DSM 5 A New Frontier

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Various diagnoses have been merged or renamed.

There is an assumption that everyone’s mental status falls on a spectrum that stretches from typical to pathological. Consequently, there is an effort to introduce a dimensional scale for virtually all disorders e.g. mild, moderate, severe, very severe.
Disorders may no longer be clustered as major mental illnesses, personality disorders, and medical problems related to mental illness (Axis I, II, III.)

The organization is chronological across the lifespan. (DSM–IV® was roughly organized according to the frequency that illnesses were seen by treaters – disorders of youth, dementia, substance use, etc.)
Overview

- Instead of the specifier Not Otherwise Specified (NOS), DSM–5® will use Condition Not Elsewhere Classified (CNEC). The DSM–5® CNEC is intended to be used with specific diagnoses that fail to meet criteria for specific reasons: subsyndromal symptoms, insufficient information, patient cannot provide data, etc..

- Presumably, DSM–5® will have a print version and an electronic version that will be continually updated (DSM 5®.1, 5.2, etc..)
The DSM–5® definition of mental disorder is essentially the same as the DSM–IV® definition, although more succinct. It says that a mental disorder is a condition characterized by dysfunction in thought, mood, or behaviors, which usually causes distress. The condition should not be primarily a result of social deviance or conflicts with society.
The DSM-5 groups are:
1. Neurodevelopmental disorders
2. Schizophrenia and primary psychotic disorders
3. Bipolar and Related Disorders
4. Mood Disorders
5. Anxiety Disorders
6. Disorders Related to Environmental Stress
7. Obsessive Compulsive Spectrum
8. Somatic Symptom Disorder
9. Feeding and Eating Disorder
10. Sleep Disorders
11. Disorders of Sexual Function
12. Antisocial and Disruptive Disorders
13. Substance Abuse–Related Disorders
14. Neurocognitive Disorders
15. Personality Disorders
16. Paraphilias
17. Other Disorders
## DSM IV–TR and DSM 5

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DSM 5

- Multiaxial format modified; it appears that the multiaxial concept will be eliminated and the focus is on diagnostics; personality disorders, medical conditions, and psychosocial aspects (Axis II, III, IV) incorporated into the diagnostics of the DSM 5.
- NOS eliminated; replaced with CNEC or NEC
- Two conditions for CNEC:
  1. When guidelines for classification met but specific diagnosis unclear
  2. Uncertainty: because client cannot provide enough info; limited time to gain info, OR not trained in a specific area
Each category has three specific features:

1. Comment on attitude considerations and whether condition presents as syntonic or dystonic; helpful for case conceptualization and related to DSM 5 concept of treatment. Some disorders will have specifiers that will be insight considerations
   - Good insight; poor insight; absent
   - Prochaska and DiClemente transtheoretical model

2. Co-related disorders and suicide risk comment; research based evidence on co-related disorders and comments on the vulnerability that diagnosis has to suicide

3. Provide statement with regard to age, gender, and culture; developmental symptom manifestation
Global Assessment of Functioning
Will take a more pronounced role in the DSM’s approach to outcome studies “psychologists will be asked to validate their effectiveness”

Dimensional Assessment

Model of outcome study:
- Asked to document behaviorally measured observation of the client’s decrease in maladaptive behavior; behavior will be identified and a stated goal in reduction of behavior and a timeline
- Asked to document behaviorally measured observations of an increase in adaptive coping (i.e., mindfulness, distress tolerance, emotional regulation, interpersonal relationship skills, etc.)
As before, a number from 0–100 assigned
  ◦ Determine the category
    • Emergency 0–30 (in–pt. services only!!)
    • Urgent 31–70 (out–pt. territory)
    • Normative 71–100
  ◦ Determine the range
    • i.e., 31–40; 41–50; 51–60; 61–70
  ◦ Determine the number in the range
    • Reflects client’s worst functioning

GAF measures psychological, social, occupational functioning
  ◦ 1–10 most extreme
  ◦ 11–20 extreme impairment
  ◦ 21–30 moderate–extreme impairment
  ◦ 31–70 major impairment; serious impairment; moderate symptoms; mild symptoms
  ◦ 71–100 slight to no impairment
Cross-cutting assessment addresses factors not necessarily included in the diagnostic criteria of a specific disorder but that may be relevant for prognosis, treatment planning, assessment of outcome, or refinement of diagnosis.

“Cross-cutting” in the sense that these measures cut across the boundaries of any single disorder.

Represent domains that are commonly seen and monitored in patients, regardless of their initial clinical presentation.

Self-report ratings by a patient or informant.

Examples include measurement of depressed mood, anxiety, substance use, or sleep problems.

The intent is to provide clinicians a brief, simple way to obtain ratings for such important areas over time regardless of the specific disorder.
Neurodevelopmental Disorders

- Intellectual developmental disorder
- Communication disorders
  - Language disorder
  - Speech disorder
    - Speech sound disorder
    - Motor speech disorders
    - Childhood onset fluency disorder
    - Voice disorder
    - Resonance disorder
  - Social communication disorder
- Autism spectrum disorder
- Attention Deficit/Hyperactivity Disorder
- Specific Learning Disorder
  - Reading, written expression, math
Neurodevelopmental Disorders

- Motor disorders
  - Developmental coordination disorder
  - Stereotypic movement disorder
  - Tourette’s disorder
  - Chronic oral or motor tic disorder
  - Provisional tic disorder
  - Tic disorder, CNEC
  - Substance induced tic disorder
  - Tic disorder due to another medical condition
Intellectual Developmental Disorder (A00)

- Intellectual Developmental Disorder (IDD) is a disorder that includes both a current *intellectual deficit* and a *deficit in adaptive functioning* with onset during the developmental period. The following 3 criteria must be met:
  - A. Intellectual Developmental Disorder is characterized by deficits in general mental abilities such as reasoning, problem-solving, planning, abstract thinking, judgment, academic learning and learning from experience.
  - B. Impairment in adaptive functioning for the individual’s age and sociocultural background. Adaptive functioning refers to how well a person meets the standards of personal independence and social responsibility in one or more aspects of daily life activities. The limitations result in the need for ongoing support at school, work, or independent life.
  - C. All symptoms must have an onset during the developmental period
The diagnosis of IDD is based on both clinical assessment and standardized testing of intelligence.

Both the AAIDD and DSM-5 define intelligence as a general mental ability that involves reasoning, problem solving, planning, thinking abstractly, comprehending complex ideas, judgment, academic learning, and learning from experience. In DSM-5, the definition is applied to reasoning in three contexts: academic learning, social understanding, and practical understanding.

Still use IQ score 2 SDs or below; discourage use of only FSIQ scores and encourage use of overall cognitive profiles.

Assessment procedures must take into account that other factors may limit performance.
DSM-5 does not list mild, moderate, severe, and profound subtypes; Instead, it lists mild, moderate, and severe severity levels.

The focus in the severity levels is on adaptive functioning and not IQ test scores; Severity listed in the conceptual, social, and practical domains.

Adaptive functioning refers to how well an individual copes with the common tasks of everyday life in three general domains (i.e., conceptual, social, and practical), and how well an individual meets the standards of personal independence and social responsibility expected for someone of a similar age, sociocultural background, and community setting in one or more aspects of daily life activities.
Changes:
- Three diagnostic criteria will become two (combine impairments in social interaction and communication)
- Rett’s Disorder and Childhood Disintegrative Disorder replaced by ASD
- PDD replaced by ASD; does not involve deficits or delays in every aspect of development -- in fact, it is largely restricted to social communication
- Asperger’s eliminated—replaced by ASD; Asperger–type of behaviors may be listed in the text
- Individuals diagnoses will be merged into a single, behaviorally defined disorder
- The types of symptoms in autism, Asperger's syndrome, PDD–NOS, Rett’s Disorder, and childhood integrative disorder were very similar; what differed was the severity or predominance of different symptoms
Examples of DSM IV–TR and DSM 5 criteria changes

- Subcriterion A.1.b: “failure to develop peer relationships and abnormal play”; the DSM 5 recommendations include higher order impairments of “difficulties adjusting behavior to suit different social contexts”
- The task force recognizes that neurodevelopmental disorders begin prior to birth, shortly after birth or sometime during the early developmental period; DSM IV–TR required that symptoms be present prior to age 3
  - DSM 5 requires that symptoms begin in early childhood with the caveat “the symptoms might not be fully manifested until social demands exceed capacity”, which may not be seen until the middle school years, later adolescence, or young adulthood
Autism Spectrum Disorder

- Decision to include Asperger’s and PDD-NOS within one ASD
  - Lack of specificity and sensitivity in separating the diagnoses
  - Lack of accurate historical information about early language development
  - If control is held for VIQ, there is a complete overlap in the symptoms
  - Media issues related to new diagnostics: Yale study vs. field trial data
    - Field trial data from Baystate Medical Center in MA and Stanford University comparing criteria for DSM IV vs. DSM 5
### Autism Spectrum Disorder

- Single spectrum but recognition that there is significant individual variability
- Number of specifiers:

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<th>Restricted interests &amp; repetitive behaviors</th>
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<tr>
<td>Level 3</td>
<td><strong>Severe</strong> deficits in verbal and nonverbal social communication skills cause <strong>severe</strong> impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others.</td>
<td>Preoccupations, fixated rituals and/or repetitive behaviors <strong>markedly interfere</strong> with functioning in all spheres. <strong>Marked distress</strong> when rituals or routines are interrupted; very difficult to redirect from fixated interest or returns to it quickly.</td>
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<tr>
<td>Level 2</td>
<td><strong>Marked</strong> deficits in verbal and nonverbal social communication skills; social impairments <strong>apparent even with supports</strong> in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others.</td>
<td><strong>RRBs and/or preoccupations or fixated interests appear frequently enough to be obvious</strong> to the casual observer and <strong>interfere with functioning</strong> in a variety of contexts. Distress or frustration is apparent when RRB’s are interrupted; difficult to redirect from fixated interest.</td>
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<tr>
<td>Level 1</td>
<td>Without supports in place, deficits in social communication cause <strong>noticeable impairments</strong>. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.</td>
<td><strong>Rituals and repetitive behaviors</strong> (RRB’s) cause <strong>significant interference with functioning</strong> in one or more contexts. Resists attempts by others to interrupt RRB’s or to be redirected from fixated interest.</td>
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Autism Spectrum Disorder

- Diagnostic criteria:
  - Currently, or *by history*, must meet Criterion A, B, C & D
    - A. Persistent deficits in social communication and social interactions across contexts, not accounted for by general developmental delays and manifest by all three of the following
      - 1. Deficits in social-emotional reciprocity
      - 2. Deficits in nonverbal communicative behaviors used for social interaction
      - 3. Deficits in developing and maintaining relationships appropriate to developmental level
Specifiers (cont.)

1. Severity of ASD symptoms. Severity anchors for social communication domain as well as for the restricted, repetitive symptoms
2. Pattern of onset and clinical course
3. Etiological factors, when known, and associated conditions
   - The co-morbid conditions of epilepsy and GI disturbances are examples of associated conditions
4. Individual weaknesses and strengths
   - An individual’s overall IQ is a better determinate of ultimate outcome when compared with the severity of autism symptoms
Autism Spectrum Disorder

- Criterion B
  - Restricted, repetitive patterns of behavior, interests or activities as manifested by at least 2 of the following:
    - 1. Stereotyped or repetitive speech, motor movements or use of objects
    - 2. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change
    - 3. Highly restricted, fixated interests that are abnormal in intensity or focus
    - 4. Hyper or hypo reactivity to sensory input or unusual interest in sensory aspects of environment
Autism Spectrum Disorder

- Criterion C
  - Symptoms must be present in early childhood, but may not become fully manifest until social demands exceed limited capacities

- Criterion D
  - Symptoms together limit and impair everyday functioning
Social Communication Disorder (A04)

- Persistent difficulties in pragmatics or the social uses of verbal and nonverbal communication in naturalistic contexts, which affects the development of social reciprocity and social relationships.
- Persistent difficulties in the acquisition and use of spoken language, written language, and other modalities of language (e.g., sign language) for narrative, expository and conversational discourse.
- **Rule out Autism Spectrum Disorder.** Autism spectrum disorder by definition encompasses pragmatic communication problems, but also includes restricted, repetitive patterns of behavior or interests.
- Symptoms must be present in early childhood (but may not become fully manifest until speech, language, or communication demands exceed limited capacities).
- The low social communication abilities result in functional limitations in effective communication, social participation, academic achievement, or occupational performance, alone or in any combination.
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- **Rule out Autism Spectrum Disorder.** Autism spectrum disorder by definition encompasses pragmatic communication problems, but also includes restricted, repetitive patterns of behavior or interests
- Symptoms must be present in early childhood (but may not become fully manifest until speech, language, or communication demands exceed limited capacities)
- The low social communication abilities result in functional limitations in effective communication, social participation, academic achievement, or occupational performance, alone or in any combination
A06 ADHD

- Criteria for Predominately Inattentive, Predominately Hyperactive, or Combined Symptoms relatively the same
- Change *Type* to *Presentation*
- Add 4\textsuperscript{th} Presentation: Inattentive (Restrictive)

- **Age**: Several inattentive or hyperactive–impulsive symptoms were present prior to *age 12* (*DSM IV–TR listed symptoms that caused impairment required prior to age 7*)
- ADHD, NEC
  - Below threshold symptoms but present symptoms cause impairment
History or current presentation of persistent difficulties in the acquisition of reading, writing, arithmetic, or mathematical reasoning skills during the formal years of schooling (i.e., during the developmental period). The individual must have at least one of the following:

- 1. Inaccurate or slow and effortful word reading
- 2. Difficulty understanding the meaning of what is read (e.g., may read text accurately but not understand the sequence, relationships, inferences, or deeper meanings of what is read)
- 3. Poor spelling (e.g., may add, omit, or substitute vowels or consonants)
- 4. Poor written expression (e.g., makes multiple grammatical or punctuation errors within sentences, written expression of ideas lack clarity, poor paragraph organization, or excessively poor handwriting).
- 5. Difficulties remembering number facts
- 6. Inaccurate or slow arithmetic calculation
- 7. Ineffective or inaccurate mathematical reasoning.
- 8. Avoidance of activities requiring reading, spelling, writing, or arithmetic
Current skills in one or more of these academic skills are well-below the average range for the individual’s age or intelligence, cultural group or language group, gender, or level of education, as indicated by scores on individually-administered, standardized, culturally and linguistically appropriate tests of academic achievement in reading, writing, or mathematics. Not better accounted for by IDD or sensory disorders. Learning difficulties identified in Criterion A (in the absence of the tools, supports, or services that have been provided to enable the individual compensate for these difficulties) significantly interfere with academic achievement, occupational performance, or activities of daily living that require these academic skills.
Descriptive Feature Specifiers

Specify which of the following domains of academic difficulties and their subskills are impaired, at the time of assessment:

1. Reading
   a) Word reading accuracy
   b) Reading rate or fluency
   c) Reading comprehension

2. Written expression
   a) Spelling accuracy
   b) Grammar and punctuation accuracy
   c) Legible or fluent handwriting
   d) Clarity and organization of written expression

3. Mathematics
   a) Memorizing arithmetic facts
   b) Accurate or fluent calculations
   c) Effective math reasoning
Separate category; no longer “mood disorders”

Diagnostic categories:
- Bipolar I C00
- Bipolar II (most vulnerable to suicide) C01
- Cyclothymia (possibly Bipolar III) C02
- Substance Induced Bipolar Disorder C03
- Bipolar Disorder Associated with Another Medical Condition C04
- Bipolar Disorder NEC C05

No modifications for childhood onset

Dystonic conditions, with exception of Bipolar I, most recent episode manic
Bipolar Disorder

- Bipolar I (C00)
  - A. Presence (or history) of one or more Manic Episodes (same criteria as in DSM IV-TR), with **addition of increased activity level being a necessary condition**.
  - B. The Manic Episode(s) are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder CNEC.
  - C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- Specify if:
  - Current or Most Recent Episode Manic
  - Current or Most Recent Episode Hypomanic
  - Current or Most Recent Episode Depressed
  - With Mixed Features
  - With Psychotic Features
  - With Catatonic Features
  - With Atypical Features (for depression)
  - With Melancholic Features (for depression)
  - With Rapid Cycling
  - With Suicide Risk Severity
  - With Anxiety, mild to severe
  - With Seasonal Pattern
  - With Postpartum Onset
Bipolar Disorder

- Bipolar II (C02)
  - A. Presence (or history) of one or more Major Depressive Episodes (same criteria as in DSM IV-TR).
  - B. Presence (or history) of at least one Hypomanic Episode (same criteria as in DSM IV-TR).
  - C. There has never been a Manic Episode
  - D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Elsewhere Classified.
  - E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- Specify if:
  - Current or Most Recent Episode Hypomanic
  - Current or Most Recent Episode Depressed
  - With Mixed Features
  - With Psychotic Features (for depression)
  - With Catatonic Features (for depression)
  - With Atypical Features (for depression)
  - With Melancholic Features (for depression)
  - With Rapid Cycling
  - With Anxiety, mild to severe
  - With Suicide Risk Severity
  - With Seasonal Pattern
  - With Postpartum Onset
Bipolar Disorder

- Cyclothymia (C03)
  - A. For at least two years (at least one year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a Hypomanic Episode and numerous periods with depressive symptoms that do not meet criteria for a Major Depressive Episode.
  - B. During the above 2-year period (1 year in children and adolescents) the symptoms in Criterion A have been present for more days than not and the person has not been without the symptoms for more than two months at a time.
  - C. No Major Depressive Episode, Manic Episode or Hypomanic Episode has been present during the first 2 years of the disturbance (one year in children and adolescents).
  - **Note:** After the initial two years (one in children and adolescents) of Cyclothymic Disorder there may be superimposed Major Depressive Episodes (in which both Major Depressive Disorder and Cyclothymic Disorder are diagnosed), Manic Episodes (in which case both Bipolar I Disorder and Cyclothymic Disorder are diagnosed), or Hypomanic Episodes (in which case both Bipolar Disorder Not Elsewhere Classified and Cyclothymic Disorder are diagnosed).
  - D. The symptoms in Criterion A are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophrheniform Disorder, Delusional Disorder, or Psychotic Disorder, NEC
  - E. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
  - F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Bipolar and Related Disorders

- No pediatric specifications; children and adolescents will meet same criteria as adults for manic, hypomanic, and depressed episodes

- Severity specifiers:
  - The Work Group is proposing several options for severity:
    - Patient Health Questionnaire
    - Clinical Global Impressions Scale
    - Severity of Illness Scale
Bipolar Disorder in Young People

• Bipolar disorder in children is enormously controversial! Depending on who you listen to, there is either an epidemic, or it is vastly over diagnosed.
• The problem is that there is little agreement on:
  – the nature of symptoms such as elated mood and
  – grandiosity in children
  – the role of irritability
  – whether symptoms must be episodic as they are in
  – adults
Classic Bipolar Symptoms in Children

- Mania
  - Hyperactivity
  - Irritability
  - Psychosis/grandiosity
- Depression
  - Personality change
  - Drop in grades
  - Morbid/suicidal
  - Elated/expansive mood
  - Rapid speech/racing
  - Sleep – doesn’t need it or want it
- Pessimistic
- Somatic
The “Narrow” Definition

• A young person meeting the classic criteria would be said to fit the “narrow phenotype.”
• They would be likely to be genetically related to another person with bipolar disorder. They will most likely continue to have bipolar disorder symptoms as an adult.
• There is little controversy about this group among clinicians.
The “Broad” Definition

- Some child psychiatrists believe that chronic severe irritability accompanied by aggression and volatility is the predominant mood state in children with bipolar disorder, even without episodes of depression, or evidence of any kind of mood cycling.
Depressive Disorders

- D00 Disruptive Mood Dysregulation Disorder
- D01 Major Depressive Disorder, Single Episode
- D02 Major Depressive Disorder, Recurrent
- D03 Dysthymic Disorder
- D04 Premenstrual Dysphoric Disorder
- D05 Substance-Induced Depressive Disorder
- D06 Depressive Disorder Associated with Another Medical Condition
- D07 Depressive Disorder, NEC
Disruptive Mood Dysregulation Disorder

A. The disorder is characterized by severe recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation.
   1. The temper outbursts are manifest verbally and/or behaviorally, such as in the form of verbal rages or physical aggression towards people or property.
   2. The temper outbursts are inconsistent with developmental level.

B. Frequency: The temper outbursts occur, on average, three or more times per week.

C. Mood between temper outbursts:
   1. Nearly every day, most of the day, the mood between temper outbursts is persistently irritable or angry.
   2. The irritable or angry mood is observable by others (e.g., parents, teachers, peers).

D. Duration: Criteria A–C have been present for 12 or more months. Throughout that time, the person has not had 3 or more consecutive months when they were without the symptoms of Criteria A–C.

E. Criterion A or C is present in at least two settings (at home, at school, or with peers) and must be severe in at least one setting.
Disruptive Mood Dysregulation Disorder

- D00 criteria, cont.
  - F. The diagnosis should not be made for the first time before age 6 or after age 18.
  - G. The onset of Criteria A through E is before age 10 years.
  - H. There has never been a distinct period lasting more than one day during which abnormally elevated or expansive mood was present most of the day, and the abnormally elevated or expansive mood was accompanied by the onset, or worsening, of three of the “B” criteria of mania (i.e., grandiosity or inflated self-esteem, decreased need for sleep, pressured speech, flight of ideas, distractibility, increase in goal directed activity, or excessive involvement in activities with a high potential for painful consequences). Abnormally elevated mood should be differentiated from developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation.
Disruptive Mood Dysregulation Disorder

- I. The behaviors do not occur exclusively during an episode of Major Depressive Disorder and are not better accounted for by another mental disorder (e.g., Autism Spectrum Disorder, Posttraumatic Stress Disorder, Separation Anxiety Disorder, Dysthymic Disorder). Note: This diagnosis cannot co-exist with Oppositional Defiant Disorder or Bipolar Disorder, though it can co-exist with Attention Deficit/Hyperactivity Disorder, Conduct Disorder, and Substance Use Disorders.

- Individuals meeting criteria for both Disruptive Mood Dysregulation Disorder and Oppositional Defiant Disorder should only be given the diagnosis of Disruptive Mood Dysregulation Disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of Disruptive Mood Dysregulation Disorder should not be assigned. The symptoms are not due to the effects of a drug or to a general medical or neurological condition.
Major Depressive Disorder, Single and Recurrent

- Criteria has stayed the same as DSM IV-TR
- Bereavement exclusion in DSM 5:
  - **Note:** The normal and expected response to an event involving significant loss (e.g., bereavement, financial ruin, natural disaster), including feelings of intense sadness, rumination about the loss, insomnia, poor appetite and weight loss, may resemble a depressive episode. The presence of symptoms such as feelings of worthlessness, suicidal ideas (as distinct from wanting to join a deceased loved one), psychomotor retardation, and severe impairment of overall function suggest the presence of a Major Depressive Episode in addition to the normal response to a significant loss.
Dysthymic Disorder

- Similar criteria; word changes regarding major depressive episode
  - Likely poor reliability of asking individual if they can recall whether or not a major depressive episode occurred during the first two years of the disturbance
- May merge dysthymia with chronic MDD
- Name may change to Chronic Depressive Disorder
Premenstrual Dysphoric Disorder

Most of the same criteria as in DSM IV–TR; now in depressive disorders section (in DSM IV–TR, was in Appendix B: Criteria Sets and Axes Provided for Further Study)

From the APA website: “The inclusion of PMDD as a diagnostic category may further facilitate development of treatments that are useful for PMDD and may encourage research into the biology, prevalence, as well as consequences of PMDD. While the inclusion of criteria in the Appendix of DSM–III R and DSM–IV facilitated research, the workgroup felt that information on the diagnosis, treatment and validators of the disorder had matured to the point that it would qualify as a category in DSM 5. A move to the position of category, rather than a criterion set in need of further study, would provide greater legitimacy for the disorder.”
Depressive Disorder, NEC

- Not a diagnosis in and of itself; one code, with specifiers:
  - **1. Recurrent Brief Depression.** Concurrent presence of depressed affect and at least four other symptoms of depression for 2–13 days at least once a month (not associated with the menstrual cycle) for at least 12 consecutive months in an individual who has never met criteria for any other mood disorder and who does not concurrently meet active or residual criteria for any psychotic disorder.
  - **2. Mixed Subsyndromal Anxiety and Depression.** Concurrent moderate to severe depressive and anxiety symptoms associated with clinically significant distress or impairment that persist for a minimum of two weeks, but do not meet full criteria for any mood or anxiety disorder. (May not be used if there is a “Mixed Anxiety and Depression Disorder”)
Depressive Disorder NEC

3. **Short duration (4–13 day) Depressive Episode.** Depressed affect and at least four of the other eight symptoms of a Major Depressive Episode associated with clinically significant distress or impairment that persists for more than four days, but less than 14 days in an individual who has never met criteria for any diagnosis in the Depressive Disorders or Bipolar and Related Disorders chapters, does not currently meet active or residual criteria for any psychotic disorder, and does not meet criteria for ‘Recurrent Brief Depression‘ or ‘Mixed Subsyndromal Anxiety and Depression’.

4. **Subthreshold Depressive Episode with Insufficient Symptoms.** Depressed affect and at least one of the other eight symptoms of a Major Depressive Episode associated with clinically significant distress or impairment that persist for at least two weeks in an individual who has never met criteria for any diagnosis in the Depressive Disorders or Bipolar and Related Disorders chapters, does not currently meet active or residual criteria for any psychotic disorder, and does not meet criteria for ‘Mixed Subsyndromal Anxiety and Depressive Disorder’.
5. **Uncertain Depressive Disorder.** This category is used for individuals with depressive symptoms associated with clinically significant distress or impairment when it is not possible to diagnose a specific depressive listed above. This diagnostic term is usually employed as a temporary ‘place holder’ while additional information is obtained. The overuse of this category in the past has seriously undermined the quality of diagnostic information systems; therefore, its use is discouraged except in the following situations:
Depressive Disorder NEC
Uncertain Depressive Disorder

- **Depressive Disorder of Unknown Etiology.** Meets symptomatic and duration criteria of one of the specific disorders listed in the Depressive Disorders chapter, but the clinician is unable to determine whether it is primary or attributable to the direct physiological effects of a substance or a general medical condition.

- **Uncertain Depressive Condition Observed in a Clinical Examination.** Depressive symptoms associated with clinically significant distress or impairment are present, but the detailed symptomatic and historical information needed for a specific diagnosis cannot be obtained.

- **Uncertain Depressive Condition in a Medical Record.** A diagnosis of ‘Depression’, ‘Depressive Episode’, ‘Depressive Disorder’ or some similar term is provided in a medical record completed by a physician or other health professional, but there are no further details available in the record that would make it possible to determine a more specific diagnosis.
• There is much discussion about the "bereavement exclusion" in DSM-IV® for a depressive episode, e.g. if you are grieving the loss of a loved one, you cannot be diagnosed with depression.
Bereavement

- Bereavement is a universal experience related to the loss of a loved one. It can be thought of as “attachment trauma.”
- The psychological response to bereavement is grief. Grief is not a single emotion, but a combination of different emotions, including the negative feelings of sadness, anxiety, guilt, anger and shame; and the positive emotions of happy reminiscence, pride in the deceased, warmth, and relief.
Acute Grief

- Acute grief lasts most of the day, every day for generally up to six months, then recurs transiently. It is characterized by a sense of disbelief, painful emotions, preoccupation with the deceased, and attenuation of interest in life.
- This painful state normally transitions into “integrated grief,” which is a permanent background state where grief can be triggered, but positive emotions predominate.
Complicated Grief

- Rarely, grief may be “complicated” – great difficulty accepting death, excessively painful memories, overwhelming feelings of guilt or yearning.
- Complicated grief is not limited to just those people who had ambivalent relationships with the deceased. It is seen just as frequently in those with very positive and close relationships.
Complicated Grief

- More than 6 months after loss
  - Continued preoccupation with deceased
  - Continued longing and yearning
  - Disbelief and inability to accept death
  - Self-blame, bitterness, anger
  - Inability to experience satisfaction or joy
  - Avoidance of reminders of loss
  - New brain scan results show that in individuals experiencing complicated grief, reminders of the loved one continue to stimulate the “pleasure” centers in the nucleus accumbens, unlike normal controls.
Anxiety Disorders

- E00 Separation Anxiety Disorder
- E01 Panic Disorder
- E02 Agoraphobia
- E03 Specific Phobia
- E04 Social Anxiety Disorder
- E05 Generalized Anxiety Disorder
- E06–11 Substance Induced Anxiety Disorder
- E12 Anxiety Disorder Associated with Another Medical Condition
- E13 Anxiety Disorder NEC
Among the most recent revisions are proposals for changes to the duration criterion (from 4 weeks to 6 months) and removal of the age of onset requirement for *Separation Anxiety Disorder*. Also, the number of associated physical symptoms in *Generalized Anxiety Disorder* has been reduced from three to two.

Most of the disorders in this section also have minor wording changes, and *duration criteria have been revised for Agoraphobia, Specific Phobia, and Social Anxiety Disorder*. Finally, proposed criteria have been added for Substance–Induced Anxiety Disorder, Anxiety Disorder Attributable to Another Medical Condition, and Anxiety Disorder, NEC.
Anxiety Disorders

- Most have severity specifiers that may be assessed with an “Anxiety Disorder Specific Severity Measure”

- Many of the disorders that were previously listed in the Anxiety Disorders chapter in DSM-IV have been distributed throughout the Anxiety Disorders chapter as well as separate chapters on Obsessive Compulsive Disorders and Trauma and Stressor Related Disorders
OCD and Related Disorders

- F00 OCD: word changes and insight specifiers (good, fair, poor)
- F01 Body Dysmorphic Disorder
- F02 Hoarding Disorder (new disorder)
- F03 Hair Pulling Disorder (Trichotillomania) (name to change)
- F04 Skin Picking Disorder (new)
- F05–06 Substance Induced OCD
- F07 OCD attributable to another medical condition
- F08 OCD NEC
Trauma and Stressor Related Disorders

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Acute Stress Disorder
- PTSD
  - Subtype: PTSD in Preschool Children
  - Subtype: PTSD with Prominent Dissociative Symptoms
- Adjustment Disorders
- Trauma or Stressor Related Disorders NEC
The proposed revision for Reactive Attachment Disorder includes the division of the two DSM-IV types into two disorders: Reactive Attachment Disorder of Infancy and Early Childhood and Disinhibited Social Engagement Disorder (no longer inhibited or disinhibited Type).

- Markedly disturbed and inappropriate attachment behavior, evident before age 5
  - Rarely seeks comfort when distressed
  - Rarely responds when comfort is offered

- Social and emotional disturbance
  - Lacks social or emotional responsiveness
  - Limited positive affect
  - Unexplained irritability, sadness, or fearfulness when interacting with adults

- Does not meet criteria for Autism
G01 Disinhibited Social Engagement Disorder

A. A pattern of behavior in which the child actively approaches and interacts with unfamiliar adults by exhibiting at least 2 of the following:
   ◦ 1) Reduced or absent reticence to approach and interact with unfamiliar adults.
   ◦ 2) Overly familiar behavior (verbal or physical violation of culturally sanctioned 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.

B. The behavior in A is not limited to impulsivity as in ADHD but includes socially disinhibited behavior.

- Developmental Age Level of at least 9 months
- Pathogenic care
Realms of pathogenic care

- Certain disorders require evidence of or history of pathogenic care; RAD and Disinhibited Social Engagement Disorder are two of them.
- Pathogenic care as evidenced by at least one of the following:
  - 1) Persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection (i.e., neglect).
  - 2) Persistent disregard of the child’s basic physical needs.
  - 3) Repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care).
  - 4) Rearing in unusual settings such as institutions with high child/caregiver ratios that limit opportunities to form selective attachments.
  - May include: Persistent harsh punishments or other grossly inept parenting/caregiving.
Some word changes: experience or witness event OR learned that the traumatic event happened to a close family member or friend; repeated exposure to aversive details

Separation of:
- Intrusion symptoms
  - Intrusive memories and dreams; dissociative reactions
- Avoidance of stimuli
  - Avoid memories and thoughts; avoid external reminders
- Negative alterations in cognition and mood
  - Persistent negative beliefs; persistent negative emotional state
- Marked alterations in arousal and reactivity associated with the event
  - Hypervigilance; difficulty concentrating; sleep problems
PTSD

- PTSD has two subtypes: In Preschool Children and With Prominent Dissociative Symptoms
- Severity assessed through the National Stressful Events Survey PTSD Short Scale (NSESSS)
- PTSD has the highest correlation with suicide attempts and completed suicides than any other diagnosis when:
  - Symptoms experienced for one year or longer
  - Result of childhood trauma and abuse that was not treated
  - Accompanied by significant depression
  - Self medicating
PTSD in Preschool Children

- Subtype specified
- Criteria regarding intrusion, avoidance, negative mood and alterations in arousal with developmental changes and lower threshold required for diagnosis
- In children less than 6 years
  - 1. directly experiencing the event(s)
  - 2. witnessing, in person, the event(s) as they occurred to others, especially primary caregivers (Note: Witnessing does not include events that are witnessed only in electronic media, television, movies or pictures.)
  - 3. learning that the traumatic event(s) occurred to a parent or caregiving figure
G 04 Adjustment Disorders

- Criteria very similar
- Subtypes the same but also include:
  - With Features of Acute Stress Disorder or Posttraumatic Stress Disorder
  - Related to Bereavement: Following the death of a close family member or close friend, the individual experiences on more days than not intense yearning or longing for the deceased, intense sorrow and emotional pain, or preoccupation with the deceased or the circumstances of the death for at least 12 months (or 6 months for children).
Disruptive, Impulse Control, and Conduct Problems

- Q00  Oppositional Defiant Disorder
- Q01  Intermittent Explosive Disorder
- Q02  Conduct Disorder
- Q02.1  Callous and Unemotional Specifier for CD
- Q03  Dyssocial Personality Disorder (Antisocial PD)
- Q04  Disruptive Behavior Disorder NEC
Q 00 ODD

- **Changes:**
  - Symptoms distinguished between emotional and behavioral
  - Exclusionary criteria for CD removed
  - Severity index based on multiple informants in cross situations and pervasiveness of symptoms in these situations
  - **Note.** The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children under 5 years of age, the behavior should occur on most days for a period of at least six months unless otherwise noted. For individuals 5 years or older, the behavior should occur at least once per week for at least six months, unless otherwise noted. While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered such as whether the frequency and intensity of the behaviors are non-normative given the individual’s developmental level, gender, and culture.
ODD Severity Level

- **0 – Absent**: Shows fewer than two symptoms
- **1 – Subthreshold**: Shows at least two but fewer than four symptoms or symptoms do not cause significant impairment in any setting
- **2 – Mild**: Shows at least four symptoms but symptoms are confined to only one setting (e.g., at home, at school, at work, with peers)
- **3 – Moderate**: Shows at least four symptoms and some symptoms are present in at least two settings
- **4 – Severe**: Shows at least four symptoms and some symptoms are present in 3 or more settings
### Q01 Intermittent Explosive Disorder

- Recurrent behavioral outbursts in which the individual does not control their aggressive impulses as manifest by either:
  - A1. Verbal or physical aggression towards other people, animals, or property occurring twice weekly, on average, for the past three months **OR**
  - A2. Three behavioral outbursts involving physical assault against other people and/or destruction of property occurring within a 12-month period with at least one behavioral outburst in the past three months.

- B. The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or any precipitating psychosocial stressors.

- C. The recurrent aggressive outbursts are not premeditated (i.e. are impulsive) and are not committed to achieve some tangible objective (e.g., money, power, intimidation, etc.).

- D. The recurrent aggressive outbursts cause either marked distress in the individual, or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences.

- E. Chronological age is *at least 18 years* (or equivalent developmental level).
Q02 Conduct Disorder

- Criteria and age at onset stays the same
- Added Q02.1 Callous and Unemotional Specifier/Trait
  - To qualify for this specifier, a person must have displayed at least two of the following characteristics persistently over at least 12 months and in multiple relationships and settings. These characteristics reflect the individual’s typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. To assess the criteria for the specifier, multiple information sources are necessary. In addition to the individual’s self-report, it is necessary to consider reports by others who have known the individual for extended periods of time (e.g., parents, teachers, co-workers, extended family members, peers).
Q02.1

1. Lack of Remorse or Guilt: Does not feel bad or guilty when he/she does something wrong

2. Callous–Lack of Empathy: Disregards and is unconcerned about the feelings of others. The individual is described as cold and uncaring.

3. Unconcerned about Performance: Does not show concern about poor/problematic performance at school, work, or in other important activities.

4. Shallow or Deficient Affect: Does not express feelings or show emotions to others, except in ways that seem shallow, insincere, or superficial.
Personality Disorders

- Six specific personality disorder types (antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and, schizotypal) are defined by criteria based on typical impairments in personality functioning and pathological personality traits in one or more trait domains.
- DSM IV–TR listed 10 different personality disorders:
  - Dependent PD, Histrionic PD, and Paranoid PD traits have been subsumed under Borderline PD; Schizoid PD has been incorporated into Schizotypal PD or traits listed under PDTS
  - The diagnosis of Personality Disorder Trait Specified (PDTS) is defined by significant impairment in personality functioning; replaces PD NOS
Levels of Personality Function Scale

- Based on the severity of disturbances in self and interpersonal functioning.
- Impairments in *self functioning* are reflected in dimensions of *identity* and *self-directedness*.
- *Interpersonal* impairments consist of impairments in the capacities for *empathy* and *intimacy*.
- Five broad personality trait domains (negative affectivity, detachment, antagonism, disinhibition and impulsivity, and psychoticism) are defined, as well as component trait facets (for example, impulsivity and rigid perfectionism).
- Severity level from 0–4; 0–1 not a PD; must be moderate to extreme for diagnosis
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- Severity level from 0–4; 0–1 not a PD; must be moderate to extreme for diagnosis.
Pathologic personality traits

- Negative affectivity
  - Labile moods; anxiousness; separation insecurity; perseveration; dysphoria
- Detachment
  - Emotional constriction; anhedonia; withdrawal; avoidance
- Antagonism
  - Manipulative, deceitful; grandious; callous
- Disinhibition and impulsivity
  - Perfectionism (− correlate), irresponsibility, impulsive, risk-taking
- Psychoticism
  - Unusual beliefs, egocentric, cognitive dysregulation
Personality Disorders

- Self functioning:
  - Identity: experience oneself as unique, boundaries, self esteem, emotion regulation
  - Self-direction: pursuit of goals, internal standards

- Interpersonal functioning:
  - Empathy: appreciate others’ experiences, tolerance, understand how one effects others
  - Intimacy: positive connection to others, desire and capacity for closeness
# Levels of Functioning Severity

<table>
<thead>
<tr>
<th></th>
<th>Self</th>
<th>Interpersonal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level</td>
<td>Identity</td>
<td>Self–direction</td>
</tr>
</tbody>
</table>
| 0    | *Ongoing awareness of a unique self; maintains boundaries*  
*Consistent and self–regulated; positive self–esteem; accurate self–appraisal*  
*Capable of experiencing, tolerating and regulating a full range of emotions* | *Sets and aspires to reasonable goals based on a realistic assessment of personal capacity*  
*Utilizes appropriate standards of behavior*  
*Can reflect on and make constructive meaning of internal experience* | *Capable of accurately understanding others’ experiences and motivations in most situations*  
*Comprehends and appreciates others’ perspectives, even if disagreeing*  
*Is aware of the effect of own actions on others* | *Maintains multiple satisfying and enduring relationships in personal and community life*  
*Desires and engages in a number of caring, close and reciprocal relationships*  
*Strives for cooperation and mutual benefit and flexibly responds to* |
## Levels of Functioning Severity

<table>
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<th>Level</th>
<th>Identity</th>
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<th>Intimacy</th>
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<tbody>
<tr>
<td>1</td>
<td><em>Relatively intact sense of self, with some decrease in clarity of boundaries when strong emotions are present</em>&lt;br&gt;<strong>Self esteem diminished at times</strong>, with overly critical or somewhat distorted self-appraisal&lt;br&gt;<em>Strong emotions may be distressing</em></td>
<td><em>Excessive goal-directed; somewhat goal-inhibited, or conflicted about goals</em>&lt;br&gt;<em>May have an unrealistic or socially inappropriate set of personal standards, limiting some aspects of fulfillment</em>&lt;br&gt;<em>Able to reflect on internal experience but may only reflect on one aspect</em></td>
<td><em>Somewhat compromised in ability to appreciate and understand others’ experiences; may tend to see other as having unreasonable expectations or a wish for control</em>&lt;br&gt;<em>Although capable of considering and understanding different perspectives, resists doing</em></td>
<td><em>Able to establish enduring relationships in personal and community life, with some limitations on degree of depth and satisfaction</em>&lt;br&gt;<em>Capacity and desire to form intimate and reciprocal relationships but may be inhibited and sometimes constrained if intense emotions arise</em></td>
</tr>
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## Levels of Functioning Severity

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<th>Identity</th>
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<th>Empathy</th>
<th>Intimacy</th>
</tr>
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</table>
| 2     | *Excessive dependence on others for identity definition; compromised boundaries*  
*Vulnerable self-esteem controlled by concern about external evaluation; wish for approval. Sense of inferiority  
*Emotional regulation depends on positive* | *Goals are often a means of gaining external approval than self-generated and lack congruence  
*Personal standards may be unreasonably high or low  
*Impaired capacity to reflect upon internal experience* | *Hyper-attuned to the experience of others, but only with respect to perceived relevance to self  
*Excessively self-referential; significantly compromised ability to understand others’ experience  
*Generally unaware of or unconcerned about effect of own behavior* | *Capacity and desire to form relationships but connections may be largely superficial  
*Intimate relationships are largely based on meeting self-regulatory and self-esteem needs; unrealistic expectation to be perfectly understood by others  
*Cooperates* |
# Levels of Functioning Severity

<table>
<thead>
<tr>
<th>Level</th>
<th>Identity</th>
<th>Self-direction</th>
<th>Empathy</th>
<th>Intimacy</th>
</tr>
</thead>
</table>
| 3     | *Weak sense of autonomy; experience a lack of identity or emptiness; boundary definition is poor or rigid; over-identify with others*  
*Fragile self-esteem is easily influenced by events; self-appraisal is self-loathing or self-aggrandizing*  
*Emotions* | *Difficulty establishing or achieving personal goals*  
*Internal standards for behavior are unclear or contradictory; life can be seen as meaningless or dangerous*  
*Significantly compromised ability to reflect upon and understand own mental* | *Significantly limited ability to understand others thoughts, feelings and behavior*  
*Generally unable to consider alternative perspectives; highly threatened by differences in opinion*  
*Confusion or unawareness of impact of own* | *Some desire to form relationships but capacity for positive and enduring relationships is impaired*  
*Feelings about intimacy alternate between fear/rejection and desperate need*  
*Others seen in terms of how the affect the self;* |
# Levels of Functioning Severity

<table>
<thead>
<tr>
<th>Level</th>
<th>Self Identity</th>
<th>Self-direction</th>
<th>Interpersonal Empathy</th>
<th>Intimacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td><em>Experience of a unique self absent; boundaries are lacking or very confused</em>&lt;br&gt; <em>Weak or distorted self-image easily threatened by interactions with others</em>&lt;br&gt; <em>Emotions not congruent with context or internal experience.</em></td>
<td><em>Poor differentiation of thoughts from actions</em>&lt;br&gt; <em>Internal standards of behavior are lacking; fulfillment is virtually inconceivable</em>&lt;br&gt; <em>Profound inability to reflect on own experience</em></td>
<td><em>Profound inability to consider and understand others’ emotions and motivations</em>&lt;br&gt; <em>Attention to others’ perspectives is virtually absent</em>&lt;br&gt; <em>Social interactions can be confusing and disorienting</em></td>
<td><em>Relationships are conceptualized almost exclusively in terms of their ability to provide comfort or inflict pain and suffering</em>&lt;br&gt; <em>Interpersonal behavior is not reciprocal; seeks fulfillment of basic needs or escape from pain</em></td>
</tr>
</tbody>
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Other Disorders

V01 Non suicidal Self Injury Disorder

A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body, of a sort likely to induce bleeding or bruising or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), for purposes not socially sanctioned (e.g., body piercing, tattooing, etc.), but performed with the expectation that the injury will lead to only minor or moderate physical harm. The behavior is not a common one, such as picking at a scab or nail biting.

B. The intentional injury is associated with at least 2 of the following:
   1. Psychological Precipitant: Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.
   2. Urge: Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to resist.
   3. Preoccupation: Thinking about self injury occurs frequently, even when it is not acted upon.
   4. Contingent Response: The activity is engaged in with the expectation that it will relieve an interpersonal difficulty, or negative feeling or cognitive state, or that it will induce a positive feeling state, during the act or shortly afterwards.
Non-Suicidal Self-Injurious Behavior

- Behavior is usually the consequence of the following stressors:
  - Emotional regulation deficits
    - Some people lack the internal regulations to handle negative emotions
  - Dissociative experiences/episodes
  - Body dysmorphic issues
  - Anxiety and depression regulation
    - Listen to language of person
  - Take care of social isolation and social cohesion needs
    - “Wear scars as badges”
V02 Suicidal Behavior Disorder

A. The individual has initiated a behavior in the expectation that it would lead to the individual’s own death within the last 24 months.

B. The behavior did not meet criteria for non-suicidal. Having undertaken one or more acts of non-suicidal self-injury in the past is not incompatible with the diagnosis.

C. The “time of initiation” is the time when the self-initiated behavior was undertaken by the individual who receives the diagnosis.

D. The act was not initiated during a confused or delirious state. However, attempts initiated during intoxication or while under the influence of a substance do not preclude this diagnosis.

E. The act was not undertaken solely for a political or religious objective.
Suicidal Behavior Disorder

- V02 Suicidal Behavior Disorder
  - Three components:
    - Suicide ideation: Individual experienced for at least 2 months; not an uncommon occurrence
    - Chronic Suicide Ideation: Over 1 year in duration. Could be coupled with secondary gain
    - Suicide Attempts: Lethal act where the intent is to die
      - Accidentally interrupted
      - Self-interrupted
      - Miscalculated lethality
Non-Suicidal Self-Injurious Behavior

- Continuous behaviors of inflicting pain upon the body (by cutting, burning, slashing, or bruising) for the purpose of gaining transient relief from psychological, emotional, or psychiatric distress.
- Treat the GOAL of the behavior.
- Intentional injury is goal oriented and not a behavior occurring during psychosis, delirium, or intoxication and NOT a socially sanctioned practice.
- Low correlation to suicide intent.
- High correlation with drug use.
- Treatment should focus on stressor and coping mechanisms to stressor.
Changes to Bulimia Nervosa
- Episodes of binge eating changed to once per week over 3 months instead of twice per week
- No purging/nonpurging subtypes

Changes to Anorexia Nervosa
- Remove the statement “refusal to maintain body weight”; many individuals deny this. Changed to: “Restriction of energy intake relative to requirements leading to a significantly low body weight…”
- Word changes to include a behavioral statement to accompany the “fear of weight gain” statement
- Delete requirement of amenorrhea
Gender Dysphoria

- Important word change from “Gender Identity Disorder”
- Requires that child, adolescent, or adult experience “clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability”
- Emphasize a negative emotion; not an issue related to gender identity as a “disorder”
Substance Use and Addictive Disorders

- DSM IV–TR listed as *Substance Related Disorders*
- DSM 5 combines *abuse* and *dependence* into Substance *Use* Disorders
- Disorders listed by substance rather than diagnosis
- Gambling Disorder included
- New additions: Hallucinogen, Sedative–Hypnotic Related, and Stimulant
- Disorders for most include separate diagnoses for use, intoxication and withdrawal
- Caffeine intoxication and withdrawal
- Tobacco use and withdrawal
- Hallucinogen persisting perception disorder
- Severity based on how many criteria met per disorder
Addiction Criteria

• Two (or more) within a 12-month period:
  1. Substance taken in larger amounts or over a longer period than intended
  2. Persistent desire or unsuccessful effort to cut down or control
  3. Excessive time in activities to obtain use, or recover from the effects of substance
  4. Use resulting in a failure in work, school, or home.
  5. Continued use despite persistent social or interpersonal problems due to use of the substance
  6. Recurrent use in situations physically hazardous, with psychological/physical problems and caused or exacerbated by the substance.
  7. Tolerance
  8. Withdrawal
Addiction Criteria Part 2

Specify the following:

• **Early Remission.** for at least 3 months, but for less than 12 months, the individual does not meet any of the criteria 1–10 for a Substance Use Disorder.

• **Sustained Remission.** If none of the criteria 1–10 for a Substance Use Disorder have been met at any time during a period of 12 months or longer.

• **In a Controlled Environment.** This additional specifier is used if the individual is in an environment where access to alcohol and controlled substances is restricted, and no criteria for a Substance Use Disorder have been met. Examples of these environments are closely supervised and substance-free jails, therapeutic communities, and hospital units.
Behavioral Addiction

- The Standard for Addiction
  - It must derive from neurogenetic and biobehavioral attributes, rather than self-report.
  - It should reflect the triad of addiction:
    - Continued use in spite of adverse consequences
    - Continual seeking of the experience (increased salience)
    - Relapse behavior
  - It must involve a combination of:
    - Overwhelming and uncontrollable impulses
    - Compulsive behavior
    - Compromised biobehavioral regulatory mechanisms
Other behavioral addictions

- Other Behavioral Addictions?
  - Internet usage
  - Shopping
  - Sexual behavior
  - Food
In 1975, casino gambling was legal in only two states – Nevada and New Jersey. By 2012, gambling was legal in 49 states (not Utah.) Today we have strong promotion of government lotteries, televised poker tournaments, and Internet gambling. Not surprisingly, more adults report gambling than 10 years ago – about 61–63% more. There is a higher rate of pathological gambling in states that provide increased opportunity to gamble.
Substance Use and Addictive Disorders Highlights

- “Substance use disorders” (for each kind of substance) would subsume both abuse and dependence in DSM-IV®. Criteria are selected from a list of 10 or 11 items. The more criteria that are met, the more severe the disorder is rated.
- As in DSM-IV®, specifiers will be added reflecting physiologic dependence and course of illness.
Problem Gambling Diagnostic Criteria

A. Persistent and recurrent problematic gambling behavior as indicated by four (or more) of the following in a 12-month period:
1. needs to gamble with increasing amounts of money in order to achieve the desired excitement
2. is restless or irritable when attempting to cut down or stop gambling
3. has repeated unsuccessful efforts to control, cut back, or stop gambling
4. is often preoccupied with gambling (e.g., persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)
5. gambles often when feeling distressed (e.g., helpless, guilty, anxious, depressed)
6. after losing money gambling, often returns another day to get even (“chasing” one’s losses)
7. lies to conceal the extent of involvement with gambling
8. has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
9. relies on others to provide money to relieve desperate financial situations caused by gambling

B. The gambling behavior is not better accounted for by a Manic Episode.

Course Specifiers.
- Episodic
- Chronic
- In Remission
Schizophrenia Spectrum Specifics

- **Attenuated Psychosis Syndrome**
  - Mild delusions, hallucinations, disorganized speech, with intact reality testing, with worsening of symptoms over the last year.
  - This diagnosis is controversial, since most people with this diagnosis (65%) do not go on to develop schizophrenia, and they may end up treated unnecessarily with antipsychotics. It will probably stay in the appendix.
– **Catatonia**
  - Research over the last 20 years has shown that catatonia is under-diagnosed, and is present in more disorders than previously recognized. Therefore, it is proposed that catatonia become a specifier for all the psychotic disorders, as well as for various medical conditions and mood disorders. The criteria for diagnosing the disorder is changed slightly from DSM–IV®.
Schizophrenia Spectrum Specifics

- It is recommended that the 5 subtypes of schizophrenia be dropped because they are not useful for clinical or research purposes:
  - Paranoid
  - Disorganized
  - Catatonic
  - Undifferentiated
  - Residual
Anxiety Disorders Highlights

- Separation Anxiety Disorder
- Panic Disorder
- Agoraphobia
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Generalized Anxiety Disorder
Anxiety Disorders Specifics

- Separation Anxiety Disorder
  - This disorder moves from the child/adolescent section of DSM-IV® and remains essentially the same (symptoms of anxiety and distress when separated from home or family that are not age appropriate.)
  - There are several proposed severity rating scales for this disorder, as for all the anxiety disorders
OCD and Related Disorders

- In the past, OCD has variously been believed to be a “religious melancholy”, a result of repressed sexual drives, or a type of anxiety disorder.
- Most experts now believe that OCD is not the result of anxiety, but rather a kind of neurological “short circuit” that causes repetitive thoughts and behaviors, similar to Body Dysmorphic Disorder, Tourette’s syndrome, and Hypochondriasis.
OCD and Related Disorders

- Obsessive–Compulsive Disorder
- Body Dysmorphic Disorder (from Somatoform Disorders)
- Hoarding Disorder
- Hair Pulling Disorder (Trichotillomania)
- Skin Picking Disorder
OCD Specifics

- Hoarding
  - Collecting and saving possessions is a widespread human activity, but hoarding consists of either acquiring or being unable to discard large quantities of worthless items to the extent that a person’s life is impaired.
  - In *DSM IV*, hoarding was described under the Obsessive–Compulsive Personality Disorder, but clinicians typically diagnosed it as OCD anxiety disorder.
OCD Specifics

- Hoarding Organic
  - Hoarding symptoms develop in patients with organic brain disorders such as autism, schizophrenia, or developmental delays. 22.6% of people with dementia show hoarding symptoms.
  - Individuals who are found to be living in squalor as a result of their hoarding tend to almost always have a related organic cause.
OCD Specifics

- Generally sudden
- Any item, including food (Rotten food unusual)
- Indiscriminate
- Purposeless
- Insidious
- Selective
- Emotional or practical
- Often able to let others dispose of items
- Self-neglect common
- No insight
- Ability to allow others help variable
- Not familial or Familial
- to let other people discard items or clean
- Self-neglect is rare
- Insight is variable
Trauma and Stressor–Related Disorders

- Reactive Attachment Disorder of Infancy
- Disinhibited Social Engagement Disorder
- Acute Stress Disorder
- Posttraumatic Stress Disorder
- Adjustment Disorder (moved from its own category in DSM–IV®)
- Bereavement related
- Acute stress (depressed mood, anxiety, PTSD–like)
Trauma /Stressor–Related Disorders Specifics

- Reactive Attachment Disorder of Infancy
- Disinhibited Social Engagement Disorder
- These two diagnoses replace Reactive Attachment
- Disorder of Infancy or Early Childhood in DSM–IV®. In that diagnosis there were two types: inhibited and disinhibited.
The two disorders in DSM-5® represent two pathological attachment styles: one in which the child rarely seeks comfort from caregivers and shows emotional distress, the other in which the child is overly familiar with strangers and does not hesitate to leave familiar caregivers. Both disorders are presumed to be caused by pathogenic care.
• Posttraumatic Stress Disorder

- The trauma does not include witnessing events on TV or other electronic media.
- PTSD no longer requires that an individual have a subjective experience of fear or horror, since that has not been useful in determining who develops PTSD. Well-trained emergency workers, for instance, often do not show emotions during the crisis, but may develop PTSD.
PTSD Highlights

- The 3 symptom clusters of DSM-IV®
  - re-experiencing
  - avoidance and numbing
  - arousal
- become 4 symptom clusters in DSM-5®
  - re-experiencing
  - avoidance
  - negative alterations in mood and cognition
  - arousal
• Dissociative Disorders

- Depersonalization/ Derealization Disorder
- Dissociative Amnesia
- Dissociative Identity Disorder
Somatic Symptom Disorders
Highlights

- Somatic Symptom Disorder
- Illness Anxiety Disorder
Feeding Eating Disorders

- Avoidant/Restrictive Food Intake Disorder
  (Feeding Disorder of Infancy or Early Childhood)
- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder

Feeding and Eating Disorders Specifics

- Binge Eating Disorder, DSM-IV®
- Recurrent episodes of binge eating 2 days/week for 6 months
- 3 of the following:
  - Eating much more rapidly than normal
  - Eating until uncomfortable
  - Eating large amounts of food when not hungry
  - Eating alone because of embarrassment
  - Feeling disgusted, depressed, guilty after overeating
Sleep–Wake Disorders Highlights

- Insomnia Disorder (Primary Insomnia)
- Hypersomnolence Disorders
  - Narcolepsy without cataplexy
- Narcolepsy – Hypocretin Deficiency (with cataplexy)
- Breathing related disorders
- Rapid Eye Movement Behavior Disorder
- Restless Legs Syndrome
Narcolepsy

- Narcolepsy may occur with or without cataplexy, but with cataplexy it is almost always associated with hypocretin deficiency.
- Hypocretin (orexin) is a neurotransmitter that regulates arousal, wakefulness, and appetite.
- Cataplexy is a sudden and temporary loss of muscle tone. (see fainting goats)
- Sleep walking and sleep terrors are subsumed into a new category – Disorder of Arousal
Sleep Wake Specifics

- Obstructive Sleep Apnea Hypopnea Syndrome
  - Central Sleep Apnea
  - Sleep–Related Hypoventilation
- Sleep–Wake Disorders Specifics
- Rapid Eye Movement Behavior Disorder:
  - periods of arousal, vocalization and
    sometimes complex motor behavior during
    REM stage sleep.
- Restless Legs Syndrome: discomfort and a desire
  to move one’s legs during periods of rest, worse
  in the evening, causing distress and impairment
  of functioning.
Treating insomnia is a major concern in primary care medicine. Since the 1970’s, the medication treatment of choice has been the BZD’s. Recently, new medications have been developed that may avoid some of the problems with those drugs. They work at the same receptor sites in the brain, but do not have anxiolytic or muscle relaxant effects. They may also have less loss of efficacy over time and less addiction potential. However, they carry an FDA warning for the side effect of “complex behavior” – sleep driving, eating, etc. while “asleep.”
Gender Dysphoria Highlights

- Gender Dysphoria in Children (Gender Identity Disorder)
- Gender Dysphoria in Adolescents and Adults (Gender Identity Disorder)
- Gender Dysphoria
- There is a lot of controversy about this category, including concerns about terminology (gender incongruence, gender identity,…), and frustration that this is listed as a “mental disorder.” Unfortunately, most insurance support for hormones or surgery for gender reassignment requires a diagnosis from DSM®.
Disruptive, Impulse Control, Conduct Disorders

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder (must be 18)
- Conduct Disorder
- Callous and Unemotional Specifier for Conduct Disorder
Disruptive, IC, CD specifics

- Callous and Unemotional Specifier
- Lack of guilt
- Lack of socialization
- Lack of remorse
- Etc.
Conduct Disorder Subtypes

- Subtypes of CD
  - Childhood onset
    - Presence of 1 criteria before age 10
    - Typically boys exhibiting high levels of aggression, may also be diagnosed as ADHD.
    - Problems tend to persist to adulthood (APD)
  - Adolescent onset
    - No criteria met before age 10
    - Less aggressive, more normal relationships
    - Most behaviors shown in conjunction with peers (e.g. gang members)
    - Less ADHD. Equal gender distribution.
    - Much better prognosis
Neurocognitive Disorders

- Neurocognitive Disorders
  - Mild Neurocognitive Disorders
  - Major Neurocognitive Disorders