DSM-5: Using Key Changes to Highlight Critical Teaching Points for Undergraduate Psychology Instructors

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Abstract

The recent release of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013a) challenges undergraduate psychology instructors to integrate DSM-5 teaching points into their Introductory, Clinical, or Abnormal Psychology courses. This article discusses several changes found in DSM-5, including modification to the definition of a mental disorder, the elimination of multiaxial diagnosis, proposed changes to Personality Disorders, and diagnostic alterations involving childhood disorders, posttraumatic stress disorder, and major depressive disorder. We also provide practical suggestions for teaching these changes to undergraduate psychology students, including ideas for classroom assignments and relevant discussion. We encourage instructors to utilize the release of DSM-5 as an opportunity to deepen undergraduate students' critical thinking skills and demonstrate the constantly evolving field of psychopathology.

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The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013a) generated great anticipation. Three opportunities for public comment spurred speculation of what would (and would not) be included in the document (APA, 2012). With the last revision to the DSM occurring well over a decade ago (APA, 2000), mental health clinicians, researchers, and consumers pondered how DSM-5 would consolidate advances in the understanding of mental disorders. Instructors of psychology awaited the release with similar interest as they contemplated how DSM-5 would affect teaching points and course revisions for abnormal psychology and other related classes.

Despite meeting with widespread controversy, DSM-5 offers a framework and common language for mental health professionals and others in health-related fields. Familiarity with DSM-5 allows undergraduates to learn this language, providing a foundation for students to communicate effectively about mental health diagnoses. The release of DSM-5 also presents an opportunity to address the evolution of the DSM with students and how advances in research as well as political and cultural shifts have shaped each subsequent volume. Lastly, teaching the DSM-5 invites students to draw their own conclusions about how to effectively describe, understand, and treat the mental health concerns that affect us all.

This article highlights several interesting and substantive changes found in DSM-5 and provides practical suggestions to teach these changes to undergraduate psychology students, including ideas for classroom assignments and relevant discussions. Although there are many more changes than can be addressed in this article, the ideas presented here serve as a launching point for undergraduate psychology instructors to update their materials for Introductory,

Clinical, or Abnormal Psychology courses based on the release of DSM-5. Teaching points address modification to the definition of a mental disorder, the elimination of multiaxial diagnosis, proposed changes to personality disorders, and diagnostic alterations involving childhood disorders, posttraumatic stress disorder, and major depressive disorder.

Definition of a Mental Disorder

Background

Many abnormal psychology textbooks address the definition of a psychological disorder within their first pages (see, e.g., Comer, 2011; Durand & Barlow, 2010; Rosenberg & Kosslyn, 2011). This definition often sparks rich classroom discussion regarding the difficulty of identifying and naming psychological dysfunction, including the usage of the term *disorder* itself (Rounsaville et al., 2002). The question of what constitutes a mental disorder, and the corollary issue of what is and is not "abnormal," are foundational elements of courses in abnormal psychology and provide rich opportunities for critical thinking.

The DSM-5 introduces an updated definition of a mental disorder. The new definition retains the ideas of distress/disability, cultural context, and individual dysfunction found in DSM-IV (APA, 1994), but adds the concepts of emotion regulation and developmental processes:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, *emotion regulation* [emphasis added], or behavior that reflects a dysfunction in the psychological, biological, *or developmental processes* [emphasis added] underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the

> death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (APA, 2013a, p. 20)

By including "emotion regulation" in its revised definition, DSM-5 affirms that mental health does not arise so much from reducing certain emotions but rather from adaptively managing the range of human "positive" and "negative" emotions. This reflects researchers' rapidly growing understanding of the deep primary roles played by human affective systems (Davidson, Jackson, & Kalin, 2000; Sander, 2013). Further, the inclusion of "developmental processes" as a potential area of dysfunction emphasizes the DSM-5's use of a lifespan developmental approach to classification (Klott, 2012).

Teaching Suggestions

Emotion regulation. *Emotion regulation* is a complex term with which students are often unfamiliar. However, most students have had experience (successful or not) in regulating their emotions. Through an in-class or take-home writing assignment, students can identify particular emotions they find challenging to experience and reflect upon how long it takes them to get "unstuck" from different emotions. Students can in turn identify healthy—as well as unhealthy—strategies that people might use to cope with their emotions.

Developmental processes. Through a series of discussion questions, students can address how a person's age and developmental trajectory might affect the expression of mental disorders. For example, how might mood disturbances be reflected differently in childhood and adulthood? When do childhood tantrums become a symptom of a disorder? Why might older adults be at greater risk for particular disorders?

Understanding the definition of a mental disorder. Exploring one of the Conditions for Further Study found in DSM-5's Section III (e.g., Internet Gaming Disorder, Caffeine Use Disorder) offers students the opportunity to demonstrate their understanding of the APA's conceptualization of a mental disorder. As shown in the example assignment (and grading criteria) in the Appendix, students can write a case study illustrating how an individual would (or would not) fit the definition of having a mental disorder based on use of video games or caffeine (both used very frequently by today's students). Students' case studies should (a) identify a dysfunction in psychological, biological, or developmental processes and (b) describe what a clinically significant disturbance in cognition, emotion regulation, or behavior would look like. Students can conclude the assignment by addressing whether or not they believe these conditions are best conceptualized as mental disorders.

DSM Axis System

Background

Another primary change to DSM-5 is a radical alteration in the five-axis system first introduced by DSM-III in 1980. This multiaxial approach to diagnosis was "notable in theory but unworkable in practice" (Paris, 2013, p. 85). Overall, diagnosticians used Axis II (Personality Disorders) in less than one-third of the cases and Axis III (medical diseases) just over one-quarter of the time, whereas Axes IV (psychosocial stressors) and V (global assessment of functioning) were used less than one time in five (Bassett & Beiser, 1991). In addition to its lack of usage, Axis V's Global Assessment of Functioning (GAF) score (APA, 2000, p. 27) suffered from low interrater reliability in clinical practice (i.e., ICC coefficients between r = .39 and .59; Vatnaland, Vatnaland, Friis, & Opjordsmoen, 2007).

DSM-5 has thus moved to a "nonaxial documentation of diagnosis (formerly Axes I, II, and III), with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V)" (APA, 2013a, p. 16). The current approach of separately noting diagnoses from lifestyle factors is consistent with established World Health Organization (WHO) and International Classification of Diseases (ICD) guidelines (WHO, 2014). Removal of the multiaxial system fits with the stated DSM-5 goal of harmonizing DSM with ICD as much as possible (APA, 2013a, p. 11; Clay, 2013), which stems from the need for clinicians to use ICD-10-CM (and later ICD-11) codes for insurance reimbursement starting October 2014 (United Behavioral Health, 2013). After listing all diagnoses (psychological and medical) without axial designations, DSM-5 instructs users to employ a selected set of V and Z codes contained in the current ICD. ICD-9 V codes include psychosocial stressors such as acculturation difficulty, military deployment, and religious or spiritual problem, whereas the newer ICD-10's Z codes subsume those V codes but add specificity to the nature of the stressor (e.g., "encounter for mental health services for victim of child psychological abuse by parent"; APA, 2013a, p. 895). Instead of Axis V (GAF), DSM-5 then recommends using the WHO Disability Assessment Schedule (WHODAS version 2.0 available at http://www.who.int/classifications/icf/whodasii/en/), which has better psychometric properties (Garin et al., 2010), although the clinical utility of this option remains in doubt due to its cumbersome scoring procedure (Paris, 2013).

Teaching Suggestions

Single-axis system. We suggest that students work in groups or individually on a clinical case selected from abnormal psychology case study books, often included as ancillaries with Abnormal Psychology textbooks or available online for free. For example, instructors could use

wiki case studies at http://abnormalpsych.wikispaces.com/casestudies, which were created by undergraduate psychology majors in Dr. Caleb Lack's Abnormal Psychology course at the University of Central Oklahoma. Students can then perform a diagnostic workup using the new single axis system but including ICD V/Z codes as well as rating the case's severity via the WHODAS.

Culture and diagnosis. Instructors can use the removal of the multiaxial system to underscore a key theme pervading the entire DSM process: the notion that DSM-5, an American publication, is explicitly (and laudably) attempting to become more international by increasing its fit with or use of the ICD. In concert with new sections on cultural formulations (APA, 2013a, pp. 749-760), this change could be a springboard for fruitful class discussions on the role of culture in psychiatric diagnosis (Clay, 2013).

Personality Disorders

Background

In addition to modifying the axis system, the APA proposed several revisions that would have significantly changed the method of diagnosing personality disorders (APA, n.d., "Personality Disorders"). Based on feedback from a multilevel review of proposed revisions, however, the American Psychiatric Association Board of Trustees ultimately decided to retain the DSM-IV-TR's (APA, 2000) categorical approach with the same 10 personality disorders. The alternative hybrid dimensional-categorical model that was not accepted for the main body of the manual has been relegated to Section III ("Conditions for Further Study") of DSM-5.

This non-change highlights the critical dichotomy in DSM between its value as a guide for researchers and its clinical utility. Some scholars have even suggested the creation of two separate diagnostic manuals—one for researchers and one for clinicians—to account for the fact

that they use the manual quite differently (Paris, 2013). Whereas researchers may follow the algorithmic model of DSM diagnosis (e.g., using a structured interview to examine and check for at least five of the nine listed symptoms of major depression), clinicians rely on a prototype model, retaining a general idea of what a specific disorder looks like rather than stopping to count criteria (Zimmerman & Galione, 2010). Both groups rejected DSM-5's proposed changes to Personality Disorders for different reasons: Researchers did not want changes to criteria for disorders with several decades of strong empirical support (e.g., borderline personality disorder), whereas clinicians found the proposed changes to personality diagnosis overly complicated and unwieldy.

Teaching Suggestions

Moving toward a dimensional model. In addition to giving students assignments to design a Personality Disorders diagnostic alternative that is dimensional (vs. categorical), psychology instructors can use these issues to illustrate the multiple constituencies of DSM-5, ranging from researchers and clinicians to the pharmaceutical industry, the legal system, and even the general public.

DSM Diagnosis of Children/Neurodevelopmental Disorders

Background

Another important pair of changes to DSM-5 lies in the realm of childhood disorders, now called Neurodevelopmental Disorders (APA, 2013a, p. 31). The first is the change to Autism and related disorders. Using DSM-IV, patients could be diagnosed with one of four separate disorders: autistic disorder, Asperger's disorder, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified. Researchers found that these separate diagnoses were not consistently applied across different clinics and treatment centers (APA, n.d.,

"Autism Spectrum Disorder"). DSM-5 therefore combined all of these disorders into a single new disorder called Autism Spectrum Disorder (ASD), defined as persistent deficits in social communication and interaction associated with restricted, repetitive patterns of behavior, interests, or activities (Paris, 2013, p. 142). Field trials revealed that the revised criteria may result in 9-12% of those previously diagnosed in DSM-IV not meeting the threshold for ASD (Frazier et al., 2012; Huerta, Bishop, Duncan, Hus, & Lord, 2012), though smaller studies have suggested that this number could be even higher (Frances, 2012b).

Attention deficit hyperactivity disorder (ADHD) is the second childhood disorder that is changing criteria, with two key revisions. The first is a later age of onset, with symptoms now only required to begin by age 12 (APA, 2013a, p. 60) rather than age 7 in DSM-IV (APA, 2000, p. 92). The second is that, for patients age 17 and older, only five symptoms are required in any subsection (inattention or hyperactivity/impulsivity) rather than six (APA, 2013a, p. 59). The DSM-5 Task Force claims this change is a special effort to address adults affected by ADHD to ensure that they are able to get care when needed (APA, n.d., "Attention Deficit/Hyperactivity Disorder"). However, these changes may expand the already worrying overdiagnosis of ADHD (Paris, 2013), with prevalence rates already ranging from 5-15% in several studies worldwide (Faraone, Sergeant, Gillberg, & Biederman, 2003; Polanczyk, de Lima, Horta, Biederman, & Rohde, 2007).

Teaching Suggestions

Case studies: DSM-IV vs. DSM-5. To effectively teach the new childhood disorder changes to students, we suggest that instructors give them short case histories in which each person meets criteria for a diagnosis in DSM-5 but not DSM-IV (or vice versa). Because these short cases necessarily have incomplete information, instructors can discuss with students what

additional details they might want from each client in the real world. In the example below, Gary and Samantha are going to a party:

> Gary came late to his own 30th birthday party at Mark's house because he forgot about it until the last minute. When he remembered, it took him another 10 minutes to find his car keys, and then he was halfway to Mark's house when he realized he was driving without his wallet. When he got to the party, Mark tried to rope him into their poker game but Gary was not listening to what Mark said; then, when Mark repeated his invitation for a third time, Gary stated that he did not like card games because he had to think too much. Gary has always been called "spacey" and has had difficulty in school since the 5th grade.
>
> Samantha came to the party because she heard the noise from next door, although she was not invited. She never had friends her age and did not appear to seek shared enjoyment or interests with anyone in any activities. As a kid, she would never play "house" or any other make-believe games. As an adult, she never seemed to understand when conversations should start or end. At the party, Sam spent most of her time examining the blades on a ceiling fan in the bathroom.

Note that Gary meets DSM-5, but not DSM-IV, criteria for ADHD (he has only five, not six symptoms in any category as an adult), whereas Samantha meets DSM-IV criteria for Autism (or Asperger's) but not DSM-5 criteria for ASD. This reversal in prevalence—with ASD diagnoses decreasing and ADHD diagnoses increasing in DSM-5—can forge an educational entrance into a discussion about why some diagnostic criteria have become more stringent and others less so in DSM-5.

Neurodevelopmental disorders discussion points. Research is one possible reason for the change in criteria, although a more pragmatic one may lie in considering the strongest interest group in DSM-5 and a key sponsor of APA in general—the pharmaceutical industry (Paris, 2013). In fact, except for ASD, all the DSM-5 changes loosen diagnosis and threaten to turn the current diagnostic inflation into diagnostic hyperinflation (Frances, 2012a), possibly because most DSM-5 disorders other than ASD have medications that are commonly used as front-line treatments. Use and misuse of psychotropic medication is perhaps most relevant for ADHD, where stimulant prescriptions are increasing rapidly (Toh, 2006) despite limited long-term evidence to indicate its effectiveness (Molina et al., 2009). This issue can also relate back to Personality Disorders, which were often underdiagnosed using the multiaxial system (Paris, 2013), possibly because they do not respond well to medication and are more effectively treated with psychotherapy (Paris, 2008).

Of course, instructors can also discuss the serious caveats of making any diagnosis based on very limited information (a one paragraph description). As a corollary to this notion, another option is to have students examine snippets or excerpts of larger cases at the beginning of the semester to pique their interest, then reconsider the same but more complete cases later on to see if their diagnoses changed when given more detailed information.

Another theme that childhood disorders can bring to light is that clinicians typically do not know whether diagnoses made in childhood are early forms of an adult disorder, separate disorders, or a bump on the developmental pathway (Paris, 2013). To answer this question, long-term prospective research is required (much like Molina et al.'s, 2009, 8-year follow-up of a large multisite trial for ADHD treatments), which is currently rare due to its great expense in

terms of time and money. Students can pair up to design their own longitudinal studies for any disorder and then present their brief research proposals to the class.

DSM Diagnosis of Posttraumatic Stress Disorder

Background

DSM-5 includes six significant changes to the criteria for posttraumatic stress disorder (PTSD), many of which open the door to engaging teaching points. First, PTSD has been moved out of the "Anxiety Disorders" section into a new section called "Trauma- and Stressor-Related Disorders." Second, the three major symptom clusters in the DSM-IV—*reexperiencing*, *avoidance/numbing*, and *arousal*—have morphed into four clusters in DSM-5: *avoidance* now constitutes its own cluster, while numbing symptoms are incorporated into a new cluster called *negative alterations in cognitions and mood*, which also includes three new symptoms (two cognitive and one emotional). Third, the *stressor* criterion (DSM-5 Criterion A) is more explicit regarding what constitutes experiencing a traumatic event and also includes a note that exposure through electronic media generally does not qualify. Fourth, the *subjective response* criterion (DSM-IV Criterion A2) that "the person's response [to the traumatic event] involved intense fear, helplessness, or horror" (APA, 2000, p. 467) has been removed. Fifth, the arousal cluster in DSM-5 is now called *marked alterations in arousal and reactivity*, and it includes a new symptom: reckless or self-destructive behavior. Sixth, separate criteria have been added for children age 6 years or younger.

The removal of PTSD from the Anxiety Disorders section and its placement into the new Trauma- and Stressor-Related Disorders section (along with Acute Stress Disorder, Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, and Adjustment Disorders) reflects researchers' evolving recognition that clinically significant maladaptive responses to

traumatic events can include a range of cognitive and affective disruptions beyond the well-established learned fear principle that drives most current models of the anxiety disorders. This recognition is underscored by the new major symptom cluster, "Criterion D: Negative alterations in cognitions and mood" (APA, 2013a, p. 271). Whereas four of the seven symptoms within this new DSM-5 cluster are essentially the familiar DSM-IV numbing symptoms (carried over from the DSM-IV avoidance/numbing symptom cluster), the other three of the seven are entirely new cognitive and affective symptoms:

> Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world; Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others; and Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame). (APA, 2013a, p. 272)

Beyond the descriptive level, the clinical differentiation of PTSD from anxiety rests partly on evidence of different etiology as well as different treatments. Although PTSD does share a set of risk factors with anxiety (genetic vulnerability, hyperactivity of the amygdala, childhood traumatic exposure, neuroticism, attention to negative cues in the environment, and behavioral conditioning), evidence suggests that PTSD development is also linked to several PTSD-specific factors, including small hippocampal volume and dissociation (Bremner et al., 2003). As the hippocampus plays a major role in the formation and consolidation of autobiographical memories, some researchers believe that PTSD might stem partly from a hippocampus-related deficient ability to process traumatic experiences into coherent verbal memories and narratives that would allow one to more effectively cope with trauma (Brewin & Holmes, 2003).

Teaching Suggestions

PTSD vs. anxiety disorders. A good initial focus for students is to have them contrast PTSD symptoms with those of the anxiety disorders. Relatedly, students can explore the seemingly subtle differences between two dominant empirically supported psychological treatments for these two syndromes: the exposure-centered cognitive-behavioral frameworks used across the range of anxiety disorders and PTSD and cognitive processing therapy (CPT; Chard, 2005) a recently developed PTSD-focused protocol. Although both types of treatment utilize exposure, they do so in service of different aims. In treating the various types of anxiety disorders, appropriate exposure facilitates unlearning the fear fueling the anxiety, whereas in CPT, exposure provides the individual with opportunities to adaptively process and understand traumatic experiences at both the cognitive and the emotional levels. Tying it all together, students can see how the DSM-5 separation of PTSD from the anxiety disorders plays out on the three interconnected planes of symptomology, etiology, and treatment.

DSM Diagnosis of Major Depressive Disorder

Background

In an effort to avoid pathologizing "normal" grief, DSM-IV discouraged clinicians from diagnosing depression after individuals experienced the death of a loved one. Known as "the bereavement exclusion," individuals meeting criteria for a depressive episode within 2 months of a major loss would not have been diagnosed with Major Depressive Disorder (MDD). The removal of this bereavement exclusion from DSM-5 has attracted much professional and public attention and has perhaps been one of the most controversial changes to the entire DSM. Students will learn much via careful consideration of this issue and its implications.

The rationale provided by the APA for removing the bereavement exclusion was three-fold: (a) depression is different from normal grief, (b) depression can and does sometimes occur

within 2 months of a major loss (and is sometimes actually precipitated by grief), and (c) there is no good scientific reason to ignore those cases of depression simply because they occur within that time-frame; in fact, leaving these individuals undiagnosed and possibly untreated obviously raises the potential for serious harm (APA, 2013b). To address the key issue of distinguishing depression from normal grief, DSM-5 includes a new detailed note within the Major Depressive Episode criteria outlining key differences between the two. For example, it notes that, in normal bereavement, emotional connection with significant others is preserved, self-esteem is preserved, suicidal ideation is uncommon, grief is mixed with positive feelings, the person is consolable, and the dysphoria is often experienced in waves triggered by memories of the deceased person. More generally, depression is intensely self-focused, whereas bereavement tends to involve focus on the deceased. Critics say that the DSM-5's distinctions between depression and normal grief are not sufficiently rooted in longitudinal data—and probably not even sufficiently understood—to justify removing the bereavement exclusion and that this change will lead to significant overdiagnosis of MDD in grieving individuals (Frances, 2013). To some, this problem is so glaringly obvious as to fuel suspicions that the social forces responsible for the widely lamented overmedicalizing of America have extended their reach into the DSM (Paris, 2013).

Teaching Suggestions

Understanding abnormality. It is likely beyond the scope of most undergraduate classes to thoroughly evaluate the decision to remove the bereavement exclusion, but students could benefit from using this issue as a framework for classroom discussions and written assignments on such topics as:

(1) The difficulty of deciding what to call normal and what to call abnormal when it comes to psychological functioning (which relates back to the changing definition of a mental disorder discussed above). Of course, this problem is a core issue in psychopathology and receives attention at the start of every relevant class; the depression/grief conundrum presents a rich opportunity to revisit the issue and add meat to the bones.

(2) The need to balance Type I and Type II error in diagnosis, given that minimizing false positives often comes at the expense of increasing false negatives (and vice versa). Many students will have already covered the basics of sensitivity and specificity, either in research/statistics classes or in other psychology classes. The challenge of adjusting the diagnostic net so that it catches depressed individuals but allows grieving people to swim free presents a vivid, real example of this issue that most students should find personally relevant.

(3) The broader social climate of skepticism regarding mental disorders, particularly in relation to widely voiced concerns about "Big Medicine," "Big Pharma," and the medicalizing of America discussed above.

(4) The shaping of popular opinions about mental health issues, including questions such as: What roles are played by the media? How well do laypeople understand the issues? What is our obligation as psychologists to educate the public?

Conclusion

Psychology instructors have a unique opportunity to introduce students to the scientific study of the causes, diagnosis, and treatment of mental disorders in classes such as Introductory, Clinical, or Abnormal Psychology. Most psychology textbooks will be or have been updated with DSM-5 categories to organize relevant material. But even though many current students will only ever learn DSM-5, the field of mental health will remain in a transition period for years

to come in which DSM-IV terms and categories will still be widely used. It is thus imperative for students to not just learn the new diagnostic criteria, but rather to understand the main differences and the genesis of this new edition of the diagnostic and statistical manual.

While psychology instructors can utilize the release of DSM-5 to update their teaching points, they can also use it to encourage students to reflect upon the current status of the field. Where do diagnostic categories come from? Is the attempt to categorize individuals using clusters of symptoms an accurate reflection of reality? Should the field work to create a comprehensive document that is more focused on etiology and/or treatment?

What will not change with the release of DSM-5 is the need to remind students that what psychologists call mental disorders are not the defining essences of a person. Diagnostic categories are constructed entities that only describe a piece of a person's functioning. Psychology instructors will continue to emphasize that the goal of any classification system, including DSM-5, is to understand psychological dysfunction enough to be of help.

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Appendix: A Class Case Study

Demonstrate your understanding of the DSM-5's definition of a mental disorder by writing a case study.

According to DSM-5,

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (APA, 2013, p. 20).

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Internet Gaming Disorder and *Caffeine Use Disorder* are both listed as Conditions for Further Study in DSM-5 (that is, at this point in time they are not considered mental disorders per se; more research is necessary to make such a determination). Craft a case study showing how an individual would fit the definition of having a mental disorder based on the use of video games or caffeine. Address whether you believe *Internet Gaming Disorder* or *Caffeine Use Disorder* should be included in future editions of the DSM (e.g., do you think these conditions are rightly conceptualized as mental disorders?).

Proposed diagnostic criteria for these conditions are available on our class webpage. Your case study should be approximately 2 pages, typed and double-spaced. It is worth 20 points and is due on the date noted in your syllabus.

Case Study Grading Criteria

	Excellent	**Good**	**Fair**	**Poor**	**COMMENTS**
Clear, specific, detailed, vivid description of individual with condition.	4	3	2	1	
Description of dysfunction in psychological, biological, or developmental processes	4	3	2	1	
Description of clinically significant disturbance in cognition, emotion regulation, or behavior.	4	3	2	1	
Discussion of inclusion of condition in DSM-6.	4	3	2	1	
Style/Format:					
Rules of grammar, spelling, and punctuation are followed	4	3	2	1	
TOTAL POINTS (20):					