedule a job interview.

Helen Continued

She had a similar episode about two years ago after she was laid off from her former job. She reports that it took four months before she began feeling "normal" again and positive about herself.

Her history indicates that her mother had severe depression and was hospitalized on several occasions when Helen was young. She describes her as "negative" and often absent in her youth. However, Helen always did well in school and had an active social life. Her work history has been very consistent up to her lay off.

Diagnostic Work-Up

- DSM-5 measures
  - Level 1(positive for depression, sleep problems and avoiding certain events)
  - PHQ-9, Score = 20 (Severe)
  - WHODAS 2.0
    - General Disability Score = 85 (2.36; Mild)
    - Subscale: Life activities = 14 (3.5; Moderate)
    - Subscale: Participation in Society = 28 (3.5; Moderate)
- Diagnostic Impression:

  296.33 Major Depressive Disorder, recurrent, severe severity

  V62.29 Other Problems related to Employment

Case Formulation

- Why is she so depressed?
  - Predisposing factors?
  - Precipitating factors?
  - Perpetuating factors?
  - Positive or protective factors?
- Formulation: Helen presents with significant major depression that appears to be precipitated by….Predisposing factors include….The current problem seems to maintained by….However, her strengths include…
- How does the diagnosis and case formulation inform your treatment plan?

Bipolar Disorders

- Overview of chapter on Bipolar Disorders
- Diagnostic criteria for Bipolar I and Bipolar II Disorders
- Diagnostic work-up and case formulation
- Review of practice guidelines

Bipolar I Disorder

- *Essential Feature*: History of a manic episode which is usually accompanied by other types of mood episodes
- *Common rule outs*: Disorders in the schizophrenia spectrum, substance use (stimulants especially), medications or medical conditions

Coding Bipolar I

1. Start with noting the most recent mood episode:
   - Bipolar I, current or most recent episode manic
   - Bipolar I, current or most recent episode hypomanic
   - Bipolar I, current or most recent episode depressed
   - Bipolar I, current or most recent episode unspecified
2. Next, state the severity term after current episode term
3. Refer to the tables on pages 126-127 for code numbers
4. Add any specifier that applies (see next slide)

SAMPLE CODE:

296.43 (F31.13) Bipolar I Disorder, current episode manic, moderate severity, with mixed features

Bipolar I Specifiers

(see pages 149-154 of DSM-5)

- With anxious distress
- With mixed features
- With rapid cycling
- With melancholic features (D only)
- With atypical features (D only)
- With mood-congruent psychotic features or with mood-incongruent psychotic features
- With catatonia (code separately)
- With peripartum onset
- With seasonal pattern

Bipolar II Disorder

- *Essential Feature*: History of a major depressive episode and a hypomanic episode but never has had a manic episode
- *Coding*: There is only one code. Note by current mood:
  - Bipolar II Disorder, current episode depressed
  - Bipolar II Disorder, current episode hypomanic
- Add specifiers (severity term plus any other)

Sample Code:

296.89 (F31.81) Bipolar II, current episode depressed, mild severity, with peripartum onset

Differences Between Bipolar I and Bipolar II Disorders

- Types of episodes
- Number of lifetime episodes
- Severity of episodes
- Remission between episodes
- Comorbidity
- Suicidality

DSM-5 Background Information

- Development and course
- Predisposing factors: Genetics and brain anomalies
- Precipitants
  - Mania/hypomania: Reward/success in environment, sleep/schedule disruption and substance use
  - Depression: Negative life events, low social support and substance use
- Perpetuating:
  - Negative cognitive schemas
  - High emotional expressiveness in family
- Protective factors

Differential Diagnosis

- DSM-5 Measures:
  - Level 1 (mania items)
  - Level 2 (mania and depression)
  - Disorder-specific: PHQ-9 for depression
- Rule-outs
  - Medical condition, medication or substance
  - Major Depressive Disorder
  - Posttraumatic Stress Disorder
  - ADHD
  - Disruptive Mood Dysregulation Disorder
  - Comorbid considerations

Bipolar Disorder I and II: Acute Phase

(Hirschfeld, 2010; VA/DoD, 2010)

- First line treatment is a psychotropic medication:
  - Manic episode: Lithium, Depakote, and/or atypical antipsychotic
  - Depressive episode: Lithium, Lamictal (lamatragine), Seroquel or Symbiax
- Psychosocial Treatments
  - Education
  - Low stimulation environment (manic)
  - Family involvement
  - Supportive psychotherapy

Bipolar Disorder: Maintenance Phase

- Lithium has strongest evidence as a prophylactic
  - For Depressive episode select Lamictal
  - Atypical anti-psychotic (Zyprexa) as alternative
- Psychosocial interventions:
  - Mood hygiene (Social Rhythm Therapy)
  - CBT
  - Family-based treatments (Family-Focused Treatment)
    - Coping skills
    - Reduce high emotional expressiveness (EE)
    - Communication and problem solving skills
  - Support groups

Case of Chip

Chip is brought to the university counseling center for evaluation by the police. The professor of his psychology class contacted the police after Chip began proclaiming his personal theory of psychotherapy in the middle of class. In an excited and enthusiastic tone of voice he announced that he had discovered the answer to all forms of mental disorders and that he would surely win the Nobel Prize. He said that an angel had come to him and given him the secret of happiness--to be shared with all on the planet. This has been a particularly challenging semester because he is taking an extra class and started a part-time job.

Chip (Continued)

About three weeks ago his energy level increased and he has only required a couple of hours of sleep a night. Most of his time is spent reading religious books and psychology texts. It is not unusual for him to be able to work fifteen hours straight. His only past treatment was a hospitalization for severe depression about two years ago. Since that time he apparently has been symptom-free until the development of the current episode. There is a positive family history for both Bipolar Disorder and depression.

DSM 5 Criteria Sets\Bipolar 1 with episode descriptions.docx

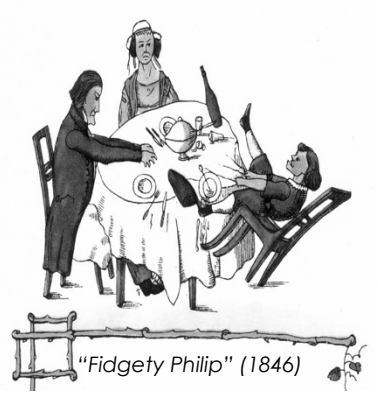
Diagnostic Work-Up

- DSM-5 measures:
  - Level 1(positive for sleeping less, starting projects and hearing voices)
  - Level 2 Mania, Score = 18 (high probability)
  - Disorder Specific: Clinician Rated Dimensions of Psychosis Symptom Severity
    - Hallucinations: 3 (Moderate)
    - Delusions: 4 (Severe)
    - Mania: 4 (Severe) DSM-5 Psychosis Rating Scale.pdf
- Diagnostic impression:

Case Formulation

- How do each of the following help to explain Chip's current presentation?
  - Predisposing factors?
  - Precipitating factors?
  - Perpetuating factors?
  - Positive or protective factors?
- Formulation: Chip is in the midst of a severe manic episode with psychotic features. Precipitating factors include….
- Implications for treatment planning?

Attention Deficit Hyperactivity Disorder (ADHD)



"Fidgety Philip" (1846)

- Overview of the Neurodevelopmental Disorders
- ADHD
- Treatment Guidelines
- Case Formulation Considerations

Neurodevelopmental Disorders

- Intellectual Disability (Intellectual Developmental Disorder)
- Communication Disorders
- Autism Spectrum Disorder
- ADHD
- Specific Learning Disorder
- Motor Disorders
- Other Neurodevelopmental Disorders
  - Other Specified vs. Unspecified options

DSM-5 ADHD Criteria

- Essential features:
  - *Symptom threshold: A*t least 6 symptoms of inattention and/or 6 symptoms of hyperactivity/ impulsivity that have lasted at least 6 months (*five or more in either area for those 17 and older)*
  - *Age of onset:* Several symptoms prior to age 12
  - *Impairment:* Several symptoms in two or more settings that interfere with functioning
  - *Common rule-outs:* Mood disorder, anxiety disorder, substance use or psychotic disorder

DSM 5 Criteria Sets\ADHD.docx

ADHD Coding

- *Presentations* replace subtypes
- Code by presentation:
  - Combined presentation
  - Predominantly inattentive presentation
  - Predominantly hyperactive/impulsive presentation
- Then add a severity rating: Mild, moderate or severe
- Partial remission can be noted, if present
- Sample code:

314.00 (F90.0) Attention Deficit/Hyperactivity Disorder, predominantly inattentive presentation, moderate severity

DSM-5 Background Information

- Development and course
- Predisposing factors:
  - Genetics
  - Drinking or smoking during pregnancy
  - Birth complications
  - Temperament
  - Early childhood stress and disruption
- Precipitants
  - School
  - Change in structure or increased attentional demands
- Perpetuating:
  - Chaotic or unstructured environments
- Protective factors

Differential Diagnosis

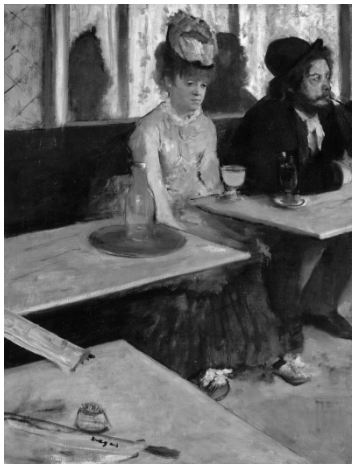
- DSM-5 Measures:
  - Level 1 (attention difficulties)
  - Level 2 Inattention (Parent version; SNAP IV)
- Rule-outs
  - ODD
  - Learning Disorder
  - Depression
  - Anxiety disorder
  - Disruptive Mood Dysregulation Disorder
  - Bipolar Disorder
  - Other neurodevelopmental disorder
  - Comorbid considerations

Practice Guidelines for ADHD

(AACAP, 2007; Subcommittee on ADHD, 2011)

- Well-Established Treatments:
  - Stimulant medications for symptoms in the moderate to severe range
  - Behavioral Parent Training (mild to moderate)
  - Behavioral Teacher Training (mild to moderate)
  - Combination treatment (medication + behavioral intervention- moderate to severe)
- Treatments with little or no evidence

Alcohol Use Disorder



- Overview of Substance-Related and Addictive Disorders
- Diagnosing Alcohol Use Disorder
- Treatment guidelines
- Diagnostic work-up and case formulation

Changes in DSM-5

- Types of disorders
  - Substance use disorders
  - Substance induced disorders
  - Behavioral addictions
- Dependence and abuse collapsed into a spectrum
- Polysubstance dependence is discontinued
- Changing face of *dependence*

Substance Categories in DSM-5

- Alcohol
- Caffeine
- Cannabis
- Hallucinogen
- Inhalants
- Opioids
- Sedative/Hypnotics/Anxiolytics
- Stimulants
- Tobacco-Related
- Other (or unknown) Substance
- Non-Substance-Related Disorders (Gambling)

Alcohol Use Disorder

- *Essential feature*: Problematic pattern of alcohol use leads to clinically significant distress or impairment

- *Symptom threshold*: At least two of the following in a 12-month period:
  1. Taken in larger amounts or over longer period of time than intended
  2. Persistent desire or efforts to cut down or control use
  3. Much time taken obtaining, using or recovering from substance
  4. Cravings or a strong desire or urge to use a substance (new criteria)
  5. Recurrent use resulting in failure to fulfill role obligations
  6. Continued use despite social and interpersonal problems
  7. Social, occupational, or recreational activities reduced due to alcohol
  8. Recurrent use in hazardous situations
  9. Continued use despite physical or psychological problems due to substance
  10. Tolerance
  11. Withdrawal

Specifiers

- *Specify Severity:*
  - Mild (2-3 symptoms)
  - Moderate (4-5 symptoms)
  - Severe (6 or more symptoms)
- *Specifiers*:
  - Early or Sustained remission
  - In controlled environment

SAMPLE CODE:
303.90 (F10.20) Moderate Alcohol Use Disorder

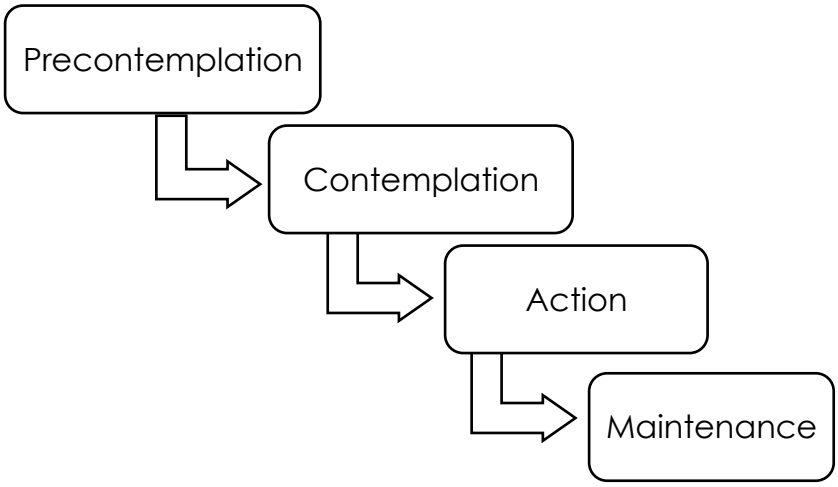
DSM-5 Background Information

- Development and course
- Predisposing factors:
  - Genetics and family history
  - Cultural attitudes toward drinking
  - Premorbid Bipolar Disorder or Schizophrenia
- Precipitants:
  - Stressful life events
  - Peer affiliation
  - Availability
- Perpetuating:
  - Cultural attitudes toward drinking
  - Peer affiliation
- Protective factors

Differential Diagnosis

- DSM-5 Measures:
  - Level 1 (drinking item)
  - Level 2 Substance Use (ASSIST)
  - Disorder-Specific: None
- Rule-outs
  - Sedative, hypnotic, or anxiolytic use disorder
  - Nonpathological drinking
  - Comorbidity is common and may mask use:
    - Anxiety Disorder
    - Depressive and Bipolar Disorders
    - Schizophrenia
    - Antisocial Personality Disorder and Conduct Disorder

Stages of Change



Practice Guidelines
(NIDA, 2012)

- For mild alcohol use disorder, provide brief therapy
- If dependent, assess detox need
- Use least restrictive level of care
- Precontemplation?
  - Motivational Interviewing
  - CRAFT
  - AL-ANON
- CBT: Develop coping repertoire for high risk drinking situations
- Consider twelve-step oriented programs for those who are willing to abstain
- Include partner in relationship enhancement
- Add Antabuse or naltrexone if continued use
- Consider AA groups as adjunct
- Dual diagnosis: Treat both either concurrently or sequentially

Issues in Case Formulation and Treatment Planning

- Assess for stage of change (readiness)
- Be sure to assess for comorbid disorders and treat both
- Precipitants and perpetuators are critical to target
- Determine both the positive and negative reinforcing functions of use
- Maintenance is a critical stage of change

Posttraumatic Stress Disorder (PTSD)

- Overview of the chapter on Trauma- and Stressor-Related Disorders
- Diagnostic criteria for PTSD
- Overview of treatment guidelines
- Diagnostic work-up and case formulation

Trauma- and Stressor-Related Disorders in DSM-5

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorder
- Other Specified Trauma- and Stressor-Related Disorder
- Specified and Unspecified Trauma- and Stressor-Related Disorder

Issues DSM-5 Attempts to Address

- Clarifying the nature of the traumatic event
- Recognizing traumatic reactions to repeated trauma may be different than single-blow trauma
- Making criteria more sensitive to early childhood presentations

Posttraumatic Stress Disorder

- *Essential feature*: Significant reaction to serious traumatic event that involves actual or threatened death, serious injury or sexual violation
- DSM-5 specifies how event has to be experienced:
  1. Directly experiencing
  2. Witnessing in person
  3. Learning the event happened to a close family member or friend
  4. Repeated exposure to aversive details of event (e.g., dead body)
- *Symptoms* are now from four general groups:
  - Intrusive symptom (e.g., intrusive memories, dreams, flashbacks)
  - Avoidance of reminders (e.g., avoiding people, places, activities)
  - Negative alterations in cognition and mood (e.g., self-blame, hopelessness, dissociative symptoms, negative emotional states)
  - Alterations of arousal and reactivity (e.g., hypervigilance, sleep problems, self-destructive behaviors)
- *Duration:* Symptoms persist for at least a month
- Specifiers that can be used
  - *With Dissociative Symptoms*
  - *With Delayed Expression*

PTSD in Children Six Years or Younger

- DSM-IV criteria were based upon adolescents and adults
- Developmental differences in children
  - Less alterations in thinking
  - Less ability to label emotions
  - Less avoidance symptoms
- Major difference is that criteria C and D are combined and only require one symptom
- Same specifiers are used

DSM-5 Background Information

- Development and course
- Predisposing factors:
  - Prior trauma including early childhood
  - Externalizing, anxiety or substance problems
  - Demographic: Gender, ethnicity and SES
- Nature of the trauma:
  - Nature of the exposure: Severity, duration and threat
  - Interpersonal violence
- Perpetuating:
  - Negative appraisals, avoidant coping, and over accommodation
  - Low social support
  - Additional stressors
- Protective factors

Differential Diagnosis

- DSM-5 Measures:
  - Level 1 (items for anxiety, avoidance, sleep, detachment)
  - Level 2 None
  - Disorder-Specific: Severity of Posttraumatic Stress Symptoms (NSESS) DSM-5 PTSD Severity.pdf
- Rule-outs
  - Acute Stress Disorder
  - Anxiety disorders and OCD
  - Major Depressive Disorder
  - Personality Disorder
  - Traumatic brain injury
  - Comorbid substance use disorder

Recommended Treatments for PTSD

(Foa et al., 2009)

- Stabilization
  - Education
  - Reduce stress
  - Structure day
  - Increase social support
  - Medication?
  - Psychological First Aid
- Treating Trauma
  - CBT exposure-based therapy
  - Stress Inoculation Training
  - Cognitive Therapy
  - Eye Movement Desensitization Reprocessing (EMDR)
  - Medications
    - Propranolol (Inderal)
    - SSRI's

Case of Ms. Allen

Ms. Allen is a 39-year–old African American who comes to treatment after witnessing the death of her best friend in an auto accident about five weeks ago. The car that they were driving in was struck head on by a drunk driver, sending her friend through the windshield. Immediately after the accident she tried to revive her friend but was unable to, and she was pronounced dead at the scene by medics. Since the accident, she has had two panic attacks when she has tried to drive by herself. As a result, she becomes anxious at the thought of driving anywhere. The only way that she can go to work is if a family member drives her.

Ms. Allen (Continued)

Throughout the day she experiences intrusive images of her friend's lifeless body. This has made it difficult for her to sleep. When she does sleep, she has bad dreams related to her deceased friend. Her husband complains that she seems very distant and "far away." She also has discontinued many of her favorite activities and avoids friends and family. Overall, she seems quite irritable and easily angered.

Prior to the event she had a good work history and has had no previous mental health treatment. However, when she was a teenager, her brother was murdered in a drug-related altercation that "took me a while to get over."

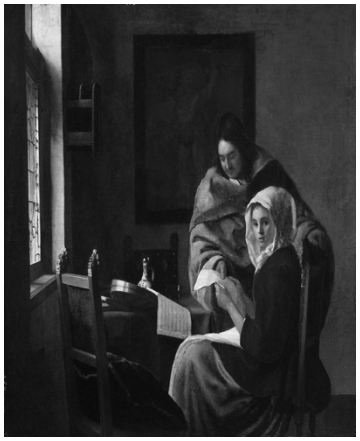
Diagnostic Work-Up

- DSM-5 measures
  - Level 1(positive for little interest, irritable, feeling panic, avoiding situations, sleeping less, and intrusive images)
  - Disorder-Specific: Severity of Posttraumatic Stress Symptoms: Score = 21(raw), 2.44 average item (moderate)
- Diagnostic Impression: ??

Case Formulation

- Which of the following help to explain Ms. Allen's current presentation?
  - Predisposing factors?
  - Precipitating factors?
  - Perpetuating factors?
  - Positive or protective factors?
- Formulation: Ms. Allen has recently experienced….. Precipitating factors include….
- Treatment considerations:

What Happened to Personality Disorders in DSM-5?



- Sweeping changes were proposed
- Did not do well in the field trials
- Opted to revert back to DSM-IV organization
- DSM-5's Alternative Personality Disorder Model in Section III: Need for further study

Final Thoughts…

- DSM-5 as a case formulation tool
- Case formulation is a skill: Use it or lose it
- A look down the road to DSM-5.1

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Websites:

DSM-5 website*: Keep up with changes to DSM-5 and codes at www.dsm5.org*

Practice Guidelines: Agency for Healthcare Research and Quality. National guideline clearinghouse. http://www.guideline.gov/content.aspx?id=36881

*** Note**: If you are interested in a complete reference list that sites the research discussed in the workshop, please email Gary Gintner, Ph.D, at gintner@lsu.edu.

Case Formulation Worksheet

Gary G. Gintner, Ph.D.

Instructions: Case formulation is the clinical bridge between assessment and treatment planning. It is the process of developing a hypothesis about what factors are contributing to and maintaining the client's problem. These factors have been referred to as the *Five P's* of case formulation: presenting problem, predisposing factors, precipitants, perpetuating factors and protective/positive factors. Use this form as tool in developing your case formulation.

1. **Presenting Problem**: State the problem in one or two sentences. Write a DSM-5 diagnosis.

2. **Predisposing Factors**: Over the course of this person's lifetime, what factors contributed to the development of the problem?

3. **Precipitating Factors**: Why is the client coming to treatment now? What factors have triggered or exacerbated the problem?

4. **Perpetuating Factors**: What factors maintain the problem and contribute to it persisting?

5. **Protective/Positive Factors**: What strengths, talents, and supports help to enhance resiliency and can be drawn upon to deal with the problem?

6. **Case formulation**: State the case formulation in a brief paragraph. You can use the following format as a guide: The client presents with…(state the problem or principle diagnosis). The problem seems to be precipitated by…(state precipitants, why now). Predisposing factors include…The current problem seems to be maintained by…. However, the client has a number of strengths and supports including…

7. **Treatment Planning**: Considering the case formulation, what are your treatment recommendations?