Learning The DSM 5

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Highlights of Changes from DSM-IV to DSM-5

Websites on DSM-5

- Official APA DSM-5 site: www.dsm5.org
- DSM-5 on: www.coping.us
- American Psychiatric Association: www.psychiatry.org/dsm5
- And there is a DSM-5 Diagnostic Criteria App for iOS and Android

Obvious Changes in DSM-5

- The DSM-5 discontinued the Multiaxial System - No more Axis I,II, III, IV & V - which means Personality Disorders will now appear as diagnostic categories and there will be no GAF scores, no listing of psychosocial stressors, and no contributing medical conditions
- The Multiaxial System will be replaced by a dimensional component to diagnostic categories

The biggest changes

- No more Axes!
- No more NOS!
- No more V71.09 (No diagnosis) or 799.9 (Deferred)!
- No more GAF!

Instead…

- List multiple diagnoses in order of primacy
  - This may and will vary based on provider and discipline
  - Primacy can be determined based on what you think is the main diagnosis, or what condition is the main focus of treatment
- Unspecified or Other Specified
- WHODAS 2.0 (World Health Organization Disability Assessment Schedule)

Your diagnosis will look like:

Horizontal list

DSM-5 Diagnostic Impression: 300.23 (F40.10) Social Anxiety Disorder, Performance Only, With Panic Attacks; V62.3 (Z55.9) Academic or Educational Problem

Vertical list

DSM-5 Diagnostic Impression:

300.23 (F40.10)	Social Anxiety Disorder, Performance Only, With Panic Attacks
V62.3 (Z55.9)	Academic or Educational Problem

Obvious Changes in DSM-5

- Developmental adjustments were added to criteria
- The goal is to have categories more sensitive to gender and cultural differences
- Diagnostic codes changed from numeric to alphanumeric e.g., Obsessive Compulsive Disorder changed from 300.3 to F42
- Discontinued NOS labeling and attempted for specificity with the dimensional categorization. NED: Not Elsewhere Defined

Revision Guidelines for DSM-5

- Recommendations are grounded in empirical evidence
- Any changes to the DSM-5 in the future must be made in light of maintaining continuity with previous editions. For this reason the DSM-5 is not using Roman numeral V but rather 5 since later editions or revision would be DSM-5.1, DSM-5.2, etc.

Revision Guidelines for DSM-5

- There are no preset limitations on the number of changes that may occur over time with the new DSM-5
- The DSM-5 will continue to exist as a living, evolving document that can be updated and reinterpreted over time

Focus of DSM-5 Changes

- DSM-5 is striving to be more etiological, however, disorders are caused by a complex interaction of multiple factors and various etiological factors that can present with the same symptom pattern

Focus of DSM-5 Changes

- The diagnostic groups have been reshuffled
- There is a dimensional component to the categories
- Emphasis on developmental adjustment criteria
- New disorders were considered and older disorders were removed

Grouping of Diagnostic Categories

1. Neurodevelopmental Disorders
2. Schizophrenia Spectrum and Other Psychotic Disorders
3. Bipolar and Related Disorders
4. Depressive Disorders
5. Anxiety Disorders
6. Obsessive-Compulsive and Related Disorders
7. Trauma- and Stressor-Related Disorders
8. Dissociative Disorders
9. Somatic Symptom and Related Disorders
10. Feeding and Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse-Control, and Conduct Disorders
16. Substance-Related and Addictive Disorders
17. Neurocognitive Disorders
18. Personality Disorders
19. Paraphillic Disorders
20. Other Mental Disorders
21. Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Decision Tree for Depressed Mood

How might you diagnose?

- Mood not related to medical problem or substance use
- No mania or hypomania symptoms or episodes
- One or more major depressive episode
- No history of delusions or hallucinations
- Depressed mood has lasted longer than 2 years

Specific Changes Per Diagnostic Category in DSM-5: *Neurodevelopmental Disorders*

Intellectual Disability (Intellectual Developmental Disorder)

- Term *Mental Retardation* is no longer in use
- Levels of severity are defined by adaptive functioning and not IQ scores, though IQ scores are considered

Specific Changes Per Diagnostic Category in DSM-5: *Neurodevelopmental Disorders*

Communication Disorders

- Language Disorder (combines Expressive and Mixed Receptive-Expressive Language disorders)
- Speech Sound Disorder (previously Phonological Disorders)
- Childhood-Onset Fluency Disorder (previously Stuttering)
- Social Communication Disorder, new condition

Specific Changes Per Diagnostic Category in DSM-5: *Neurodevelopmental Disorders*

Autism Spectrum Disorder

- New disorder encompassing previous DSM-IV disorders of Autism Spectrum Disorder, Asperger's Disorder, Childhood Disintegrative Disorder, Rett's Disorder, and Pervasive Developmental Disorder NOS
- Characterized by two core domains: 1) deficits in social communication and interaction and 2) restricted repetitive patterns of behavior, interests, and activities

Specific Changes Per Diagnostic Category in DSM-5: *Neurodevelopmental Disorders*

Attention-Deficit/Hyperactivity Disorder

- Examples have been added to criterion to aid in diagnosis across the life span
- Age of onset description has changed from "some" to "several" and from "before age 7" to "prior to age 12"
- Subtypes have been replaced with presentation specifiers
- Comorbid diagnosis with ASD is now allowed
- Symptom threshold change for adults

Specific Changes Per Diagnostic Category in DSM-5: *Neurodevelopmental Disorders*

Specific Learning Disorder

- Combines DSM-IV diagnoses of Reading Disorder, Mathematics Disorder, Disorder of Written Expression, and Learning Disorder NOS
- Learning deficits in the areas of reading, written expression, and mathematics are coded as separate specifiers
- Deficits know as *dyslexia* and *dyscalculia* are acknowledged

Decision Tree on Poor School Perf.

How might you diagnose?

- No intellectual functioning problems, good communication, no learning disability, no symptoms of inattention & hyperactivity.
- Has a pattern of severe and excessive temper outbursts
- Persistent anger and irritability

Specific Changes Per Diagnostic Category in DSM-5: *Neurodevelopmental Disorders*

Motor Disorders

- Developmental Coordination Disorder
- Stereotypic Movement Disorder
- Tourette's Disorder
- Persistent Motor or Vocal Tic Disorder
- Provisional Tic Disorder
- Other Specified Tic Disorder
- Unspecific Tic Disorder
  - Tic criteria have been standardized across disorders

Specific Changes Per Diagnostic Category in DSM-5: *Schizophrenia Spectrum & Other Psychotic Disorder*

- Changes to criterion for Schizophrenia in regard to delusions, hallucinations, and disorganized speech
- Subtypes for Schizophrenia eliminated; replaced by a dimensional approach to severity and symptom type
- Schizoaffective Disorder now conceptualized a as longitudinal disorder and requires a major mood episode

Specific Changes Per Diagnostic Category in DSM-5: *Schizophrenia Spectrum & Other Psychotic Disorder*

- Change in criterion for Delusional Disorder in regard to nonbizarre delusions
- Catatonia now described uniformly throughout DSM-5
- Schizotypal Personality Disorder added to this category as part of the schizophrenia spectrum of disorders
- Addition of Attenuated Psychosis Syndrome (in Other Specified Schizophrenia Spectrum and Other Psychotic Disorders)

Decision Tree on Delusions

How might you diagnose?

- Delusions for more than a month that are not culturally appropriate, no medical cause or substance use, and not related to a mood disorder.
- Apart from delusions is functioning relatively well.

Specific Changes Per Diagnostic Category in DSM-5: *Bipolar and Related Disorders*

- Now free standing category
- Criteria for Bipolar Disorders now include changes in mood and changes in activity or energy
- Bipolar I Disorder, Mixed Episode is replaced with a specifier “with mixed features”
- Additional category of Other Specified Bipolar and Related Disorder
- Addition of an “anxious distress” specifier

Specific Changes Per Diagnostic Category in DSM-5: *Depressive Disorders*

- Dysthymia now called Persistent Depressive Disorder, which includes both chronic depressive disorder and the previous dysthymic disorder
- Addition of Disruptive Mood Dysregulation Disorder (for children up to age 18) and Premenstrual Dysphoric Disorder

Specific Changes Per Diagnostic Category in DSM-5: *Depressive Disorders*

- Coexistence within a Major Depressive Episode of at least three manic symptoms is now acknowledged by "with mixed features"
- Removed exclusion criteria for Major Depressive Episode with depressive symptoms lasting less than 2 months following the death of a loved one (i.e., the bereavement exclusion)
- Addition of an "anxious distress" specifier

Decision Tree on Irritable Mood

How would you diagnose?

- Mood is not related to medical problem or substance use
- Doesn't meet criteria for current or previous manic or hypomanic episode.
- 2+ years of hypomanic symptoms & periods of depression

Specific Changes Per Diagnostic Category in DSM-5: *Anxiety Disorders*

- OCD, PTSD, and Acute Stress Disorder no longer in this category
- Social Phobia renamed Social Anxiety Disorder
- Changes in regard to "excessive or unreasonable" criteria of anxiety for Specific Phobia and Social Anxiety Disorder; 6-month duration extended to all ages

Specific Changes Per Diagnostic Category in DSM-5: *Anxiety Disorders*

- "Generalized" specifier for Social Anxiety has been deleted; replaced with "Performance Only" specifier
- Agoraphobia and Panic Attacks are unlinked; Panic Attacks can be listed as a specifier applicable to all DSM-5 disorders
- Separation Anxiety Disorder and Selective Mutism are now classified as anxiety disorders

Decision Tree on Anxiety

How might you diagnose?

- No medical problems or substance use
- Has intense fear and discomfort
- Meets criteria for panic attacks (switch trees)
- No particular concern about having more panic attacks
- Triggers are spiders and other insects

Specific Changes Per Diagnostic Category in DSM-5: *Obsessive-Compulsive and Related Disorders*

- Now a free standing category
- Category includes: Hoarding Disorder, Excoriation (Skin Picking) Disorder, and OCD-related disorders
- Trichotillomania now called Trichotillomania (Hair-Pulling Disorder) under this category
- "Poor insight" specifier has been refined to allow for "good or fair insight," "poor insight," and "absent insight/delusional"

Specific Changes Per Diagnostic Category in DSM-5: *Obsessive-Compulsive and Related Disorders*

- "Insight" specifiers also added to Body Dysmorphic Disorder (BDD) and Hoarding Disorder
- "Tic-related" specifier added to OCD
- "Muscle dysmorphia" added to BDD; "delusional variant" is no longer coded as delusional disorder, somatic type, and BDD

Specific Changes Per Diagnostic Category in DSM-5: *Trauma- & Stressor-Related Disorders*

- Trauma related disorders are now a stand alone category encompassing PTSD, Acute Stress Disorder, Reactive Attachment Disorder, and Adjustment Disorders
- For Acute Stress Disorder, qualifying traumatic events are now explicit as to whether they were experienced directly, witnessed, or experienced indirectly. Also, criterion regarding subjective reaction to the traumatic event has been eliminated.

Specific Changes Per Diagnostic Category in DSM-5: *Trauma- & Stressor-Related Disorders*

- For Adjustment Disorders, re-conceptualized as an array of stress-response syndromes rather than as a category for individuals who exhibit distress but do not meet criteria for another disorder
- Reactive Attachment Disorder does not have subtypes, but rather there are separate diagnoses of Disinhibited Social Engagement Disorder and Reactive Attachment Disorder

Specific Changes Per Diagnostic Category in DSM-5: *Trauma- & Stressor-Related Disorders*

- PTSD criteria differ significantly
  - The stressor criteria is more explicit with regard to events
  - Subjective reaction has been removed
  - Now four symptom clusters
    - Re-experiencing
    - Avoidance
    - Negative alterations in cognitions and mood
    - Marked alterations in arousal and reactivity
  - Thresholds have been lowered for children and adolescents
  - Separate criteria added for children age 6 and younger

Decision Tree on Trauma

How might you diagnose?

- Lost family home in natural disaster
- No history of current abuse/neglect
- No psychotic, motor or sensory symptoms
- Memory of life history is intact
- No concerns about death of self or others
- Reaction is excessive and maladaptive

Specific Changes Per Diagnostic Category in DSM-5: *Dissociative Disorders*

- Depersonalization Disorder now called Depersonalization/Derealization Disorder
- Dissociative Fugue is now a specifier of Dissociative Amnesia rather than separate diagnosis
- Criteria for Dissociative Identity Disorder have been changed

Specific Changes Per Diagnostic Category in DSM-5: *Somatic Symptom & Related Disorders*

- Somatoform Disorders are now referred to as Somatic Symptom and Related Disorders
- Diagnoses of Somatization Disorder, Hypochondriasis, Pain Disorder, and Undifferentiated Somatoform Disorder have been removed

Specific Changes Per Diagnostic Category in DSM-5: *Somatic Symptom & Related Disorders*

- Individuals previously diagnosed with hypochondriasis who have high health anxiety but no somatic symptoms would receive DSM-5 diagnosis of Illness Anxiety Disorder
- Addition of Psychological Factors Affecting Other Medical Conditions; this condition and Factitious Disorder placed in this category because of somatic symptoms
- Conversion Disorder (Functional Neurological Symptom Disorder) modified to emphasize psychological factors

Decision Tree for Memory Loss

How might you diagnose?

- Not due to substance use or medical problem
- No identity disturbance
- Not related to a trauma
- Remembers autobiographical information
- May be faking the memory loss
- Is receiving special treatment from family because of memory loss

Specific Changes Per Diagnostic Category in DSM-5: *Feeding and Eating Disorders*

- Pica and Rumination Disorder moved to this category
- Avoidant/Restrictive Food Intake Disorder has been named for the feeding disorder of infancy or early childhood
- Amenorrhea has been eliminated from criteria for Anorexia Nervosa
- In Bulimia Nervosa, reduction in required minimum average frequency of binge eating and compensatory behavior from twice to once weekly
- Addition of Binge-Eating Disorder to this category

Specific Changes Per Diagnostic Category in DSM-5: *Elimination Disorders*

- Newly formed category
- No significant changes to the disorders in this category
  - Enuresis
  - Encopresis
  - Other Specified Elimination Disorder
  - Unspecified Elimination Disorder

Specific Changes Per Diagnostic Category in DSM-5: *Sleep-Wake Disorders*

- Sleep Disorder Related to Another Medical Disorder and Sleep Disorder Related to Another Medical Condition have been removed
- Greater specification of existing sleep-wake disorders is provided
- Primary Insomnia has been renamed Insomnia Disorder
- Narcolepsy is distinguished from other disorders

Specific Changes Per Diagnostic Category in DSM-5: *Sleep-Wake Disorders*

- Breathing-Related Sleep Disorders is divided
  - Obstructive Sleep Apnea Hypopnea
  - Central Sleep Apnea
  - Sleep-Related Hypoventilation
- Circadian Rhythm Sleep Disorders are expanded to include advanced sleep phase type and irregular sleep-wake type; jet lag type has been removed
- Rapid Eye Movement Sleep Behavior Disorder and Restless Legs Syndrome are now independent diagnoses

Specific Changes Per Diagnostic Category in DSM-5: *Sexual Dysfunctions*

- For females, Sexual Desire and Arousal Disorders have been combined into one disorder: Female Sexual Interest/ Arousal Disorder
- All sexual dysfunctions (except medically induced) now require a minimum duration of 6 months and more precise severity criteria
- Genito/Pelvic Pain/Penetration Disorder has been added and represents both vaginismus and dyspareunia

Specific Changes Per Diagnostic Category in DSM-5: *Sexual Dysfunctions*

- Sexual Aversion Disorder has been removed
- Only two subtypes of Sexual Dysfunctions: lifelong versus acquired and generalized versus situational
- Associated features have been added to denote presence and degree of medical and other correlates

Specific Changes Per Diagnostic Category in DSM-5: *Gender Dysphoria*

- New diagnostic class emphasizing "gender incongruence" rather than previous identification
- There are separate sets of criteria for children and for adults and adolescents
- A posttransition specifier has been added

Specific Changes Per Diagnostic Category in DSM-5: *Disruptive, Impulse-Control, & Conduct D/O*

- New category with disorders characterized by problems in emotional and behavioral self-control
- Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) moved to this category
  - ODD criteria are now grouped into three subtypes: Angry/Irritable mood, Argumentative/Defiant Behavior, and Vindictiveness
  - CD criteria include descriptive features specifiers for individuals who meet criteria for this disorder but also present with Limited Prosocial Emotions

Specific Changes Per Diagnostic Category in DSM-5: *Disruptive, Impulse-Control, & Conduct D/O*

- Intermittent Explosive Disorder outbursts now include verbal aggression and nondestructive/ noninjurious physical aggression; minimum age of 6 years (or developmentally equivalent)
- Trichotillomania removed from this category
- Antisocial Personality Disorder moved to this category because of its close ties to Conduct Disorder

Specific Changes in DSM-5: *Substance Abuse and Addictive Disorders*

- Diagnoses of Substance Abuse and Substance Dependence are not separate but are together replaced by Substance Use Disorder
- Category includes criteria for Intoxication, Withdrawal, Substance-Induced Disorder, and Unspecified Substance-Related Disorders
- New criterion: craving, or strong desire or urge to use a substance
- Threshold for substance use is set at two or more criteria

Specific Changes in DSM-5: *Substance Abuse and Addictive Disorders*

- Threshold for substance use is set at two or more criteria
- New specifiers: “in a controlled environment” and “on maintenance therapy”
- Addition of Caffeine Withdrawal and Cannabis Withdrawal
- Gambling moved to this to category
- Polysubstance Dependence categories discontinued

Substance Abuse & Addictive Disorders

Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria:

1. Taking the substance in larger amounts or for longer than the you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts the you in danger
9. Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

Substance Abuse & Addictive Disorders

Specifiers:

- Mild: two or three of the 11 symptoms
- Moderate: four or five symptoms
- Severe: six or more symptoms
- In early remission
- In sustained remission
- On maintenance therapy
- In a controlled environment

Specific Changes Per Diagnostic Category in DSM-5: *Neurocognitive Disorders*

- Diagnoses of Dementia and Amnestic Disorder are subsumed under the newly named Major Neurocognitive Disorder (NCD)
  - *Dementia* is admissible in the etiological subtypes where standard, though the DSM-5 discourages the use of the term *Dementia*
- Mild NCD is a less severe level of cognitive impairment
- For both types of NCD, there are criteria for different etiological subtypes
- New and separate criteria are presented for major or mild NCDs of different types

Specific Changes Per Diagnostic Category in DSM-5: *Personality Disorders*

- Schizotypal Personality Disorder also under Schizophrenia Spectrum and Other Psychotic Disorders
- Antisocial Personality Disorder also under Disruptive Impulse Control and Conduct Disorders
- This category is no longer AXIS II but rather as a diagnosed category with dimensions

Specific Changes Per Diagnostic Category in DSM-5: *Personality Disorders*

- There is an Alternate DSM-5 Model for Personality Disorders with updated criteria
- In the alternate model, personality functioning and personality traits can be assessed whether or not the individual has a personality disorder

Specific Changes Per Diagnostic Category in DSM-5: *Personality Disorders*

General Criteria for Personality Disorder

- The essential features of a personality disorder are:
  - Moderate or greater impairment in personality (self/ interpersonal) functioning
  - One or more pathological personality traits

Specific Changes Per Diagnostic Category in DSM-5: *Personality Disorders*

The impairments in personality functioning and the individual's personality trait expression are:

- relatively inflexible and pervasive across a broad range of personal and social situations.
- Relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood.
- Not better explained by another mental disorder.
- Not solely attributable to the physiological effects of a substance or another medical condition (e.g., severe head trauma).
- Not better understood as normal for an individual's developmental stage or sociocultural environment.

Specific Changes Per Diagnostic Category in DSM-5: *Paraphilic Disorders*

- Addition of specifiers "in a controlled environment" and "in remission" for all paraphilic disorders
- Distinction between paraphilias and paraphilic disorders
  - If a paraphilia causes distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others it is considered a paraphilic disorder

DSM-5 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 Associated with Prenatal Alcohol Exposure
- Suicidal Behavior Disorder
- Nonsuicidal Self-Injury

DSM Comparison Chart

DSM-IV-TR	**DSM-5 (Revisions in bold)**
Multi-axial system	**Single line diagnosis with specifiers**

Disorders Usually First Diagnosed in Infancy, Childhood and Adolescence		**Neurodevelopmental Disorders**	
317.0-318.2	Mental Retardation	**319**	**Intellectual Disability (specify adaptive functioning)**
317	Mild		
318.0	Moderate severe		
318.2	Profound		
			Communication Disorders
315.31	Expressive and Mixed Receptive Language Disorders	**315.39**	**Language Disorders**
		315.39	**Speech and Sound Disorders**
		315.35	**Childhood-Onset Fluency (stuttering)**
		315.39	**Social (Pragmatic) Communication Disorder**
299.0	Autism	**299.0**	**Autism Spectrum Disorder (ASD) with severity levels of Level 1- "requires support" to Level 2- "requires substantial support" to Level 3-"requires very substantial support on both social communication and repetitive behaviors.**
299.8	Asperger's Disorder		
299.10	Childhood Disintegrative Disorder		
314.00-314.01	Attention Deficit Hyperactivity Disorder	**314.01**	**Attention Deficit Hyperactivity Disorder, Combined presentation severity levels of mild, moderate, severe**
		314.00	**Predominately inattentive presentation; mild, moderate, severe**
		314.01	**Predominantly hyperactive/impulsive presentation of mild, moderate and severe**
	Learning Disorders		**Specific Learning Disorders with specifiers of mild, moderate, severe and skill deficit**
315.0	Reading Disorder	**315.00**	**with impairment in reading**
315.1	Mathematics Disorder	**315.2**	**with impairment in written expression**
315.2	Disorder of Written Expression	**315.1**	**with impairment in math**
315.9	Learning Disorder Not Otherwise Specified		

DSM-IV-TR		DSM-5 (Revisions in bold)	
Disorders Usually First Diagnosed in Infancy, Childhood and Adolescence		**Neurodevelopmental Disorders**	
	Motor Skills Disorder		**Motor Disorders**
315.4	Developmental Coordination Disorder	**315.4**	**Developmental Disorder**
		307.3	**Stereotypes Movement Disorder**
		307.23	**Tourette's Disorders**
		307.22	**Persistent/Chronic Motor or Vocal Tic**
		307.21	**Provisional Tic Disorder**

Schizophrenia and Other Psychotic Disorders		**Schizophrenia Spectrum and Other Psychotic Disorders**	
			Schizophrenia Subtypes
295.10	Disorganized Type	**297.1**	**Delusional Disorder with specifiers**
295.30	Paranoid Type	**298.8**	**Brief Psychotic Disorder**
		295.40	**Schizophreniform Disorder**
		295.90	**Schizophrenia**
		295.70	**Schizoaffective with Bipolar Type Schizoaffective with Depressive Type**

Mood Disorders		**Bipolar and Related Disorders**	
296.10	Bi-polar 1, mixed episode	**296.41**	**Bipolar 1, mild, manic**
		296.52	**Bipolar 1, moderate, depressed**

Mood Disorders		**Depressive Disorders**	
300.4	Dysthymic Disorder	**300.4**	**Persistent Depressive Disorder with depression and severity index (dysthymia)**
		296.99	**Disruptive Mood Dysregulation Disorder**
		625.4	**Premenstrual Dysphonic Disorder**

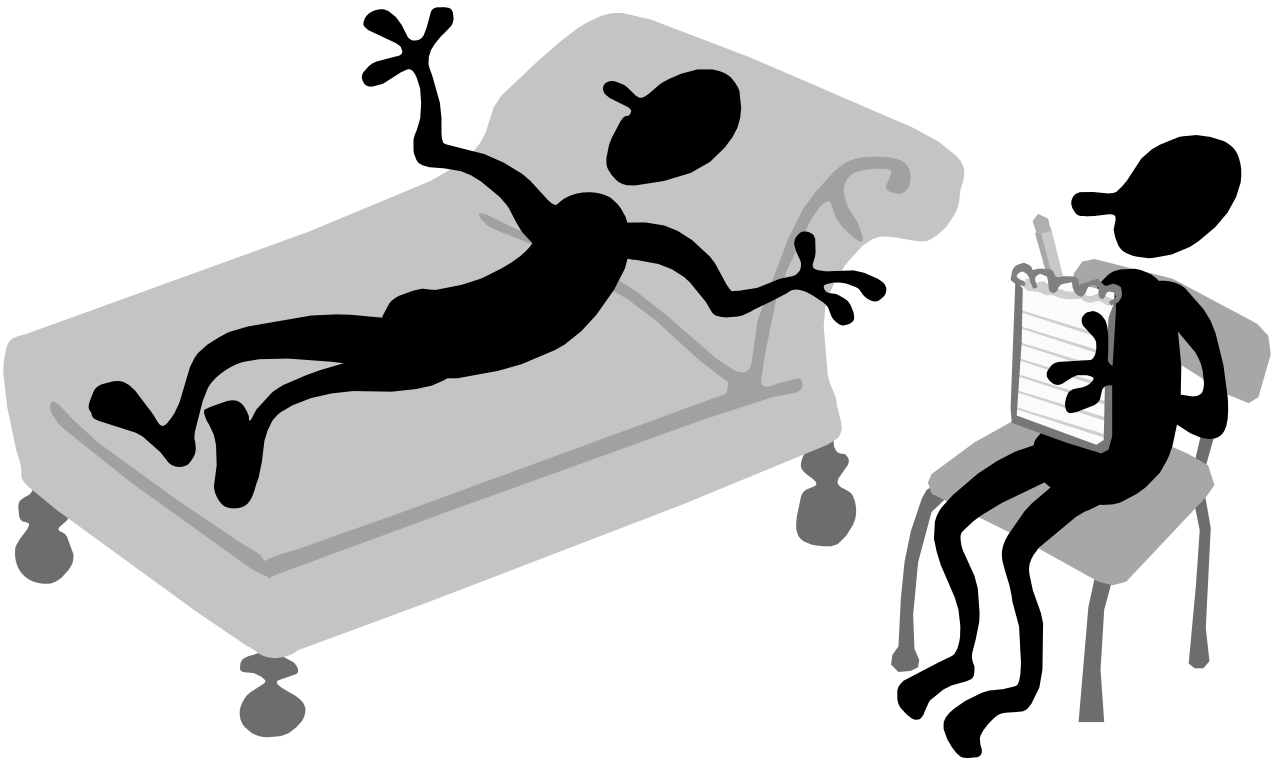
DSM-IV-TR		**DSM-5 (Revisions in bold)**	
Anxiety Disorders		**Anxiety Disorders**	
300.21	Panic Disorder with Agoraphobia	**300.01**	**Panic Disorder**
300.3	Obsessive Compulsive Disorder	**309.21**	**Separation Anxiety Disorder**
		300.22	**Agoraphobia**

Impulse-Control Disorders Not Elsewhere Classified		**Obsessive-Compulsive and Related Disorders with specifiers of good or fair, poor and absent, insight and delusional beliefs**	
312.39	Trichotillomania – Impulse Control Disorder	**312.39**	**Trichotillomania (hair pulling)**
312.31	Pathological Gambling	**300.3**	**OC Disorder**
		300.3	**Hoarding**
		300.7	**Body Dysmorphic Disorder**
		698.4	**Excoriation (skin picking)**

Anxiety Disorders		**Trauma and Stressor-Related Disorders**	
308.3	Acute Stress Disorder	**308.3**	**Acute Stress Disorder – Criterion A – whether qualifying traumatic events were directly experienced, witnessed or experienced indirectly, not included; 9 out of 14 symptoms of intrusion, negative mood, disassociation, avoidance and arousal**
309.0 – 309.9	Adjustment Disorders	**309.0-309.9**	**Adjustment Disorders with specifiers – remain the same but added as a stress related disorder**
309.81	PTSD – three major symptom clusters of re-experiencing, avoiding/numbing and arousal; subjective reaction	**309.81**	**PTSD - four symptom clusters: avoidance, persistent negative alterations, alterations in arousal and reactivity, ≠ subjective reaction, added separate criterion for children under 6 years**
313.23	Selected Mutism – Disorders Usually First Diagnosed in Infancy	**312.23**	**Selected Mutism – in the anxiety section**
313.89	Reactive Attachment Disorder - two subtypes of emotionally withdrawn/inhibited and indiscrimately social engagement	**313.89**	**RAD - two distinct disorders: reactive attachment with specifiers of persistent and severe**
		313.89	**Disinhibited Social Engagement Disorder with specifiers of persistent and severe**

DSM-IV-TR		DSM-5 (Revisions in bold)	
Dissociative Disorders		Dissociative Disorders	
300.14	Dissociative Identity Disorder	**300.6**	**A. Depersonalization/Derealization Dissociative Disorders**
300.6	Depersonalization disorder	**300.14**	**DID - Cluster A expands to certain possession - form phenomena and functional neurological symptoms**
Somazation Disorder		**Somatic Symptom and Related Disorders**	
300.81	Somazation Disorder	**300.82**	**A. Removed somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform dismoved B. New somatic symptom disorder with specifiers**
300.7	Hypochondriasis		
307.8	Pain Disorder		
300.82	Undifferentiated Somatofam		
Eating Disorders		**Feeding and Eating Disorders**	
307.1	Anorexia Nervosa	**307.1**	**Anorexia Nervosa Disorder; restricting, moderate**
		307.51	**Bulimia Nervosa; mild, partial remission**
		307.59	**Avoidant/Restrictive Food Intake Disorder**
Disorders of Infancy, Childhood, Adolescence		**Elimination Disorder**	
307.6	Enuresis	**307.6**	**Enuresis**
Sleep Wake Disorders		**Sleep Wake Disorders**	
307.42	Primary Insomnia	**780.52**	**Insomnia Disorder**

DSM-IV-TR		DSM-5 (Revisions in bold)	
Sexual Dysfunctions		**Sexual Dysfunctions**	
625.8	Sexual dysfunction due to a medical condition in a female	**302.72**	**New – female sexual interest/arousal disorder**
625.89	Sexual dysfunction due to a medical condition in a male	**302.76**	**New – Genito-pelvic/penetration disorder** **New – Sexual Dysfunction due to a medical condition - removed**
Sexual and Gender Identity Disorders		**Gender Dysphoria**	
302.6	Gender Identity Disorder in Children	**302.6**	**Gender Dysphoria in Children**
Disorders Usually First Diagnosed in Infancy		**Disruptive Impulse-Control and Conduct Disorders**	
313.81	Oppositional Defiant Disorder	**313.81**	**Oppositional Defiant Disorder** **Childhood-onset type** **Three types of symptoms: angry/irritable mood, argumentative/defiant, and vindictiveness** **No exclusion criteria** **Normal developmental criteria are offered.** **Severity ratings of mild, moderate, and severe are needed.**
312.8	Conduct Disorder	**312.82**	**Adolescent – on set type**
312.34	Intermittent Explosive Disorder	**312.89**	**Intermittent Explosive Disorder**
Substance-Related Disorder		**Substance-Related and Addictive Disorders**	
305.00	Alcohol Abuse	**305.0**	**Alcohol Use Disorder**
		312.31	**Gambling**
391.9	Alcohol-Related Disorder Not Otherwise Specified	**391.9**	**Unspecified Alcohol Mild-Related Disorder**
		Neurocognitive Disorders	
		332.0 (620)	**Parkinson's Disease**
		294.11 (F0.81)	**Major Neurological Disorder due to Parkinson's Disease**



BIOPSYCHOSOCIAL ASSESSMENT

1. Establish - WHY NOW?
2. Review client's mental health history
3. Explore client's use history:
   (What substances, when did it start, how much, how often, etc.)
4. Determine if client is on any psychotropic medications
5. Review client's relevant medical history
6. Review client's family history
7. Review client's social history
8. Review client's vocational history
9. List client's strengths
10. Finally list liabilities client brings to therapy
11. Explore 6 dimensions of problematic substance use
12. Mental Health Status Exam

BIOPSYCHOSOCIAL ASSESSMENT

Problematic Substance Use

1. **Intoxication & Withdrawal**
2. **Medical and Physical Health**
3. **Emotional, Behavioral & Cognitive Conditions**
4. **Readiness for Change**
5. **Relapse Potential**
6. **Recovery Environment**

BIOPSYCHOSOCIAL ASSESSMENT

- Appearance
- Consciousness
- Orientation to person, place & time
- Speech
- Affect
- Mood
- Concentration
- Activity level
- Thoughts
- Memory
- Judgment

MENTAL HEALTH STATUS EXAM

- Rule out malingering & factitious d/o
- R/O Substance etiology (Drugs & Meds)
- R/O Disorder due to medical condition
- Determine specific primary disorder(s)
- Differentiate adjustment disorders or is it residual from another disorder(s)
- Establish the boundary of no mental d/o
- Differential diagnoses and comorbidity

DIFFERENTIAL DIAGNOSIS

- How might you diagnose?
- Problematic use of multiple substances
- Unable to work because of use
- No pre-existing mental health diagnosis
- Reports being depressed and anxious since the onset of heavy use

DECISION TREE FOR SUBSTANCE USE

At the age of 2, Ben Simon's parents new something was different about their son. The family struggled to get the help they needed in their rural community and were referred to your agency for help diagnosing and treating their son. Ben is currently 4 years-old and his struggles have become more prominent since entering pre-school. Initially, Ben's parents noticed he wouldn't make eye contact and when around other small children he tended to ignore them. They also noticed that he didn't respond to his name being called and at first were concerned about hearing loss. After having him tested by an audiologist, no hearing impairments were found and the family was puzzled by Ben's lack of response.

Ben has a toy box full of dinosaur figures. His parents report that they never see him "playing" with these dinosaur figures, but have noticed his intense concentration on them, which they took to mean he liked dinosaurs so they continued to buy them for him. They stated he carries the dinosaurs around, typically 2-3 at a time, and the only play-like behavior they have ever seen him engage in with the dinosaurs is carefully lining them up in order of size. Ben becomes very upset if someone picks up one of his dinosaurs from his meticulously organized line and has been having what his parents describe as "meltdowns." His mother noted when he has a "meltdown," he doesn't want to be comforted and actively avoids touch.

While Ben's language hasn't developed well compared to his peers, he does engage in single word speech. Generally, his words are not directed at another person and his parents and peers struggle to determine if he is trying to communicate with them or talking to himself. Ben's pre-school teacher reports that he seems to understand lessons, as evidenced by his ability to engage in some of the activities with little assistance, but this seems to depend upon his interest level in the subject. His pre-school teacher sometimes modifies activities to include dinosaurs in an effort to engage his interest in a lesson, which has helped to a degree. During play activities, Ben has been observed by his pre-school teacher and other classroom assistants to wander into the middle of other children's play activities without appearing to realize this is unusual behavior. Recently, children were playing store and Ben sat down with his dinosaurs right in the middle of their store setup. The other children tried telling Ben to move but he didn't seem to notice they were even talking to him. His teacher has mentioned that she has never seen Ben engage in imaginative play, even when specifically directed to pretend to be an animal during a class activity. Ben has no friends, though his classmates seem to understand he is different and are kind to him.

Ben dislikes change and insists on eating the exact same foods each day for breakfast, lunch, and dinner. When his parents try to introduce a new food at one of those meals, Ben can become so distraught that he hits his own chest. At this time Ben's parents and his teacher try to keep his meals and routines as similar as possible. His teacher has tried different methods of gradually introducing him to new activities by using familiar/routine objects and tasks but sometimes she simply excuses him from the activity, allowing him to engage in whatever task he thinks must be done at that specific time of day.

His parents have tried getting him assessed medically, but no doctor has found a medical, genetic, or environmental cause for Ben's behaviors and lack of interest in the social world. His parents are coming to you as a last hope to figure out what is happening with their son and how best to help him. They are exhausted and concerned that

Evaluation of Ben Simon

Ben's lack of social interest and social skill, combined with difficulty in language development are suggestive of Autism Spectrum Disorder. While no formal intelligence test has yet been conducted, reports from his pre-school teacher do not appear to suggest an intellectual problem (he is able to complete activities as long as he is interested in them). Additionally, no other cause has been found to better account for his behavior (medical, genetic, environmental). Ben meets all three sub-criteria for Criterion A for Autism Spectrum Disorder. He lacks the ability to engage in socially appropriate behavior and communication; he lacks typical nonverbal communication skills (lack of eye contact); and appears unable to make friends or have any interest in doing so. The severity level for Criterion A is Level 3: Requiring Very Substantial Support." Ben meets the first two of the four sub-criteria for Criterion B: lining up toys and insistence on sameness. His Criterion B severity level is somewhat unclear from the information provided, but likely is best described by Level 3: "Requiring Very Substantial Support."

Diagnosis: 299.0 [F84.0] Autism Spectrum Disorder, requiring very substantial support for deficits in social communication and requiring very substantial support for restricted, repetitive behaviors; without accompanying intellectual impairment; with accompanying language impairment—single word speech.

Peter Wilson, a 17 year-old male is mandated to treatment with you. He comes in wearing an Anarchy Rules t-shirt. He has more tattoos and piercings than you can count and he proudly tells you that his parents objected to every single one of them. His paperwork shows that he started using drugs when he was 9 years old and notes from his education file indicate a number of suspensions for bullying, fighting, bringing weapons to school, theft, destroying school property, and not obeying school rules. He has been arrested 27 times for getting in fights and for property destruction since the age of 11. He was kicked out of school 4 years ago and has just started serving time for armed robbery. By the time he was 13 his parents had given up on him. He wouldn't obey their rules, flagrantly disregarded curfew, and had run away 4 times in a span of 3 years. The notes in his file indicate he has never demonstrated remorse for any of his actions, though early on he would say what people wanted to hear (I'm sorry, I'll never do it again) while already thinking about what his next "adventure" would be or how he would get revenge on the person who turned him in. His parents confirmed a lack of remorse in Peter from a young age, and stated his early elementary school friends were only ever temporary because eventually Peter would hurt them (physically or through theft/deceit) and they would find someone else to hang out with. Former friends/classmates, teachers, and his parents all described him as not caring or even trying to understand how others feel or experience his behaviors.

By age 13 he had completely stopped attending school, which resulted in his expulsion. Peter stated he didn't care about being expelled, because school was a waste of time and he never bothered to do any of his work anyway. He had "better ways to spend [his] time." All of his "friends" since age 11 were people he had met through his criminal behavior and he noted he wouldn't risk anything for any of them. He stated they were only friends when he wanted something from them. He reports using heroin daily. He reports experiencing withdrawal symptoms and cravings. He says that he is high so much that he could never get a job and he wouldn't want to anyway. He stated he can just steal what he needs or earn money by doing "jobs" for other criminals. Sometimes he uses in very dangerous ways. His use has increased to get the same high he had when he first started using. He doesn't do much for fun but get high. Most of his life is spent using heroin and he has reported needing increasing amounts of heroin to achieve the same high.

Evaluation of Peter Wilson

While the information of Peter's activities does not explicitly state everything that occurred within the past 12 months, it appears he has engaged in sufficient activities recently and in the past that are suggestive of Conduct Disorder. The information provided by Peter and his school and treatment records indicate a history of aggression towards people, destruction of property, deceitfulness or theft, and serious violations of rules in quantities that exceed the minimum of 3 out of 15 criteria for criterion A of Conduct Disorder. The onset of his symptoms occurred prior to age 10, indicating Childhood-onset type. Given the number of information sources (Peter, his parents, school and treatment records) it is possible to assess for the specifier "with limited prosocial emotions." Based on the information above, it appears Peter meets criteria for the specifier "with limited prosocial emotions—lack of remorse or guilt; callous—lack of empathy; unconcerned about performance; and shallow or deficient affect. Additionally, his severity level appears to be severe because he far exceeds the number of behaviors for criterion A needed to make the diagnosis.

Peter also appears to meet criteria for Opioid Use Disorder. The information isn't plentiful on his heroin-using behaviors, however it is apparent that he spends a great deal of time using (it's his source of fun), he has cravings, he has had recurrent legal problems (though not specifically stated as being related to substance use, it is quite likely some of his arrests were drug-related), and using in physically hazardous situations. He meets criteria for tolerance (needing more of the substance to experience the same high), and he reports withdrawal symptoms. Since he is currently incarcerated, he may meet criteria for the specifier "In a controlled environment." He also appears to fall under the specifier of "moderate" given the number of criteria he meets for Opioid Use Disorder (4-5).

312.81 [F91.1] Conduct Disorder, Childhood-Onset Type; With Limited Prosocial Emotions—lack of remorse or guilt; callous—lack of empathy; unconcerned about performance; shallow or deficient affect
304.00 [F11.20] Opioid Use Disorder, In a Controlled Environment, Moderate

An 8-year-old girl, named Suzie Harold, is brought in by her mother. Her father has also given consent for Susie to be evaluated. The parents are in the midst of a divorce. Suzie is biracial. Her mother is Asian and her father is African American. Suzie has been struggling in school for the past 3 years and in the past year her school has demanded that she get evaluated by a mental health professional in order to continue attending her school. Suzie's parents first noticed that she was a very easily distracted child but thought this was typical of other children her age at first. As Suzie progressed in school, it became apparent that her concentration problems were more than a developmental period and began creating problems for her at school and at home. Suzie has difficulty making and maintaining friendships with her classmates and tends to perform more poorly on a variety of tasks than her peers. From reports by the teacher, Suzie is capable of learning the material but has difficulty applying herself to any given task for an extended amount of time. At home, her parents report Suzie getting easily distracted by all kinds of things when trying to carry out a chore or task. At first her parents thought she was just trying to get out of cleaning her room or other household chores, but realized sometimes even during play she would get distracted.

Suzie's teacher described the quality of Suzie's work as often filled with careless mistakes (leaving a letter off a word for example). She mentioned that Suzie often does not appear to be listening and rarely is able to follow instructions completely (typically stopping before the last couple of steps in an assignment are completed). These work quality issues do not appear restricted to one subject at school. Suzie also frequently loses her homework (both at home and at school) as well as other important items. Suzie's parents report that she frequently forgets to complete routine tasks, such as picking up her toys or brushing her teeth. They both note they have to remind her an average of 4 times to complete a task before she does so successfully. Suzie seems lonely and frustrated, both at home and at school.

Evaluation of Suzie Harold

Suzie appears to meet criteria for Attention-Deficit Hyperactivity Disorder, predominantly inattentive presentation. Suzie has many difficulties with sustained attention in multiple settings yet does not appear incapable of completing the tasks (which would be suggestive of an intellectual disorder). The difficulties aren't restricted to one area (which would suggest a possible learning disorder) and are creating difficulties in Suzie's life. She doesn't appear to meet criteria for hyperactivity at this time, which suggests the inattentive presentation is the most appropriate specifier. Additionally, she meets the minimum number of criteria for criterion A1, which suggests a severity specifier of mild.

314.00 [F90.0] Attention-Deficit Hyperactivity Disorder, Predominantly Inattentive Presentation, Mild.

A 10 year-old girl named Jackie Johnson is brought in by her parents for an updated evaluation. Jackie struggles in school and at home. Recently she completed an IQ test and received a standard score of 73. Her parents have been working with a professional who helps Jackie in the classroom, developing her skills both socially and academically. They've had some success improving her performance but it has been quite limited. The school is advising Jackie's parents to move her to a special classroom for students with limited academic abilities or behavioral problems. Jackie's struggles in school have been somewhat expected based on her social interactions and difficulty learning as a toddler. Her parents report Jackie has never had meningitis or encephalitis, there is no family history of intellectual problems, and Jackie hasn't experienced any head injuries despite her tendency to be somewhat clumsy. Her parents reported they had Jackie when Mrs. Johnson was 42 and Mr. Johnson was 46.

Her parents are particularly concerned about Jackie's social abilities. She has been taken advantage of by some of her more manipulative peers. Last year one of her classmates told her she had to give him her lunch, except for fruit, every day as her "lunch tax." Jackie believed him and it took her parents and teacher about a week to figure out what was happening and why she was eating so much when she got home from school.

Jackie's academic performance has been gradually declining as she continues in school, likely because she hasn't learned the foundational skills needed to progress in each grade. She has great difficulty reading and is currently reading children's books geared for the 5 year-old age range. Jackie seems to have difficulty retaining information and learning from experience. Her professional helper, who started working with her this year, reviews the same concepts with her every day and often they seem rather novel to Jackie. Jackie's parents have to constantly remind her to take care of her personal hygiene, such as brushing her hair and teeth, though she has made some improvements in the past 6 months. When playing with other children, Jackie tends to interact with them at a younger level. She becomes upset and frustrated easily, and often laughs at inappropriate times/situations. This has made it difficult for her to find and maintain friendships though one or two students in her class have made a point to try to include Jackie at recess.

Evaluation of Jackie Johnson

Jackie's IQ score of 73 is potentially suggestive of an intellectual disability. Her progress at school has been somewhat limited, even with help, and she struggles with social and practical domains as well. Jackie's intellectual difficulties do not appear to be accounted for by a medical issue. Given Jackie's struggles at school (conceptual), socially, and with daily tasks (practical) it appears she may meet criteria for an Intellectual Disability. Her functioning indicates she struggles a decent amount in all three areas and while she has made a few improvements with assistance, her performance is still markedly below her peers. Her struggles do not appear to meet criteria for Severe or Profound, but are more than Mild, thus suggesting the specifier of Moderate is most appropriate for Jackie.

318.0 [F71] Intellectual Disability (Intellectual Developmental Disorder), Moderate.

DSM 5 Cultural Formulation

Cultural Formulation

DSM-5 not only includes an updated version of the Outline but also presents an approach to assessment, using the Cultural Formulation Interview (CFI), which has been field-tested for diagnostic usefulness among clinicians and for acceptability among patients.

Cultural identity of the individual

- Describe the individual's racial, ethnic, or cultural reference groups that may influence his or her relationships with others, access to resources, and developmental and current challenges, conflicts, or predicaments.
- For immigrants and racial or ethnic minorities, the degree and kinds of involvement with both the culture of origin and the host culture or majority culture should be noted separately.
- Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and the need for an interpreter.
- Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation.

Cultural conceptualizations of distress

- Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others.
  - Cultural syndromes
  - Idioms of distress
  - Explanatory models or perceived causes.
- The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural reference groups.
- Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.

Psychosocial stressors & cultural features of vulnerability & resilience

- Identify key stressors and supports in the individual's social environment (local and distant events) and the role of religion, family, and other social networks in providing emotional, instrumental, and informational support.
- Social stressors and social supports vary with cultural interpretations of events, family structure, developmental tasks, and social context.
- Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural reference groups.

Cultural features of the relationship between the individual & the clinician:

- Identify differences in culture, language, and social status between an individual and clinician that may cause difficulties in communication and may influence diagnosis and treatment.
- Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter.
- Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance.

Overall Cultural Assessment

Integrate information from the cultural formulation when diagnosing and designing treatment interventions.

Cultural Concepts of Distress

- There is seldom a one-to-one correspondence of any cultural concept with a DSM diagnostic category or specific diagnosis.
- Cultural presentations of distress may be interpreted as multiple DSM diagnoses.
- Be careful to not overpathologize cultural presentations of distress or impaired level of functioning.

Cultural Concepts of Distress

- Cultural concepts may apply to a wide range of severity, including presentations that do not meet DSM criteria for any mental disorder.
- For example, an individual with acute grief or a social predicament may use the same idiom of distress or display the same cultural syndrome as another individual with more severe psychopathology.

Cultural Concepts of Distress

- In common usage, the same cultural term frequently denotes more than one type of cultural concept.
- A familiar example may be the concept of "depression," which may be used to describe a syndrome (e.g., major depressive disorder), an idiom of distress (e.g., as in the common expression "I feel depressed"), or a perceived cause (similar to "stress").
- Like culture and DSM itself, cultural concepts may change over time in response to both local and global influences

Cultural Concepts of Distress

- **To avoid misdiagnosis:**
  - Cultural variation in symptoms and in explanatory models associated with these cultural concepts may lead clinicians to misjudge the severity of a problem or assign the wrong diagnosis (e.g., unfamiliar spiritual explanations may be misunderstood as psychosis)(Alarcón et al. 1999).

Cultural Concepts of Distress

- **To obtain useful clinical information:**
  - Cultural variations in symptoms and attributions may be associated with particular features of risk, resilience, and outcome(Lewis-Fernández et al. 2009).
- **To improve clinical rapport and engagement:**
  - "Speaking the language of the patient," both linguistically and in terms of his or her dominant concepts and metaphors, can result in greater communication and satisfaction, facilitate treatment negotiation, and lead to higher retention and adherence(Kleinman and Benson 2006).

Cultural Concepts of Distress

- **To improve therapeutic efficacy:**
  - Culture influences the psychological mechanisms of disorder, which need to be understood and addressed to improve clinical efficacy(Hinton and Lewis-Fernández 2010).
  - For example, culturally specific catastrophic cognitions can contribute to symptom escalation into panic attacks(Hinton et al. 2010).
- **To guide clinical research:**
  - Locally perceived connections between cultural concepts may help identify patterns of comorbidity and underlying biological substrates(Kirmayer 1991).

Cultural Concepts of Distress

- **To clarify the cultural epidemiology:**
  - Cultural concepts of distress are not endorsed uniformly by everyone in a given culture. Distinguishing syndromes, idioms, and explanations provides an approach for studying the distribution of cultural features of illness across settings and regions, and over time. It also suggests questions about cultural determinants of risk, course, and outcome in clinical and community settings to enhance the evidence base of cultural research(Weiss 2001).

- DSM-5 includes information on cultural concepts in order to improve the accuracy of diagnosis and the comprehensiveness of clinical assessment.
- Clinical assessment of individuals presenting with these cultural concepts should determine whether they meet DSM-5 criteria for a specified disorder or ano*ther specified or unspecified* diagnosis.
- Once the disorder is diagnosed, the cultural terms and explanations should be included in case formulations; they may help clarify symptoms and etiological attributions that could otherwise be confusing.

- Individuals whose symptoms do not meet DSM criteria for a specific mental disorder may still expect and require treatment; this should be assessed on a case-by-case basis.
- In addition to the CFI and its supplementary modules, DSM-5 contains the following information and tools that may be useful when integrating cultural information in clinical practice

Data in DSM-5 criteria and text for specific disorders

- The text includes information on cultural variations in prevalence, symptomatology, associated cultural concepts, and other clinical aspects.
- It is important to emphasize that there is no one-to-one correspondence at the categorical level between DSM disorders and cultural concepts.
- Differential diagnosis for individuals must therefore incorporate information on cultural variation with information elicited by the CFI.

Other Conditions That May Be a Focus of Clinical Attention

- Some of the clinical concerns identified by the CFI may correspond to V codes or Z codes.
- For example, acculturation problems, parent-child relational problems, or religious or spiritual problems.

Glossary of Cultural Concepts of Distress

Located in the Appendix, this glossary provides examples of well-studied cultural concepts of distress that illustrate the relevance of cultural information for clinical diagnosis and some of the interrelationships among cultural syndromes, idioms of distress, and causal explanations.

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Small Group Activity

- On the next few pages is structured interview that can be useful to gathering information about the client's culture and the impact it may have diagnosis and treatment.
- Review the interview form. Talk about how you can integrate a cultural formulation into diagnosing and treatment planning.

The APA is offering the Cultural Formulation Interview (including the Informant Version) and the Supplementary Modules to the Core Cultural Formulation Interview for further research and clinical evaluation. They should be used in research and clinical settings as potentially useful tools to enhance clinical understanding and decision-making and not as the sole basis for making a clinical diagnosis. Additional information can be found in DSM-5 in the Section III chapter "Cultural Formulation." The APA requests that clinicians and researchers provide further data on the usefulness of these cultural formulation interviews at http://www.dsm5.org/Pages/Feedback-Form.aspx.

Cultural Formulation Interview (CFI)

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

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

CULTURAL DEFINITION OF THE PROBLEM

(Explanatory Model, Level of Functioning)

Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?
Ask how individual frames the problem for members of the social network.	2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
Focus on the aspects of the problem that matter most to the individual.	3. What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

CAUSES

(Explanatory Model, Social Network, Older Adults)

This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. *Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.*	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.	5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

STRESSORS AND SUPPORTS

(Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)

Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

ROLE OF CULTURAL IDENTITY

(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

SELF-COPING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)

Clarify self-coping for the problem.	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

PAST HELP SEEKING

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing). *Probe as needed (e.g., "What other sources of help have you used?").* *Clarify the individual's experience and regard for previous help.*	12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]? *PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:* What types of help or treatment were most useful? Not useful?

BARRIERS

(Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. *Probe details as needed (e.g., "What got in the way?").*	13. Has anything prevented you from getting the help you need? *PROBE AS NEEDED:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

PREFERENCES

(Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)

Clarify individual's current perceived needs and expectations of help, broadly defined. *Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").*	Now let's talk some more about the help you need. 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
Focus on the views of the social network regarding help seeking.	15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?

CLINICIAN-PATIENT RELATIONSHIP

(Clinician-Patient Relationship, Older Adults)

Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. *Probe details as needed (e.g., "In what way?").* *Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.*	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

Supplementary Modules to the Core Cultural Formulation Interview (CFI)

Guidelines for Implementing the CFI Supplementary Modules

These modules supplement the core Cultural Formulation Interview and can help clinicians conduct a more comprehensive cultural assessment. The first eight supplementary modules explore the domains of the core CFI in greater depth. The next three modules focus on populations with specific needs, such as children and adolescents, older adults, and immigrants and refugees. The last module explores the experiences and views of individuals who perform caregiving functions, in order to clarify the nature and cultural context of caregiving and how they affect social support in the immediate environment of the individual receiving care. In addition to these supplementary modules, an Informant version of the core CFI collects collateral information on the CFI domains from family members or caregivers.

Clinicians may use these supplementary modules in two ways:

- As adjuncts to the core CFI for additional information about various aspects of illness affecting diverse populations. The core CFI refers to pertinent modules under each subheading to facilitate such use of the modules.
- As tools for in-depth cultural assessment independent of the core CFI. Clinicians may administer one, several, or all modules depending on what areas of an individual's problems they would like to elaborate.

Clinicians should note that a few questions in the modules duplicate questions in the core CFI (indicated by an asterisk [*]) or in other modules. This makes it possible to administer each module independently. Clinicians who use the modules as an adjunct to the core CFI or who administer the modules independently may skip redundant questions.

As with the core CFI, follow-up questions may be needed to clarify the individual's answers. Questions may be rephrased as needed. The modules are intended as a guide to cultural assessment and should be used flexibly to maintain a natural flow of the interview and rapport with the individual. In situations where the individual cannot answer these questions (e.g., due to cognitive impairment or severe psychosis) these questions can be administered to the identified caregiver. The caregiver's own perspective can also be ascertained using the module for caregivers.

In every module, instructions to the interviewer are in *italics.* The modules may be administered during the initial clinical evaluation, at a later point in care, or several times over the course of treatment. Multiple administrations may reveal additional information as rapport develops, especially when assessing the patient-clinician relationship.

Please refer to DSM-5 Section III, chapter "Cultural Formulation," section "Outline for Cultural Formulation," for additional suggestions regarding this type of interview.

1. Explanatory Model

Related Core CFI Questions: 1, 2, 3, 4, 5 Some of the core CFI question are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

GUIDE TO INTERVIEWER: *This module aims to clarify the individual's understanding of the problem based on his or her ideas about cause and mechanism (explanatory models) and past experiences of, or knowing someone with, a similar problem (illness prototypes). The individual may identify the problem as a symptom, a specific term or expression (e.g., "nerves," "being on edge"), a situation (e.g., loss of a job), or a relationship (e.g., conflict with others). In the examples below, the individual's own words should be used to replace "[PROBLEM]". If there are multiple problems, each relevant problem can be explored. The following questions may be used to elicit the individual's understanding and experience of that problem or predicament.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to understand the problems that bring you here so that I can help you more effectively. I will be asking you some questions to learn more about your own ideas about the causes of your problems and the way they affect your daily life.

General understanding of the problem

1. *Can you tell me more about how you understand your [PROBLEM]? [RELATED TO CFI Q#1-2.]
2. What did you know about your [PROBLEM] before it affected you?

Illness prototypes

3. Had you ever had anything like your [PROBLEM] before? Please tell me about that.
4. Do you know anyone else, or heard of anyone else, with this [PROBLEM]? If so, please describe that person's [PROBLEM] and how it affected that person. Do you think this will happen to you too?
5. Have you seen on television, heard on the radio, read in a magazine, or found on the internet anything about your [PROBLEM]? Please tell me about it.

Causal explanations

6. *Can you tell me what you think caused your [PROBLEM]? (*PROBE AS NEEDED*: Is there more than one cause that may explain it?] [RELATED TO CFI Q#4.)
7. Have your ideas about the cause of the [PROBLEM] changed? How? What changed your ideas about the cause?
8. *What do people in your family, friends, or others in your community think caused the [PROBLEM]? (*PROBE AS NEEDED*: Are their ideas about it different from yours? How so?) [RELATED TO CFI Q#5.]
9. How do you think your [PROBLEM] affects your body? Your mind? Your spiritual wellbeing?

Course of illness

10. What usually happens to people who have this [PROBLEM]? In your own case, what do you think is likely to happen?
11. Do you consider your [PROBLEM] to be serious? Why? What is the worst that could happen?
12. How concerned are other people in your family, friends or community about your having this [PROBLEM]? Please tell me about that.

Help seeking and treatment expectations

13. What do you think is the best way to deal with this kind of problem?
14. What do your family, friends, or others in your community think is the best way of dealing with this kind of problem?

2. Level of Functioning

Related Core CFI Question: 3

GUIDE TO INTERVIEWER: *The following questions aim to clarify the individual's level of functioning in relation to his or her own priorities and those of the cultural reference group. The interview begins with a general question about everyday activities that are important for the individual. Questions follow about domains important for positive health (social relations, work/school, economic viability, and resilience). Questions should be kept relatively broad and open to elicit the individual's own priorities and perspective. For a more detailed evaluation of specific domains of functioning, a standard instrument such as the WHO-DAS II may be used together with this interview.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to know about the daily activities that are most important to you. I would like to better understand how your [PROBLEM] has affected your ability to perform these activities, and how your family and other people around you have reacted to this.

1. How has your [PROBLEM] affected your ability to do the things you need to do each day, that is, your daily activities and responsibilities?
2. How has your [PROBLEM] affected your ability to interact with your family and other people in your life?
3. How has your [PROBLEM] affected your ability to work?
4. How has your [PROBLEM] affected your financial situation?
5. How has your [PROBLEM] affected your ability to take part in community and social activities?
6. How has your [PROBLEM] affected your ability to enjoy everyday life?
7. Which of these concerns are most troubling to you?
8. Which of these concerns are most troubling to your family and to other people in your life?

3. Social Network

Related Core CFI Questions: 5, 6, 12, 15

GUIDE TO INTERVIEWER: *The following questions identify the influences of the informal social network on the individual's problem.* **Informal social network** *refers to family, friends and other social contacts through work, places of prayer/worship or other activities and affiliations. Question #1 identifies important people in the individual's social network, and the clinician should tailor subsequent questions accordingly. These questions aim to elicit the social network's response, the individual's interpretation of how this would impact on the problem, and the individual's preferences for involving members of the social network in care.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to know more about how your family, friends, colleagues, co-workers, and other important people in your life have had an impact on your [PROBLEM].

Composition of the individual's social network

1. Who are the most important people in your life at present?
2. Is there anyone in particular whom you trust and can talk with about your [PROBLEM]? Who? Anyone else?

Social network understanding of problem

3. Which of your family members, friends, or other important people in your life know about your [PROBLEM]?
4. What ideas do your family and friends have about the nature of your [PROBLEM]? How do they understand your [PROBLEM]?
5. Are there people who do not know about your [PROBLEM]? Why do they not know about your [PROBLEM]?

Social network response to problem

6. What advice have family members and friends given you about your [PROBLEM]?
7. Do your family, friends, and other people in your life treat you differently because of your [PROBLEM]? How do they treat you differently? Why do they treat you differently?
8. (IF HAS NOT TOLD FAMILY OR FRIENDS ABOUT PROBLEM): Can you tell me more about why you have chosen not to tell family or friends about the [PROBLEM]? How do you think they would respond if they knew about your [PROBLEM]?

Social network as a stress/buffer

9. What have your family, friends, and other people in your life done to make your [PROBLEM] better or easier for you to deal with? (*IF UNCLEAR:* How has that made your [PROBLEM] better?)
10. What kinds of help or support were you expecting from family or friends?
11. What have your family, friends, and other people in your life done to make your [PROBLEM] worse or harder for you to deal with? (*IF UNCLEAR:* How has that made your [PROBLEM] worse?)

Social network in treatment

12. Have any family members or friends helped you get treatment for your [PROBLEM]?
13. What would your family and friends think about your coming here to receive treatment?
14. Would you like your family, friends, or others to be part of your treatment? If so, who would you like to be involved and how?
15. How would involving family or friends make a difference in your treatment?

4. Psychosocial Stressors

Related Core CFI Questions: 7, 9, 10, 12

GUIDE TO INTERVIEWER: *The aim of these questions is to further clarify the stressors that have aggravated the problem or otherwise affected the health of the individual. (Stressors that initially caused the problem are covered in the module on Explanatory Models.) In the examples below, the individual's own words should be used to replace "[STRESSORS]". If there are multiple stressors, each relevant stressor can be explored*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: You have told me about some things that make your [PROBLEM] worse. I would like to learn more about that.

1. Are there things going on that have made your [PROBLEM] worse, for example, difficulties with family, work, money, or something else? Tell me more about that.
2. How are the people around you affected by these [STRESSORS]?
3. How do you cope with these [STRESSORS]?
4. What have other people suggested about coping with these [STRESSORS]?
5. What else could be done about these [STRESSORS]?

GUIDE TO INTERVIEWER: *Patients may be reluctant to discuss areas of their life they consider sensitive, which may vary across cultural groups. Asking specific questions may help the patient discuss these stressors. Insert questions about relevant stressors here. For example:*

7. Have you experienced discrimination or been treated badly as a result of your background or identity? By background or identity I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your racial or ethnic background, your gender or sexual orientation, and your faith or religion. Have these experiences had an impact on [STRESSORS] or your [PROBLEM]?

5. Spirituality, Religion, and Moral Traditions

Related Core CFI Questions: 6, 7, 8, 9, 10, 11, 12, 14, 15

GUIDE TO INTERVIEWER: *The following questions aim to clarify the influence of spirituality, religion, and other moral or philosophical traditions on the individual's problems and related stresses. People may have multiple spiritual, moral, and religious affiliations or practices. If the individual reports having specific beliefs or practices, inquire about the level of involvement in that tradition and its impact on coping with the clinical problem. In the examples below, the individual's own words should be used to replace "[NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)]". If the individual identifies more than one tradition, each can be explored. If the individual does not describe a specific tradition, use the phrase "spirituality, religion or other moral traditions" instead of the specific name of a tradition (e.g., Q5: "What role do spirituality, religion or other moral traditions play in your everyday life?")*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: To help you more effectively, I would like to ask you some questions about the role that spirituality, religion or other moral traditions play in your life and how they may have influenced your dealing with the problems that bring you here.

Spiritual, religious, and moral identity

1. Do you identify with any particular spiritual, religious or moral tradition? Can you tell me more about that?
2. Do you belong to a congregation or community associated with that tradition?
3. What are the spiritual, religious or moral tradition backgrounds of your family members?
4. Sometimes people participate in several traditions. Are there any other spiritual, religious or moral traditions that you identify with or take part in?

Role of spirituality, religion, and moral traditions

5. What role does [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] play in your everyday life?
6. What role does [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] play in your family, for example, family celebrations or choices in marriage or schooling?
7. What activities related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] do you carry out <u>in the home</u>, for example, prayers, meditation, or special dietary laws? How often do you carry out these activities? How important are these activities in your life?
8. What activities do you engage in <u>outside the home</u> related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)], for example, attending ceremonies or participating in a [CHURCH, TEMPLE OR MOSQUE]? How often do you attend? How important are these activities in your life?

Relationship to the [PROBLEM]

9. How has [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] helped you cope with your [PROBLEM]?
10. Have you talked to a leader, teacher or others in your [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] community, about your [PROBLEM]? How have you found that helpful?
11. Have you found reading or studying [BOOK(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S), (E.G. BIBLE, KORAN)], or listening to programs related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] on TV, radio, the Internet or other media [e.g., DVD, tape] to be helpful? In what way?
12. Have you found any practices related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)], like prayer, meditation, rituals, or pilgrimages to be helpful to you in dealing with [PROBLEM]? In what way?

Potential stresses or conflicts related to spirituality, religion, and moral traditions

13. Have any issues related to [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] contributed to [PROBLEM]?
14. Have you experienced any <u>personal challenges or distress</u> in relation to your [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] identity or practices?
15. Have you experienced any <u>discrimination</u> due to your [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] identity or practices?
16. Have you been in conflict with others over spiritual, religious or moral issues?

6. Cultural Identity

Related Core CFI Questions: 6, 7, 8, 9, 10 Some of the core CFI question are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

GUIDE TO INTERVIEWER: *This module aims to further clarify the individual's cultural identity and how this has influenced the individual's health and well being. The following questions explore the individual's cultural identity and how this may have shaped his or her current problem. We use the word* **culture** *broadly to refer to all the ways the individual understands his or her identity and experience in terms of groups, communities or other collectivities, including national or geographic origin, ethnic community, racialized categories, gender, sexual orientation, social class, religion/spirituality, and language.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Sometimes peoples' background or identity influences their experience of illness and the type of care they receive. In order to better help you, I would like to understand your own background or identity. By background or identity I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your racial or ethnic background, your gender or sexual orientation, and your faith or religion.

National, Ethnic, Racial Background

1. Where were you born?
2. Where were your parents and grandparents born?
3. How would you describe your family's national, ethnic, and/or racial background?
4. In terms of your background, how do you usually describe yourself to people outside your community? Sometimes people describe themselves somewhat differently to members of their own community. How do you describe yourself to them?
5. Which part of your background do you feel closest to? Sometimes this varies, depending on what aspect of your life we are talking about. What about at home? Or at work? Or with friends?
6. Do you experience any difficulties related to your background, such as discrimination, stereotyping, or being misunderstood?
7. *Is there anything about your background that might impact on your [PROBLEM] or impact on your health or health care more generally? [RELATED TO CFI Q#9.]

Language

8. What languages do you speak fluently?
9. What languages did you speak growing up?
10. What languages are spoken at home? Which of these do you speak?
11. What languages do you use at work or school?
12. What language would you prefer to use in getting health care?
13. What languages do you read? Write?

Migration

GUIDE TO INTERVIEWER*: If the individual was born in another country, ask questions 1-7. [For refugees, refer to the module on Immigrants and Refugees to obtain more detailed migration history.]*

14. When did you come to this country?
15. What made you decide to leave your country of origin?
16. How has your life changed since coming here?
17. What do you miss about the place or community you came from?
18. What are your concerns for your own and your family's future here?
19. What is your current status in this country (e.g., refugee claimant, citizen, student visa, work permit)? *Be aware this may be a sensitive or confidential issue for the individual, if they have precarious status.*
20. How has migration influenced your health or that of your family?
21. Is there anything about your migration experience or current status in this country that has made a difference to <u>your [PROBLEM]</u>?
22. Is there anything about your migration experience or current status that might influence your ability to <u>get the right kind of help</u> for your [PROBLEM]?

Spirituality, Religion, and Moral Traditions

23. Do you identify with any particular religious, moral or spiritual tradition?

GUIDE TO INTERVIEWER: *In the next question, the individual's own words should be used to replace "[NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)]".*

24. What role does [NAME(S) OF SPIRITUAL, RELIGIOUS OR MORAL TRADITION(S)] play in your everyday life?
25. Do your family members share your spiritual, religious or moral traditions? Can you tell me more about that?

Gender Identity

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Some individuals feel that their gender [e.g. the social roles and expectations they have related to being male, female, transgender, genderqueer, or intersex] influences their health and the kind of health care they need.

GUIDE TO INTERVIEWER: *In the examples below, the individual's own words should be used to replace "[GENDER]". The interviewer may need to exemplify or explain the term 'GENDER" with relevant wording (e.g., "being a man," "being a transgender woman").*

26. Do you feel that your [GENDER] has influenced your [PROBLEM] or your health more generally?
27. Do you feel that your [GENDER] has influenced your ability to get the kind of health care you need?
28. Do you feel that health care providers have certain assumptions or attitudes about you or your [PROBLEM] because of your [GENDER]?

Sexual Orientation Identity

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Sexual orientation may also be important to individuals and their comfort in seeking health care. I would like to ask you some questions about your sexual orientation. Are you comfortable answering questions about your sexual orientation?

29. How would you describe your sexual orientation (e.g., heterosexual, gay, lesbian, bisexual, queer, pansexual, asexual)?
30. Do you feel that your sexual orientation has influenced your [PROBLEM] or your health more generally?
31. Do you feel that your sexual orientation influences your ability to get the kind of health care you need for your [PROBLEM]?
32. Do you feel that health care providers have assumptions or attitudes about you or your [PROBLEM] that are related to your sexual orientation?

Summary

33. You have told me about different aspects of your background and identity and how this has influenced your health and well being. Are there other aspects of your identity I should know about to better understand your health care needs?
34. What are the most important aspects of your background or identity in relation to [PROBLEM]?

7. Coping and Help-Seeking

Related Core CFI Questions: 6, 11, 12, 14, 15 Some of the core CFI question are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

GUIDE TO INTERVIEWER: *This module aims to clarify the individual's ways of coping with the current problem. The individual may have identified the problem as a symptom or mentioned a term or expression (e.g., "nerves," "being on edge," spirit possession), or a situation (e.g., loss of a job), or a relationship (e.g., conflict with others). In the examples below, the individual's own words should be used to replace "[PROBLEM]". If there are multiple problems, each relevant problem can be explored. The following questions may be used to learn more about the individual's understanding and experiencing of that problem.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to understand the problems that bring you here so that I can help you more effectively. I will be asking you questions about how you have tried to cope with your problems and get help for them.

Self-coping

1. *Can you tell me more about how you are trying to cope with [PROBLEM] at this time? Has that way of coping with it been helpful? If so, how? [RELATED TO CFI Q#11.]
2. *Can you tell me more about how you tried to cope with the [PROBLEM] or with similar problems in the past? Was that way of coping with it helpful? If so, how? [RELATED TO CFI Q#11.]
3. Have you sought help for your [PROBLEM] on the internet, by reading books, by viewing television shows, or by listening to audiotapes, videos or other sources? If so, which of these? What did you learn? Was it helpful?
4. Do you engage by yourself in practices related to a spiritual, religious or moral tradition to help you cope with your [PROBLEM]? For example, prayer, meditation, or other practices that you carry out by yourself?
5. Have you sought help for your [PROBLEM] from natural remedies or medications that you take without a doctor's prescription, such as over-the-counter medicines? If so, which natural remedies or medications? Were they helpful?

Social network

6. *Have you told a family member about your [PROBLEM]? Have family members helped you cope with the [PROBLEM]? If so, how? What did they suggest you do to cope with the [PROBLEM]? Was it helpful? [RELATED TO CFI Q#15.]
7. *Have you told a friend or co-worker about your [PROBLEM]? Have friends or co-workers helped you cope with the [PROBLEM]? If so, how? What did they suggest you do to cope with the [PROBLEM]? Was it helpful? [RELATED TO CFI Q#15.]

Help- and treatment-seeking beyond social network

8. Are you involved in activities that involve other people related to a spiritual, religious or moral tradition? For example, do you go to worship or religious gatherings, speak with other people in your religious group or speak with the religious or spiritual leader? Have any of these been helpful in coping with [PROBLEM]? In what way?
9. Have you ever tried to get help for your [PROBLEM] from your general doctor? If so, who and when? What treatment did they give? Was it helpful?
10. Have you ever tried to get help for your [PROBLEM] from a mental health clinician, such as a counselor, psychologist, social worker, psychiatrist, or other professional? If so, who and when? What treatment did they give? Was it helpful?
11. Have you sought help from any other kind of helper to cope with your [PROBLEM] other than going to the doctor, for example, a chiropractor, acupuncturist, homeopath, or other kind of healer? What kind of treatment did they recommend to resolve the problem? Was it helpful?

Current treatment episode

12. What were the circumstances that led to your coming here for treatment for your [PROBLEM]? Did anyone suggest you come here for treatment? If so, who, and why did he or she suggest you come here?
13. What help are you hoping to get here [at this clinic] for your [PROBLEM]?

8. Patient–Clinician Relationship

Related Core CFI Question: 16 Some of the core CFI question are repeated below and are marked with an asterisk (*). The CFI question that is repeated is indicated in brackets.

GUIDE TO INTERVIEWER: *The following questions address the role of culture in the patient–clinician relationship with respect to the individual's presenting concerns and to the clinician's evaluation of the individual's problem. We use the word* **culture** *broadly to refer to all the ways the individual understands his or her identity and experience in terms of groups, communities or other collectivities, including national or geographic origin, ethnic community, racialized categories, gender, sexual orientation, social class, religion/spirituality, and language.*

The first set of questions evaluates four domains in the clinician-patient relationship from the point of view of the patient: experiences, expectations, communication, and possibility of collaboration with the clinician. The second set of questions is directed to the clinician to guide reflection on the role of cultural factors in the clinical relationship, the assessment, and treatment planning.

INTRODUCTION FOR THE PATIENT: I would like to learn about how it has been for you to talk with me and other clinicians about your [PROBLEM] and your health more generally. I will ask some questions about your views, concerns, and expectations.

QUESTIONS FOR THE PATIENT:

1. What kind of experiences have you had with clinicians in the past? What was most helpful to you?
2. Have you had difficulties with clinicians in the past? What did you find difficult or unhelpful?
3. Now let's talk about the help that you would like to get here. Some people prefer clinicians of a similar background (for example, age, race, religion, or some other characteristic) because they think it may be easier to understand each other. Do you have any preference or ideas about what kind of clinician might understand you best?
4. *Sometimes differences among patients and clinicians make it difficult for them to understand each other. Do you have any concerns about this? If so, in what way? [RELATED TO CFI Q#16.]

GUIDE TO INTERVIEWER: *Question #5 addresses the patient-clinician relationship moving forward in treatment. It elicits the patient's expectations of the clinician and may be used to start a discussion on how the two of them can collaborate in the individual's care.*

5. What patients expect from their clinicians is important. As we move forward in your care, how can we best work together?

QUESTIONS FOR THE CLINICIAN AFTER THE INTERVIEW:

1. How did you feel about your relationship with the patient? Did cultural similarities and differences influence your relationship? In what way?
2. What was the quality of communication with the patient? Did cultural similarities and differences influence your communication? In what way?
3. If you used an interpreter, how did the presence of an interpreter or his/her way of interpreting influence your relationship or your communication with the patient and the information you received?
4. How do the patient's cultural background or identity, life situation, and/or social context influence your understanding of his/her problem and your diagnostic assessment?
5. How do the patient's cultural background or identity, life situation, and/or social context influence your treatment plan or recommendations?
6. Did the clinical encounter confirm or call into question any of your prior ideas about the cultural background or identity of the patient? If so, in what way?
7. Are there aspects of your own identity that may influence your attitudes toward this patient?

9. School-Age Children and Adolescents

Related Core CFI Questions: 8, 9, 10

GUIDE TO INTERVIEWER*: This supplement is directed to adolescents and mature school-age children. It should be used in conjunction with standard child mental health assessments that evaluate family relations (including intergenerational issues), peer relations, and the school environment. The aim of these questions is to identify, from the perspective of the child/youth, the role of age-related cultural expectations, the possible cultural divergences between school, home, and the peer group, and whether these issues impact on the situation or problem that brought the youth for care. The questions indirectly explore cultural challenges, stressors and resilience, and issues of cultural hybridity, mixed ethnicity or multiple ethnic identifications. Peer group belonging is important to children and adolescents, and questions exploring ethnicity, religious identity, racism or gender difference should be included following the child's lead. Some children may not be able to answer all questions; clinicians should select and adapt questions to ensure they are developmentally appropriate for the individual. Children should not be used as informants to provide socio-demographic information on the family or an explicit analysis of the cultural dimensions of their problems. An Addendum lists cultural aspects of development and parenting that can be evaluated during parents' interviews.*

INTRODUCTION FOR THE CHILD/YOUTH: We have talked about the concerns of your family. Now I would like to know more about how you feel about being ___ years old.

Feelings of age appropriateness in different settings

1. Do you feel you are like other children/youth your age? In what way?
2. Do you sometimes feel different from other children/youth your age? In what way?
3. *IF THE CHILD/YOUTH ACKNOWLEDGES SOMETIMES FEELING DIFFERENT:* Does this feeling of being different happen more at home, at school, at work, and/or some other place?
4. Do you feel your family is different from other families?
5. Do you use different languages? With whom and when?
6. Does your name have any special meaning for you? Your family? Your community?
7. Is there something special about you that you like or that you are proud of?

Age-related stressors and supports

8. What do you like about being a child/youth at home? At school? With friends?
9. What don't you like about being a child/youth at home? At school? With friends?
10. Who is there to support you when you feel you need it? At home? At school? Among your friends?

Age-related expectations

GUIDE TO INTERVIEWER*: Concepts of childhood and age-appropriate behavior vary significantly across cultures. The aim of these questions is to elicit the normative frame(s) of the child /family and how this may different from other cultural environments.*

11. What do your parents or grandparents expect from a child/youth your age? (*CLARIFY*: For example, chores, schoolwork, play, religious observance.)
12. What do your school teachers expect from a child/youth your age?
13. *IF INDIVIDUAL HAS SIBLINGS*: What do your siblings expect from a child/youth your age? (*CLARIFY*: For example, babysitting, help with homework, dating, dress.)
14. What do other children/youth your age expect from a child/youth your age?

Transition to adulthood/maturity (FOR ADOLESCENTS ONLY)

15. Are there any important celebrations or events in your community to recognize reaching a certain age or growing up?
16. When is a youth considered ready to become an adult in your family or community?
17. When is a youth considered ready to become an adult according to your school teachers?
18. What is good or difficult about becoming a young woman or a young man in your family? In your school? In your community?
19. How do you feel about "growing up" or becoming an adult?
20. In what ways are your life and responsibilities different from the life and responsibilities of your parents?

ADDENDUM FOR PARENTS' INTERVIEW

GUIDE TO INTERVIEWER: *Information on cultural influences on development and parenting is best obtained by interviewing the child's parents or caretakers. In addition to issues directly related to presenting problems, it is useful to inquire about:*

- The child's particular place in the family (e.g.. oldest boy, only girl)
- The process of naming the child (Who chose the name? Does it have special meaning? Who else is called like this?)
- Developmental milestones in the culture of origin of the mother (and father): expected age for weaning, walking, toilet training, speaking. Vision of normal autonomy/dependency, appropriate disciplining and so on
- Perceptions of age-appropriate behaviors (e.g., age for staying home alone, participation in chores, religious observance, play)
- Child-adult relations (e.g., expression of respect, eye contact, physical contact)
- Gender relations (expectations around appropriate girl-boy behavior, dress code)
- Languages spoken at home, in daycare, at school
- The importance of religion, spirituality, and community in family life and related expectations for the child.

10. Older Adults

Related Core CFI Questions: 5, 6, 7, 8, 9, 10, 12, 13, 15, 16

GUIDE TO INTERVIEWER: *The following questions are directed to older adults. The goal of these questions is to identify the role of cultural conceptions of aging and age-related transitions on the illness episode.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: I would like to ask some questions to better understand your problem and how we can help you with it, taking into account your age and specific experiences.

Conceptions of aging and cultural identity

1. How would you describe a person of your age?
2. How does your experience of aging compare to that of your friends and relatives who are of a similar age?
3. Is there anything about being your age that helps you cope with your current life situation?

Conceptions of aging in relationship to illness attributions and coping

4. How does being older influence your [PROBLEM]? Would it have affected you differently when you were younger?
5. Are there ways that being older influences how you deal with your [PROBLEM]? Would you have dealt with it differently when you were younger?

Influence of comorbid medical problems and treatments on illness

6. Have you had health problems due to your age?
7. How have your health conditions or the treatments for your health conditions affected your [PROBLEM]?
8. Are there any ways that your health conditions or treatments influence how you deal with your [PROBLEM]?
9. Are there things that are important to you that you are unable to do because of your health or age?

Quality and nature of social supports and caregiving

10. Who do you rely on for help or support in your daily life in general? Has this changed now that you are going through [PROBLEM]?
11. How has [PROBLEM] affected your relationships with family and friends?
12. Are you receiving the amount and kind of support you expected?
13. Do the people you rely on share your view of your [PROBLEM]?

Additional age-related transitions

14. Are there other changes you are going through related to aging that are important for us to know about in order to help you with your [PROBLEM]?

Positive and negative attitudes towards aging and clinician-patient relationship

15. How has your age affected how health providers treat you?
16. Have any people, including health care providers, discriminated against you or treated you poorly because of your age? Can you tell me more about that? How has this experience affected your [PROBLEM] or how you deal with it?
17. [*IF THERE IS A SIGNIFICANT AGE DIFFERENCE BETWEEN PROVIDER AND PATIENT:*] Do you think that the difference in our ages will influence our work in any way? If so, how?

11. Immigrants and Refugees

Related Core CFI Questions: 7, 8, 9, 10, 13

GUIDE TO INTERVIEWER: *The following questions aim to collect information from refugees and immigrants about their experiences of migration and resettlement. Many refugees have experienced stressful interviews with officials or health professionals in their home country, during the migration process (which may involve prolonged stays in refugee camps or other precarious situations), and in the receiving country, so it may take longer than usual for the interviewee to feel comfortable with and trust the interview process. When patient and clinician do not share a high level of fluency in a common language, accurate language translation is essential.*

INTRODUCTION FOR THE INDIVIDUAL BEING INTERVIEWED: Leaving one's country of origin and resettling elsewhere can have a great impact on people's lives and health. To better understand your situation, I would like ask you some questions related to your journey here from your country of origin.

Background information

1. What is your country of origin?
2. How long have you been living here in _____ (HOST COUNTRY)?
3. When and with whom did you leave _____ (COUNTRY OF ORIGIN)?
4. Why did you leave _____ (COUNTRY OF ORIGIN)?

Pre-migration difficulties

5. Prior to arriving in _____ (HOST COUNTRY), were there any challenges in your country of origin that you or your family found especially difficult?
6. Some people experience hardship, persecution, or even violence before leaving their country of origin. Has this been the case for you or members of your family? Can you tell me something about your experiences?

Migration-related losses and challenges

7. Of the persons important/close to you, who stayed behind?
8. Often people leaving a country experience losses. Did you or any of your family members experience losses upon leaving the country? If so, what are they?
9. Were there any challenges on your journey to _____ (HOST COUNTRY) that you or your family found especially difficult?
10. Do you or your family miss anything about your way of life in (COUNTRY OF ORIGIN)?

Ongoing relationship with country of origin

11. Do you have concerns about relatives that remain in (COUNTRY OF ORIGIN)?
12. Do relatives in (COUNTRY OF ORIGIN) have any expectations of you?

Resettlement and new life

13. Have you or your family experienced any difficulties related to your visa, citizenship, or refugee status here in _____ (HOST COUNTRY)?
14. Are there any (other) challenges or problems you or others in your family are facing related to your resettlement here?
15. Has coming to [HOST COUNTRY] resulted in something positive for you or your family? Can you tell me more about that?

Relationship with problem

16. Is there anything about your migration experience or current status in this country that has made a difference to your [PROBLEM]?
17. Is there anything about your migration experience or current status that might make it easier or harder to get help for your [PROBLEM]?

Future expectations

18. What hopes and plans do you have for you and your family in the coming years?

12. Caregivers

Related Core CFI Question: 6, 12, 14

GUIDE TO INTERVIEWER: *This module is designed to be administered to individuals who provide caregiving for the individual being assessed with the CFI. This module aims to explore the nature and cultural context of caregiving, and the social support and stresses in the immediate environment of the individual receiving care, from the perspective of the caregiver.*

INTRODUCTION FOR THE CAREGIVER: People like yourself who take care of the needs of patients are very important participants in the treatment process. I would like to understand your relationship with [INDIVIDUAL RECEIVING CARE] and how you help him/her with his/her problems and concerns. By *help,* I mean support in the home, community, or clinic. Knowing more about that will help us plan his/her care more effectively.

Nature of relationship

1. How long have you been taking care of [INDIVIDUAL RECEIVING CARE]? How did this role for you start?
2. How are you connected to [INDIVIDUAL RECEIVING CARE]?

Caregiving activities and cultural perceptions of caregiving

3. How do you help him/her with the [PROBLEM] or with day-to-day activities?
4. What is most rewarding about helping him/her?
5. What is most challenging about helping him/her?
6. How, if at all, has his/her [PROBLEM] changed your relationship?

   Sometimes caregivers like yourself are influenced in doing what they do by cultural traditions of helping others, such as beliefs and practices in your family or community. By cultural traditions I mean, for example, what is done in the communities you belong to, where you or your family are from, or among people who speak your language or who share your race or ethnic background, your gender or sexual orientation, or your faith or religion.

7. Are there any cultural traditions that influence how you approach helping [INDIVIDUAL RECEIVING CARE]?
8. Is the amount or kind of help you are giving him/her different in any way from what would be expected in the community that you come from or the one he/she comes from? Is it different from what society in general would expect?

Social context of caregiving

9. [*IF CAREGIVER IS A FAMILY MEMBER*:] How do you, as a family, cope with this [PROBLEM]?
10. Are there others, such as family members, friends, or neighbors, who also help him/her with the [PROBLEM]? If so, what do they do?
11. How do you feel about how much or how little others are helping with his/her [PROBLEM]?

Clinical support for caregiving

12. How do you see yourself helping to provide care to [INDIVIDUAL RECEIVING CARE] now and in the future?
13. [*IF UNCLEAR*:] How do you see yourself helping with the care that he/she receives in this clinic?
14. How can we make it easier for you to be able to help [INDIVIDUAL RECEIVING CARE] with the [PROBLEM]?

Reggie Ansnes

When he was 35, Reggie Ansnes was admitted to a mental hospital 3,000 miles from home. The admitting note reported that he was agitated, was somewhat grandiose, and didn't even know what city he was in. Although he talked a lot, nothing he said made much sense. "I have schizophrenia," was one of his few unambiguous statements. "It must be his schizophrenia," Faye, his wife, said on the telephone to the clinician who admitted him. "He told me he had it once before. We've only been married 3 years."

Five years earlier, Reggie had been admitted with psychosis to a mental hospital in Boston. Faye thought that he had then believed he was the son of Jesus, but she didn't know anything else about his symptoms. A doctor had told him he had paranoid schizophrenia. He had been treated with chlorpromazine; Faye knew that because he was still taking it when they began dating.

For about 2 years after that hospitalization, Reggie had been depressed. He used to complain of trouble concentrating at work, and Faye thought that not long after the hospital released him, he had had suicidal ideas. However, the depression had gradually remitted, leaving him with relatively mild problems with appetite and sleep. Even these had resolved by the time they got married, and he had been well ever since. It had now been several years since he had taken any medication at all.

For several days before Reggie's recent business trip, he had been unusually cheerful. He talked a lot, seemed to have increased energy, and arose early to complete the work he would miss while he was gone. Faye stated that her husband was in good physical health except for a "slight thyroid condition," for which he took a small dose of a thyroid medication. She thought it had been checked the last time he visited his doctor, 3 months earlier. To her knowledge, he neither drank nor used drugs.

During his first 24 hours in the hospital, Reggie was extremely hyperactive and did not sleep at all. His mood was markedly elevated, and he spoke so fast that he was often unintelligible. His statements that could be understood included "I am the son of God," and he shared some ideas for improving the operation of the hospital. He paid little attention to whatever task was at hand, so the MMSE could not be completed.

Evaluation of Reggie Ansnes

Thyroid disease is a general medical condition that can cause mood symptoms; how- ever, Reggie's physician had recently evaluated his thyroid condition, and it had never before produced symptoms that resembled his current condition. Reevaluation of thyroid function tests would be a reasonable course to follow, in any event. (You're right, I *am* getting tired of typing "principle C.")

As for substance use, Faye's information would militate against **substance-induced psychotic disorder**, with onset during withdrawal. However, the blood toxicity screen should rule out any possibility of such a psychosis with onset during intoxication (such as phencyclidine intoxication). With the other history available, this would seem highly unlikely. It is much more usual for patients to use alcohol to attenuate the uncomfortable, driven feeling caused by mania or other psychosis.

A **mood disorder** would seem a much stronger candidate. Five years earlier, Reggie had had grandiose delusions; afterward, he had been depressed for months or years. After a 2-year period of apparent complete normality, he had once again become psychotic, with elevated mood, hyperactivity, insomnia (a decreased need for sleep), and distractibility. Assuming that the tests for thyroid function and toxicity screen came back normal, he would completely fulfill the Essential Features of a manic episode (p. 116), and thus for **bipolar I disorder**, current episode manic (p. 129). If you like, you can check out these criteria in DSM-5—it's tedious, but great exercise.

The previous history of **schizophrenia** might appear to provide a readymade diagnosis for this obviously psychotic patient. If Reggie's earlier illness really had been schizophrenia, it would have been in full remission until the current episode. This would be highly unusual, and with mood symptoms as prominent then as they were now, his new history would demand a serious rethink (principle H). Furthermore, no matter how psychotic Reggie might appear on cross-sectional appearance, his history of episodic illness with complete recovery virtually compels (principle G) us to diagnose bipolar I disorder. An apparent mood disorder now and schizophrenia years ago would also violate the parsimony rule (principle M), not to mention the basic criteria for schizophrenia.

Reggie's current manic symptoms were markedly disabling; severe would be the only appropriate level for him. His psychotic features were completely congruent with manic themes—he thought he was the son of God—which dictates the code numbers listed below. The other possible specifiers (Chapter 3, Table 3.3) do not apply. His previous schizophrenia diagnosis was simply wrong, and should be expunged (as far as possible) from his records.

F31.13 [296.43]	Bipolar I disorder, current episode manic, severe with mood-congruent psychotic features
244.9	Acquired hypothyroidism

Gemma Livingstone

"I eat, then I throw up." That was how Gemma Livingstone described her problem during her first interview. Beginning when she was 23, this behavior had been almost continual in the intervening 4 years. Even as a teenager, Gemma was concerned about the way she looked. Along with classmates, she had crash-dieted from time to time during high school. But her weight had seldom varied by more than a few pounds from 116. At 5 feet, 6 inches tall, she had been svelte but not too thin.

Dealing with the aftermath of an unwanted pregnancy and a subsequent abortion, Gemma had had the opportunity to test her theory. Eating what she wanted, she had ballooned from a size 8 to a size 14 in less than half a year. Once she finally regained control, she vowed she would never lose it again. For 3 years, she had bought nothing larger than a size 4. Back when Gemma was a teenager, she and her friends simply didn't eat. When- ever dining in a restaurant or with friends, she would still push her food around on her plate to disguise how little she was actually taking in. But when she was at home she would often eat a full meal, then retire to the bathroom and throw up. At first, this had required touching the back of her throat with the handle of a teaspoon she kept in the bathroom for that purpose. With practice, she had learned to regurgitate just by willing it. "It's as easy as blowing your nose," she reported later.

Gemma's fear of obesity had become the organizing principle of her life. On her refrigerator door, she kept a picture of herself when she was in her "toad" phase. She said that every time she looked at it, she lost her appetite. Whereas she previously relied on laxatives only for constipation, recently she had begun to use them as another means of purging her system: "If I don't have a bowel movement every day, I feel as if I'll burst. Even my eyes get all puffy." She had also taken some diuretics, but had stopped doing so when her periods stopped. She didn't really believe there was a connection, but recently she had begun to menstruate again. If there was one thing she feared more than getting fat, it was getting pregnant. She had never been very active sexually, but now she and her husband seldom had intercourse more than once a month. Even then, she insisted on using both a diaphragm and a condom.

Other than her weight, which had fallen under 90 pounds, Gemma appeared to be in good health. She had never had manic episodes, hallucinations, obsessions, compulsions, phobias, panic attacks, or thoughts about suicide.

Gemma's only brush with the law had occurred 2 years earlier, when she'd forged some prescriptions to obtain amphetamines for dieting. She had copped a plea and been placed on probation for a year; she'd scrupulously avoided amphetamines since then. She had tried marijuana once or twice when she was first out of high school, but had never used alcohol or tobacco. Her only surgical procedure had been bilateral breast augmentation, which had been done with autologous fat rather than silicone.

In a separate interview, Gemma's husband stated that he thought his wife felt inadequate and insecure. He said that she usually dressed in revealing, even alluring clothing, which looked less enticing now that she had lost so much weight. When she was denied her way, she would sometimes pout for hours, though he didn't think there was much real feeling behind this expression of her emotion.

Gemma was a dark-haired, slightly built woman who had probably been quite pretty before shed lost so much weight. She smiled readily and somewhat self-consciously. She wore a V-necked blouse and a very short skirt that she did not attempt to pull down when she crossed her legs. She spoke with a good deal of rolling of eyes and varying inflections of her voice, but her answers to the examiner's questions were themselves vague and often discursive. She denied feeling depressed or wishing she were dead; she had never had delusions or hallucinations, but she claimed that she was still "fat as a pig." To illustrate, she pinched between thumb and forefinger a fold of skin that hung loosely from her arm. She scored a perfect 30 on the MMSE.

Evaluation of Gemma Livingstone

Gemma had a history of disordered eating that dated back to her high school years. She bore the following features of **anorexia nervosa**: She was gaunt and fearful of gaining weight, and she perceived herself as being fat. Her current subtype would be binge- eating/purging type; as a teenager, she had been of the restricting type. Just how severe do we rate her anorexia? The DSM-5 criteria grade solely on the basis of body mass index (BMI), which is an error, in my opinion; surely the type of behavior should count for something. Gemma's weight is under 90 (let's say 89), so for a height of 66 inches, her BMI works out to 14.4, putting her in the *extreme* category of severity.

Based only on the information she herself provided, Gemma could not have been diagnosed with a **personality disorder**—that's our usual clinical experience derived solely from a patient's own reports. But from her husband's information (principle I) and from that of the mental status evaluation (principle L), the following criteria for **histrionic personality disorder** were established: needing to be the center of attention, shifting and shallow emotions, drawing attention to herself (wearing revealing clothing and crossing her legs), speaking vaguely, and expressing herself dramatically. Histrionic personality disorder is often associated with **somatization/somatic symptom disorder**, but a review of systems revealed minimal symptoms, and she didn't express the disproportionate health concerns normally attached to a somatic symptom diagnosis.

Forging prescriptions and using drugs are of course illegal, but Gemma hadn't pursued either behavior after her probation; I certainly wouldn't regard them as evidence of diagnosable pathology.

F50.02 [307.1]	Anorexia nervosa, binge-eating/purging type, extreme F60.4 [301.50] Histrionic personality disorder

Jeremy Dowling

"I feel miserable," was the chief complaint of Jeremy Dowling, a 24-year-old graduate student. For a lifelong perfectionist, a thesis deadline a fortnight off wasn't improving matters. He was weeks behind schedule, partly because he needed to perfect every paragraph before he began to write the next. Most of the time since his teen years, he had felt "not good enough" and somewhat depressed. He had never had a manic episode. He was socially withdrawn and claimed never to take much pleasure in things. "I'm a pessimist, more or less," he said.

Jeremy described his appetite as being fine, and he had never had suicidal ideas. His sleep, however, was another matter. With the approaching thesis deadline, he felt that he had to stay up most nights in order to do his work. Therefore, he drank lots of coffee. "If I have to sleep less than 8 hours a night, I drink a cup every 2 or 3 hours. When I'm up all night, its four or five cups. Strong coffee." Other than coffee, Jeremy denied ever misusing substances such as alcohol or street drugs. Lately, Jeremy had stayed up all night three nights a week; he always felt tired. He also admitted to chronic feelings of guilt and irritability. He had never had crying spells, but his concentration was "a lifelong major problem." For example, while he was working at the computer, other thoughts and worries intruded upon his consciousness, to the point that he had difficulty getting his work done.

Jeremy also complained of anxiety. Toward the end of supper, for example, he would begin to worry about the amount of work he had to do. A knot would tighten in his stomach, and the world would seem to be closing in. Time of day made little difference to how he felt, but he would usually improve briefly once he turned in a term paper or other major assignment. He denied ever having problems with shortness of breath, muscle twitching, or palpitations of his heart, unless he had had an extraordinarily large amount of coffee. At those times, he also would notice that he felt nervous and often had an upset stomach, sometimes to the point that he had to stay home from class. He denied feelings of impending doom or disaster.
Though Jeremy had always been a list maker, he didn't describe any obsessional thinking or compulsive behavior. ("I do sometimes straighten out my sock drawer," he was careful to point out.) He described himself as a person who had always had difficulty making decisions, even to the point that he couldn't discard worthless things that he no longer needed—an Easter basket from when he was 10 was one example.

Jeremy had been born in Brazil, where his father had been studying insects of the rain forests. The family returned to live in southern California when Jeremy was 4. His mother was a professional harpist; she had been in therapy with one counselor or another for 25 years. She had always been somewhat dour and had never gotten much pleasure out of life. When Jeremy was 16, she had obtained a divorce, because she had never felt that her husband was committed to their relationship. After the divorce, she had changed to such an extent that she had finally consented to take an antidepressant medication. It had "turned her life around," and now she was happy for the first time in her life. It was partly at her urging that Jeremy was now seeking treatment. Several maternal relatives had had depression, including a cousin who'd killed himself by drinking antifreeze. Another relative had also committed suicide, but Jeremy didn't know the details.

Jeremy was a tall, rather gangling man whose haggard face and baggy eyes made him look almost aged. His speech was clear, coherent, relevant, and spontaneous. When he talked spontaneously, it was largely to discuss his concerns about getting his thesis done; he denied any death wishes or suicidal ideas. He was fully oriented, had an excellent fund of information, and could do calculations quickly. His recent and remote memory were unimpaired; his insight and judgment seemed excellent.

Evaluation of Jeremy Dowling

Jeremy had four symptoms (five required) of major depressive episode, and two symptoms (two required) of **persistent depressive disorder**, or **dysthymia** for short. So we have to ask: Is it reasonable to insist that a patient exactly fulfill the criteria? After all, Jeremy nearly met criteria for major depressive episode, and his family history was strongly positive. A diagnosis of **major depressive disorder** would point the way to treatment and alert clinicians to possible worsening symptoms (such as suicidal ideas) later on. But this clinician felt that it was more important to emphasize the prolonged course of Jeremy's symptoms, which seemed almost to shade into his **personality disorder** (see below). Dysthymia often sets the stage for later major depressive disorder, and the DSM-5 criteria have blended them anyway, by explicitly stating that even a full major depressive disorder can be diagnosed as a specifier to dysthymia.

I wouldn't waste a lot of time in argument about this area—where two excellent diagnosticians may disagree forever, and where you can see the benefits of judging a patient not on the basis of (obsessively) counting symptoms but matching to a prototype of an idealized patient. Let's go ahead and give him a diagnosis that will promote possibly effective treatment.

There's also the matter of Jeremy's anxiety symptoms. He had never had actual anxiety attacks, phobias, obsessions, or compulsions. But he'd certainly been anxious, however. He worried about a variety of things—school, his personality, the intensity of his relationship with his girlfriend. He complained of fatigue, troubles with his sleep, and concentration, which would seem (barely) enough to qualify for a diagnosis of **generalized anxiety disorder**. However, these symptoms occurred during the course of a mood disorder, so his clinician felt that no concurrent anxiety diagnosis was needed. (He even failed to meet the criteria for the mood specifier *with anxious distress*; seep. 159). Besides, his anxiety symptoms could be all bound up with his caffeinism, so I'd not add this extra dollop of diagnostic verbiage.

As for substance use, although Jeremy had never used alcohol or street drugs, his coffee use had on many occasions produced nervousness, upset stomach, palpitations, muscle twitching, and insomnia. These were sometimes serious enough that he couldn't go to school; the symptoms would qualify for a diagnosis of **caffeine intoxication**. You might wonder about a diagnosis of **caffeine use disorder**, but this is one that isn't sanctioned by DSM-5. His usage does make one wonder, though.

Finally, self-described as a perfectionistic pessimist who chronically felt he was not good enough, Jeremy was also a maker of lists and a straightener of drawers who had trouble making decisions and couldn't discard things. These features, plus his moralistic condemnation of his father, would be diagnostic of **obsessive–compulsive personality disorder**.

Jeremy's dysthymia appeared to have begun years ago, probably when he was still a teenager. His hypersomnia and increased appetite would qualify him for the specifier *with atypical features* (p. 160), were it not for the fact that I couldn't find any evidence of mood reactivity in the vignette. Maybe we just needed to interview some more. A psychosocial/environmental problem was noted with a Z-code because it could affect management, at least for the next couple of weeks.

F34.1 [300.4]	Persistent depressive disorder, early onset F15.929
[305.90]	Caffeine intoxication
F60.5 [301.4]	Obsessive–compulsive personality disorder Z55.9 [V62.3]
	Academic problem (thesis deadline)

Dean Wannamaker

"I keep hearing voices that I can't turn off," said Dean Wannamaker. They bothered him every day, and he wasn't sure how much longer he could stand it. Dean was 54, but he had first heard voices when he was only in his early 40s. In fact, he had been hospitalized on three separate occasions; each time he had been successfully treated with medication. It had now been over 6 years since he was last hospitalized.

Dean admitted that he was a drinker. He had begun drinking sweet wine when he was only 12. In the military he had had a few fights and was even threatened with court-martial once, but he'd managed to "escape with an honorable discharge." Over the years, he'd been arrested several times for driving while under the influence of alcohol; the most recent time was only 2 weeks ago. Dean's usual pattern was to drink heavily for several months, then stop suddenly and stay dry for years. His three previous benders had occurred 3, 5, and 11 years earlier. It was during the bender of 11 years ago that his wife walked out on him for good; she was tired of paying his traffic tickets and supporting him when he got fired for missing work. But he had a girlfriend then, Annie—the same woman he was with now—so he didn't mind so much about his wife. What he remembered most vividly was the time he'd heard voices for nearly 3 months. "It was enough to drive a man to drink," he commented, without a trace of irony.

On the present occasion, it was the IRS that had supplied the drive. He made good money at his trade (he was a meat cutter), and, apparently while he was in the coils of his last bender 3 years earlier, he had neglected to report some of it. Now he was being dunned for back taxes, interest, and penalties, and he didn't even have any records. "I didn't intend to start drinking," he said. "I only meant to take a drink." Now he had been drinking over a quart of bourbon a day for 2 months. Annie added that he "never seemed drunk," and she confirmed that he only had these hallucinations after he'd been drinking for a while.

The middle of three children, Dean had been born in Chicago, where his father worked as a meat salesman. His parents had divorced when he was 9; his mother had remarried twice. In the course of a depression 4 years earlier, his older brother had shot and killed himself. His sister was a nurse who had once been hospitalized for abusing barbiturates.

After the military, Dean had attended 2 years of junior college, but he didn't think it ever did him much good. "I've never been anything more than a big, dumb city slicker who cuts up dead animals for a living," he said. Annie reported that Dean had been depressed most of the time for the last month and a half—not quite as long as he'd been drinking. He had cried some and slept poorly, often awakening early in the morning, unable to get back to sleep. His appetite had diminished, and he'd lost about 20 pounds. He seemed chronically tired, and his sex interest was diminished except when he was drunk, which was most of the time.

Dean looked closer to 60 than to 54. He had clearly lost weight. He was over 6 feet tall, but his outsized clothes seemed to diminish his size. He slumped quietly in his chair and only spoke when spoken to. His voice was a low monotone, but his speech was relevant and coherent. He was fully alert, and he paid close attention to the conversation. There was very little variation in his mood, which he admitted was depressed. He was fully oriented to time, place, and person; he scored 29 out of 30 on the MMSE, failing only to recall a street address after 5 minutes. He had never had delusions, but neither did he seem to have any insight into the fact that what he heard was not real.

Dean had had some thoughts about dying. They had begun with the depression, and now the voices had jumped on the idea. "They aren't ordering me to do it or any- thing like that," he said. "They just think I might be a lot better off."

Evaluation of Dean Wannamaker

To begin with, what were Dean's diagnosable drinking behaviors? Of course, he had a variety of the criteria for **alcohol use disorder** (p. 397): There were social symptoms (divorce, arrests). During the current episode of drinking, he demonstrated tolerance (he didn't appear drunk on a quart per day of hard liquor), continued to drink despite having hallucinations, and used more alcohol than he intended ("I only meant to take a drink"). Even if withdrawal symptoms were not taken into account, he would qualify for a diagnosis of alcohol use disorder. He had been actively drinking within the past month, so he could have no course specifier.

Dean's somatic complaints included appetite and weight loss, reduced libido, and insomnia. These represent three separate DSM-5 categories (eating, sleep–wake, and sexual disorders), and a differential diagnosis could be constructed for each. However, the resulting burden of independent major mental diagnoses would be highly unlikely, from either a statistical or a logical viewpoint (principle M—keep it simple). These somatic complaints can all be found in patients who have depression, psychosis, or alcohol-related disorders. A **mood disorder due to another medical condition** must always be considered, especially in a patient who has been ignoring health needs (principle B). Although we'd need a physical examination and laboratory tests to be certain, no information given in the vignette suggests that Dean had any such medical disorder. Throughout his later adult life, Dean had intermittently heard voices. A principal concern for any psychotic patient is whether schizophrenia is a possibility. But Dean lacked the A portion of the basic criteria—he heard voices, but that was the only psychotic symptom he had—knocking out **schizophrenia**, as well as **schizophreniform** and **schizoaffective disorders**. He had hallucinations but no other symptoms (OK, his affect was constricted, but I'd chalk that up to the depression). Annie pointed out that he only developed hallucinations subsequent to drinking. The results of his MMSE would rule out **delirium** and a **major or mild neurocognitive disorder**; the history would exclude **psychotic disorder due to another medical condition**. Of course, all other psychotic disorders require that the symptoms not be directly related to the use of a substance. Furthermore, neither **delusional disorder** nor **brief psychotic disorder** can be diagnosed if a mood disorder is a more likely etiology.

Look at the criteria for **substance/medication-induced psychotic disorder** in Chapter 2 (p. 93). These require prominent hallucinations or delusions (or disorganized speech). Inasmuch as Dean always drank before the hallucinations appeared, and they never lasted longer than a few weeks after the drinking stopped, he would seem to fulfill the criteria for alcohol-induced psychotic disorder, with hallucinations. If this became the working diagnosis, we'd add the qualifier *with onset during withdrawal*.

As for mood disorder, Dean fulfilled the inclusion criteria for **major depressive episode**: He had had more than 2 weeks of persistent low mood, fatigue, weight loss, insomnia, and thoughts of suicide. His symptoms weren't due to a medical condition, represented a change from his usual self, and certainly distressed him. However, they did occur subsequent to the time he began drinking, and therefore could be alcohol- related; if so, this would rule out **major depressive disorder**.

The criteria for **substance-induced mood disorder** are simple, and Dean would appear to fulfill them: He was persistently depressed, meeting full criteria for a major depressive disorder; he had also been drinking for several months, and we know that alcohol is fully capable of inducing severe depression. DSM-5 mentions several bits of evidence that would support a non-substance-related depression. Although his brother had shot himself during a depression, we do not know whether he was also a drinker; a sister had used drugs. OK, genetic information isn't a

criterion, but it is a useful principle (B).

Major depressive disorder is treatable, and it can be lethal. It should be given a high priority for investigation and possible treatment (principle F). However, it should not be diagnosed automatically in a substance-using patient; many instances of mood disorder will improve when the patient stops using the substance.

Therefore, symptoms of substance use, mood disorder, and psychosis must be accounted for in Dean's final diagnosis. It would not appear that cognitive or general medical conditions can explain these symptoms (principle C). It would be elegant to explain all of them simply, on the basis of one underlying disease mechanism (principle M). Because substance use was surely the first of these symptom groups to appear (principle X)—Dean began drinking at age 12 and had some behavioral problems resulting from it when he was a young man in the military—it is reasonable to consider it first.

Now we have two ways of looking at Dean's symptoms: (1) Alcohol usage induced a psychosis, and he had an independent major depressive disorder; or (2) alcohol usage induced both a psychosis and a mood disorder. The simplicity of the second formulation, plus the desire not to rush in with possibly unnecessary treatment before it is needed, would lead a conservative clinician initially to regard the mood disorder as substance-induced—at least until Dean could be withdrawn completely from alcohol. Under ICD-9, the clinician's perception that the alcoholism was the underlying problem, and thus the one that should be addressed first, would determine the order in which we list the diagnoses. Under ICD-10, where we code the use disorder at the same time as the psychosis or depression, I'd list the psychosis first; it seems to require treatment more urgently. But I'd be happy to entertain arguments.

F10.259 [303.90, 291.9]	Severe alcohol use disorder, with alcohol-induced psychotic disorder, with onset during withdrawal
F10.24 [303.90, 291.89]	Alcohol-induced depressive disorder, with onset during intoxication

Dual Diagnosis 2015

Cathy Moonshine
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Ken Minkoff on DDx

Dual Diagnosis
is an expectation
not an exception.

DDx Prevalence

Research estimates that 30-80% of individuals with either a substance use or mental health diagnosis have the other problem as well.

The Mental Health Counselor

The Mental Health counselor needs to be able to:

- Recognize problems with use of substances
- Understand how substance use problems develop
- Identify symptoms and indications of substance use diagnoses
- Be aware of the psychosocial issues that occur from substance use problems
- Be able to provide effective addictions treatment
- Understand which MH interventions are contraindicated for substance use problems

(Evans & Sullivan, 2002)

The Addictions Counselor

The addictions counselor needs to be able to:

- Recognize mental health problems
- Understand how mental health problems develop
- Identify major mental health diagnoses & symptoms
- Be aware of the psychosocial issues that occur from MH problems
- Accept that psychiatric medications may be therapeutic
- Understand which AOD treatment interventions are contraindicated

(Evans & Sullivan, 2002)

DDx Focus of Treatment

- Increased Level of Functioning
- Reduction in Symptoms
- Relapse Prevention
- Healthy Support System
- Employment & Housing
- Case Management & Skill Building

Substance Use Disorders

Specific Changes Per Diagnostic Category in DSM-5: *Substance Abuse & Addictive Disorders*

Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria:

1. Taking the substance in larger amounts or for longer than the you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts the you in danger
9. Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

Specific Changes Per Diagnostic Category in DSM-5: *Substance Abuse & Addictive Disorders*

Specifiers:

- Mild: two or three of the 11 symptoms
- Moderate: four or five symptoms
- Severe: six or more symptoms
- In early remission
- In sustained remission
- On maintenance therapy
- In a controlled environment

Neurobiology of Dual Diagnosis

- Most mental health disorders can be tied to insufficient or excessive serotonin, norepinephrine, and/or dopamine.
- Most drugs work on these same neurotransmitters.
- This leads to the self-medication theory of dual diagnosis.

Neurobiology of Dual Diagnosis

- The dopamine system plays a large role in the reward- and pleasure-seeking system.
- Many drugs of abuse block the function of the dopamine transporter, resulting in a large increase of dopamine in the synapse.

Neurobiology of Dual Diagnosis

- Chronic use of drugs and alcohol impact dopamine in the brain which produce changes in the nucleus accumbens cellular protein expression, cellular morphology, and functional alterations in local mechanisms of neuroplasticity underlying learning and memory.
- These changes likely comprise some of the chronic network adaptations underlying motivational sensitization whereby drug-seeking and drug taking become increasingly prioritized in the behavioral repertoire.

Psychopharmacology

A major component of deciding what course of treatment is likely to be successful is based on estimating to what extent the dual diagnosis is psychological and biological. Components that speak to the biological are:

- Family History
- Response to medications in the past
- Physical symptoms
- Lack of psycho-social factors

Psychopharmacology

Modes of treatment:

- Active
- Continuation
- Maintenance

Addiction & Depression

Depression Disorders
US Prevalence Rates

- Lifetime prevalence for depressive disorders is 17%.
- Major Depression suicide rate: 9%.
- Over 25 million individuals in the U.S. experience symptoms of depression.
- Women are twice as likely to have depression.
- Only about 50% of those with major depression seek treatment.
- Treatment has been shown to be 80% effective.

(Preston, O'Neal, Talaga, 2013)

Depressive Disorders
Psychopharmacology

If this is the first episode of depression, then medication is usually prescribed until symptoms have remitted and client has returned to previous level of functioning.

When depression reoccurs, lifetime medication is often warranted.

Most medications usually begin to reduce symptoms in 10-21 days.

Medication non-compliance is a significant issue. This can be related to clients beginning to feel better, discomfort from side effects, and stigma about being on medications. For the health and safety of the client, these issues should be assessed and dealt with in the moment.

Depressive Disorders Treatment Guidelines

The single most important component of the treatment process is assessing and dealing with risk factors that indicate the client may be a danger to themselves or others.

This should be done at the beginning of treatment and any time during the treatment process that concern is raised about these issues.

Depressive Disorders Treatment Guidelines

1. Understand & manage feelings
2. Change negative thoughts & dysfunctional beliefs
3. Improve family & social relationships
4. Increase skills such as coping, social, refusal, etc.
5. Change behaviors & lifestyle
6. Manage persistent symptoms
7. Prepare for resurgence/relapse of DDx

(Daley & Moss, 2002)

Addiction & Bipolar Disorders

Bipolar Disorders
US Prevalence Rates

- Lifetime prevalence: Type I: 1% Type II: 4%
- Suicide rate: 15 - 20%
- Between 47-75% of bipolar episodes include psychotic features.
- There is a family history of bipolar in more than 60% of the cases.
- Over-representation in higher SES and educational groups.
- Typical first episodes are mania for men & depression for women.
- Age of onset usually occurs between 20-40 years old.
- Average lifetime episodes range from 7-9.
- Average recovery time from depressed episode is 9 weeks.
- Average recovery time from manic state is 5 weeks.
- Average recovery time from mixed state is 14 weeks.

(Preston, O'Neal, Talaga, 2013)

Bipolar Disorders
Psychopharmacology

- Bipolar medications serve to stabilize mood.
- The first goal is typically to remediate current symptoms, then to prevent future relapses of manic and/or depressed episodes.

Bipolar Disorders
Psychopharmacology

Medication compliance for individuals with bipolar disorder is a significant concern for a variety of reasons:

- Feeling slowed and/or blunted
- Unpleasant side effects
- Believing that they are cured when asymptomatic
- Poor judgment
- Pressure from others that meds are no longer needed
- Recurrence of symptoms that lead to distorted thoughts

Bipolar Disorders
Treatment Guidelines

Focus of treatment:

- Abstinence from drugs & alcohol
- Assessment of psychotic thinking & poor reality testing
- Monitoring energy, sleep patterns, eating habits, sexual behavior, spending, etc.
- Establishing frustration tolerance and impulse control
- Processing grief and loss related to diagnosis and lifestyle

Bipolar Disorders
Treatment Guidelines

Focus of treatment:

- Indications of moods elevating or decreasing
- Stress level & level of functioning
- Connection to family & support system
- Establishing structure and routine in day-to-day life
- Consider group therapy, self-help, & community supports

Addiction & Anxiety D/O

Anxiety Disorders
US Prevalence Rates

- Lifetime prevalence for anxiety disorders is 25%.
- Over 37 million individuals in the U.S. experience symptoms of anxiety.
- Suicide attempts are 18 times more likely with clients who have panic disorder.
- Double the number of women have anxiety than men.
- Only about 30% of those with anxiety seek treatment.
- Treatment has been shown to be 70-90% effective.

(Preston, O'Neal, Talaga, 2013)

Anxiety Disorders
Psychopharmacology

Treatment is very different depending on the type of the anxiety disorder and the symptoms experienced by the client.

PCPs and psychiatric prescribers will often prescribe benzodiazepines. These medications are highly problematic for dual diagnosis clients due to the addictive nature of the medication.

Emotional Stress & Trauma
US Prevalence Rates

- Lifetime prevalence for trauma is 14%, but is largely effected by environmental events such as war, terrorism, blackouts, violent crimes, etc.
- Up to 2 million children are at risk of being victims of physical abuse.
- More than 2.4 million children are reported to Child Protective Services each year:
  - 49% for neglect
  - 27% for physical abuse
  - 16% for sexual abuse
  - 8% for emotional abuse

(Preston, O'Neal, Talaga, 2013)

Emotional Stress & Trauma Treatment Guidelines

Research-validated therapeutic modalities:

Cognitive Behavioral Therapy:

- Seeking safety
- Exposure therapy
- Systematic desensitization
- Stress inoculation training
- Cognitive processing
- Dysfunctional thought changes
- Assertiveness trainings
- Biofeedback
- Relaxation training

(Daley & Moss, 2002)

Emotional Stress & Trauma Treatment Guidelines

- Establish safety of treatment
- Be warm, open, and empathic
- Learn from the client about the traumatic event and collect additional data from media, collateral contacts, treatment team, and supervisor.
- Consider the appropriateness of survivor group
- Refer to family therapy as indicated

(Daley & Moss, 2002)

Addiction & Thought Disorders

Schizophrenia & Psychotic D/O US Prevalence Rates

- Approximately 1% of the U.S. population are diagnosed with Schizophrenia.
- 1-4% of psychiatric admissions are for delusional disorder.
- Schizophrenia is more common in men.
- Schizophrenia and a considerable number of delusional disorders are lifetime conditions.

(Daley & Moss, 2002)

Schizophrenia & Psychotic D/O Treatment Guidelines

- Medications are almost always indicated for these conditions, however, clients have the right to decide whether or not to take the medicine.
- There is a relapse rate of 70% if not on medication.
- Secondary depression and suicide risk is present when the hallucinations and delusions are not contained.

(Daley & Moss, 2002)

Schizophrenia & Psychotic Disorders Treatment Guidelines

- Supportive therapy
- Psycho-educational interventions
- Skill building
- Establishing and maintaining support network
- Complying with treatment regimen

(Daley & Moss, 2002)

Schizophrenia & Psychotic Disorders Treatment Guidelines

- Reinforce that medications are a helpful
- Avoid intensive interpersonal interactions
- Self-disclosure and insight oriented interventions typically not appropriate
- Support strengths and existing coping skills
- Relapse prevention and early warning sign logs

(Daley & Moss, 2002)

DSM 5 Mini Vignettes

1. A 37-year-old female client with a long history of high and low moods comes into your office. Sometimes she only sleeps 2 hours a night for several weeks and other times she sleeps more than 10 hours a night. She reports having a lot of distress and is anxious most of the time. She uses meth to keep her energy up and enhance her mood. She has cravings for meth. She spends a lot of time getting meth, being high and then sleeping it off. No other criteria for drug use are met.

   Diagnoses: _____

2. A 51-year-old male who has been living in the same home for more than 30 years comes in for therapy. He reported his wife left him years ago, stating the home was unlivable. On a home visit you witness that he has newspapers stacked to the ceiling in nearly every room. There are 2 foot wide paths to get through the home. The kitchen is unusable and the door to the bedroom is blocked because of the papers. A doctor prescribed him oxycodone several years ago. When he couldn't get refills from the doctor anymore, he started buying it on the streets. The client has stopped most of his usual activities since his house has gotten so overwhelming and he is using more and more of the pain pills. Most of his day is spent getting the pills, being high and then sleeping it off. If he goes more than a day without pills he starts to experience painful withdrawal. No other criteria present for the pain pills.

   Diagnoses: _____

3. A 22-year-old female client enters therapy with you. Client reports a lot of nervousness and rapid thoughts. She states she worries a lot. She is especially nervous in social interactions. She reports drinking alcohol and smoking marijuana to help her calm down and relax. Client doesn't report having cravings, tolerance or withdrawal for either substance. She is able to control her use while still engaging in work. Her use does cause some problems in her relationships and she wishes she could give the substances up.

   Diagnoses: _____

4. 45 year old male client requests therapy services for long term depression. He states he has felt like he has had a low level depression for many years. He states there is not much enjoyment in his life and he has little energy. He tends to procrastinate projects and has a pessimistic outlook on life. Client reports drinking nearly all day every day. He has tolerance and withdrawal. He knows drinking this much is probably not good for him. He doesn't have any other criteria for a substance use disorder.

   Diagnoses: _____

5. A 17 year old male is mandated to treatment with you. He comes in wearing an Anarchy Rules t-shirt. He has more tattoos and piercings than you can count. He has been arrested many times for getting in fights and for property destruction. He was kicked out of school 4 years ago. His paperwork shows that he started using drugs when he was 10 years old. He says he has no particular favorite. He will use any and all drugs he has access to. The more the better. He often uses multiple substances at the same time. He reports using heroin daily. He reports experiencing withdrawal symptoms and cravings. He says that he is high so much that he could never get a job. Sometimes he uses in very dangerous ways. His use has increased to get the same high he had when he first started using. He doesn't do much for fun but get high. Most of his life is spent using heroin. He reports using meth to give him energy. He has some mild cravings for meth. Client doesn't report any other criteria for meth use.

   Diagnoses: _____

6. A 29 year old female requests therapy after being sexual assaulted. She is having trouble sleeping and feels unsafe. At night, she can only leave her home if she is accompanied by someone she feels safe with. She is drinking to cope with the painful event. She reports the alcohol numbs the pain and helps her forget the event for a little while. She wants to cut down, but can't seem to do that. Recently she started drinking in the morning because she is experiencing withdrawal. She also reports that she needs to have more drinks before she feels drunk. Her family and friends express a lot of concern about her drinking and wishes she would stop. Her primary care doctor told her that she is at risk of damaging her liver if she continues to drink as often and as much as she does.

   Diagnoses: _____