DSM 5
The Changing Landscape

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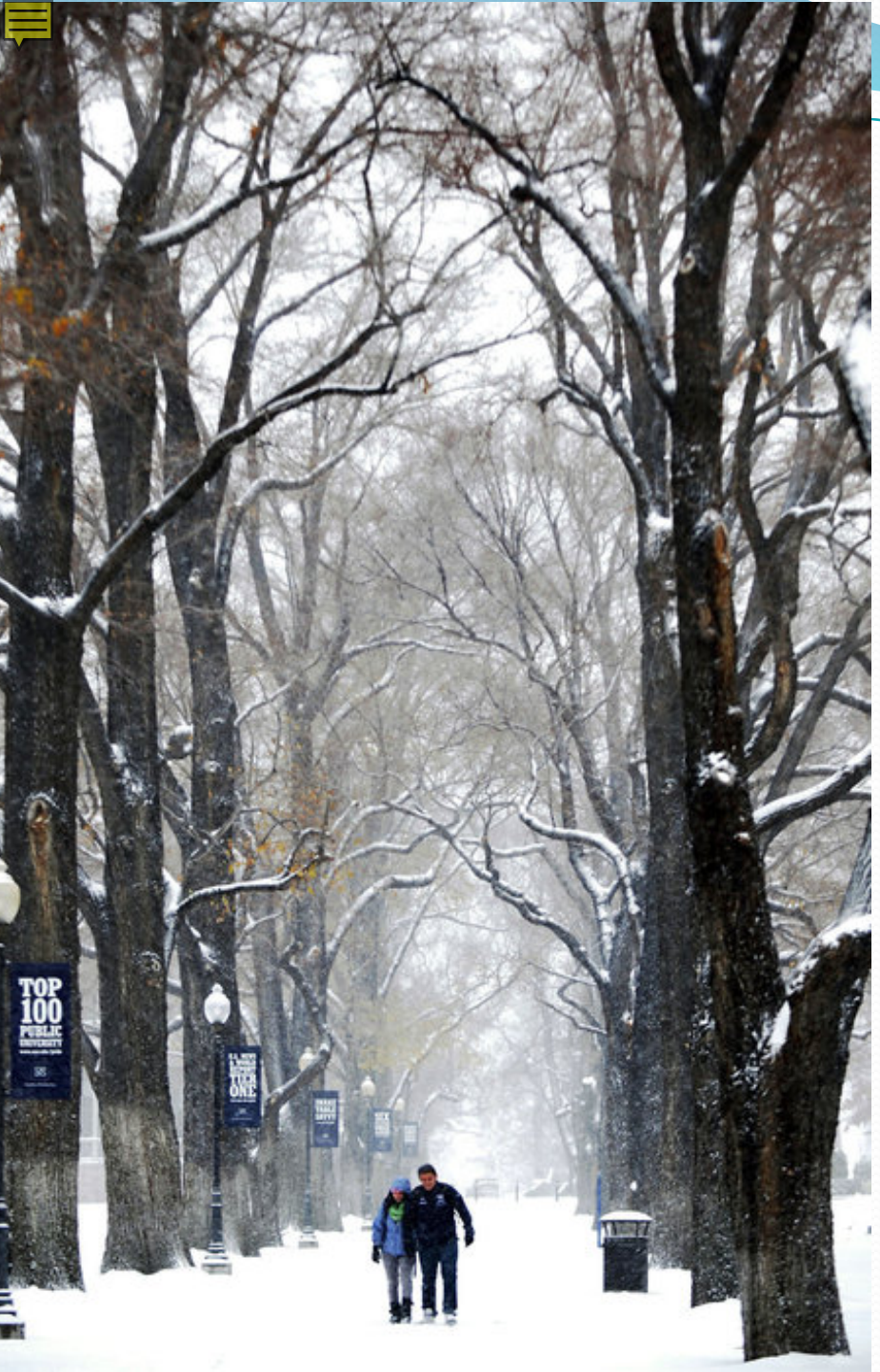
References:

Diagnostic and Statistical Manual of Mental Disorders, Fifth Addition, American Psychiatric Association, 2013.



CASAT at University of Nevada, Reno

CASAT

Substance Abuse Prevention & Treatment Agency (SAPTA)

Center for the Application of Substance Abuse Technologies

(CASAT):

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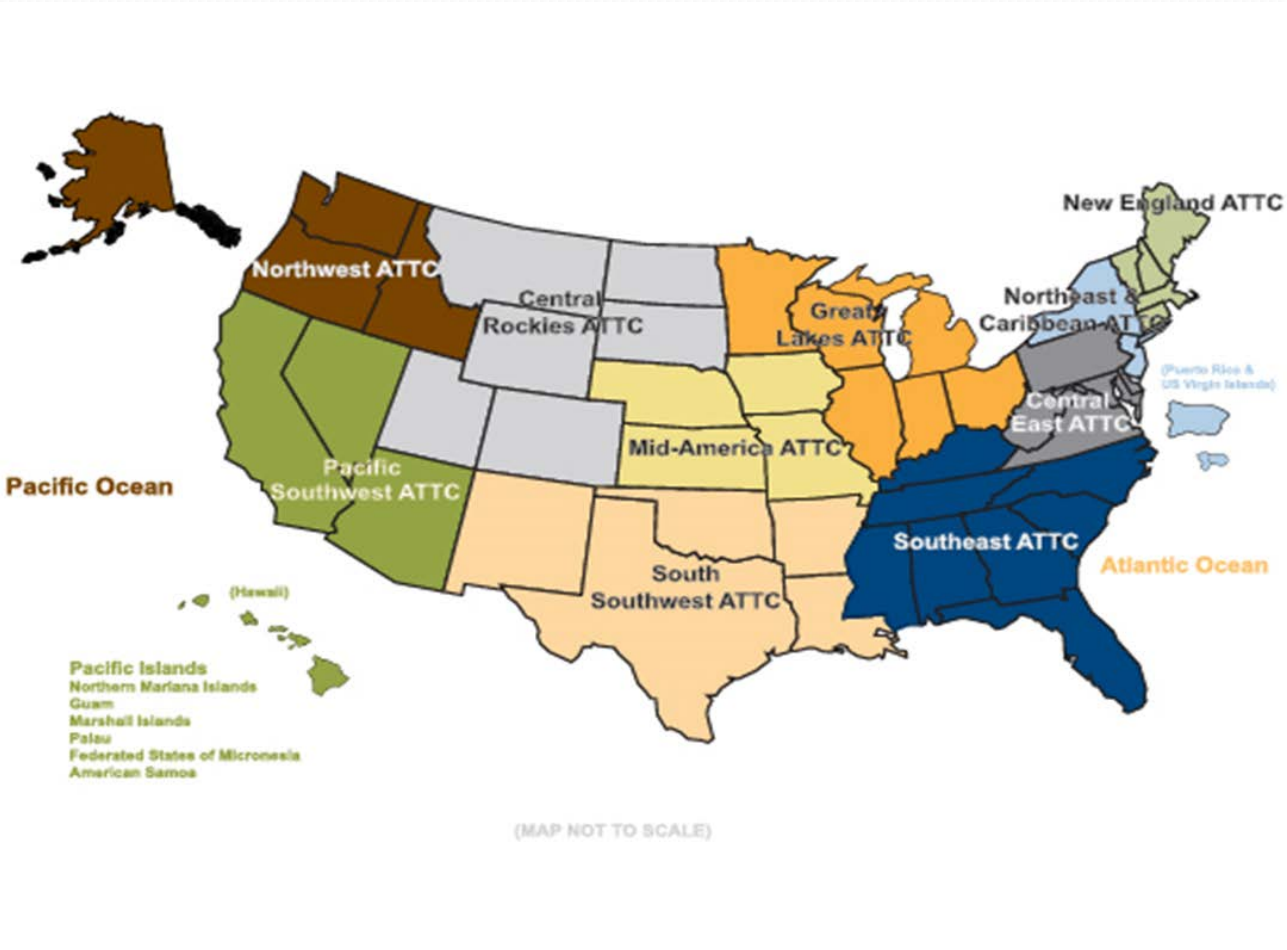
The ATTC Network

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S Department of Health and Human Services

Ten Regional Centers

Central Rockies ATTC is now the Mountain Plains ATTC (UNR, UND)



Greetings

- Name
- Location
- Credentials

Learning Objectives

Develop a working knowledge regarding

- Comprehensive Screening and Assessment
- Multiaxial System Changes
- Case Formulation
- Diagnostic Criteria and Descriptors
- Subtypes and Specifiers

Learning Objectives, cont.

Develop a working knowledge regarding:

- Principle Diagnosis
- Provisional Diagnosis
- Coding and Reporting Procedures
- Highlights of Changes from DSM-IV to DSM-5
- Overview of Common Disorders in theDSM-5 with focus on Substance-Related and Addictive Disorders
- Case Studies (Research to Practice)

Comprehensive Assessment

- Screening Tools
- Biopsychosocial
- DSM 5 Diagnosis
- ASAM Criteria
- LOCUS Criteria

Screening Tools

- DSM 5 Cross Cutting 1 and 2
- Columbia (C-SSRS)
- PHQ-9A (Patient Health Questionnaire) Child Age 11-17
- PHQ-9 Adult
- CAMS (Collaborative Assessment and Management of Suicidality
- CRAFFT Ages 14-21
- DAST Drug Abuse Screening Test 16 + Years (Adolescent and Adult Version)
- WHODAS 2.0 (World Health Organization Disability Assessment Schedule)
- Achenbach Child Behavior Checklist (CBCL) Ages 6-18 There is a checklist for 1.5-5 and Caregiver Report for this age as well. (Screening tool for emotional and behavior symptomology)
- CIA/CIWA-Ar Clinical Institute Withdrawal Assessment of Alcohol
- COWS Clinical Opiate Withdrawal Scale

Biopsychosocial Assessment

- Medical
- Developmental History
- Employment/Academic
- Family/Social
- Substance Use History
- Criminal Justice History
- Psychiatric History (Mental Status)
- Trauma History

ASAM 6 Dimensions

1. Acute Alcohol and Withdrawal Potential
2. Biomedical Condition and Complications
3. Emotional, Behavioral or Cognitive Condition and Complications
4. Readiness to Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery/Living Environment

LOCUS

1. Risk of Harm
2. Functional Status
3. Medical, Addictive and Psychiatric Co-Morbidity
4. Recovery Environment
5. Treatment and Recovery History
6. Engagement and Recovery Status

The Multiaxial System

- Never specifically required in DSM IV
- There was no real separation between Axis III, II and I
- Medical issues should still be noted
- Axis IV Psychosocial Stresses, should also be noted, but not under a specific Axis like in DSM IV
- Global Assessment of Functioning (GAF) has been eliminated

Use of the Manual

- Approach to Clinical Case Formulation
- Careful clinical history and concise summary of social, psychological, and biological factors
- It's not sufficient just to check off a list to determine if a diagnosis is merited
- Clinical judgment is critical
- Use the available information to develop a comprehensive treatment plan with the client in their cultural and social context

Criterion for Clinical Significance

- Normal and pathological symptom expression
- Disturbance causes clinically significant distress or impairment in social, occupational or other functioning
- Useful with identification and referral

Per Diagnosis:

- Diagnostic features
- Prevalence
- Development and course
- Risk and prognostic factors
- Gender related diagnostic issues
- Suicide risk

Diagnostic Criteria and Descriptors

- Guidelines for making a diagnosis
- Text Descriptors
- Subtypes
- Specifiers

Provisional Diagnosis

- Strong presumption that criteria will be met
- “provisional” after the coding
- Differential diagnosis depends on the duration of the illness

Coding and Reporting Procedures

- Data collection and billing purposes
- ICD-10-PCS are the new F-codes. The ICD-9 codes are on the left with the F-codes next to them.
- Everyone should be using ICD-10 codes now. Note there are updated codes for 2019.

Substance-Related Addictive Disorders

- Expanded to include gambling disorder
- DSM 5 does not separate the diagnoses of substance abuse and dependence as in DSM IV
  - rather criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance-induced disorders, and unspecified substance related disorders, where relevant

Substance-Related Addictive Disorders, cont.

- Within substance use disorders, the DSM IV recurrent substance-related legal problems criterion has been deleted from DSM 5, and new criterion: craving, or a strong desire or urge to use a substance-has been added

- The threshold for substance use disorder in DSM 5 is set at 2 or more criteria, in contrast to a threshold of one or more criteria for a Diagnosis in DSM IV for substance abuse and three or more for substance dependency

Substance-Related Addictive Disorders, cont.

- Cannabis withdrawal and caffeine withdrawal are new disorders
- Severity of the DSM 5 substance use disorders is based on the number of criteria endorsed
- The specifier for physiological subtypes is eliminated in DSM 5 as is the diagnosis of polysubstance dependence
- Unspecified Substance Related Disorder

Substance-Related Addictive Disorders, cont.

- Early remission from a DSM 5 substance use disorder is defined as
  - at least 3 but less than 12 months without meeting substance use disorder criteria (except craving)
  - sustained remission is defined as at least 12 months without meeting criteria (except craving)
- Additional specifiers include
  - “in a controlled environment”
  - “on maintenance therapy”

Substance-Related Addictive Disorders, cont.

- The diagnosis of Substance Abuse and Substance Dependency will no longer be utilized in the new DSM 5.
- There will now be one main area called Substance Use Disorder specific to the substance and criteria met will determine severity of condition.

Here is the Criterion Breakdown

Much of the language is utilized from the DSM IV-TR, but Criterion areas have been changed with some language enhancement and revised.

Criterion 1-4: Impulse Control

- Individual may take the substances in larger amounts or over a longer period than was originally intended
- Individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use
- All daily activities revolve around the substance
- Craving for the substance is present

Criterion 5-7: Social Impairment

- Recurrent substance use may result in failure to meet major role obligations at work, school, or home
- May continue to use despite persistent or recurrent social or interpersonal problems
- Important social, occupational and recreational activities may be given up or reduced because of use

Criterion 8-9: Risky Use

- Recurrent substance use in situations in which it could be physical hazardous
- Continued use despite knowledge of having a persistent or recurrent physical and psychological problems

Criterion 10-11: Pharmacological

- Tolerance
- Withdrawal

Note: There is still separate diagnoses for Withdrawal and Intoxication similar to the DSM IV-TR

Severity Rating

In Relationship to Criterion Stated In Previous Slides

- Mild: 2-3 Symptoms
- Moderate: 4-5 Symptoms
- Severe: 6 or more Symptoms

DSM 5 Case Study

“Tami Smith” is a twenty-one year old female of Euromerican (white) and Native American descent. She is unemployed and reports she has only worked sporadically in the fast food industry. Tami has two children ages two and one. The whereabouts of their father is unknown. The children are in CPS/DCFS custody because her neighbor (and babysitter) called CPS twenty-four hours after Tami said she would return to pick the children up and she did not. Tami later admitted that she had been smoking heroin at a friend's house. Her children went into custody six months ago and at that time Tami went into residential treatment for the first time. She was asked to leave that treatment facility after three weeks when she was found with prescription valium that she apparently had been keeping in her room. Tami was referred to a higher level of care but she refused to follow recommendations. Per the social worker, Tami could lose custody of her children if she does not follow through with treatment. Tami lives with a partner who has two teenage children who do not live with them but visit periodically. The partner (who works as a restaurant manager) reports to Tami that she supports treatment and the reunification with the children. Per Tami, the partner is under a doctor's care for a work injury and is using hydrocodone as prescribed. Tami is being urged by her mother as well as the social worker to follow through with treatment despite the fact that Tami has not smoked heroin or used any substance other than caffeine for over a month. The social worker has been testing Tami every time she visits with her children. Per Tami, her mother believes Tami could return to drugs because she has not had more than six weeks of clean time in several years. Tami reports she does not like counselors because they make her talk about her past. She makes reference to an uncle who sexually abused her when she was fourteen and fifteen, when he introduced her to smoking heroin. She had smoked marijuana a few times before trying heroin. Around the time, she started heroin and her uncle started assaulting her, she started cutting on herself. She is not sure if the family knew she cut on herself. She has refused to follow through with psychological evaluations recommended by social services. Tami has not cut on herself for four years but thinks about it when she is craving heroin and cannot have her drug of choice. The sexual abuse was never reported to anyone when she was under eighteen, and Tami did not disclose it until she was nineteen. She has not told her family as they have always thought of her as a troublemaker because she used drugs. Per Tami, the family did not try to obtain treatment for her drug use when she was a teenager. Per Tami, the family is not aware that the uncle introduced her to heroin. She does not want any family members to know about her past with her uncle. The uncle has current access to children of all ages in his neighborhood and in the family. Tami reports that she does not have any physical problems and presents well-groomed but with anxious affect. She reports she told you too much information.

Example on How to Code

- Diagnosis code for specific substance such as Alcohol Use, followed by severity rating of mild, moderate or severe based on criteria met. You can add medical condition(s) and psychosocial stressors as well.
- Other specifiers would include “in early remission, sustained remission, on maintenance therapy and in controlled environment”.

Highlights of Changes, cont.

- ADHD

  Examples of some changes from DSM IV

  - Subtypes changed to presentation specifiers
  - Co-morbid diagnosis with autism spectrum disorder is now allowed
  - Symptom threshold change has been made for adults to 5 in contrast to 6 for children

ADHD Diagnosis
Falls under Neurodevelopment Disorders

- **A persistent pattern of inattention and/or hyperactivity-impulsivity** that interferes with functioning or development, as **characterized by (1) and/or (2):**
  - **(1) Inattention: Six (or more)** of the following symptoms have persisted for at least **6 months** to a degree that is inconsistent with developmental level and that negatively impacts directly with social and academic/occupational activities:
    - Often **fails to give close attention**
    - Often has **difficulty sustaining attention**

Continued:

- Often **does not seem to listen** when spoken to directly
- Often **does not follow through on instructions**
- Often has **difficulty organizing** tasks and activities
- Often avoids, dislikes, or is **reluctant to engage in tasks that require mental effort**
- Often **looses things** necessary for tasks or activities
- Often **easily distracted** by extraneous stimuli
- Is often **forgetful** in daily activities

Continued:

- **(2) Hyperactivity and impulsivity**: **Six (or more)** of the following symptoms have persisted for at least **6 months** to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities.
  - Often **fidgets** with or **taps hands or feet** or **squirms** in seat.
  - Often **leaves seat** in situations when remaining seated is expected.
  - Often runs about or **climbs in situations where it is inappropriate.**
  - Often **unable to play or engage** in leisure activities quietly.

Continued:

- Often fails to give close **attention**
- Often has difficulty sustaining **attention**
- Is often "on the go," acting as if "driven by a motor."
- Often **talks excessively.**
- Often **blurts out an answer** before a question has been completed.
- Often has **difficulty waiting** his or her turn.
- Often **interrupts or intrudes** on others.

(note: other symptoms)

Schizophrenia Spectrum & Other Psychotic Disorders

- Two changes were made to Criterion A for schizophrenia
  - Elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (2 or more voices conversing) leading to the requirement of at least 2 Criterion A symptoms for any diagnosis of schizophrenia
  - The addition of the requirement that as least one of the Criterion A symptoms must be delusions, hallucinations, or disorganized speech
- DSM IV subtypes were dropped
  - Rating severity for core symptoms has replaced the subtypes

Schizophrenia Diagnosis

- Criterion A: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated) At least one of these must be (1), (2), or (3):
  1. Delusions
  2. Hallucinations
  3. Disorganized speech
  4. Grossly disorganized or catatonic behavior
  5. Negative symptoms

Continued:

- For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self care, is markedly below the level achieved prior to the onset.
- Continuous signs of the disturbance persist for at least 6 months. This 6 month period must include at least 1 month of symptoms (or less if successfully treated)
- Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out…
- Other symptoms:

Schizoaffective Disorder

- Reconceptualized as a longitudinal instead of a cross sectional diagnosis
- More comparable to schizophrenia, bipolar and major depression
- Major mood episode must be present for a majority of the total disorder's duration after Criterion A has been met

Delusional Disorder

- No longer has the requirement that the delusions must be non-bizarre
- Specifier can be used to note bizarre type delusions

Bipolar & Related Disorders

Includes both changes in Mood &Changes in Activity or Energy

- Bipolar I, mixed disorder, mixed episodes-requiring that the individual simultaneously meet full criteria for both mania and major depressive episode-is replaced with a new specifier “with mixed features”

Bipolar 1 Diagnosis

- Manic Episode:
  - A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
  - B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

Manic Episode Continued

- **inflated self-esteem or grandiosity**
- **decreased need for sleep** (e.g., feels rested after only 3 hours of sleep)
- **more talkative** than usual or pressure to keep talking
- **flight of ideas** or subjective experience that thoughts are racing
- **distractibility** (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
- **increase in goal-directed activity** (either socially, at work or school, or sexually) or psychomotor agitation
- **excessive involvement in pleasurable activities** that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

Manic Episode Continued:

- C. The mood disturbance is **sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others**, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- D. **The symptoms are not due to the direct physiological effects of a substance** (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism). Note: Manic-like episodes that are clearly caused by somatic

Bipolar 2 Diagnosis

- The same symptoms as a manic episode, but
  - E. The episode is **not severe enough to cause marked impairment in social or occupational functioning** or to necessitate hospitalization.

Cyclothymic Diagnosis

- Fluctuating mood disturbance involving numerous periods of hypomanic symptoms and periods of depressive symptoms that are distinct from each other (Criterion A).
- Symptoms don't meet full criteria for hypomanic episode or full criteria for a depressive episode.

Depressive Disorders

- Disruptive mood dysregulation Disorder
- Premenstrual dysphoric
- Persistent depressive disorder
- Mixed episode
- Bereavement

Major Depressive Diagnosis

A. **Five (or more) of the following symptoms have been present during the same 2- week period** and represent a **change from previous functioning**; at least one of the symptoms is either (1) **depressed mood or (2) loss of interest or pleasure.**

Continued:

- **Depressed mood most of the day, nearly every day, as indicated by either subjective report** (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

Continued:

- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

Continued:

- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The symptoms are not due to the direct physiological effects of a substance or to another medical condition.

DSM 5 Case Study

A 27-year-old woman presents to your office stating that she is troubled by headaches and fatigue. She says that she always feels tired and can't sleep well, often waking up early. She describes her headaches as dull, aching and generalized. These symptoms began about three weeks ago and have been getting worse. She reports a lack of interest in her usual activities. She also reports that she is missing work due to fatigue and inability to concentrate. Although her two children are both in school, she is concerned that she is not spending quality time with them. She is worried that she might have "something bad" because she has difficulty concentrating and is having frequent crying spells. She reports not sleeping well and a loss of appetite, with a weight loss of 10 pounds in the last month. Social History: The patient has no significant past medical or psychiatric history and takes no regular medications. However, she takes ibuprofen for headaches. She denies using alcohol or drugs. The patient is married, with two elementary school-age children.

A Teaching Case Vignette, American Association of Colleges of Osteopathic Medicine 2012 AACOM

Persistent Depressive Diagnosis

- The essential feature of persistent depressive disorder (dysthymia) is a depressed mood that occurs for most of the day, for more days than not, **for at least 2 years** (at least 1 year for children and adolescents).
- This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.
- Major depression may precede persistent depressive disorder, and major depressive episodes may occur during persistent depressive disorder.
- Individuals whose symptoms meet major depressive disorder criteria for 2 years should be given a diagnosis of persistent depressive disorder as well as major depressive disorder.

Anxiety Disorders

- No longer includes obsessive-compulsive disorder which is in the new chapter "Obsessive-compulsive and related disorder or Posttraumatic stress disorder (PTSD) and acute stress disorder (which are in the new chapter "Traumatic and stress-related disorders)
- Changes in criteria for specific phobia and social anxiety disorder include deletion of the requirement that individuals over age 18 recognize that their anxiety is unreasonable
- 6 month duration in now extended to all ages

Anxiety Disorders, cont.

- Panic attacks can now be listed as a specifier that is applicable to all DSM 5 disorders
- Panic disorder and agoraphobia are unlinked in DSM-5, thus, the former DSM IV diagnosis of panic disorder with agoraphobia, panic disorder without agoraphobia and agoraphobia with history of panic disorder are now replaced with 2 diagnoses, panic disorder and agoraphobia, each with separate criteria
- Separation anxiety and selective mutism are now classified as anxiety disorders

Generalized Anxiety Diagnosis

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The individual finds it difficult to control the worry.
C. The anxiety and worry are associated with 3 or more of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months);

Continued:

Note: Only one item is required for children)

- **Restlessness** or feeling keyed up or on edge
- Being easily **fatigued**
- Difficulty **concentrating** or mind going blank
- Irritability
- **Muscle** tension
- **Sleep** disturbance

DSM 5 Case Study

Mary complains of feeling 'stressed' all the time and constantly worries about 'anything and everything'. She describes herself as always having been a 'worrier' but her anxiety has become much worse in the past 12 months since her mother became unwell, and she no longer feels that she can control these thoughts. When worried, Mary feels tension in her shoulders, stomach and legs, her heart races and sometimes she finds it difficult to breathe. Her sleep is poor with difficulty getting off to sleep due to worrying and frequent wakening. She feels tired and irritable. She does not drink any alcohol.

National Institute for Health and Clinical Excellence, 2011. Clinical case scenarios: Generalized anxiety disorder (2011)

Trauma-and Stressor-Related Disorders

- Trauma-and Stressor-Related Disorders
  - Acute stress disorder, qualifying traumatic events are now explicit
  - Adjustment disorders are reconceptualized as a heterogeneous array of stress response syndromes that occur after exposure to a distressing event rather than residual like in DSM IV
  - PTSD differs significantly
    - More explicit regarding events under criterion A
    - Criterion A-2 has been eliminated regarding subjective reactions
    - Developmentally sensitive

Posttraumatic Stress Diagnosis

A. Exposure to actual or threatened death, serious injury, or sexual violence in 1 or more of the following:

- directly experiences the traumatic event;
- Witnessing, in person, the event(s) as it occurred to others;
- learning that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
- experiences first-hand repeated or extreme exposure to aversive details of the traumatic event(s).

Continued:

B. Presence of 1 (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) are occurred.

- Recurrent, involuntary, and intrusive memories of the traumatic event(s)
- Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)
- Dissociative reactions
- Intense or prolonged psychological stress at exposure
- Marked physiological reaction to internal and external cues

Continued:

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidence by one or both of the following:

- Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories thoughts, or feelings about or closely associated with the traumatic event(s).

Continued:

D. Negative alterations in cognitions and mood associated with the traumatic events(s) beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

- Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
- Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world.

Continued:

- Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead to the individual to blame himself/herself or others.
- Persistent negative emotional state.
- Markedly diminished interest or participation in significant activities.
- Feelings of detachment or estrangement from others.
- Persistent inability to experience positive emotions.

Continued:

E. Marked **alterations in arousal and reactivity associated with the traumatic event**(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

- Irritable behavior and angry outbursts…
- Reckless or self-destructive behavior.
- Hypervigilance.
- Exaggerated startle response…
- Problems with concentration…
- Sleep disturbance…

Feeding and Eating Disorders

- Due to the elimination of the DSM IV chapter "Disorders Usually First Diagnosed During Infancy, Childhood, or Adolescence, this chapter describes several disorders found in the DSM IV
- The core diagnosis criteria for anorexia nervosa are conceptually unchanged with one exception, the requirement for amenorrhea is eliminated

Feeding & Eating Disorders, cont.

- Criterion B is expanded to include not only overtly expressed fear of weight gain but also persistent behavior that interferes with weight gain
- The only change regarding bulimia nervosa is a reduction in the required minimum average frequency of binge eating and inappropriate, compensatory behavior frequency from twice to once weekly
- Binge-eating disorder related to frequency is the same as bulimia criteria

Anorexia Nervosa Diagnosis

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in context to age, sex, development trajectory, and physical health.
B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

Continued:

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Bulimia Nervosa Diagnosis

A. Recurrent episodes of binge eating. An episode of binge is characterized by both the following:
   - Eating, in a discrete period of time.
   - A sense of lack of control over eating during the episode.

B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self induced vomiting, misuse of laxatives, diuretics, or other medications; fasting or excessive exercise.

Continued:

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Using the DSM 5 to Write Treatment Plans

- Problem or Challenge Statement
- Symptom/behavioral Goal
- Action Statements (client)
- Intervention (clinician)

Questions

Thanks for participating!