DSM-5 Cross-Cutting Assessment for Adults
Frequently Asked Questions

1. Why are you developing a cross-cutting assessment?

Earlier reviews of DSM identified the heterogeneity of patients within specific diagnostic categories, the high use of NOS categories, and the overlap across diagnostic categories (Spectra Study Group). These reviews led to suggestions that patients should be assessed with dimensional measures on a range of areas to provide a richer characterization than the categorical diagnoses offer. Similarly, as the review of specific categories began, Work Groups identified areas outside their own focus that would be important to assess because they might influence treatment planning or response to treatment. Frequently cited examples include measures of mood and anxiety in psychotic conditions; measures of substance use in mood disorders; or measures of suicide risk in any disorder.

As a result of both types of interest, the Task Force meeting in March, 2009, asked the Study Group on Diagnostic Instruments to develop a cross-cutting assessment using dimensional measures that would be suitable for most patients in most clinical settings. (The development of a cross-cutting assessment for children and adolescents has a parallel track; most of this statement will emphasize the adult assessment).

2. Don't clinicians already take these points into consideration in a clinical examination, so this is just unnecessary and time-consuming work for them?

Providing a way to document these areas with dimensional measures is the fundamental goal for this cross-cutting assessment, and that is not part of routine clinical examinations now. We hope to accomplish it without adding to the clinician's burden; we also believe it will be helpful to clinicians. The quantitative information is intended to be useful to the clinician at the initial examination and periodically on follow-up. To minimize clinician burden, the emphasis has been on self-report by a patient or informant as much as possible.

In a careful diagnostic evaluation, these areas are typically considered and used in formulating a DSM diagnosis. Opinions differ about how well this formulation is conducted in routine practice, but even in a highly skilled, expert evaluation, we anticipate this dimensional information will be useful to a clinician, as recommended by the Spectra Study Group.

We also anticipate that incorporation of such cross-cutting ratings into clinical information systems will provide a stronger basis for studying such issues as long-term outcome in routine clinical practice.

3. Doesn't this approach lead to diagnostic output that would either devalue, or needlessly complicate, a clinician's examination?

No, the information from this assessment is intended to be interpreted by the clinician. It is expected to inform the diagnostic formulation and/or the treatment provided to a patient by the clinician. It does not yield diagnoses and cannot be used on its own without clinical judgment. It is expected to give clinicians quantitative information that can inform the initial evaluation and periodic follow-up visits.

4. Who dreamed up this list of areas to assess?

After considering the focus of their Work and Study Groups, and similar areas covered on the PROMIS initiative of NIH, the Task Force members generated a list of possible domains. After discussion and review, they ranked the importance of these domains, and an initial list was identified as having priority for the cross-cutting assessment. The current working list of these clinical areas for adults is attached. David Shaffer and Prudence Fisher have queried the relevant Work Groups to identify relevant domains for children and adolescents.

5. Why were my disorders left off the list?

The list is not intended to represent specific disorders, and it is not possible to make it extensive enough to cover all DSM clinical areas. Some areas that ranked lower in priority for "most patients in most settings" were thought more suitable for dimensional assessment once a diagnostic evaluation has been completed. Once any diagnosis has been assigned, specific areas relevant to that disorder will be evaluated with instruments suitable to the condition, whether or not there are any corresponding items on the cross-cutting assessment.

6. Why did you have to invent something new?

Although we have not found a single, brief instrument that would cover the domains identified by the Task Force, we have attempted to base this assessment as much as possible on prior work. Beyond the Level 1 items that we adapted from a range of other instruments, we are using the PROMIS paper and pencil versions for field testing as they offer the best established assessment of the several of the domains identified by Task Force members as important for mental disorder assessment. As part of the NIH Clinical Roadmap initiative, they also offer the basis for comparability with the rest of medicine. We expect that future approaches using computerized-adaptive testing will provide the basis for a brief assessment that offers more precision.

7. My area is much more important than you realize, and it needs to be represented by a lot more items on Level 1. How many can I add?

Our goal is to keep Level 1 as brief as possible. In constructing this first draft, we tried to use one item if possible, two if necessary, and three at the most. We hope that some items can be eliminated if they are shown to be expendable during the field trials or other tests. So, if you want to eliminate an item now, notify us immediately. If you want to substitute an item, we would be happy to hear from you. If you want to add items, wait for us to contact you….

8. Is Level 1 a screening test for DSM disorders?

No, it is not designed as a "screening test" and should not be used that way. It is not comprehensive, as it only covers clinical areas viewed as important or common in patients being seen with psychiatric disorders. It has not been designed to provide estimates of caseness for any specific disorder. We also want to emphasize that a clinician, not an instrument, makes the diagnosis.

9. What happens next?

A version for field testing will be distributed by December 15, 2009, after final review of suggested changes in the Level 1 items.