

# Evaluating Emerging Measures in the DSM-5 for Counseling Practice



The Professional Counselor  
Volume 4, Issue 3, Pages 216–231  
<http://tpcjnl.nbcc.org>  
© 2014 NBCC, Inc. and Affiliates  
doi:10.15241/els.4.3.216

Erika L. Schmit

Richard S. Balkin

The American Psychiatric Association introduced emerging measures to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* classification system. The authors present a primer on dimensional assessment and a review of the emerging measures endorsed by the American Psychiatric Association. The development of the emerging measures is discussed in light of the 1999 *Standards for Educational and Psychological Testing* and the *DSM-5* criteria, showing that the measures lack conformity to various evidences of validity and lack alignment with the *DSM-5* criteria. Hence, counselors should be cautious in the adoption of such measures because the measures may not augment comprehensively the categorical system of diagnosis currently endorsed by the American Psychiatric Association.

**Keywords:** diagnosis, dimensional assessment, *DSM-5*, measures, American Psychiatric Association

Historically, counselors relied on the categorical system of diagnosis employed by the American Psychiatric Association (APA) and included in the variations of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Jones (2012) highlighted the introduction of dimensional measures for diagnosis in the fifth edition of the *DSM (DSM-5)*. Whereas a categorical approach to diagnosis classifies a diagnosis as either present or absent, a dimensional approach to diagnosis entails using measures to evaluate the extent to which symptoms exist (Jones, 2012). Hence, the dimensional approach provides a continuum to evaluate symptoms, whereas a categorical system does not. The APA (2013g) affirmed that the measures in the *DSM-5* are to be used in conjunction with other diagnostic materials and that they are designed to provide a dimensional approach to diagnosis, as opposed to a categorical approach. The purpose of this article is to review the dimensional measures in conjunction with diagnostic criteria and standards for psychological measures.

The dimensional approach to diagnosis does have certain advantages, such as the ability to address comorbid symptoms and an increased utility in research (Bjelland et al., 2009; Jones, 2012; Kraemer, Noda, & O'Hara, 2004). However, categorical approaches to diagnosis are more easily operationalized (Bjelland et al., 2009) and dimensional diagnoses can be converted easily to cut-points to provide a categorical system (Kraemer et al., 2004). Clinical utility is a primary concern with implementing dimensional classifications for diagnoses (Livesley, 2007). With respect to the medical model, physicians diagnose and treat an illness; hence, an illness is present (and therefore treated) or is not present. Dimensional diagnoses present a different paradigm in which a disorder exists on a continuum. If a disorder is only somewhat present, the justification for treatment often becomes ambiguous, and consequently, the processes of charting the course of the diagnosis and conducting

---

Erika L. Schmit is a doctoral student at Texas A&M University – Corpus Christi. Richard S. Balkin, NCC, is an Associate Professor and Assistant Dean at Texas A&M University – Corpus Christi. Correspondence can be addressed to Erika L. Schmit, Texas A&M University – Corpus Christi, Counseling and Educational Psychology Department, College of Education, ECDC 232, 6300 Ocean Drive, Unit 5834, Corpus Christi, TX 78412-5834, erikalschmit@gmail.com.

research become ambiguous as well. However, given the propensity of researchers to utilize instruments that measure constructs on a continuum, dimensional classifications may offer a method of demonstrating variability within a diagnosis (Helzer, van den Brink, & Guth, 2006). Dimensional classifications may be more helpful in measuring symptoms related to personality disorders (Livesley, 2007), anxiety and depression (Bjelland et al., 2009), and substance use (Helzer et al., 2006), due to the employment of different treatment modalities based on symptom severity. For example, medication management may not be considered with mild depression even though it may be effective; however, it may become a stronger consideration with moderate or severe depression (Stewart, Deliyannides, Hellerstein, McGrath, & Stewart, 2012).

Livesley (2007) advocated for integrating categorical and dimensional classifications for diagnoses. However, Helzer et al. (2006) indicated that a dimensional diagnosis must be associated with the operational definition of the said diagnosis, which implies that dimensional assessments must address the appropriate content to obtain a valid measure of the intended classification (i.e., diagnosis). What follows is an overview of evidences of validity for measures and an evaluation of dimensional measures advocated by the APA (2013g).

### Cross-Cutting Symptom Measures

The APA (2013g) provided a section in the *DSM-5* titled “Emerging Measures and Models” (p. 729) that contained “tools and techniques to enhance the clinical decision-making process, understand the cultural context of mental disorders, and recognize emerging diagnoses for further study” (p. 731). At the forefront of this section the APA introduced *cross-cutting symptom measures* (CCSMs), which are utilized for consideration across diagnostic symptoms. The *DSM-5* only includes a few CCSMs, but the APA’s website (2014) offers access to a comprehensive list of CCSMs. CCSMs include two levels; Level 1 is concise, including 1–4 items on each domain, while Level 2 is more comprehensive, including a measure for each domain. The Level 1 CCSMs are more general measures that include symptoms across domains consistent with common diagnostic categories (e.g., depression, anxiety; APA, 2013g) and assess a wider scope of time (i.e., two weeks). The Level 1 CCSMs are designed for adults (23 items across 13 domains) or children (25 items across 12 domains). Adults and children/adolescents between the ages of 11 and 17 may complete self-report versions. A parent/guardian version is available for children between the ages of 6 and 17.

The Level 2 CCSMs are utilized after finding threshold scores from Level 1 measures. Level 2 measures contain more detailed symptom investigation that can help with diagnosis and treatment, including assessment of a shorter time period (i.e., 7 days). Level 2 measures include such symptoms as depression, anger, mania, anxiety, somatic symptoms, sleep disturbance, repetitive thoughts and behaviors, substance abuse, inattention, and irritability. Certain measures address how often the individual has been bothered by a symptom within a time period of 7 days, and others ask the individual to pick a statement in a cluster that best represents the way he or she has been feeling within the past 7 days. Similar to the Level 1 measures, adults and children/adolescents between the ages of 11 and 17 may complete a self-report version; a parent/guardian version is available for children between the ages of 6 and 17. These measures are to be used at the early stages of treatment and throughout the treatment process.

When comparing the Level 2 measures advocated by the APA (2013g) to the emotional and behavioral symptoms included in the *DSM-5* diagnoses, many crucial criteria are absent, thereby inadequately addressing validity evidence based on test content. This dearth of missing criteria may indicate a lack of consistency between the measures and the *DSM-5* diagnostic criteria. Furthermore, the Level 2 measures focus more on specific symptoms than on actual diagnoses. For example, the CCSMs include assessments of anger, which is a symptom of many disorders in the *DSM-5*, but not a disorder itself. In addition, common psychometric properties, such as the reporting of reliability estimates of the scores, are not readily apparent, if published at all.

Therefore, standards related to the alignment of the instruments with *DSM* symptoms (i.e., evidence based on test content) are circumspect. As Helzer et al. (2006) reported, the dimensional approach to diagnosis must align with the definition of the diagnosis in the *DSM-5*.

### **Connecting Validity Standards to CCSMs**

Pertinent to the utilization of the emerging measures for the purposes of diagnosis and clinical decision making is the extent to which the measures align with diagnostic criteria and are useful. The American Educational Research Association (AERA), the American Psychological Association, and the National Council on Measurement in Education (NCME) jointly publish the *Standards for Educational and Psychological Testing*. AERA et al. (1999) outlined issues related to instrument development, fairness and bias, and application of results to various settings (e.g., educational, vocational, psychological). With respect to evaluating research, issues of test construction, specifically evaluating validity and reliability, need to be addressed. According to AERA et al., "validity refers to the degree to which evidence and theory support the interpretations of test scores entailed by proposed uses of test" (1999, p. 9). Validity, therefore, is not simply about the alignment of an instrument with theory and research, but also about how the scores are used. The most recent edition of the standards was published in 1999, which represented the fourth edition of the joint publication and the sixth publication by at least one of the representative bodies. As of August 2013, AERA et al. approved a revision to the 1999 *Standards*; however, a publication date is pending the development of a new agreement regarding how the revised *Standards* will be managed and published (AERA et al., 2009). Thus, the 1999 *Standards* represent the most current edition for measurement guidelines.

AERA et al. (1999) identified five evidences for evaluating the validity of a measure: (a) evidence based on test content, (b) evidence based on response processes, (c) evidence based on internal structure, (d) evidence based on relationships to other variables and (e) evidence based on consequences of testing. *Evidence based on test content* is specifically related to the extent to which the items are aligned with existing theory and the operational definition of the construct. Evidence of test content often is established through documentation of a review of extant literature and expert review. *Evidence based on response processes* includes an analysis of how respondents answer or perform on given items. In counseling research, some documentation about how respondents interpret the items may be noted. *Evidence based on internal structure* refers to the psychometric properties of the instrument. For example, items on a scale should be correlated as they measure the same construct, but they should not be overly correlated, as that could indicate that the items are not measuring anything unique. Generally, factor analysis and reliability estimates are used to indicate adequate factor structure and accurate and consistent responses for scores. *Evidence based on relationships to other variables* is usually demonstrated through some type of correlational research in which the scores on an instrument are correlated with scores on another instrument. Hence, how an instrument correlates to another instrument provides evidence that the same construct is being measured. *Evidence based on consequences of testing* refers to the need to document the "intended and unintended consequences" of test scores (AERA et al., 1999, p. 16). The choice of using scores on an instrument should be aligned with theory and practice.

### **Evidence of Validity for the Emerging Measures**

To address the psychometric properties of each of the measures is outside the scope of this article. The APA promoted various measures with common psychometric properties reported extensively in research, while other measures' psychometric properties were not as evident (Aldea, Rahman, & Storch, 2009; Allgaier, Pietsch, Frühe, Sigl-Glöckner, & Schulte-Körne, 2012; Altman, Hedeker, Peterson, & Davis, 1997; Feldman, Joormann, & Johnson, 2008; Han et al., 2009; Livianos-Aldana & Rojo-Moreno, 2001; Storch et al., 2007; Storch et al., 2009; Stringaris et al., 2012; Titov et al., 2011). From the reported measures, fairly strong psychometric properties were apparent. However, not all of the measures promoted have extensive reports (e.g., PROMIS

measures). In addition, some measures do not adequately parallel the *DSM-5* diagnoses that one might expect. The following sections include detailed comparisons of emerging measures and their corresponding *DSM-5* diagnoses. The overall purpose of this manuscript is to identify the measures' level of congruency with *DSM-5* criteria. Thus, counselors need to be aware that certain measures may provide different information about a disorder, and therefore, counselors should make informed choices regarding whether to follow the *DSM-5*'s criteria. The *DSM-5* criteria are a major source for providing diagnoses; and counselors should be cautious when interpreting measures, particularly when the measures are inconsistent with *DSM-5* criteria.

**Emotional Measures.** When comparing the symptoms on the PROMIS Emotional Distress—Depression—Short Form (PROMIS Health Organization [PHO] and PROMIS Cooperative Group, 2012g) for adults to symptoms in the *DSM-5* on depressive disorders, the former seems to lack many crucial symptoms for depression (APA, 2013g). Containing eight statements—each asking how often the individual has been bothered by the symptom with a time period of 7 days—the measure lacks clarity as to what depression actually looks like. Common symptoms of depression such as lack of pleasure in activities, lack of appetite, weight loss, sleep loss, fatigue and thoughts of death are not addressed. The APA (2013g) noted that irritability can be a mood shown in children with the diagnoses. The parent and pediatric measures (PHO and PROMIS Cooperative Group, 2012h; 2012i) fail to include the aforementioned mood symptom, nor do they mention thoughts of death. Therefore, the *DSM-5* criteria for depression appear to be more inclusive than the PROMIS Short Form criteria.

The PROMIS Emotional Distress—Anger—Short Form, the PROMIS Emotional Distress—Calibrated Anger Measure—Pediatric, and the PROMIS Emotional Distress—Calibrated Anger Measure—Parent (PHO and PROMIS Cooperative Group, 2012a, 2012b, 2012c) are comprised of five to six short statements (e.g. "I felt angry") completed on a 1 (*never*) to 5 (*always*) scale. Anger is included in many diagnoses, but the closest example in the *DSM-5* is the chapter titled "Disruptive, Impulse-Control, and Conduct Disorders," whose disorders can include angry moods (APA, 2013g, p. 461). Although this chapter of the *DSM-5* is most likely intended for children and adolescents, all the criteria listed in the *DSM-5* for angry/irritable mood from the diagnosis of oppositional defiant disorder (ODD) are included in the PROMIS measures for anger. Furthermore, because anger is present in many diagnoses in *DSM-5*, all measures can be helpful in providing information on anger depiction with individuals.

The PROMIS Emotional Distress—Anxiety—Short Form (PHO and PROMIS Cooperative Group, 2012d) for adults includes seven items that measure symptoms observed in an individual experiencing anxiety (e.g., "I felt anxious," "I felt fearful"). The adult measure examines both the feelings of anxiety and fear but, unlike the child measure, omits specific places or situations where fear or anxiety is experienced. The pediatric and parent measures (PHO and PROMIS Cooperative Group, 2012e, 2012f) are more detailed, examining a few situations and places (e.g., home and school) while the adult measure (PHO and PROMIS Cooperative Group, 2012d) examines only feelings associated with anxiety (e.g., fearful, anxious, worried). When comparing anxiety measures to *DSM-5* criteria, the measures lack many important criteria, particularly the adult measure which focuses on specific feelings only.

Mania is a symptom most often seen in bipolar and related disorders in the *DSM-5* (APA, 2013g). The Altman Self-Rating Mania Scale (ASRM; Altman et al., 1997) is utilized for mania depiction. The five clusters focus on happiness, self-confidence, sleep, talk and activeness. When compared to the *DSM-5* criteria for mania, the ASRM is lacking in certain areas such as distractibility, racing thoughts and high-risk activity involvement (APA, 2013g). Also, the ASRM does not address the importance of an irregular mood disturbance (i.e. elevated, expansive or irritable). The measure does not encompass all symptoms needed for mania, whereas the *DSM-5* criteria are more expansive.

**Behavioral Measures.** The somatic symptom measures, which were modified from the Patient Health Questionnaire Physical Symptoms (PHQ-15; Spitzer, Williams, & Kroenke, n.d.-a, n.d.-b, n.d.-c), examine different somatic symptoms and the frequency of each symptom in a given week. The modified somatic symptom measures inform the individual and his or her clinician of the severity of symptoms such as headaches, shortness of breath and stomach pain. The main difference between the symptoms measured by the scales and those discussed in the “Somatic Symptom and Related Disorders” chapter of the *DSM-5* is that the scales do not include any analysis of the excessive thoughts and feelings associated with the somatic symptoms (APA, 2013g, p. 309). The modified somatic symptom measures tell the client or clinician if and how much a symptom is present, but unlike the *DSM-5* criteria, they do not focus on the individual’s actual concern over the symptom. The *DSM-5* is not focused on the child population for most somatic disorders, but it does describe the most common symptoms of somatic symptom disorder as abdominal pain, headaches, fatigue and persistent nausea. Children can exhibit somatic symptoms, but they rarely worry about these symptoms before adolescence (APA, 2013g). The adult, child and parent/guardian versions of the somatic symptom measure are similar, but with two exclusions on the child and parent/guardian version (“menstrual cramps or other problems with your periods WOMEN ONLY” and “pain or problems during sexual intercourse”; Spitzer et al., n.d.-a, n.d.-b, n.d.-c).

The PROMIS—Sleep Disturbance—Short Forms (PHO and PROMIS Cooperative Group, 2012j, 2012k, 2012l) are utilized to determine sleep issues in the past week. The measures contain such questions as “my sleep was refreshing” and “I had trouble sleeping” (PHO and PROMIS Cooperative Group, 2012j, 2012k). The sleep-wake disorders in the *DSM-5* include individual discontent with sleep, which can result in distress and impairment (APA, 2013g). Therefore, the PROMIS measures lack in that they do not have statements regarding whether the sleep disturbance is affecting the individual’s life negatively. The *DSM-5* (APA, 2013g) does include different manifestations of certain symptoms for children (e.g., a child may struggle to fall asleep without a caregiver). Symptoms in children can occur because of particular situations such as inconsistent sleep schedule and conditioning issues. The onset of some sleep disorders happens in late adolescence or adulthood, with the exception of narcolepsy, which has an average onset in childhood and adolescence/young adulthood. Also, nightmare disorder happens most often in children and adolescence (APA, 2013g).

The repetitive thoughts and behaviors measures, which were adapted from the Florida Obsessive-Compulsive Inventory (FOCI) Severity Scale (Part B) and the Children’s Florida Obsessive-Compulsive Inventory (C-FOCI) Severity Scale, each include five items directing the individual to rate each question. The questions are focused on time, distress, control, avoidance and interference of the thoughts or behaviors (Goodman & Storch, 1994a, 1994b). The “Obsessive-Compulsive and Related Disorders” chapter in the *DSM-5* examines main symptoms such as obsessions and compulsions (APA, 2013g, p. 235). Although the *DSM-5* specifically identifies the symptoms as obsessions and compulsions, the adaptations of the FOCI and C-FOCI identify the symptoms as simply thoughts and behaviors. The FOCI and C-FOCI include fairly similar symptoms of obsessive-compulsive disorder with simpler terms and language. The FOCI does not include the anxiety portion, but does ask about distress. Also, the FOCI and C-FOCI do not include a specific repetitive behaviors component (Goodman & Storch, 1994a, 1994b). For the most part these two measures are very similar. Each of the five questions is focused on the same topic; the minor difference is language. For example, the adult scale asks how much distress the thoughts/behaviors cause, while the child version asks how much they bother the child. The adult measure utilizes the word *work* while the child measure uses the word *job* (Goodman & Storch, 1994a, 1994b). The measures have components similar to *DSM-5* criteria, but there are inconsistencies between the two.

The Level 2—Substance Use—Adult measure, adapted from the National Institute on Drug Abuse (NIDA)-Modified ASSIST (NIDA, n.d.-a), includes 10 items that measure how often an individual used a substance in

the past two weeks. The substances included are painkillers, stimulants, sedatives or tranquilizers, marijuana, cocaine or crack, club drugs, hallucinogens, heroin, inhalants or solvents, and methamphetamine. The interviewee answers from 0–4 based on how many days the substance is used. The measure does not include alcohol, tobacco or caffeine as substances (NIDA, n.d.-a). In *DSM-5*, the chapter “Substance-Related and Addictive Disorders” focuses on substance addictions as well as process or behavioral addictions (APA, 2013g, p. 481). The Level 2—Substance Use—Adult measure and the criteria for substance use disorders in the *DSM-5* have very little in common besides the use of a substance. The *DSM-5* contains topics such as intoxication, withdrawal, social impairment, risky use, behavioral issues, psychological issues and all of their related symptoms (APA, 2013g). The possible symptoms of substance use are important to examine when treating an individual who has used a substance, and therefore the expanded criteria of the *DSM-5* are necessary. The parent and child versions (NIDA, n.d.-b, n.d.-c) of the substance use measures (15 items each) are longer than the adult version (10 items). The parent and child versions include tobacco, alcohol, steroids and other medicines, while the adult version does not. None of the above measures examine caffeine use (NIDA, n.d.-a, n.d.-b, n.d.-c).

The Swanson, Nolan, and Pelham, version IV (SNAP-IV; Swanson, 2011) for inattention in children aged 6–17 is an eight-item measure answered by a parent or guardian of the child. The items can be answered on a scale of 0 (*not at all*) to 3 (*very much*). The items center on the lack of attention to certain people, items and behaviors, such as organizing tasks, paying attention to details, and being distracted (Swanson, 2011). Inattention in children is included in the attention-deficit/hyperactivity disorder in the *DSM-5* (APA, 2013g, p. 59). Items 1–8 on the SNAP-IV (Swanson, 2011) are worded very similarly to the inattention items in the *DSM-5* (APA, 2013g), with only minor changes. The only *DSM-5* item not included in SNAP-IV regards forgetfulness of daily activities (APA, 2013g). The SNAP-IV measure and the *DSM-5* criteria appear to be relatively equal in diagnostic usefulness.

The irritability measures, identified as Affective Reactivity Index (ARI; Stringaris et al., 2012), for parent/guardian of child age 6–17 and child age 11–17, contain the same items and are rated either 0 (*not true*), 1 (*somewhat true*), or 2 (*certainly true*). Anger is a topic used in three of the seven items. Other main topics include annoyance, temper and irritability (Stringaris et al., 2012). The irritability measures can be compared to the “Angry/Irritable Mood” section of the ODD diagnosis in *DSM-5* (APA, 2013g, p. 462). The three criteria here are included in each measure, making both resources useful.

**Disorder-Specific Severity Measures.** The disorder-specific severity measures are similarly complementary to diagnostic criteria in the *DSM-5* and are made for those who have met or are close to meeting a diagnosis. The two types of measures included are self-administered (adult and child age 11–17) and clinician-administered. Disorders included in the self-administered measures are depression, separation anxiety disorder, specific phobia, social anxiety disorder (social phobia), panic disorder, agoraphobia, generalized anxiety disorder, post-traumatic stress symptoms, acute stress symptoms, and dissociative symptoms (APA, 2014). Disorders and symptoms included in the clinician-administered measures are autism spectrum and social communication disorders, psychosis symptoms, somatic symptom disorder, ODD, conduct disorder, and nonsuicidal self-injury (APA, 2013b, 2013a, 2013f, 2013e, 2013c, 2013d).

Generally, the disorder-specific severity measures have a different time frame for meeting criteria for symptoms than the *DSM-5* does and do not discuss significant distress or proportion to danger. Few, if any, differences exist between the adult and child measures. The clinician-rated measures are short and lack clarity on definitions. For example, the measures on ODD as well as nonsuicidal self-injury do not include the construct definitions (APA, 2013e, 2013d).

**Self-Administered Measures.** The Severity Measure for Depression—Adult and Severity Measure for Depression—Child Age 11–17 (Spitzer et al., n.d.-d, 2002), which were adapted from the Patient Health Questionnaire-9 (PHQ-9), include nine items rated from 0 (*not at all*) to 3 (*nearly every day*) with a time period of the past 7 days. The first two items on these measures are similar to the first two symptoms needed for major depressive disorder in the *DSM-5*, both referring to depressed mood and decreased interest or pleasure (APA, 2013g). These measures include somewhat of a weight component similar to that of the *DSM-5*, although the weight items on the measures examine appetite/overeating, while symptoms in the *DSM-5* examine an extra component of weight loss/gain or appetite changes. The components regarding sleeping and psychomotor symptoms, fatigue, worthlessness, concentration and thoughts of death on the measures are all similar to criteria in the *DSM-5*, although worded differently. Irritability is added to an item on the child measure (Spitzer et al., 2002), but was not included in the adult measure (Spitzer et al., n.d.-d). The child measure's item on eating refers to “poor appetite, weight loss, or overeating,” (Spitzer et al., 2002) whereas the adult measure does not mention weight loss (Spitzer et al., n.d.-d); similarly, one *DSM-5* criterion for major depressive disorder states, “in children, consider failure to make expected weight gain” (APA, 2013g, p. 161). In spite of a few differences, the Severity Measures for Depression are mostly consistent with *DSM-5* criteria for major depressive disorder.

The Severity Measure for Separation Anxiety Disorder—Adult and Severity Measure for Separation Anxiety Disorder—Child Age 11–17 (Craske et al., 2013g, 2013h) include 10 items examining the past 7 days based on a scale of 0 (*never*) to 4 (*all of the time*). The statements focus on separation and thoughts, behaviors and feelings behind the separation (Craske et al., 2013g, 2013h). The 10 items from the measure are mostly similar to criteria for separation anxiety disorder in the *DSM-5* (APA, 2013g). Items 1 and 2 on the measures (which refer to terror, fear, fright, anxiety, worry and nervousness) appear similar to the distress from separation criteria in the *DSM-5* with different wording. Thoughts of bad things happening, avoidance of places, physical symptoms of anxiety and difficulty sleeping are similar criteria to those in the *DSM-5*. The four items included in the measures but not in the *DSM-5* criteria are as follows: “when separated, left places early to go home,” “spent a lot of time preparing for how to deal with separation,” “distracted myself to avoid thinking about being separated,” and “needed help to cope with separation” (Craske et al., 2013g, 2013h). Although these measures and the *DSM-5* contain similar criteria for separation anxiety disorder, the measure includes items that may not be congruent to *DSM-5* criteria.

The Severity Measure for Specific Phobia—Adult and Severity Measure for Specific Phobia—Child Age 11–17 (Craske et al., 2013k, 2013l) have 10 items that include five different groups of phobias, including (a) driving, flying, tunnels, bridges or enclosed spaces; (b) animals or insects; (c) heights, storms or water; (d) blood, needles or injections; and (e) choking or vomiting. The individual completing the form chooses one phobia and answers items according to that phobia on a scale of 0 (*never*) to 4 (*all of the time*; Craske et al., 2013k, 2013l). The measures include more items than the criteria in the *DSM-5*. Items 1 and 2 (terror, fear, fright; anxiety, worry, nervousness) on the measures resemble criterion A (fear or anxiety) in the *DSM-5* for specific phobia (APA, 2013g, p. 197). Physical symptoms (e.g., racing heart, tense muscles) are not included in the *DSM-5* criteria. Avoidance of a situation is included both in the measures and in the *DSM-5*. The items in the measures which are not included in the *DSM-5* are “spent a lot of time preparing for, or procrastinating about (i.e., putting off), these situations,” “distracted myself to avoid thinking about these situations” and “needed help to cope with these situations” (Craske et al., 2013k, 2013l). The specifiers in the *DSM-5* (animal, natural environment, blood-injection-injury, situational and other) are similar to phobias included in the measures (APA, 2013g, p. 198). The *DSM-5* states that “in children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging” (APA, 2013g, p. 197), and this information is not included in the child version of this measure.

The Severity Measure for Social Anxiety Disorder (Social Phobia)—Adult and Severity Measure for Social Anxiety Disorder (Social Phobia)—Child Age 11–17 (Craske et al., 2013i, 2013j) are 10-item measures completed on a scale of 0 (*never*) to 4 (*all of the time*). The social situations described in the measures are the same as those described in the *DSM-5* for social anxiety disorder (social phobia; APA, 2013g). Items 1, 2 and 3 on the measures are similar to criteria A and B in the *DSM-5*. Physical symptoms such as racing heart and tense muscles are included in the measures but are not included in the *DSM-5* criteria. Avoidance of social situations is included in both the measures and the *DSM-5* criteria. There are items included in the measures that are not included in the *DSM-5* criteria, such as “spent a lot of time preparing what to say or how to act in social situations” and “distracted myself to avoid thinking about social situations” (Craske et al., 2013i, 2013j). One *DSM-5* criterion states that “the social situations almost always provoke fear or anxiety” (APA, 2013g, p. 202), an item which is not present in the measures. In the *DSM-5* there are a few differences for children with social anxiety disorder. Anxiety has to take place with peers and not only with adults. Furthermore, fear/anxiety can be expressed through crying, tantrums, freezing, clinging, shrinking or not speaking. These differences are not included in the child version of the measure (Craske et al., 2013j).

The Severity Measure for Panic Disorder—Adult and Severity Measure for Panic Disorder—Child Age 11–17 (Craske et al., 2013e, 2013f) are 10-item measures completed on a scale of 0 (*never*) to 4 (*all of the time*). The measures provide a definition and the symptoms of a panic attack in an individual (Craske et al., 2013e, 2013f). This information is similar to the definition of panic disorder in the *DSM-5* (APA, 2013g). The measures include six of the 13 symptoms included in the *DSM-5*. Items on the measures that are not included in the *DSM-5* criteria include “left situations early, or participated only minimally, because of panic attacks,” “spent a lot of time preparing for, or procrastinating about (putting off), situations in which panic attacks might occur,” “distracted myself to avoid thinking about panic attacks” and “needed help to cope with panic attacks” (Craske et al., 2013e, 2013f). The *DSM-5* includes certain symptoms that the measures do not, including choking feelings, pain in chest, nausea, sensations of chills or heat, sensations of numbness or tingling, and derealization or depersonalization (APA, 2013g, p. 208). The measures have an item on sleeping issues, which was not included in the *DSM-5*.

The Severity Measure for Agoraphobia—Adult and Severity Measure for Agoraphobia—Child Age 11–17 (Craske et al., 2013a, 2013b) are 10-item measures to be completed on a scale of 0 (*never*) to 4 (*all of the time*). The instructions for the measures include situations on which to base the items (e.g., being in crowds or public spaces, traveling). The criteria for agoraphobia in the *DSM-5* include significant distress caused by at least two of the following five situations: “being outside of the home alone,” “using public transportation,” “standing in line or being in a crowd” and being in “open spaces” and/or “enclosed spaces” (APA, 2013g, p. 217). The fear and anxiety experienced and the avoidance of situations are included in both the measures and the *DSM-5* criteria. Although avoidance is included in the measures, the reason for the avoidance is not. Items included in the measures but not in the *DSM-5* criteria include “had thoughts about panic attacks, uncomfortable physical sensations, getting lost, or being overcome with fear in these situations”; “spent a lot of time preparing for, or procrastinating about (putting off), these situations”; “distracted myself to avoid thinking about these situations”; and “needed help to cope with these situations” (Craske et al., 2013a, 2013b). Also, two items on physical sensations from the measures are not present in the *DSM-5* criteria (APA, 2013g; Craske et al., 2013a, 2013b).

The Severity Measure for Generalized Anxiety Disorder—Adult and Severity Measure for Generalized Anxiety Disorder—Child Age 11–17 (Craske et al., 2013c, 2013d) are 10-item scales completed on a scale from 0 (*never*) to 4 (*all of the time*). Differences are found when comparing the measures to generalized anxiety disorder in the *DSM-5* (APA, 2013g). The measures do not include the following *DSM-5* criteria: anxiety

and worry occurring for 6 months or more, difficulty controlling worry, the anxiety and worry perhaps being associated with difficulty concentrating and irritability, and the anxiety and worry causing distress (APA, 2013g, p. 222). The measures include the following items that the *DSM-5* does not: “avoided, or did not approach or enter, situations about which I worry”; “left situations early or participated only minimally due to worries”; “spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries”; “sought reassurance from others due to worries”; and “needed help to cope with anxiety” (Craske et al., 2013c, 2013d). Also, item 3 on the measures (“had thoughts of bad things happening”) is similar to criterion A in the *DSM-5* (“anxiety and worry . . . about a number of events or activities”) with different wording (APA, 2013g, p. 222; Craske et al., 2013c, 2013d).

The National Stressful Events Survey PTSD Short Scale (NSESSS; Kilpatrick, Resnick, & Friedman, 2013c) contains nine items and is to be completed on a scale of 0 (*not at all*) to 4 (*extremely*). The criteria for post-traumatic stress disorder (PTSD) in the *DSM-5* include a list of possible stressful events and situations (APA, 2013g). The NSESSS does not include a list of stressful events and situations for the individual. Criteria and items that are the same or similar on the NSESSS and in *DSM-5* PTSD criteria include flashbacks, emotional (NSESSS) or psychological distress (*DSM-5*), avoidance, negative feelings about self, distorted cognitions and blame, negative emotional states, loss of interest in activities, anger and irritability, self-destructive behavior, hypervigilance and startle response (APA, 2013g; Kilpatrick et al., 2013c). The items/criteria may be worded and/or organized differently but they have the same meaning. Although all items on the NSESSS are included in the *DSM-5*’s criteria for PTSD, the *DSM-5* includes additional criteria beyond what the NSESSS measures, which suggests the *DSM-5* as being more thorough of the two, and indicates the inconsistencies of the NSESSS when compared to the *DSM-5* criteria. The following criteria from the *DSM-5* are not included in the NSESSS: dreams, physiological reactions, dissociative amnesia, detachment/estrangement from others, inability to experience positive emotions, concentration issues and sleep issues. There are notes in the *DSM-5* for application to children. Children may partake in recurring play/reenactment having to do with the traumatic event. Dreams with unrecognizable content may occur (APA, 2013g). The criteria above were not included in the child version of the NSESSS (Kilpatrick, Resnick, & Friedman, 2013d). Also, the *DSM-5* has a different section for children 6 and under, but the NSESSS is to be completed by children 11–17 (APA, 2013g; Kilpatrick et al., 2013d).

The National Stressful Events Survey Acute Stress Disorder Short Scale (NSESSS; Kilpatrick et al., 2013a) for severity of acute stress symptoms includes seven items and is to be completed on a scale of 0 (*not at all*) to 4 (*extremely*). Six out of the seven items on this measure are the same as those on the measure for PTSD above. Items that are also included in acute stress disorder in the *DSM-5* are flashbacks, emotional (NSESSS) or psychological distress (*DSM-5*), detachment, avoidance, hypervigilance, startle response and irritability/anger (APA, 2013g). Similar to the NSESSS for PTSD, all seven items on the NSESSS for acute stress disorder are included in the *DSM-5* criteria, but certain *DSM-5* criteria are not included in the NSESSS. The criteria not included are as follows: dreams, inability to experience positive emotions, dissociative amnesia, sleep disturbance and concentration issues. There are notes in the *DSM-5* for application to children. Children may partake in recurring play/reenactment having to do with the traumatic event. Dreams with unrecognizable content may occur. The criteria above were not included in the child version of the NSESSS (Kilpatrick et al., 2013b). Neither of the NSESSS measures fully assess an individual for the *DSM-5* criteria for PTSD or acute stress disorder.

The Brief Dissociative Experiences Scale (DES-B)—Modified (Dalenberg & Carlson, 2010a) has eight items and is completed on a scale of 0 (*not at all*) to 4 (*more than once a day*) in the past 7 days. When comparing this measure to dissociative disorders in the *DSM-5*, it is hard to find a specific criterion that matches closely to

items on the scale (APA, 2013g, p. 291). The closest criterion is found under dissociative identity disorder (DID; APA, 2013g). Although the wording is different, disruption of identity and gaps in recollections are both present in the DES-B and *DSM-5* criteria for DID. Some items on the DES-B are also included in depersonalization/derealization disorder (APA, 2013g, p. 302). Both depersonalization and derealization symptoms are included in DES-B. There is one note under DID in the *DSM-5* applicable to children: symptoms in children are not better justified by imaginary or fantasy play. This is not included in the child version of the DES-B (Dalenberg & Carlson, 2010b). Although items included in the measures are present in *DSM-5* criteria, overall, the measures are inconsistent with *DSM-5* criteria.

**Clinician-Rated.** The Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders is a measure that assesses “the level of interference in functioning and support required as a result of: a) any social communication problems AND b) any restricted interests and repetitive behaviors” (APA, 2013b). The two disorders included are autism spectrum disorder (APA, 2013g, p. 50) and social (pragmatic) communication disorder (APA, 2013g, p. 47). The clinician must choose one of these disorders. The clinician rates the two items above (social communication and restricted interests /repetitive behaviors) based on levels 0 (*none*), 1 (*mild; requiring support*), 2 (*moderate; requiring substantial support*), and 3 (*severe; requiring very substantial support*). The measure does not go into detail about these disorders’ diagnostic criteria, but the *DSM-5* offers a detailed account (APA, 2013b, 2013g). Besides simply stating the two issues above, the measure fails to include specific criteria from the *DSM-5*.

The Clinician-Rated Dimensions of Psychosis Symptom Severity (APA, 2013a) is a measure that rates symptoms of psychosis based on presence and severity in the last 7 days. The eight domains included in the measure are hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, negative symptoms (restricted emotional expression or avolition), impaired cognition, depression and mania. The clinician rates the symptoms either 0 (*not present*), 1 (*equivocal*), 2 (*present, but mild*), 3 (*present and moderate*) or 4 (*present and severe*; APA, 2013a). According to the *DSM-5*, the five main features of psychotic disorders include delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms (APA, 2013g, pp. 96, 99). These main features are included in the measure as well as three others. Schizophreniform disorder (APA, 2013g, p. 96) and schizophrenia (APA, 2013g, p. 99) include the five main features for criteria in the *DSM-5* but not the last three included in the measure, which are impaired cognition, depression and mania (APA, 2013a). Other disorders, such as depressive or bipolar disorders with psychotic features, would include either a depressive or manic symptom (APA, 2013g, 2013a). Because the measure assesses psychosis symptoms that are consistent with *DSM-5*, this measure could be useful in determining severity but not consistent with any specific diagnosis.

The Clinician-Rated Severity of Somatic Symptom Disorder (APA, 2013f) includes three items in which the clinician rates somatic symptoms based on presence and severity in the last 7 days. The scale is to be completed from 0 (*not at all*) to 4 (*very much*). The main themes of the three questions are concerns, anxiety, and time and energy (APA, 2013f). The somatic symptom disorder in the *DSM-5* includes the three themes above in criterion B with similar wording, but also includes criteria not present in the measure (APA, 2013g, p. 311), so the measure is again inconsistent with *DSM-5* criteria.

The Clinician-Rated Severity of ODD (APA, 2013e) and the Clinician-Rated Severity of Conduct Disorder (APA, 2013c) both include only one item to assess based on the presence and severity of any ODD or conduct disorder symptoms (APA, 2013g). The scales are to be completed from level 0 (*none*) to level 3 (*severe*). The items simply state, “Rate the level or severity of the OPPOSITIONAL DEFIANT problems that are present for this individual” (APA, 2013e) and “Rate the level or severity of the conduct problems that are present for this

individual" (APA, 2013c). The criteria for diagnosis are not listed in the measures but can be found under ODD and conduct disorder in the *DSM-5* (APA, 2013g). Although the criteria for both are absent in the measures, APA refers clinicians to the *DSM-5*, which suggests that the measures completely parallel the diagnostic criteria.

The Clinician-Rated Severity of Nonsuicidal Self-Injury (APA, 2013d) is a one-item measure that examines the presence and severity of any nonsuicidal self-injury problems that have happened in the past year. The scale is to be completed based on five levels, including 0 (*none*), 1 (*subthreshold*), 2 (*mild*), 3 (*moderate*), and 4 (*severe*). The item simply states, "Rate the level or severity of the NONSUICIDAL SELF-INJURY problems that are present for this individual" (APA, 2013d). The symptoms are not listed but can be found under nonsuicidal self-injury in the *DSM-5* (APA, 2013g, p. 803). Similarly to the previous measures stated, the APA directs clinicians to the *DSM-5*, which again indicates an alignment to diagnostic criteria.

## Implications for Counseling Practice

The APA (2013g) endorsed dimensional assessment to be used in conjunction with categorical diagnoses. An effort to establish measurement protocols in a process often deemed rather subjective is laudable. The APA indicated that the assessment system was an "emerging" (2013g, p. 729) system, which indicates a rather circumspect decision by the APA. The *DSM* system represents a system of classifying diagnoses, whose current framework is 20–30 years old and widely established (Jones, 2012). Given the influence of the *DSM* system of diagnosis (e.g., reimbursement, research studies, treatment planning), the publication of the emerging measures that fail to meet basic standards of testing and measurement could be confusing to counselors expecting that scores of the emerging measures would provide consistent and accurate information about severity and be consistent with diagnostic classifications in the *DSM-5*.

The presence of validity evidence across the emerging measures is inconsistent, based on erratic reporting of psychometric information and lack of alignment with diagnostic criteria, such as what was documented regarding the disorder-specific severity measures. Although many of the measures were validated for clinical use, other measures lack this information. Perhaps the most basic critique of the system is that the publication of these measures lack alignment with the very diagnostic categories they are supposed to evaluate.

Evidence based on test content (AERA et al., 1999) is perhaps the most basic type of evidence for providing validity evidence of measures. The process entails that instruments that are developed be aligned with published research and expert review. Hence, the presence of dimensional measures that are supposed to align with the *DSM-5* classification system but fail to be comprehensive in the breadth of symptoms covered could be a serious limitation of these emerging measures.

Professional counselors should be cautious in the adoption of the dimensional measures. Many quality measures already exist that adequately align with the categorical diagnostic system of the APA. For example, in the development of the Beck Depression Inventory (BDI)-II, Beck, Steer, and Brown (1996) updated the initial BDI to align with the diagnostic symptoms of depression used in the *DSM-IV*. The APA should follow similar processes in terms of content alignment and the collection and analysis of data to provide evidence of psychometric properties; counselors must be aware that adherence to this process was not systematically implemented. Both the CCSMs and severity measures were designed to review general symptoms commonly apparent across a broad range of clients and to "be administered both at initial interview and over time to track the patient's symptom status and response to treatment" (APA, 2013g, p. 733). However, the variability with respect to the diagnostic classifications and absence of psychometric properties limits the potential for these measures to provide accurate and valid assessments.

The measures may be helpful in confirming clinical impressions or identifying potential problem areas that warrant further exploration. To some degree, however, counselors should be aware of potential ethical dilemmas that could arise from using the emerging measures endorsed by the APA. According to the American Counseling Association (ACA), “counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies” (2014, p. 8). Clearly, the extent to which the published emerging measures represent rigorous research is at issue. APA does identify the measures as “emerging” (2013g, p. 729), thereby acknowledging the preliminary nature of the dimensional assessments. From a public health standpoint, the consequences of basing diagnoses or justifying clinical care or improvement solely on the emerging measures could be egregious. As third-party payers and managed care companies scramble to adopt the new classification system, the presence of the emerging measures could be mistaken as an endorsement for their adoption by organizations (e.g., managed care companies) that lack the understanding of the measurement and evaluation principles. The presence of the emerging measures in the *DSM-5* presents an incomplete system that may not augment comprehensively the categorical system of diagnosis currently endorsed by the APA (2013g). Counselors using the emerging measures should employ other well-established measures and protocols to corroborate their clinical impressions and findings.

Counselors should be careful when interpreting the results of instruments that lack adequate empirical data to support respondent results; they should also qualify any conclusions, diagnoses, or recommendations that are based on assessments or instruments (ACA, 2014, p. 12). When emerging measures are used for diagnostic classification or to denote changes in symptoms or distress, counselors should identify the extent to which the findings from the dimensional assessment match the clinical impressions or findings from other assessment tools. Assessment tools, in general, provide information that should not stand alone (Balkin & Juhnke, 2014), and the use of the dimensional measures is not an exception to this rule.

### ***Conflict of Interest and Funding Disclosure***

*The author reported no conflict of interest or funding contributions for the development of this manuscript.*

---

## **References**

- Aldea, M. A., Rahman, O., & Storch, E. A. (2009). The psychometric properties of the Florida Obsessive Compulsive Inventory: Examination in a non-clinical sample. *Individual Differences Research*, 7, 228–238.
- Allgaier, A.-K., Pietsch, K., Frühe, B., Sigl-Glöckner, J., & Schulte-Körne, G. (2012). Screening for depression in adolescents: Validity of the patient health questionnaire in pediatric care. *Depression and Anxiety*, 29, 906–913. doi:10.1002/da.21971
- Altman, E. G., Hedeker, D., Peterson, J. L., & Davis, J. M. (1997). The Altman Self-Rating Mania Scale. *Biological Psychiatry*, 42, 948–955.
- American Counseling Association. (2014). *2014 ACA code of ethics*. Alexandria, VA: Author.
- American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (1999). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.
- American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (2009). *Standards for educational and psychological testing*. Retrieved from <http://www.teststandards.org>
- American Psychiatric Association. (2013a). *Clinician-Rated Dimensions of Psychosis Symptom Severity* [Measurement

- instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- American Psychiatric Association. (2013b). *Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- American Psychiatric Association. (2013c). *Clinician-Rated Severity of Conduct Disorder* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- American Psychiatric Association. (2013d). *Clinician-Rated Severity of Nonsuicidal Self-Injury* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- American Psychiatric Association. (2013e). *Clinician-Rated Severity of Oppositional Defiant Disorder* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- American Psychiatric Association. (2013f). *Clinician-Rated Severity of Somatic Symptom Disorder* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- American Psychiatric Association. (2013g). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
- American Psychiatric Association. (2014). *Online assessment measures*. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Balkin, R. S., & Juhnke, G. A. (2014). *The theory and practice of assessment in counseling*. Boston, MA: Pearson.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *BDI-II manual*. San Antonio, TX: The Psychological Corporation.
- Bjelland, I., Lie, S. A., Dahl, A. A., Mykletun, A., Stordal, E., & Kraemer, H. C. (2009). A dimensional versus a categorical approach to diagnosis: Anxiety and depression in the HUNT 2 study. *International Journal of Methods in Psychiatric Research*, 18, 128–137. doi:10.1002/mpr.284
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013a). *Severity Measure for Agoraphobia—Adult* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013b). *Severity Measure for Agoraphobia—Child Age 11–17* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013c). *Severity Measure for Generalized Anxiety Disorder—Adult* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013d). *Severity Measure for Generalized Anxiety Disorder—Child Age 11–17* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013e). *Severity Measure for Panic Disorder—Adult* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013f). *Severity Measure for Panic Disorder—Child Age 11–17* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013g). *Severity Measure for Separation Anxiety Disorder—Adult* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013h). *Severity Measure for Separation Anxiety Disorder—Child Age 11–17* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013i). *Severity Measure for Social Anxiety Disorder (Social Phobia)—Adult* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013j). *Severity Measure for Social Anxiety Disorder (Social Phobia)—Child Age 11–17* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>

- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013k). *Severity Measure for Specific Phobia—Adult* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013l). *Severity Measure for Specific Phobia—Child Age 11–17* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Dalenberg, C., & Carlson, E. (2010a). *Severity of Dissociative Symptoms—Adult (Brief Dissociative Experiences Scale [DES-B]—Modified)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Dalenberg, C., & Carlson, E. (2010b). *Severity of Dissociative Symptoms—Child Age 11–17 (Brief Dissociative Experiences Scale [DES-B]—Modified)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Feldman, G. C., Joormann, J., & Johnson, S. L. (2008). Responses to positive affect: A self-report measure of rumination and dampening. *Cognitive Therapy and Research*, 32, 507–525. doi:10.1007/s10608-006-9083-0
- Goodman, W. K., & Storch, E. (1994a). *LEVEL 2—Repetitive Thoughts and Behaviors—Adult (Adapted from the Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale [Part B])* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Goodman, W. K., & Storch, E. (1994b). *LEVEL 2—Repetitive Thoughts and Behaviors—Child Age 11–17 (Adapted from the Children's Florida Obsessive-Compulsive Inventory [C-FOCI] Severity Scale)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Han, C., Pae, C.-U., Patkar, A. A., Masand, P. S., Kim, K. W., Joe, S.-H., & Jung, I.-K. (2009). Psychometric properties of the patient health questionnaire-15 (PHQ-15) for measuring the somatic symptoms of psychiatric outpatients. *Psychosomatics*, 50, 580–585.
- Helzer, J. E., van den Brink, W., & Guth, S. E. (2006). Should there be both categorical and dimensional criteria for the substance use disorders in DSM-V? [Suppl. S1]. *Addiction*, 101, 17–22. doi:10.1111/j.1360-0443.2006.01587.x
- Jones, K. D. (2012). Dimensional and cross-cutting assessment in the *DSM-5*. *Journal of Counseling & Development*, 90, 481–487. doi:10.1002/j.1556-6676.2012.00059.x
- Kilpatrick, D. G., Resnick, H. S., & Friedman, M. J. (2013a). *Severity of Acute Stress Symptoms—Adult (National Stressful Events Survey Acute Stress Disorder Short Scale [NSESSS])* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Kilpatrick, D. G., Resnick, H. S., & Friedman, M. J. (2013b). *Severity of Acute Stress Symptoms—Child Age 11–17 (National Stressful Events Survey Acute Stress Disorder Short Scale [NSESSS])* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Kilpatrick, D. G., Resnick, H. S., & Friedman, M. J. (2013c). *Severity of Posttraumatic Stress Symptoms—Adult (National Stressful Events Survey PTSD Short Scale [NSESSS])* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Kilpatrick, D. G., Resnick, H. S., & Friedman, M. J. (2013d). *Severity of Posttraumatic Stress Symptoms—Child Age 11–17 (National Stressful Events Survey PTSD Short Scale [NSESSS])* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Kraemer, H. C., Noda, A., & O'Hara, R. (2004). Categorical versus dimensional approaches to diagnosis: Methodological challenges. *Journal of Psychiatric Research*, 38, 17–25. doi:10.1016/S0022-3956(03)00097-9
- Livesley, W. (2007). A framework for integrating dimensional and categorical classifications of personality disorder. *Journal of Personality Disorders*, 21, 199–224.
- Livianos-Aldana, L., & Rojo-Moreno, L. (2001). Rating and quantification of manic syndromes [Suppl. 409]. *Acta Psychiatrica Scandinavica*, 104, 2–33.
- National Institute on Drug Abuse. (n.d.-a). *Level 2—Substance Use—Adult (Adapted from the NIDA-Modified ASSIST)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- National Institute on Drug Abuse. (n.d.-b). *Level 2—Substance Use—Child Age 11–17 (Adapted from the NIDA-Modified ASSIST)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>

- National Institute on Drug Abuse. (n.d.-c). *Level 2—Substance Use—Parent/Guardian of Child Age 6–17 (Adapted from the NIDA-Modified ASSIST)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012a). *LEVEL 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012b). *LEVEL 2—Anger—Child Age 11–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Pediatric)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012c). *LEVEL 2—Anger—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Parent)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012d). *LEVEL 2—Anxiety—Adult (PROMIS Emotional Distress—Anxiety—Short Form)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012e). *LEVEL 2—Anxiety—Child Age 11–17 (PROMIS Emotional Distress—Anxiety—Pediatric Item Bank)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012f). *LEVEL 2—Anxiety—Parent/Guardian of Child Age 6–17 (Adapted from PROMIS Emotional Distress—Anxiety—Parent Item Bank)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012g). *LEVEL 2—Depression—Adult (PROMIS Emotional Distress—Depression—Short Form)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012h). *LEVEL 2—Depression—Child Age 11–17 (PROMIS Emotional Distress—Depression—Pediatric Item Bank)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012i). *LEVEL 2—Depression—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Depression—Parent Item Bank)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012j). *Level 2—Sleep Disturbance—Adult (PROMIS—Sleep Disturbance—Short Form)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012k). *Level 2—Sleep Disturbance—Child Age 11–17 (PROMIS—Sleep Disturbance—Short Form)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- PROMIS Health Organization and PROMIS Cooperative Group. (2012l). *Level 2—Sleep Disturbance—Parent/Guardian of Child Age 6–17 (PROMIS—Sleep Disturbance—Short Form)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Spitzer, R. L., Williams, J. B. W., & Kroenke, K. (n.d.-a). *Level 2—Somatic Symptom—Adult Patient (Adapted from the Patient Health Questionnaire Physical Symptoms [PHQ-15])* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Spitzer, R. L., Williams, J. B. W., & Kroenke, K. (n.d.-b). *Level 2—Somatic Symptom—Child Age 11–17 (Adapted from the Patient Health Questionnaire Physical Symptoms [PHQ-15])* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Spitzer, R. L., Williams, J. B. W., & Kroenke, K. (n.d.-c). *Level 2—Somatic Symptom—Parent/Guardian of Child Age 6–17 (Adapted from the Patient Health Questionnaire Physical Symptoms [PHQ-15])* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Spitzer, R. L., Williams, J. B. W., & Kroenke, K. (n.d.-d). *Severity Measure for Depression—Adult (adapted from the Patient Health Questionnaire—9 [PHQ-9])* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>

- Spitzer, R. L., Williams, J. B. W., & Kroenke, K. (2002). *Severity Measure for Depression—Child Age 11–17 (PHQ-9 modified for Adolescents [PHQ-A]—Adapted)* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Stewart, J. A., Deliyannides, D. A., Hellerstein, D. J., McGrath, P. J., & Stewart, J. W. (2012). Can people with nonsevere major depression benefit from antidepressant medication? *The Journal of Clinical Psychiatry*, 73, 518–525. doi:10.4088/JCP.10m06760
- Storch, E. A., Bagner, D., Merlo, L. J., Shapira, N. A., Geffken, G. R., Murphy, T. K., & Goodman, W. K. (2007). Florida Obsessive-Compulsive Inventory: Development, reliability, and validity. *Journal of Clinical Psychology*, 63, 851–859. doi:10.1002/jclp.20382
- Storch, E. A., Khanna, M., Merlo, L. J., Loew, B. A., Franklin, M., Reid, J. M., . . . Murphy, T. K. (2009). Children's Florida Obsessive Compulsive Inventory: Psychometric properties and feasibility of a self-report measure of obsessive-compulsive symptoms in youth. *Child Psychiatry and Human Development*, 40, 467–483. doi:10.1007/s10578-009-0138-9
- Stringaris, A., Goodman, R., Ferdinando, S., Razdan, V., Muhrer, E., Leibenluft, E., & Brotman, M. A. (2012). The Affective Reactivity Index: A concise irritability scale for clinical and research settings. *Journal of Child Psychology and Psychiatry*, 53, 1109–1117. doi:10.1111/j.1469-7610.2012.02561.x
- Swanson, J. M. (2011). *LEVEL 2—Inattention—Parent/Guardian of Child Age 6–17 (Swanson, Nolan, and Pelham, version IV [SNAP-IV])* [Measurement instrument]. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Titov, N., Dear, B. F., McMillan, D., Anderson, T., Zou, J., & Sunderland, M. (2011). Psychometric comparison of the PHQ-9 and BDI-II for measuring response during treatment of depression. *Cognitive Behaviour Therapy*, 40, 126–136. doi:10.1080/16506073.2010.550059

