Differential Diagnosis Using the DSM-5:

Improving Clinical Outcomes through Clear Assessment & Diagnosis

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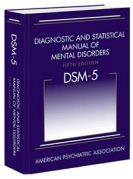

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Scope of Practice

Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of mental health professionals. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with and in compliance with your profession's standards.

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Conflict of Interest Disclosure

Richard Sears holds several faculty appointments at the University of Cincinnati. He has written a number of books on mindfulness and psychotherapy, and offers mindfulness courses on his personal website.

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Conflict of Interest Disclosure

DSM© and DSM-5© are registered trademarks of the American Psychiatric Association.

Dr. Sears has no affiliation with either the DSM or the American Psychiatric Association

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Introductions

- Name
- Background with DSM & diagnosis
- Why you came to this workshop

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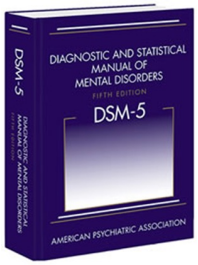
DSM Background, Development, Strengths, & Limitations



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DSM Background, Development, Strengths, & Limitations

History of the Diagnostic and Statistical Manual of Mental Disorders

- **Initially based on Freudian Theory**
- **Over time, became less theory based and more descriptive**

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DSM Background, Development, Strengths, & Limitations

DSM I	**1952**
DSM II	**1968**
DSM III	**1980**
DSM III-R	**1987**
DSM IV	**1994**
DSM IV-TR	**2000**
DSM 5	**2013**

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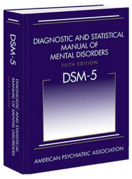
DSM-5 updates



- **Uses “5” instead of “V” – anticipating 5.1, 5.2, etc.**
- **Already has quite a few changes – update list available at: https://dsm.psychiatryonline.org/**

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DSM Background, Development, Strengths, & Limitations

Strengths
- Common language for clinicians
- Clearly listed criteria for research
- Standardizes diagnoses and treatment
- Decades of refinement

Limitations
- Oversimplifies human behavior
- Categorical vs. dimensional
- Subjective biases from clinicians
- Increases risk of overdiagnosis or misdiagnosis
- Provides labels, which can be stigmatizing
- Does not always account for context of behaviors

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DSM Background, Development, Strengths, & Limitations

Objective Standards vs. Subjective Biases

- Clinicians can have varied definitions of "normal"
- Confirmation bias – tendency to look for what confirms your opinion and ignore what does not fit
- Objective standards help keep clinicians anchored

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DSM Background, Development, Strengths, & Limitations

Importance of Cultural Factors

- Though they may have different prevalence rates, many studies show the major mental health disorders are common across the globe.
- However, these disorders may manifest in different ways in different culture
- Important to tease apart "disorders" from cultural factors
- Clinicians must be cautious about their own inherent biases

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DSM Background, Development, Strengths, & Limitations

Importance of Cultural Factors (from DSM-5):

- To avoid misdiagnosis
- To obtain useful clinical information
- To improve clinical rapport and engagement
- To improve therapeutic efficacy
- To guide clinical research
- To clarify the cultural epidemiology

DSM-5 contains a "Cultural Formulation Interview (CFI)"

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DSM Background, Development, Strengths, & Limitations

DSM-5 Glossary of Cultural Concepts of Distress:

- Ataque de nervios
- Dhat syndrome
- Khyâl cap
- Kufungisisa
  Maladi moun
- Nervios
- Shenjing shuairuo
- Susto
- Taijin kyofusho

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DSM Background, Development, Strengths, & Limitations

Defining Mental Disorder

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.

Ruling Out Other Factors

Developmental considerations, cultural, situational, medical issues, grief, normal reactions, etc.

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DSM Background, Development, Strengths, & Limitations

General Principles of Differential Diagnosis

- Step 1: Gather client data
  - Interview (structured & informal), assessments
- Step 2: Identify syndrome
  - Key symptoms (eg, anx, depr, trauma)
- Step 3: Differential diagnosis
  - Differentiate & rule out different dxes
- Step 4: Initial DSM diagnosis list

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DSM Background, Development, Strengths, & Limitations

General Principles of Differential Diagnosis

- Provisional/Tentative/Rule Out Diagnoses
  - What do you need to rule it out?
- Parsimony vs Completeness
  - Is there a diagnosis that best encapsulates the presenting issues, or do they really have multiple disorders?

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Evidence-Based Screening & Assessment Tools

Importance of standardization, validation, and reliability

-Standardization – tested on a sample of a wide variety of individuals

-Validity – does it measure what it is intended to measure

-Reliability – Consistently of results

All valid tests are reliable, not all reliable tests are valid.

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Evidence-Based Screening & Assessment Tools

Intelligence and Aptitude Measures

- Most require specialized qualifications and training to administer and interpret
- Neuropsychological tests: assesses brain functioning (Halsteid-Reitan, Luria, NAB, etc.)
- IQ tests: measure intelligence (WAIS, WISC, Stanford-Binet, etc)
- Aptitude tests: measure potential (Wonderlic)
- Achievement tests: measure performance (Kaufman, WIAT, Woodcock-Johnson, etc.)

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Evidence-Based Screening & Assessment Tools

Personality Measures

- MMPI-3
- MCMI-IV
- 16-PF
- NEO-PI-3
- Personality Inventory for Children (PIC)
- Personality Inventory for Youth (PIY)
- Projective Tests

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Evidence-Based Screening & Assessment Tools

Symptom and Other Measures

- Mini Mental State Exam (MMSE)
- PTSD Checklist for DSM-5 (PCL-5)
- Yale Brown Obsessive Compulsive Scale (YBOCS)
- Beck Depression Inventory (BDI)
- Beck Anxiety Inventory (BAI)
- Hamilton Anxiety Rating Scale (HAM-A)
- Hamilton Depression Rating Scale (HAM-D)
- Patient Health Questionnaires (PHQ)
- Suicide Behaviors Questionnaire-Revised (SBQ-R)

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DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name:_____ Age:_____ Sex: [ ] Male [ ] Female Date:_____

If the measure is being completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

		During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	None-Not at all	Slight-Rare, less than a day or two	Mild-Several days	Moderate-More than half the days	Severe-Nearly every day	Highest Domain Score (clinician)
I.	1.	Little interest or pleasure in doing things?	0	1	2	3	4	
	2.	Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3.	Feeling more irritated, grouchy, angry than usual?	0	1	2	3	4	
III.	4.	Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5.	Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6.	Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7.	Feeling panic or being frightened?	0	1	2	3	4	
	8.	Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9.	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10.	Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11.	Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12.	Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13.	Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14.	Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15.	Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17.	Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19.	Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20.	Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21.	Drink at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22.	Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco?	0	1	2	3	4	
	23.	Use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed))?	0	1	2	3	4	

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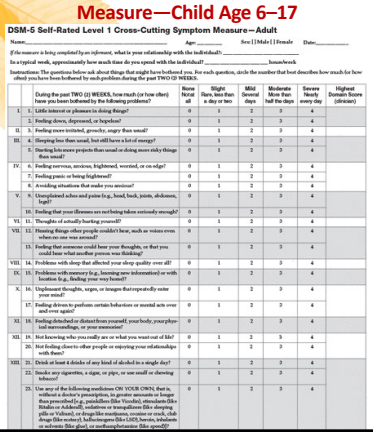
Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure—Child Age 6–17



DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name:_____ Age:_____ Sex: [ ] Male [ ] Female Date:_____

If the measure is being completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

		During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	None-Not at all	Slight-Rare, less than a day or two	Mild-Several days	Moderate-More than half the days	Severe-Nearly every day	Highest Domain Score (clinician)
I.	1.	Little interest or pleasure in doing things?	0	1	2	3	4	
	2.	Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3.	Feeling more irritated, grouchy, angry than usual?	0	1	2	3	4	
III.	4.	Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5.	Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6.	Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7.	Feeling panic or being frightened?	0	1	2	3	4	
	8.	Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9.	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10.	Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11.	Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12.	Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
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VIII.	14.	Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15.	Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17.	Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19.	Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20.	Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21.	Drink at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22.	Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco?	0	1	2	3	4	
	23.	Use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed))?	0	1	2	3	4	

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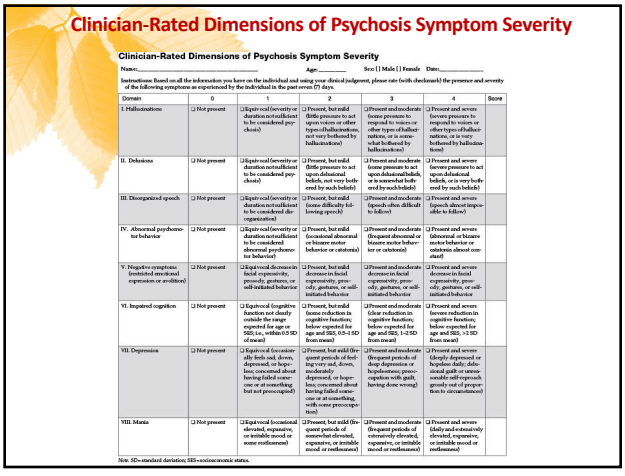
Clinician-Rated Dimensions of Psychosis Symptom Severity



Clinician-Rated Dimensions of Psychosis Symptom Severity

Name:_____ Age:_____ Sex: [ ] Male [ ] Female Date:_____

Instructions: Based on all the information you have on the individual and using your clinical judgment, please rate (with checkmark) the presence and severity of the following symptoms as experienced by the individual in the past seven (7) days.

Domain	0	1	2	3	4	Score
I. Hallucinations	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered psychosis)	❑ Present, but mild (little pressure to act upon voices or other types of hallucinations, not very bothered by hallucinations)	❑ Present and moderate (some pressure to respond to voices or other types of hallucinations, or is somewhat bothered by hallucinations)	❑ Present and severe (severe pressure to respond to voices or other types of hallucinations, or is very bothered by hallucinations)	
II. Delusions	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered psychosis)	❑ Present, but mild (little pressure to act upon delusional beliefs, not very bothered by such beliefs)	❑ Present and moderate (some pressure to act upon delusional beliefs, or is somewhat bothered by such beliefs)	❑ Present and severe (severe pressure to act upon delusional beliefs, or is very bothered by such beliefs)	
III. Disorganized speech	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered disorganization)	❑ Present, but mild (some difficulty following speech)	❑ Present and moderate (speech often difficult to follow)	❑ Present and severe (speech almost impossible to follow)	
IV. Abnormal psychomotor behavior	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered abnormal psychomotor behavior)	❑ Present, but mild (occasional abnormal or bizarre motor behavior or catatonia)	❑ Present and moderate (frequent abnormal or bizarre motor behavior or catatonia)	❑ Present and severe (abnormal or bizarre motor behavior or catatonia almost constant)	
V. Negative symptoms (restricted emotional expression or avolition)	❑ Not present	❑ Equivocal decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present, but mild decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present and moderate decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present and severe decrease in facial expressivity, prosody, gestures, or self-initiated behavior	
VI. Impaired cognition	❑ Not present	❑ Equivocal (cognitive function not clearly outside the range expected for age or SES; i.e., within 0.5 SD of mean)	❑ Present, but mild (some reduction in cognitive function; below expected for age and SES, 0.5–1 SD from mean)	❑ Present and moderate (clear reduction in cognitive function; below expected for age and SES, 1–2 SD from mean)	❑ Present and severe (severe reduction in cognitive function; below expected for age and SES, >2 SD from mean)	
VII. Depression	❑ Not present	❑ Equivocal (occasionally feels sad, down, depressed, or hopeless; concerned about having failed someone or at something but not preoccupied)	❑ Present, but mild (frequent periods of feeling very sad, down, moderately depressed, or hopeless; concerned about having failed someone or at something, with some preoccupation)	❑ Present and moderate (frequent periods of deep depression or hopelessness; preoccupation with guilt, having done wrong)	❑ Present and severe (deeply depressed or hopeless daily; delusional guilt or unreasonable self-reproach grossly out of proportion to circumstances)	
VIII. Mania	❑ Not present	❑ Equivocal (occasional elevated, expansive, or irritable mood or some restlessness)	❑ Present, but mild (frequent periods of somewhat elevated, expansive, or irritable mood or restlessness)	❑ Present and moderate (frequent periods of extremely elevated, expansive, or irritable mood or restlessness)	❑ Present and severe (daily and extremely elevated, expansive, or irritable mood or restlessness)	

Note. SD=standard deviation; SES=socioeconomic status.

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Neurodevelopmental Disorders

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Intellectual Disability

…onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

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Intellectual Disability

B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

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Intellectual Disability

C. Onset of intellectual and adaptive deficits during the developmental period.

Mild, Moderate, Severe, or Profound based on table in DSM-5/clinical judgement/functioning, not just IQ scores

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Autism Spectrum Disorder

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following, currently or by history (examples are illustrative, not exhaustive; see text):

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Autism Spectrum Disorder

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

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Autism Spectrum Disorder

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

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Autism Spectrum Disorder

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

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Autism Spectrum Disorder

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

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Autism Spectrum Disorder

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

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Autism Spectrum Disorder

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

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Attention-Deficit/Hyperactivity Disorder

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

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Attention-Deficit/Hyperactivity Disorder

a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).

b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).

c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).

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Attention-Deficit/Hyperactivity Disorder

d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).

e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).

f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

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Attention-Deficit/Hyperactivity Disorder

g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).

h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).

i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appts).

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Attention-Deficit/Hyperactivity Disorder

2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

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Attention-Deficit/Hyperactivity Disorder

a. Often fidgets with or taps hands or feet or squirms in seat.

b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).

c. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)

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Attention-Deficit/Hyperactivity Disorder

d. Often unable to play or engage in leisure activities quietly.

e. Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).

f. Often talks excessively.

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Attention-Deficit/Hyperactivity Disorder

g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).

h. Often has difficulty waiting his or her turn (e.g., while waiting in line).

i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

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Attention-Deficit/Hyperactivity Disorder

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

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Attention-Deficit/Hyperactivity Disorder

Specifiers:

- Combined presentation
- Predominantly inattentive presentation
- Predominantly hyperactive/impulsive presentation
- In partial remission
- Mild
  Moderate
- Severe

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Neurodevelopmental Disorders

- Communication Disorders
- Specific Learning Disorder
- Motor Disorders
- Other Neurodevelopmental Disorders

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Case Example

Brandon was a 12-year-old boy brought in by his mother for psychiatric evaluation for temper tantrums that seemed to be contributing to declining school performance. The mother became emotional as she reported that things had always been difficult but had become worse after Brandon entered middle school. (from DSM-5 Clinical Cases)

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Schizophrenia Spectrum and Other Psychotic Disorders

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Delusional Disorder

A. The presence of one (or more) delusions with a duration of 1 month or longer.

B. Criterion A for schizophrenia has never been met.

Note: Hallucinations, if present, are not prominent and are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation).

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Delusional Disorder

C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd.

D. If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional periods.

E. The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

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Delusional Disorder

Subtypes -- Specify whether:

Erotomanic type: central theme of the delusion is that another person is in love with the individual.

Grandiose type: central theme is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery.

Jealous type: central theme is that his or her spouse or lover is unfaithful.

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Delusional Disorder

Persecutory type: believe they are being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals.

Somatic type: involves bodily functions/sensations.

Mixed type: when no one theme predominates.

Unspecified type: delusion belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).

52

Delusional Disorder

-Specify if:
With bizarre content: if delusions are clearly implausible, not understandable, and not derived from ordinary life experiences (e.g., belief that a stranger has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars).
-After 1 year, specify if:
First episode, multiple episodes, full or partial remission, continuous, unspecified
-Specify Current Severity

53

Brief Psychotic Disorder

A. Presence of one (or more) of the following symptoms. At least one must be (1), (2), or (3):

1. **Delusions.**
2. **Hallucinations.**
3. **Disorganized speech (e.g., frequent derailment or incoherence).**
4. **Grossly disorganized or catatonic behavior.**

Note: Do not include a symptom if it is a culturally sanctioned response.

54

Brief Psychotic Disorder

B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.

C. The disturbance is not better explained by major depressive or bipolar disorder with psychotic features or another psychotic disorder such as schizophrenia or catatonia, and is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

55

Brief Psychotic Disorder

Specify if:
With marked stressor(s) (brief reactive psychosis): If sxs occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual's culture.
Without marked stressor(s)
With peripartum onset: If onset is during pregnancy or within 4 weeks postpartum.
Specify if: With catatonia
Specify current severity

56

Schizophreniform Disorder

A. 2 (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. **Delusions.**
2. **Hallucinations.**
3. **Disorganized speech (e.g., frequent derailment or incoherence).**
4. **Grossly disorganized or catatonic behavior.**
5. **Negative symptoms (i.e., diminished emotional expression or avolition).**

57

Schizophreniform Disorder

B. An episode of the disorder lasts at least 1 mo but less than 6 mos. When the dx must be made without waiting for recovery, it should be qualified as "provisional."

C. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

58

Schizophreniform Disorder

D. Disturbance not attributable to physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify if:

With good prognostic features: Requires the presence of at least 2 of the following features: onset of prominent psychotic symptoms within 4 wks of the first noticeable change in usual behavior or functioning; confusion or perplexity; good premorbid social and occupational functioning; and absence of blunted or flat affect.

Without good prognostic features

Specify if: With catatonia

Specify current severity

59

Schizophrenia

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions.
2. Hallucinations.
3. Disorganized speech (e.g., frequent derailment or incoherence).
4. Grossly disorganized or catatonic behavior.
5. Negative symptoms (i.e., diminished emotional expression or avolition).

60

Schizophrenia

B. For a significant portion of time since onset, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

C. Continuous signs persist for at least 6mos, and must include at least 1 mo of sxs (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms, manifested by only negative symptoms or by 2 or more sxs listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

61

Schizophrenia

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

62

Schizophrenia

F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

63

Schizophrenia

Specify:

- First episode, currently in acute episode
- First episode, currently in partial remission
- First episode, currently in full remission
- Multiple episodes, currently in acute episode
- Multiple episodes, currently in partial remission
- Multiple episodes, currently in full remission
- Continuous
- Unspecified
- With catatonia
- Severity

64

Schizoaffective Disorder

A. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia.
Note: The major depressive episode must include Criterion A1: Depressed mood.

B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.

65

Schizoaffective Disorder

C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.

D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

66

Schizoaffective Disorder

Specifiers:

- Bipolar type
- Depressive type
- First episode, currently in acute episode
- First episode, currently in partial remission
- First episode, currently in full remission
- Multiple episodes, currently in acute episode
- Multiple episodes, currently in partial remission
- Multiple episodes, currently in full remission
- Continuous
- Unspecified
- Current Severity

67

Other Diagnoses

- Substance/Medication-Induced Psychotic Disorder
- Psychotic Disorder Due to Another Medical Condition
- Catatonia Associated With Another Mental Disorder (Catatonia Specifier)
- Catatonic Disorder Due to Another Medical Condition
- Unspecified Catatonia
- Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

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Case Example

Itsuki Daishi was a 23-year-old engineering student from Japan who was referred to his university student mental health clinic by a professor who had become concerned about his irregular school attendance. When they had met to discuss his declining performance, Mr. Daishi had volunteered to the professor that he was distracted by the "listening devices" and "thought control machines" that had been placed in his apartment.

(from DSM-5 Clinical Cases)

69

Bipolar & Related Disorders

70

Manic Episode

A. Distinct period of abnormally & persistently elevated, expansive, or irritable mood & abnormally & persistently increased activity or energy, lasting at least 1 wk & present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance & increased energy or activity, 3 (or more) of the following symptoms (4 if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

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Manic Episode

1. **Inflated self-esteem or grandiosity.**
2. **Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).**
3. **More talkative than usual or pressure to keep talking.**
4. **Flight of ideas or subjective experience that thoughts are racing.**

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Manic Episode

5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).

7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

73

Manic Episode

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other tx) or another medical condition.

Note: A full manic episode that emerges during antidepressant tx (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that tx is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

74

Hypomanic Episode

A. Distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally & persistently increased activity or energy, lasting at least 4 consecutive days & present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, 3 (or more) of the following symptoms (4 if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:

[same 7 criteria listed under manic episode]

75

Hypomanic Episode

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

76

Hypomanic Episode

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition.

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

77

Major Depressive Episode

A. 5 (or more) of the following sxs have been present during the same 2-week period and represent a change from previous functioning; at least 1 of the sxs is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

78

Major Depressive Episode

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).

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Major Depressive Episode

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

80

Major Depressive Episode

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

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Distinguish Major Depressive episode from responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability), consider cultural factors.

81

Specifiers for Bipolar Dxs

Record as:
diagnosis (eg, bipolar I disorder), type of current or most recent episode, severity/psychotic/remission specifiers, followed by as many specifiers without codes as apply to the current or most recent episode.

82

Specifiers for Bipolar Dxs

- With anxious distress
- With mixed features (sxs of both depr & hypo/mania)
- With rapid cycling (4 mood episodes in 12 months)
- With melancholic features
- With atypical features (mood reactivity, weight gain/appetite increase, hypersomnia, leaden paralysis, interpersonal rejection sensitivity)
- With mood-congruent psychotic features (applies to manic episode and/or major depressive episode)
- With mood-incongruent psychotic features (applies to manic episode and/or major depressive episode)
- With catatonia
- With peripartum onset
- With seasonal pattern
- Mild/Moderate/Severe, Partial/Full Remission

83

Bipolar I Disorder

A. Criteria have been met for at least one manic episode (Criteria A–D under "Manic Episode" above).

B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

84

Bipolar II Disorder

A. Criteria have been met for at least one hypomanic episode and at least one major depressive episode.

B. There has never been a manic episode.

C. Episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

D. The sxs of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

85

Cyclothymic Disorder

A. At least 2 yrs (1 yr children & adol) numerous periods w hypomanic sxs that do not meet criteria for a hypomanic episode & numerous periods with depressive sxs that do not meet criteria for a major depressive episode.

B. Hypomanic & depressive periods present at least half the time and individual has not been without the sxs for more than 2 mos at a time.

C. Criteria for a major depressive, manic, or hypomanic episode have never been met.

86

Cyclothymic Disorder

D. Sxs not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other schizophrenia spectrum or psychotic disorder.

E. Sxs not attributable to physiological effects of a substance (e.g., drug of abuse, medication) or another med condition(e.g., hyperthyroidism).

F. Sxs cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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Differential Dx Considerations

- If a manic episode any time in life, dx is Bipolar I.
- Hypomanic episodes and major depressive episodes are common in Bipolar I, but not required for dx.
- Bipolar II requires a hypomanic episode and a major depressive episode.
- Cyclothymia is at least 2 yrs, hypomanic episodes, never a major depressive episode

88

Other Bipolar-Related Dxs

- Substance/Medication-Induced Bipolar and Related Disorder
- Bipolar and Related Disorder Due to Another Medical Condition
- Other Specified Bipolar and Related Disorder
- Unspecified Bipolar and Related Disorder

89

Case Example

An African American man who appeared to be in his 30s was brought to an urban emergency room (ER) by police. The referral form indicated that he was schizophrenic and an "emotionally disturbed person." One of the police officers said that the man offered to pay them for sex while in the back seat of their patrol car. He referred to himself as the "New Jesus" and declined to offer another name. He refused to sit and instead ran through the ER. He was put into restraints and received intramuscularly administered lorazepam 2 mg and haloperidol 5 mg. Intravenous diphenhydramine (Benadryl) 50 mg was readied in case of extrapyramidal side effects. The admitting team wrote that he had "unspecified schizophrenia spectrum and other psychotic disorder" and transferred him to the psychiatry team that worked in the ER.
(from DSM-5 Clinical Cases)

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Depressive Disorders

91

Disruptive Mood Dysregulation D/O

"In order to address concerns about the potential for the overdiagnosis of and tx for bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, referring to the presentation of children with persistent irritability and frequent episodes of extreme behavioral dyscontrol, is added to the depressive disorders for children up to 12 years of age. Its placement in this chapter reflects the finding that children with this sx pattern typically develop unipolar depressive disorders or anxiety disorders, rather than bipolar disorders, as they mature into adolescence and adulthood."

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Disruptive Mood Dysregulation D/O

A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) grossly out of proportion in intensity or duration to the situation or provocation.

B. Are inconsistent with developmental level.

C. Occur, on average, 3 or more times per wk.

D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).

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Disruptive Mood Dysregulation D/O

E. Criteria A–D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A–D.

F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.

G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.

H. By hx or observation, onset of Criteria A–E is <10yrs.

94

Disruptive Mood Dysregulation D/O

I. Never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

Note: Developmentally appropriate mood elevation, eg in context of a highly positive event or its anticipation, should not be considered as a sx of mania or hypomania.

J. Behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, PTSD, separation anxiety disorder, persistent depressive disorder [dysthymia]).

95

Disruptive Mood Dysregulation D/O

Note: This dx cannot coexist w oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, ADHD, conduct disorder, and substance use disorders. Individuals whose sxs meet criteria for both disruptive mood dysregulation disorder & ODD should only be dx disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the dx of disruptive mood dysregulation disorder should not be assigned.

K. Sxs not attributable to the physiological effects of a substance or another medical or neurological condition.

96

Major Depressive Disorder

Criteria A–C represent a major depressive episode (described earlier)

D. Not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other schizophrenia spectrum/other psychotic D/O.

E. Never been a manic or hypomanic episode. Note: Does not apply if all manic-like or hypomanic-like episodes are substance-induced or due to effects of another medical condition.

97

Persistent Depressive Disorder (Dysthymia)

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.

A. Depressed mood for most of the day, more days than not, as indicated by subjective account or observation by others, for at least 2 yrs.

Note: In children and adolescents, mood can be irritable and duration must be at least 1 yr.

98

Persistent Depressive Disorder

B. Presence, while depressed, of two (or more) of the following:

1. **Poor appetite or overeating.**
2. **Insomnia or hypersomnia.**
3. **Low energy or fatigue.**
4. **Low self-esteem.**
5. **Poor concentration or difficulty making decisions.**
6. **Feelings of hopelessness.**

99

Persistent Depressive Disorder

C. During the 2-year period (1 yr-children/adol), the individual has never been without the sxs in Criteria A and B for more than 2 mos at a time.

D. Criteria for a major depressive disorder may be continuously present for 2 years.

E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

100

Persistent Depressive Disorder

F. Not better explained by persistent schizo-affective DO, schizophrenia, delusional DO, or other schizophrenia spectrum/psychotic DO.

G. Sxs not attributable to effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g. , hypothyroidism).

H. Sxs cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

101

Persistent Depressive Disorder

Specify:

- Early onset: If onset is before age 21 years.
- Late onset: If onset is at age 21 yrs or older.

Specify if (for most recent 2 years):

- With pure dysthymic syndrome (No MDE)
- With persistent major depressive episode
- With intermittent major depressive episodes, with current episode
- With intermittent major depressive episodes, without current episode

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Other Depressive Disorders

- Premenstrual Dysphoric Disorder
- Substance/Medication-Induced Depressive DO
- Depressive Disorder Due to Another Medical Condition
- Other Specified Depressive Disorder
- Unspecified Depressive Disorder

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Specifiers for Depressive D/Os

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- W seasonal pattern (recurrent episode only)
- Partial/full remission
- Mild/Moderate/Severe

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Case Example

Wyatt was a 12yo boy referred by his psychiatrist to an adolescent partial hospitalization program because of repeated conflicts that have frightened both classmates and family members.

According to his parents, Wyatt was generally moody and irritable, with frequent episodes of being "a raging monster." It had become almost impossible to set limits. Most recently, Wyatt had smashed a closet door to gain access to a video game that had been withheld to encourage him to do homework. At school, Wyatt was noted to have a hair-trigger temper, and he had recently been suspended for punching another boy in the face after losing a chess match.

(from DSM-5 Clinical Cases)

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Anxiety Disorders

106

Separation Anxiety Disorder

A. Developmentally inappropriate & excessive fear or anxiety concerning separation from those to whom the individual is attached -- at least 3 of the following:

1. Recurrent excessive distress when anticipating or experiencing separation from home or major attachment figures.

2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.

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Separation Anxiety Disorder

3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.

4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.

5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.

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Separation Anxiety Disorder

6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.

7. Repeated nightmares involving the theme of separation.

8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.

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Separation Anxiety Disorder

B. Lasting at least 4 wks in children & adolescents & typically 6 mos or more in adults.

C. Clinically sign distress/impairment-social, academic, occupational, or other important areas of functioning.

D. Not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in ASD; delusions or halluc concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in GAD; or concerns about having an illness in illness anxiety disorder.

110

Specific Phobia

A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.

B. The phobic object or situation almost always provokes immediate fear or anxiety.

C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.

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Specific Phobia

D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.

E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

112

Specific Phobia

G. Not better explained by the sxs of another disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).

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Specific Phobia

Specify:
Animal (e.g., spiders, insects, dogs).

Natural environment (e.g., heights, storms, water).

Blood-injection-injury (e.g., needles, invasive medical procedures).

Situational (e.g., airplanes, elevators, enclosed places).

Other (e.g., situations that may lead to choking or vomiting; in children, e.g., loud sounds or costumed characters).

114

Social Anxiety DO (Social Phobia)

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).
Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

B. Fears will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).

115

Social Anxiety Disorder

C. The social situations almost always provoke fear or anxiety.
Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

116

Social Anxiety Disorder

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

117

Social Anxiety Disorder

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if: Performance only: If the fear is restricted to speaking or performing in public.

118

Panic Disorder

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or discomfort-reaches a peak within minutes, w four (or more) of the following:
Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.

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Panic Disorder

5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or "going crazy."
13. Fear of dying.

Note: Culture-specific sxs (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such sxs should not count as 1 of the 4 required sxs.

120

Panic Disorder

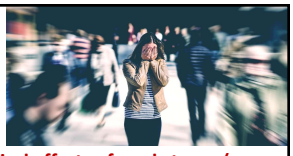
B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").

2. A significant maladaptive change in beh related to the attacks (e.g., behs designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

121

Panic Disorder



C. Not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

D. Not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in OCD; in response to reminders of traumatic events, as in PTSD; or in response to separation from attachment figures, as in separation anxiety disorder).

122

Agoraphobia

A. Marked fear or anxiety about 2 (or more) of the following 5 situations:

1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).
2. Being in open spaces (e.g., parking lots, marketplaces, bridges).
3. Being in enclosed places (e.g., shops, theaters, cinemas).
4. Standing in line or being in a crowd.
5. Being outside of the home alone.

123

Agoraphobia

B. Fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence).

C. The situations almost always provoke fear or anxiety.

D. The situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.

124

Agoraphobia

E. The fear or anxiety out of proportion to actual danger posed by the situations & to sociocultural context.
F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational or other important areas of functioning
H. If another medical condition (e.g., inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.

125

Agoraphobia

I. Not better explained by the sxs of another mental DO—for example, the sxs are not confined to specific phobia, situational type; do not involve only social situations (as in social anxiety disorder); and are not related exclusively to obsessions (as in OCD), perceived defects or flaws in physical appearance (as in body dysmorphic DO), reminders of traumatic events (as in PTSD), or fear of separation (as in separation anxiety DO).

Note: Agoraphobia is dxed irrespective of the presence of panic disorder. If criteria met for panic disorder and agoraphobia, both diagnoses should be assigned.

126

Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. 3 (or more) of the following 6 symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
Note: Only one item is required in children.

127

Generalized Anxiety Disorder

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

128

Generalized Anxiety Disorder

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
F. Not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic DO, neg evaluation in social anxiety DO, contamination or other obsessions in OCD, separation from attachment figures in separation anxiety DO, reminders of traumatic events in PTSD, gaining weight in anorexia nervosa, physical complaints in somatic symptom DO, perceived appearance flaws in body dysmorphic DO, having a serious illness in illness anxiety DO, or the content of delusional beliefs in schizophrenia or delusional DO).

129

Other Anxiety Disorders

- Selective Mutism
- Panic Attack Specifier (added to other disorders, such as PTSD with Panic Attacks)
- Substance/Medication-Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition
- Other Specified Anxiety Disorder
- Unspecified Anxiety Disorder

130

Case Example

Peggy Isaac was a 41-year-old administrative assistant who was referred for an outpatient evaluation by her primary care physician with a chief complaint of "I'm always on edge." She lived alone and had never married or had children. She had never before seen a psychiatrist.

(from DSM-5 Clinical Cases)

131

Obsessive-Compulsive and Related Disorders

132

Obsessive Compulsive Disorder

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):
1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. Attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

133

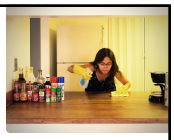
Obsessive Compulsive Disorder

Compulsions are defined by (1) and (2):
1. Repetitive behs (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently), feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behs or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behs or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

134

Obsessive Compulsive Disorder

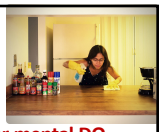


B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

135

Obsessive Compulsive Disorder



D. Not better explained by the symptoms of another mental DO (e.g., excessive worries, as in generalized anxiety DO; preoccupation with appearance, as in body dysmorphic DO; difficulty discarding or parting with possessions, as in hoarding DO; hair pulling, as in trichotillomania; skin picking, as in excoriation DO; stereotypies, as in stereotypic movement DO; ritualized eating behavior, as in eating DOs; preoccupation with substances or gambling, as in substance-related and addictive DOs; preoccupation with having an illness, as in illness anxiety DOs; sexual urges or fantasies, as in paraphilic DOs; impulses, as in disruptive, impulse-control, and conduct DOs; guilty ruminations, as in major depressive DO; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic DOs; or repetitive patterns of behavior, as in autism spectrum DO).

136

Obsessive Compulsive Disorder

Specifiers:

With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight/delusional beliefs: The individual is completely convinced that OCD beliefs are true.

Specify if: Tic-related

137

Body Dysmorphic DO

A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.

B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.

C. Causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

138

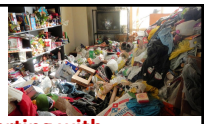
Body Dysmorphic DO

Specify if: With muscle dysmorphia:
The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case.

Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., "I look ugly" or "I look deformed").
- With good or fair insight
- With poor insight
- With absent insight/delusional beliefs

139

Hoarding Disorder



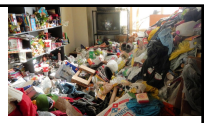
A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.

B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.

C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

140

Hoarding Disorder



D. Causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self & others).

E. Not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome).

F. Not better explained by sxs of another mental DO (e.g., obsessions in OCD, decreased energy in major depressive DO, delusions in schizophrenia or another psychotic DO, cognitive deficits in major neurocognitive DO, restricted interests in autism spectrum DO).

141

Hoarding Disorder

Specify if:
With excessive acquisition: If difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space.

Specify if:
With good or fair insight
With poor insight
With absent insight/delusional beliefs

142

Other Obsessive-Compulsive Related Disorders

-Trichotillomania (Hair-Pulling Disorder)
-Excoriation (Skin-Picking) Disorder
-Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
-Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
-Other Specified Obsessive-Compulsive and Related Disorder
-Unspecified Obsessive-Compulsive & Related DO

143

Case Example

Samuel King, a 52-year-old never-married janitor, presented for treatment of depression. He had been struggling with depressive symptoms for years and had tried fluoxetine, citalopram, and supportive psychotherapy, with minor improvement. He worked full-time but engaged in very few activities outside of work.

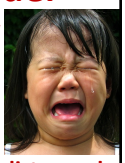
(from DSM-5 Clinical Cases)

144

Trauma- and Stressor-Related Disorders

145

Reactive Attachment Disorder

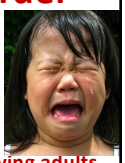


A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
1. Rarely/minimally seeks comfort when distressed.
2. Rarely/minimally responds to comfort when distressed.

B. A persistent social and emotional disturbance characterized by at least two of the following:
1. Minimal social & emotional responsiveness to others.
2. Limited positive affect.
3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.

146

Reactive Attachment Disorder



C. Has experienced a pattern of extremes of insufficient care as evidenced by at least 1:

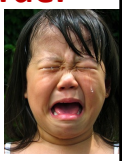
1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, & affection met by caregiving adults.

2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).

3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

147

Reactive Attachment Disorder



D. The care in Criterion C is presumed to be responsible for the disturbed beh in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).
E. Criteria are not met for autism spectrum DO.
F. Evident before age 5 years.
G. Has a developmental age of at least 9 mos.

Specify if: Persistent (more than 12mos)
Specify current severity

148

Disinhibited Social Engagement DO

A. Pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least 2 of the following:

1. Reduced or absent reticence in approaching and interacting with unfamiliar adults.
2. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
4. Willingness to go off with an unfamiliar adult with minimal or no hesitation.

149

Disinhibited Social Engagement DO

B. Behs in Criterion A are not limited to impulsivity (as in ADHD) but include socially disinhibited behavior.

C. Has experienced a pattern of extremes of insufficient care as evidenced by at least 1 of the following:

1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

150

Disinhibited Social Engagement DO

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

E. Has a developmental age of at least 9 mos.

Specify if: Persistent: present more than 12 mos.
Specify current severity

151

Posttraumatic Stress Disorder

(Adults, Adol, Children >6 yrs old)

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

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) occur to others.
3. Learning that violent or accidental event(s) occurred to a close family member or close friend
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). (Does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related)

152

PTSD (>6 yrs old)

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

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children >6 yrs, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content.

153

PTSD (>6 yrs old)

3. Dissociative reactions (e.g., flashbacks) in which feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological rxs to internal or external cues that symbolize or resemble an aspect of traumatic evt(s)

154

PTSD (>6 yrs old)

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

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

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

155

PTSD (>6 yrs old)

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by 2 (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia & not other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

156

PTSD (>6 yrs old)

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

157

PTSD (>6 yrs old)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by 2 (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

158

PTSD (>6 yrs old)

F. Duration is more than 1 month.
G. Causes clinically significant distress or impairment in social, occupational, or other important areas of funxing.
H. Not attributable to the physiological effects of a subs (e.g., medication, alcohol) or another medical condition.

Specify whether: With dissociative sxs: (not due to subs or med condition)

1. Depersonalization
2. Derealization

Specify if: With delayed expression: If the full diagnostic criteria not met until at least 6 mos after event (although the onset and expression of some sxs may be immediate).

159

Acute Stress Disorder

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

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) occur to others.
3. Learning that violent or accidental event(s) occurred to a close family member or close friend
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). (Does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related)

160

Acute Stress Disorder

B. 9 (or more) of the following sxs:

Intrusion Symptoms

1.Recurrent, involuntary, & intrusive distressing memories of the traumatic event(s). In children, repetitive play may express themes or aspects of the traumatic event(s)
2. Recurrent distressing dreams w content and/or affect related to the event(s). In children, may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. In children, reenactment may occur in play.
4. Intense or prolonged psychological distress or marked physiological rxs in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

161

Acute Stress Disorder

Negative Mood

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms

6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia or other factors such as head injury, alcohol, or drugs).

162

Acute Stress Disorder

Avoidance Symptoms

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

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

163

Acute Stress Disorder

Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
12. Hypervigilance.
13. Problems with concentration.
14. Exaggerated startle response.

164

Acute Stress Disorder

C. Duration is 3 days to 1 mo after trauma exposure. (Sxs typically begin immediately, but persistence for at least 3 days and up to a mo is needed to meet disorder criteria.

D. Causes clinically significant distress or impairment in social, occupational, or other important areas of funxing.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic DO.

165

Adjustment Disorders

A. Development of emotional or beh sxs in response to an identifiable stressor(s) occurring within 3 mos of the onset of the stressor(s).

B. Sxs or behs are clinically significant, w 1 or both:

1. Marked distress out of proportion to severity or intensity of stressor, taking into account external context and cultural factors that might influence sx severity and presentation.
2. Significant impairment in social, occupational, or other important areas of functioning.

166

Adjustment Disorders

C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.

D. The symptoms do not represent normal bereavement.

E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

167

Adjustment Disorders

Specify whether:

- With depressed mood
- With anxiety
- With mixed anxiety and depressed mood
- With disturbance of conduct
- With mixed disturbance of emotions and conduct
- Unspecified

Specify if:
Acute: lasts <6 months
Persistent (chronic): lasts for >6 months

168

Other Trauma- and Stressor-Related Disorders

Posttraumatic Stress Disorder for Children 6 Years and Younger

Other Specified Trauma- and Stressor-Related Disorder

Unspecified Trauma- and Stressor-Related Disorder

169

Case Example

Bethany Pinsky, age 23, had gone to a theater to see the local premiere of a big-budget movie. As she settled into her seat, waiting for the show to begin, a young man in a ski mask suddenly appeared in front of the screen. Brandishing an assault rifle, he fired directly into the audience. She saw many people get shot, including the woman sitting next to her. People all around began screaming, and there was a confused stampede for the exit door. Terrified, she somehow fought her way to the exit and escaped, uninjured, to the parking lot, where police cars were just arriving.

Charles Quigley, age 25, went to the same movie theater at the same time. He too feared for his life. Hiding behind a row of seats, he was able to crawl to the aisle and quickly sprint to the exit. Although covered in blood, he escaped without physical injury. (from DSM-5 Clinical Cases)

170

Dissociative Disorders

171

Dissociative Identity Disorder

A. Disruption of identity characterized by 2 or more distinct personality states, which may be described in some cultures as an experience of possession. Involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

172

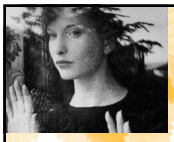
Dissociative Identity Disorder

C. Sxs cause clinically significant distress or impairment in social, occupational, or other important areas of funxing.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice.
Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

E. Not attributable to the physiological effects of a subs (e.g., blackouts or chaotic behavior during alcohol intoxication) or med cond (e.g., complex partial seizures).

173



Depersonalization/ Derealization Disorder

A. The presence of persistent or recurrent experiences of depersonalization, derealization, or both:

1. Depersonalization: Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional &/or physical numbing).
2. Derealization: Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).

174

Depersonalization/ Derealization Disorder

B. During the experiences, reality testing remains intact.
C. Sxs cause clinically significant distress or impairment in social, occupational, or other important areas of funxing.
D. Not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or another medical condition (e.g., seizures).
E. Not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, PTSD, or another dissociative disorder.

175

Other Dissociative Disorders

Dissociative Amnesia
(Specify if with Dissociative Fugue)

Other Specified Dissociative Disorder

Unspecified Dissociative Disorder

176

Case Example

Jason Vaughan, a 20-year-old college sophomore, was referred by his dorm's resident adviser to the school's mental health clinic after appearing "strange and out of it." Mr. Vaughan told the evaluating therapist that he had not been his "usual self" for about 3 months. He said his mind often felt blank, as if thoughts were not his own. He had felt increasingly detached from his physical body, going about his daily activities like a "disconnected robot." At times, he felt uncertain if he were alive or dead, as if existence were a dream. He said he almost felt like he had "no self." These experiences left him in a state of terror for hours on end. His grades declined, and he began to socialize only minimally.

(from DSM-5 Clinical Cases)

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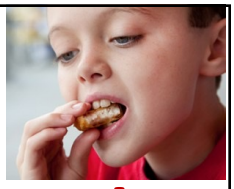
Somatic Symptom and Related Disorders

178

Somatic Sx & Related DOs

- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder (Functional Neurological Symptom Disorder)
- Psychological Factors Affecting Other Medical Conditions
- Factitious Disorder
- Other Specified Somatic Symptom and Related Disorder

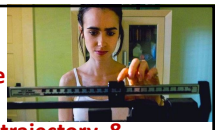
179



Feeding and Eating Disorders

180

Anorexia Nervosa



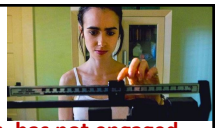
A. Restriction of energy intake relative to reqs, leading to a sign low body wt in context of age, sex, developmental trajectory, & physical health. Sign low weight is defined as a weight less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining wt or bcming fat, or persistent beh that interferes w weight gain, even tho at sign lo wt.

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

181

Anorexia Nervosa



Specify whether:
Restricting type: During the last 3 mos, has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). Weight loss accomplished primarily thru dieting, fasting, and/or excessive exercise.

Binge-eating/purging type: During last 3 mos, engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify: partial/full remission: mild/mod/sev/extreme

182

Bulimia Nervosa

A. Recurrent episodes of binge eating, characterized by both:

1. Eating, in a discrete period of time (e.g., 2-hrs), an amount of food definitely larger than most would eat in a similar period under similar circumstances.

2. A sense of lack of control over eating during the episode (e.g., a feeling that cannot stop eating or control what or how much one is eating).

183

Bulimia Nervosa

B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
C. The binge eating and inappropriate compensatory behaviors both occur, on avg, at least 1x/wk for 3 mos.
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

184

Bulimia Nervosa

A. Recurrent episodes of binge eating, characterized by both:

1. Eating, in a discrete period of time (e.g., 2-hrs), an amount of food definitely larger than most would eat in a similar period under similar circumstances.

2. A sense of lack of control over eating during the episode (e.g., a feeling that cannot stop eating or control what or how much one is eating).

185

Bulimia Nervosa

Specify if:
In partial remission/In full remission

Specify current severity:
The minimum level of severity is based on the frequency of inappropriate compensatory behaviors (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- Mild: Avg of 1–3 episodes of inappropriate compensatory behaviors per week.
- Moderate: Average of 4–7 per week.
- Severe: Average of 8–13 per week.
- Extreme: Avg of 14 or more episodes per week.

186

Other Feeding & Eating Disorders

- Pica (eating non-food substances)
- Rumination Disorder (regurgitating and re-chewing, re-swallowing, or spitting out)
- Avoidant/Restrictive Food Intake Disorder ("not fat-phobic Anorexia Nervosa")
- Binge-Eating Disorder (no purging)
- Other Specified Feeding or Eating Disorder
- Unspecified Feeding or Eating Disorder

187

Case Example

Valerie Gaspard was a 20-year-old single black woman who had recently immigrated to the United States from West Africa with her family to do missionary work. She presented to her primary care physician complaining of frequent headaches and chronic fatigue. Her physical examination was unremarkable except that her weight was only 78 pounds and her height was 5 feet 1 inch, resulting in a body mass index (BMI) of 14.7 kg/m2, and she had missed her last menstrual period. Unable to find a medical explanation for Ms. Gaspard's symptoms, and feeling concerned about her extremely low weight, the physician referred Ms. Gaspard to the hospital eating disorders program.

(from DSM-5 Clinical Cases)

188

Gender Dysphoria

189

Gender Dysphoria-Adol & Adults

A. Marked incongruence btw experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. Marked incongruence btw experienced/expressed gender & primary and/or secondary sex characteristics (or in young adol, anticipated secondary sex charactxs).

2. Strong desire to be rid of one's primary and/or secondary sex characteristics bc of marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

190

Gender Dysphoria-Adol & Adults

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

191

Gender Dysphoria-Adol & Adults

B. Assoc w clinically significant distress or impairment in social, occupational, or other important areas of funxing.

Specify if: With a disorder of sex development (e.g., a congenital adrenogenital disorder).

Specify if: Posttransition: Transitioned to full-time living in desired gender (w or wo legalization of gender change) & undergone (or preparing for) at least one cross-sex medical procedure or tx regimen—namely, regular cross-sex hormone tx or gender reassignment surgy confirming desired gender (e.g., penectomy, vaginoplasty in natal male; mastectomy or phalloplasty in natal female).

192

Other Gender Dysphoria Dxs

- Gender Dysphoria in Children
- Other Specified Gender Dysphoria
- Unspecified Gender Dysphoria

193

Case Example

Jody Rohmer, a 52-year-old salesperson, presented to a psychiatrist as part of a court proceeding that was intended to legally reassign her gender to female.

(from DSM-5 Clinical Cases)

194

Disruptive, Impulse-Control, and Conduct Disorders

195

Oppositional Defiant Disorder

A. A pattern of angry/irritable mood, argumentative/ defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least 4 symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry/Irritable Mood

1. Often loses temper.
2. Is often touchy or easily annoyed.
3. Is often angry and resentful.

196

Oppositional Defiant Disorder

Argumentative/Defiant Behavior

4. Often argues with authority figures or, for children and adolescents, with adults.

5. Often actively defies or refuses to comply with requests from authority figures or with rules.

6. Often deliberately annoys others.

7. Often blames others for his or her mistakes or misbehavior.

197

Oppositional Defiant Disorder

Vindictiveness
8. Spiteful or vindictive at least twice within past 6 mos.

Note: The persistence and freq of these behs should be used to distinguish a beh that is wnl from a beh that is sxmatic. For children <5yrs, beh should occur on most days for at least 6 mos unless otherwise noted. For >5yrs, beh should occur at least 1x/wk for at least 6 mos, unless otherwise noted. While these freq criteria provide guidance on a minimal level to define sxs, other factors should also be considered, such as whether the freq and intensity of the behs are outside a range that is normative for developmental level, gender, and culture.

198

Oppositional Defiant Disorder

B. Assoc w distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other imp areas of funx.

C. Behs do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar DO. Also, criteria not met for disruptive mood dysreg DO.

Specify current severity:
Mild: Symptoms are confined to only one setting (e.g., at home, at school, at work, with peers).
Moderate: Some sxs in at least two settings.
Severe: Some sxs are present in three or more settings.

199

Intermittent Explosive Disorder

A. Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by either of the following:

1. Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals, or other indivs, 2x/wk on avg, for 3mo period. Physical aggression does not result in damage/ destrux of prop or physical injury to animals or indivs.

2. 3 beh outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals w/in 12-mo period.

200

Intermittent Explosive Disorder

B. Magnitude of aggressiveness grossly out of proportion to provocation or to precipitating psychosocial stressors.

C. Outbursts not premeditated (i.e., impulsive and/or anger-based) and not committed to achieve some tangible objective (e.g., money, power, intimidation).

D. Outbursts cause either marked distress in the indiv or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences.

E. At least 6 yrs old (or equivalent developmental level).

201

Intermittent Explosive Disorder

F. Not better explained by another mental DO (e.g., major depressive DO, bipolar DO, disruptive mood dysregulation DO, a psychotic DO, antisocial pers DO, borderline pers DO) and not attributable to another med condition (e.g., head trauma, Alz's disease) or to the physiological effects of a subs (e.g., a drug of abuse, a med). For 6–18 yos, aggressive beh that occurs as part of an adjustment DO should not be considered for this dx.

Note: Dx can be made in addition to dx of ADHD, conduct DO, oppositional defiant DO, or autism spectrum DO when recurrent impulsive aggressive outbursts are in excess of those usually seen in these DOs and warrant independent clinical attn.

202

Conduct Disorder

A. Repetitive and persistent pattern of beh in which the basic rights of others or major age-appropriate societal norms or rules are violated, at least 3 of the following 15 criteria in past 12 mos from any of the categories below, with at least one criterion present in the past 6 mos:

Aggression to People and Animals
1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
4. Has been physically cruel to people.
5. Has been physically cruel to animals.

203

Conduct Disorder

6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
7. Has forced someone into sexual activity.

Destruction of Property
8. Has deliberately engaged in fire setting with the intention of causing serious damage.
9. Has deliberately destroyed others' property (other than by fire setting).

Deceitfulness or Theft
10. Broken into someone else's house, building, or car.
11. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).

204

Conduct Disorder

12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).

Serious Violations of Rules

13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
15. Often truant from school, beginning before age 13.

B. Causes clinically significant impairment in social, academic, or occupational functioning.

C. If 18 yrs or older, criteria not met for antisocial PD.

205

Conduct Disorder

Specify if:

- With limited prosocial emotions
- Lack of remorse or guilt
- Callous—lack of empathy
- Unconcerned about performance
- Shallow or deficient affect

Specify current severity:

- Mild
- Moderate
- Severe

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Other Disruptive, Impulse-Control, and Conduct Disorders

- Antisocial Personality Disorder
- Pyromania
- Kleptomania
- Other Specified Disruptive, Impulse-Control, and Conduct Disorder
- Unspecified Disruptive, Impulse-Control, and Conduct Disorder

207

Case Example

Kyle was a 12-year-old boy who reluctantly agreed to admission to a psychiatric unit after getting arrested for breaking into a grocery store. His mother said she was "exhausted," adding that it was hard to raise a boy who "doesn't know the rules."

(from DSM-5 Clinical Cases)

208

Substance-Related and Addictive Disorders

209

Alcohol Use Disorder

A. Problematic pattern of alcohol use w clinically sign impairment or distress, w at least 2 of the following, within a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.

210

Alcohol Use Disorder

6. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of use.
8. Recurrent use in situations in which it is physically hazardous.
9. Use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

211

Alcohol Use Disorder

10. Tolerance, as defined by either of the following:
    a. Need for markedly increased amounts to achieve intoxication or desired effect.
    b. Markedly diminished effect w continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following:
    a. Characteristic withdrawal syndrome for alcohol
    b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

212

Alcohol Use Disorder

Specify:
In early remission: 3-12 mos
In sustained remission: >12mos
In a controlled environment
Mild: Presence of 2–3 symptoms.
    Mild, In early remission
    Mild, In sustained remission
Moderate: Presence of 4–5 symptoms.
    Moderate, In early remission
    Moderate, In sustained remission
Severe: Presence of 6 or more symptoms.
    Severe, In early remission
    Severe, In sustained remission

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Other Substance/Addictive Disorders

Alcohol Intoxication, Alcohol Withdrawal,
Unspecified Alcohol-Related Disorder
Caffeine Intoxication, Caffeine Withdrawal,
Unspecified Caffeine-Related Disorder
Cannabis Use Disorder, Cannabis Intoxication,
Cannabis Withdrawal, Unspecified Cannabis-Related DO
Phencyclidine Use Disorder
Other Hallucinogen Use Disorder
Phencyclidine Intoxication
Other Hallucinogen Intoxication
Hallucinogen Persisting Perception Disorder
Unspecified Phencyclidine-Related Disorder
Unspecified Hallucinogen-Related Disorder

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Other Substance/Addictive Disorders

Inhalant Use Disorder, Inhalant Intoxication,
Unspecified Inhalant-Related Disorder
Opioid Use Disorder, Opioid Intoxication,
Opioid Withdrawal, Unspecified Opioid-Related Disorder
Sedative, Hypnotic, or Anxiolytic Use Disorder
Sedative, Hypnotic, or Anxiolytic Intoxication
Sedative, Hypnotic, or Anxiolytic Withdrawal
Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related DO
Stimulant Use Disorder, Stimulant Intoxication,
Stimulant Withdrawal, Unspecified Stimulant-Related DO

215

Other Substance/Addictive Disorders

Tobacco Use Disorder, Tobacco Withdrawal,
Unspecified Tobacco-Related Disorder

Other (or Unknown) Substance Use Disorder
Other (or Unknown) Substance Intoxication
Other (or Unknown) Substance Withdrawal
Unspecified Other (or Unknown) Substance–Related DO

Gambling Disorder

216

Case Example

Matthew Tucker, a 45-year-old white plumber, was referred for a psychiatric evaluation after his family did an intervention to express their concern that his alcohol problems were getting out of hand. Mr. Tucker denied having had a drink since making the appointment 3 days earlier.

(from DSM-5 Clinical Cases)

217

Neurocognitive Disorders

218

Neurocognitive Domains

Complex attn (sustained attn, divided attn, selective attn, processing speed)

Executive function (planning, decision making, working memory, responding to feedback/error correction, overriding habits/inhibition, mental flexibility)

Learning & memory (immediate memory, recent memory [including free recall, cued recall, & recognition memory], very-long-term memory [semantic; autobiographical], implicit learning)

219

Neurocognitive Domains

Language (expressive language [including naming, word finding, fluency, and grammar, and syntax] and receptive language)

Perceptual-motor (includes abilities subsumed under the terms visual perception, visuoconstructional, perceptual-motor, praxis, and gnosis)

Social cognition (recognition of emotions, theory of mind)

220

Neurocognitive Disorders

Delirium
Other Specified Delirium
Unspecified Delirium
Major and Mild Neurocognitive Disorders
Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease
Major or Mild Frontotemporal Neurocognitive Disorder
Major or Mild Neurocognitive DO With Lewy Bodies
Major or Mild Vascular Neurocognitive Disorder
Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury

221

Neurocognitive Disorders

Substance/Medication-Induced Major or Mild Neurocognitive Disorder
Major or Mild Neurocognitive DO Due to HIV Infection
Major or Mild Neurocognitive DO Due to Prion Disease
Major or Mild Neurocognitive Disorder Due to Parkinson's Disease
Major or Mild Neurocognitive Disorder Due to Huntington's Disease
Major or Mild Neurocognitive Disorder Due to Another Medical Condition

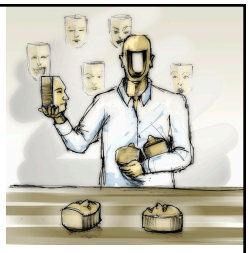
222

Case Example

Arthur Cullman, a 71-year-old man, was referred to a psychiatrist by his primary care physician for evaluation of depressive symptoms that had not responded to medication trials. His wife reported that Mr. Cullman had begun to change at age 68, about a year after his retirement. He had gradually stopped playing golf and cards, activities he had enjoyed "for decades." He had explained that seeing his friends was no longer "fun," and he generally refused to socialize. Instead, he sat on the couch all day, worrying about finances and the future. He denied sadness, however, and any suicidal or homicidal ideation. His wife said he was sleeping 10–12 hours a day instead of his customary 7 hours and that he had, uncharacteristically, gained 8 pounds in less than 1 year.

(from DSM-5 Clinical Cases)

223



Personality Disorders

224

Personality Disorders

- DSM-5 Debate
  - -Categorical vs Dimensional
  - -Normal/Healthy vs. Disorder
- 15-19% prevalence for all PDs, cross-culturally and globally
- 39-100% in clinical populations

225

Personality Disorders

- Lifelong pattern present
- If <18, at least 1 year
- For antisocial, must be >18
- Features/Traits
- 6 criteria must be met

226

Personality Disorders

Criterion A:

Enduring pattern of inner experience & behavior, deviates markedly from cultural expectations in 2 or more areas:

- Cognition
- Affectivity
- Interpersonal functioning
- Impulse control

227

Personality Disorders

Criterion B:

Enduring pattern is inflexible and pervasive across a broad range of personal & social situations

228

Personality Disorders

Criterion C:
Leads to significant distress or impairment in important area of functioning (social, occupational, etc.)

229

Personality Disorders

Criterion D:
Stable and of long duration, onset can be traced back at least to adolescence/early adulthood

230

Personality Disorders

Criterion E:
Not better explained by another mental health disorder

Criterion F:
Not attributable to substance or medical condition

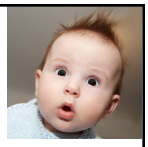
231

Top indicators of PD you won't find in the DSM-5®

- Discussions with them are not reciprocal – they don't "feel right"
- They don't always follow social rules
- You find yourself choosing words carefully to avoid upsetting them
- You hope the client no-shows

232

5 things you probably never knew about pers disorders



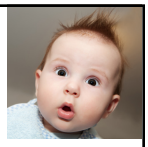
1. PDs are character disorders – deficits and excesses within personality, not sxs

   -For people with anxiety and depression, the symptoms are the problem

   -For people with personality disorders, the system of the person is the problem

233

5 things you probably never knew about pers disorders



2. Updated research suggests they are genetic and neurological conditions

   Concordance rates for identical twins:

   Borderline: 78%

   Histrionic: 70%

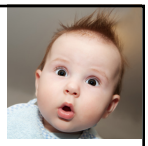
   Narcissistic: 77%

   Antisocial: 80%

   (Gregory Lester; Karolinska Institutet, Stockholm, Sweden)

234

5 things you probably never knew about pers disorders



3. Spending lots of time examining childhood does not help or can make worse
4. 25% of individuals with Borderline PD have trauma history (same as general pop) (Joel Paris)
5. Most experts consider Antisocial PD untreatable -- do management only (esp if no guilt or remorse)

235

Judgment and Labeling

- Use person-centered language
- Watch out for blaming – it is a biological condition like schizophrenia
- Their behavior is why they are there – they are trying to be happy
- Give client narrative vs label

236

Cluster A Personality Disorders

"odd" cluster

- Paranoid
- Schizoid
- Schizotypal

237

Paranoid Personality Disorder

A pattern of pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent.

238

Paranoid Personality Disorder

At least 4 of the following:

1. Suspects, w/o sufficient basis, others are exploiting, harming, or deceiving him or her.
2. Preoccupied w unjustified doubts about loyalty or trust-worthiness of friends/associates

239

Paranoid Personality Disorder

3. Reluctant to confide in others bc of unwarranted fear that info will be used maliciously against him or her.

4. Reads hidden demeaning or threatening meanings into benign remarks or events.

5. Persistently bears grudges.

240

Paranoid Personality Disorder

6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.

7. Has recurrent suspicions, without justification, regarding fidelity of partner

241

Paranoid Personality Disorder

Excessive Trait: Suspiciousness

Biggest Deficiency: Trust

(Lester)

242

Paranoid Personality Disorder

The Hidden Agenda

Their behavior sets things up to prove that other people are untrustworthy and will betray them, and that they are justified in retaliating and inflicting their pain on the world. (Lester)

243

Paranoid Personality Disorder

Prevalence: 2.3% - 4.4%

244

Schizoid Personality Disorder

A pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings

245

Schizoid Personality Disorder

At least 4 of the following:

1. Neither desires nor enjoys close relationships/family.
2. Almost always chooses solitary activities.
3. Has little, if any, interest in sexual experiences.

246

Schizoid Personality Disorder

4. Takes pleasure in few, if any, activities
5. Lacks close friends or confidants other than 1st degree relatives
6. Appears indifferent to praise or criticism
7. Shows emotional coldness, detachment, or flat affect

247

Schizoid Personality Disorder

Prevalence: 3.1% - 4.9%

248

Schizoid Personality Disorder

Excessive Trait: Indifference

Biggest Deficiency: Attachment

(Lester)

249

Schizoid Personality Disorder

The Hidden Agenda

Their behavior sets things up to prove that relationships are messy and undesirable, that there is no value in attaching or relating, and that being self sufficient and needing nothing from anyone is the best way to live. (Lester)

250

Schizotypal Personality Disorder

A pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior

251

Schizotypal Personality Disorder

At least 5 of the following:

1. **Ideas of reference (not delusions)**
2. **Odd beliefs or magical thinking that influences behavior, inconsistent w subcultural norms**
3. **Unusual perceptual experiences, including bodily illusions**

252

Schizotypal Personality Disorder

4. Odd thinking & speech
5. Suspiciousness or paranoid ideation
6. Inappropriate or constricted affect

253

Schizotypal Personality Disorder

7. Behavior or appearance that is odd, eccentric, or peculiar
8. Lack of close friends or confidants other than 1st degree relatives
9. Excessive social anx that does not diminish w familiarity & tends to be assoc w paranoid fears rather than neg judgments about self

254

Schizotypal Personality Disorder

Prevalence: 3.9% - 4.6%

255

Schizotypal Personality Disorder

Excessive Trait: Eccentricity

Biggest Deficiency: Conformity

(Lester)

256

Schizotypal Personality Disorder

The Hidden Agenda

Their behavior sets things up to prove that they are gifted and smarter than others, that they can see that life works strangely and magically, and that others are overly conventional and do not understand the real ways that life works. (Lester)

257

Cluster B Personality Disorders

"dramatic" cluster

- Borderline
- Antisocial
- Narcissistic
- Histrionic

258

Borderline Personality Disorder

A pattern of instability in interpersonal relationships, self-image, and affect, and marked impulsivity

259

Borderline Personality Disorder

At least 5 of the following:

1. Frantic efforts to avoid real or imagined abandonment
2. Pattern of unstable and intense relationships alternating between extremes of idealization and devaluation

260

Borderline Personality Disorder

3. Unstable self-image or sense of self
4. Impulsivity in at least 2 self-damaging areas (spending, sex, substances, driving, eating)
5. Recurrent suicidal behavior, gestures, threats, self-mutilating
6. Affective instability due to a marked reactivity of mood

261

Borderline Personality Disorder

7. Chronic feelings of emptiness
8. Inappropriate/intense anger, difficulty controlling anger
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

262

Borderline Personality Disorder

- Prevalence: 1.6-5.9%
- 6% primary care, 10% outpatient, 20% inpatient
- Decreases with age

263

Borderline Personality Disorder

Excessive Trait: Instability

Biggest Deficiency:
Proportionality

(Lester)

264

Borderline Personality Disorder

The Hidden Agenda

Their behavior sets things up to prove that the world is hurtful and dangerous, that other people wound them, that no one sufficiently meets their needs, that others are bad, and that they are too. (Lester)

265

Borderline Personality Disorder

Neurological findings:

- 16.0% smaller hippocampus
- 7.5% smaller amygdala
- Reduced activity in prefrontal cortex

266

Antisocial Personality Disorder

A pattern of disregard for, and violation of, the rights of others

267

Antisocial Personality Disorder

A: At least 3 of the following:

1. Failure to conform to social norms/laws, repeatedly doing acts that are grounds for arrest
2. Deceitfulness (lying, using aliases, conning others for profit or pleasure)
3. Impulsivity/failure to plan ahead

268

Antisocial Personality Disorder

4. Irritability & aggressiveness (fights and assaults)
5. Reckless disregard for safety of self or others
6. Irresponsibility (work/financial)
7. Lack of remorse – indifference or rationalizing having hurt, mistreated, or stolen from another

269

Antisocial Personality Disorder

B: At least 18 years old
C: Evidence of conduct disorder before age 15
D: Behavior not due to schizophrenia or bipolar disorder

270

Antisocial Personality Disorder

- Prevalence: 0.2-3.3%
- >70% in most severe samples of males w alc/subs use in forensic settings

271

Antisocial Personality Disorder

Excessive Trait: Exploitation

Biggest Deficiency: Honor /keeping agreements

(Lester)

272

Antisocial Personality Disorder

The Hidden Agenda

Their behavior sets things up to prove that it is a dog-eat-dog world, that they are justified in doing anything to get their needs met, that others are suckers, and that they are smarter, stronger, and better than other people. (Lester)

273

Antisocial Personality Disorder

Neurological findings:
Reduced grey matter and decreased activity in prefrontal cortex

274

Narcissistic Personality Disorder

A pattern of grandiosity, need for admiration, and lack of empathy

275

Narcissistic Personality Disorder

5 or more of the following:

- Grandiose sense of self-importance
- Preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love

276

Narcissistic Personality Disorder

- Believes is special, and can only be understood or assoc w other special people/institutions
- Requires excessive admiration
- A sense of entitlement (unreasonable expectations of special tx or automatic compliance with expectations)

277

Narcissistic Personality Disorder

- Interpersonally exploitative (takes advantage of others)
- Lacks empathy
- Is often envious of others and believes others envious
- Arrogant, haughty behaviors or attitudes

278

Narcissistic Personality Disorder

- Prevalence: 0 to 6.2% in community samples
- Biological component: 77%

279

Narcissistic Personality Disorder

Excessive Trait: grandiosity

Biggest Deficiency: equality

(Lester)

280

Narcissistic Personality Disorder

The Hidden Agenda

Their behavior sets things up to prove that they are better than everyone else, that they deserve to be served and admired, that they are entitled to special treatment, and that other people are fools. (Lester)

281

Narcissistic Personality Disorder

Neurological findings:

- smaller gray matter volume in the left anterior insula (emotional empathy)
- smaller GM volume in fronto-paralimbic brain regions comprising the rostral and median cingulate cortex as well as dorsolateral and medial parts of the prefrontal cortex

282

Histrionic Personality Disorder

A pattern of excessive emotionality and attention seeking

283

Histrionic Personality Disorder

5 or more of the following:

- Uncomfortable when not the center of attention
- Inappropriate sexually seductive or provocative behavior
- Rapidly shifting and shallow expression of emotions

284

Histrionic Personality Disorder

- Uses physical appearance to draw attention to self
- Speech is excessively impressionistic and lacking in detail
- Self-dramatization, theatricality, and exaggerated expression of emotion

285

Histrionic Personality Disorder

- Suggestible (easily influenced by others or circumstances)
- Considers relationships to be more intimate than they actually are

286

Histrionic Personality Disorder

- Prevalence: 1.84%
- One of the least studied PDs

287

Histrionic Personality Disorder

Excessive Trait: Expressiveness

Biggest Deficiency: Shame

(Lester)

288

Histrionic Personality Disorder

The Hidden Agenda

Their behavior sets things up to prove that they must be provocative and demanding to get their needs met, and that they are attractive and are worthy of being admired and sought-after. (Lester)

289

Cluster C Personality Disorders

"anxious" cluster

- Avoidant
- Dependent
- Obsessive-Compulsive

290

Avoidant Personality Disorder

A pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation (DSM 5)

291

Avoidant Personality Disorder

At least 4 of the following:

1. Avoids occupational activities w sign interpersonal contact bc of fears of criticism, disapproval, or rejection
2. Is unwilling to get involved w people unless certain of being liked

292

Avoidant Personality Disorder

3. Restraint in intimate rel bc of fear of shame or ridicule
4. Preoccupied w being criticized or rejected in social situations
5. Inhibited in new interpersonal situation bc of feelings of inadequacy

293

Avoidant Personality Disorder

6. Views self as socially inept, personally unappealing, or inferior
7. Is unusually reluctant to take personal risks or to engage in any new activities bc may prove embarrassing

294

Avoidant Personality Disorder

Prevalence: 2.4%

295

Avoidant Personality Disorder

Excessive Trait: timidity

Biggest Deficiency: resilience

(Lester)

296

Avoidant Personality Disorder

The Hidden Agenda

Their behavior sets things up to prove that the world is hurtful and dangerous, that the only safety comes through distancing, and that although they feel lonely, there is no safe alternative to being isolated. (Lester)

297

Dependent Personality Disorder

A pattern of pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation (DSM 5)

298

Dependent Personality Disorder

At least 5 of the following:

1. Has difficulty making everyday decisions wo an excessive amount of advice & reassurance
2. Needs others to assume responsibility for most major areas of his or her life

299

Dependent Personality Disorder

3. Has difficulty expressing disagreement w others bc of fear of loss of support or approval (excluding realistic)
4. Has difficulty initiating projects or doing things on own (bc of lack of self-conf in judgment or abilities not motivation/energy)

300

Dependent Personality Disorder

5. Goes to excessive lengths to obtain nurturance & support, incl volunteering to do unpleasant things
6. Feels uncomfortable or helpless when alone bc of exaggerated fears of being unable to care for self

301

Dependent Personality Disorder

7. Urgently seeks another rel for care & support when a close rel ends
8. Is unrealistically preoccupied w fears of being left to take care of self

302

Dependent Personality Disorder

Prevalence: .49% - .6%

303

Dependent Personality Disorder

Excessive Trait: submissiveness

Biggest Deficiency: independent thinking

(Lester)

304

Dependent Personality Disorder

The Hidden Agenda

Their behavior sets things up to prove that they are not competent to handle their own lives, that others need to take care of things for them and to be responsible for their life, and that they cannot live without others handling things for them. (Lester)

305

Obsessive-Compulsive Personality Disorder

A pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency (DSM 5)

306

Obsessive-Compulsive Personality Disorder

At least 4 of the following:

1. Is preoccupied w details, rules, lists, order, organization, or schedules to extent that major point of activity is lost
2. Perfectionism interferes w task completion

307

Obsessive-Compulsive Personality Disorder

3. Excessively devoted to work and productivity to exclusion of leisure and friends (not economic need)
4. Is overconscientious, scrupulous, & inflexible about morality, ethics, or values (not cult/relig)

308

Obsessive-Compulsive Personality Disorder

5. Unable to discard worn-out or worthless objects even w/o sentimental value
6. Reluctant to delegate tasks or work w others unless they submit to doing things his/her way

309

Obsessive-Compulsive Personality Disorder

7. Adopts a miserly spending style toward self & others; money hoarded for future catastrophes
8. Shows rigidity and stubbornness

310

Obsessive-Compulsive Personality Disorder

Prevalence: 2.1% - 7.9%

311

Obsessive-Compulsive Personality Disorder

Excessive Trait: rigidity

Biggest Deficiency: flexibility

(Lester)

312

Obsessive-Compulsive Personality Disorder

The Hidden Agenda

Their behavior sets things up to prove that no one else does things right or well enough, and that they have to dominate, control, and demand in order to make things go right. (Lester)

313

Case Study: Arthur

- 55 years old
- Created a business for kids (28 and 30)
- Estranged from kids

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Case Example

Ike Crocker was a 32-year-old man referred for a mental health evaluation by the human resources department of a large construction business that had been his employer for 2 weeks. At his initial job interview, Mr. Crocker presented as very motivated and provided two carpentry school certifications that indicated a high level of skill and training. Since his employment began, his supervisors had noted frequent arguments, absenteeism, poor workmanship, and multiple errors that might have been dangerous. When confronted, he was reportedly dismissive, indicating that the problem was "cheap wood" and "bad management" and added that if someone got hurt, "it's because of their own stupidity."

(from DSM-5 Clinical Cases)

315

Other Conditions That May Be a Focus of Clinical Attention (V/Z codes)

316

V/Z Codes

- Relational Problems
- Abuse and Neglect
- Educational and Occupational Problems
- Housing and Economic Problems
- Other Problems Related to the Social Environment
- Problems Related to Crime / Interaction w Legal System
- Other Health Service Encounters for Counseling and Medical Advice
- Problems Related to Other Psychosocial, Personal, & Environmental Circumstances
- Other Circumstances of Personal History

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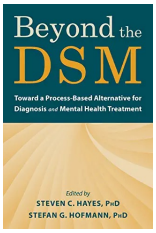
Beyond the DSM: A Processed-Based Approach to Diagnosis



318

Processes of Change: Alternative to Syndromal Dx

- *theory-based* because they are associated with a clear statement of relations among events and lead to testable predictions and method of influence
- *dynamic* because processes may involve feedback loops and nonlinear changes
- *progressive* because they may need to be arranged in an order to reach the treatment goal
- *contextually bound and modifiable* to focus on their implications for practical changes and intervention kernels within reach of practitioners
- *multilevel* because some processes supersede or are nested within others.

Hayes & Hoffman, 2020

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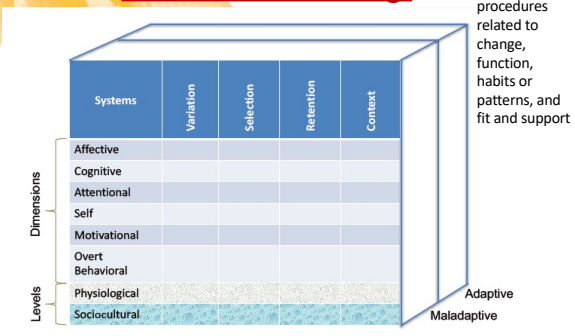
Extended Evolutionary Meta-Model of Processes of Change



processes and procedures related to change, function, habits or patterns, and fit and support

Hayes & Hoffman, 2020

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Functional Contextualism

Context and function of behaviors are important

-Bucket with holes

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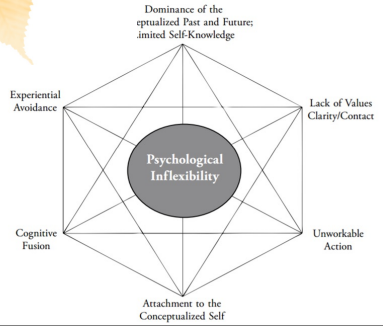
Processed Based Model of Psychopathology



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Acceptance and Commitment Therapy (ACT)

Psychological Flexibility:

"contacting the present moment fully as a conscious, historical human being, and based on what the situation affords, changing or persisting in behavior in the service of chosen values"

Steven C. Hayes -- contextualscience.org

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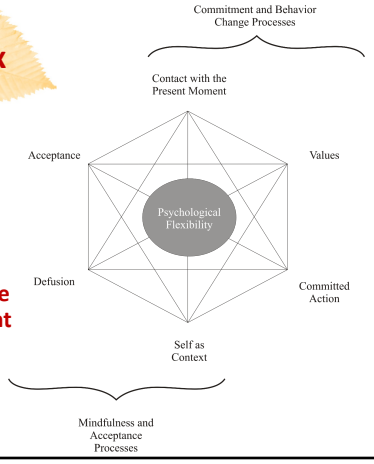
Hexaflex

The Six Core Processes of ACT:

- **Self as Context**
- **Defusion**
- **Acceptance**
- **Contact with the Present Moment**
- **Values**
- **Committed Action**



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Discussion & Questions

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