Practicing with the DSM5®: Diagnosing Psychological and Emotional Disorders in Adults

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Practicing with the DSM5: Diagnosing Psychological and Emotional Disorders in Adults

10:30 – 10:45	Introduction
10:45 – 12:00	Section I – Overview and Major Changes
12:00 – 1:15	Lunch
1:15 – 2:15	Section II – Affective, Bipolar, Schizophrenia
2:15 – 3:15	Section III – Substance Use, Eating Disorders, ADHD
3:15 – 3:30	Break
3:30 – 4:30	Section IV – Sexual Disorders, Anxiety, PTSD
4:30 – 4:45	Evaluation

History of Diagnostic and Statistical Manual (DSM)

- 1840 Census had one category - idiocy/insanity
- 1880 Seven categories - mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy
- Post WWII, VA nomenclature included 10 psychoses, 9 neuroses, and 7 disorders of character, behavior, and intelligence
- The American Psychiatric Association published Diagnostic and Statistical Manual: Mental Disorders (DSM-I) in 1952 reflecting a psychological view and included the term reaction.
- DSM-II was published in 1968 and was very similar to DSM-I, but eliminated the concept of reaction. Heavily criticized for lack of diagnostic reliability due to three or four sentence descriptions of Disorders

History of Diagnostic and Statistical Manual (DSM)

- Work began in 1974 that resulted in the publication of *DSM-III* in 1980. Major advances included the use of explicit diagnostic criteria, a multi-axial system, and a descriptive approach that was neutral to theories or etiology (eliminated terminology of neurosis and psychosis). The number of diagnoses in "child" section increased fourfold.

- Inconsistencies and unclear criteria resulted in a revision of *DSM-III (DSM-III-R)* being published in 1987.

- *DSM-IV* was published in 1994 containing 340 conditions, 120 more than contained in *DSM-III-R. DSM-IV-TR published in 2001updates current research.* Attempted to be more consistent with ICD-10.

- Criticisms included: "artificial constructs," comorbid conditions blur boundaries, changes to criteria created "false epidemics," dimensional vs. dichotomous approach would allow for age and gender variations.

- Diagnostic and Statistical Manual for Primary Care (DSM-PC) 2005 views symptoms in a developmental context, on a continuum from normal to mental disorders, and reflects stressful environmental **situations**

History of Diagnostic and Statistical Manual Fifth Edition (DSM-5)

- Work began on DSM5 in 2000 under a grant from NIMH
- Series of meetings with WHO (ICD)
- 2006 Am Psychiatric announced Drs. Kupfer and Reiger as chair and vice chair
- 2007 Work Groups appointed and began meeting
- February 2010 draft was published for comment
- May 2010 Field Trials of proposed criteria
- Additional comment period Spring 2012
- Final Drafts to printer December 2012
- Publication date of May 18, 2013

Broad Controversies

- Allen Frances (Chair of DSM-IV) resigned due to lack of scientific integrity
- Assumption that all disorders stem from biological brain and neurological disorders ("medicalization" of mental disorders)
- 70% of committee members have economic ties to pharmaceutical industry
- Critics fear that many ordinary reactions to life (grief, anger, angst) will be labeled as illnesses and people will be prescribed unnecessary medications. "One of the raps against psychiatry is that you and I are the only two people in the US without a psychiatric diagnosis" Chicago Tribune Interview12/27/08 with David Kupper, MD
- International members of the personality disorders work group resigned in protest over lack of scientific integrity
- May, 2013 NIMH withdraws support from DSM5 and advocates a biological approach based on their own system, RDoC (Research Domain Criteria) Negative Valence Systems, Positive Valence Systems, Cognitive Systems, Systems for Social Processes, Arousal/Modulatory Systems.

DSM5 Philosophy

Traditional approaches look at diagnosis of disorders from a Categorical Model or Dimensional Model

- **Categorical Model** geared toward separating phenomena (observed behavior) into discrete categories.
  - DSM-II, IV, and IV-TR
  - Presence or absence
  - Relatively separate phenomena

- **Dimensional Models** view behavior on a continuum
  - Adaptive to dysfunctional
  - Absent to severe
  - Achenbach: Internalizing vs. Externalizing

DSM-5 Philosophy

- Disorders were distributed along an internalizing/externalizing continuum based on genetic markers and underlying mechanisms
- Shift towards a more dimensional approach to diagnosis than categorical. Some authors have criticized this as a "**hybrid**" approach
- Disorders were distributed on developmental and lifespan considerations
- Cultural Issues were given special attention under the construct of "culture bound syndromes"
- Both DSM and WHO attempt to separate mental disorder from Disability (impairment in social, occupational, and relational functioning)
- Cautionary statements about using DSM in Forensics

DSM5 and ICD-10 and 11

- Congress and Health and Human Services have continued to delay the implementation of ICD -10 for insurance. (October 1, 2014) ****On April 1, 2014 Congress amended legislation to October 1, 2015
- ICD-11 is due to be released by WHO in 2015
- Some question the wisdom of switching twice in a short time period
- Agreement between ICD Committee and DSM for consistency was a priority for DSM Work Groups
- Some ICD disorders are not in DSM and vice versa
- Results in some situations where two DSM Disorders have same number
- Under HIPAA, insurance companies are only required to accept ICD
- May require conversion of DSM codes to ICD codes
- Crosswalk to convert DSM to ICD is included as Appendix in DSM5
- DSM5 contains both ICD-9(DSM-TR-IV) and ICD-10 codes in parenthesis
- **The World Health Organization Disability Assessment Schedule** (WHO-DAS 2.0) is included in Section III and is the same as used for medical disability.

Cross-Cutting Dimensional Assessment in DSM-5

- In addition to categorical diagnoses, dimensional assessments are proposed
- The goal is to provide additional information for the purpose of assessment, treatment planning, and treatment evaluation
- A full range of dimensional assessments (from paper-based self report to computerized assessment) were considered and field tested (DSM-5 trials)
- Severity scales are proposed for most disorders. An initial evaluation is used to establish a base-line
- Cross-Cutting – crosses the boundaries of single disorders

Cross-Cutting Dimensional Assessment in DSM-5

- Criteria for Assessment System

- ✓ Useful in clinical practice
- ✓ Are brief, simple to read, and simple to evaluate
- ✓ Can be completed by a patient or informant, rather than clinician
- ✓ Provide coverage suitable for most patients in most clinical settings
- ✓ Use ratings on a 5-point scale, with 0 indicating the absence of the problem
- ✓ *DSM-5 Self-Rated Level 1 Cross Cutting Symptom Measure-Adult* and *Parent/Guardian-Rated DSM-5 Level 1Cross Cutting Symptom Measure-Child Age 6-17* are contained in Section III p.738

Clinically significant items on Level 1 Assessment (rating above 2) trigger a Level 2 Assessment (Disorder Specific) Level II Assessment tools can be found at www.psychiatry.org/dsm5

Level 1 Assessment

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

Name: _____ **Age:** ___ **Sex:** ❑ Male ❑ Female **Date:**_____

If this questionnaire is 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, or 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	

Level I Assessment

- I. Depression Mild or greater LEVEL 2—Depression—Adult (PROMIS Emotional Distress—Depression—Short Form)1
- II. Anger Mild or greater LEVEL 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form)1
- III. Mania Mild or greater LEVEL 2—Mania—Adult (Altman Self-Rating Mania Scale)
- IV. Anxiety Mild or greater LEVEL 2—Anxiety—Adult (PROMIS Emotional Distress—Anxiety—Short Form)1
- V. Somatic Symptoms Mild or greater LEVEL 2—Somatic Symptom—Adult (Patient Health Questionnaire 15 Somatic Symptom Severity [PHQ-15])
- VI. Suicidal Ideation Slight or greater None
- VII. Psychosis Slight or greater None
- VIII. Sleep Problems Mild or greater LEVEL 2—Sleep Disturbance - Adult (PROMIS—Sleep Disturbance—Short Form)1
- IX. Memory Mild or greater None
- X. Repetitive Thoughts and Behaviors Mild or greater LEVEL 2—Repetitive Thoughts and Behaviors—Adult (adapted from the Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale [Part B])
- XI. Dissociation Mild or greater None
- XII. Personality Functioning Mild or greater None
- XIII. Substance Use Slight or greater LEVEL 2—Substance Abuse—Adult (adapted from the NIDA-modified ASSIST

Cultural Considerations in the DSM-5

- **Cultural Definition of the Problem:** the presenting issues that led to the current illness episode, cast within the patient's worldview.
- **Cultural Perceptions of Cause, Context, and Support:** the patient's explanations for the circumstances of illness, including the cause of the problem. The patient also clarifies factors that improve or worsen the problem, with particular attention to the role of family, friends, and cultural background.
- **Cultural Factors Affecting Self Coping & Past Help Seeking:** the strategies employed by the patient to improve the situation, including those that have been most and least helpful. The patient also identifies past barriers to care. .
- **Current Help Seeking**: the patient's perception of the relationship with the clinician, current potential treatment barriers, and preferences for care.
- **DSM5** appendix **Glossary of Cultural Concepts of Distress – Dhat** Southeast Asia (semen loss**) Maladi moun** –Hatian (sent sickness by another who is envious). **Nervios**-Latin America (combination of somatic and emotional issues)
- The **Cultural Formulation Interview** is available at www.psychiatry.org/dsm5 or in Section III of the DSM-5, p. 752

Module II: Major Differences Between DSM-IV-TR and DSM5

"Cliff Notes" Version

Differences Between DSM-IV and DSM5 (Cliff Notes Version)

- **General Changes**
  - **No Longer Numeric System**, but *Alphanumeric* to be consistent with ICD-10 e.g. OCD was 300.3 now will be (F42)
  - **Removal of the Multiaxial System**
    - *Only one axis* with notations and descriptors
    - Axis I, II, and III combined in a descriptive fashion. Medical issues should continue to be listed as part of diagnosis i.e. 296.24 (F32.0) Major Depressive Disorder, Single Episode, Severe with Psychotic Features, HIV positive, Z59.5 Extreme Poverty, WHODAS 23
    - Dimensional Assessments emphasize severity and course of a category of disorders
    - Axis IV decision to use ICD-9 and ICD-10 V Codes and Z Codes
    - Axis V as a measure of functioning is covered by using Disability Assessment Schedule (WHODAS) found in Section III

Differences Between DSM-IV and DSM5 (Cliff Notes Version)

- **Coding and Reporting Procedures**
  - **Subtypes and specifiers (coded in the 4th, 5th, or 6th digit) increase specificity are reflected in "specify whether" (subtype) and "specify" or "specify if" (specifier)**
  - **NOS (Not Otherwise Specified) is eliminated and replaced by two terms: Other Specified Disorder and Unspecified Disorder**
  - ***Other Specified Disorder* allows communicating the specific reason that it does not meet criteria: "Other Specified Depressive Disorder, insufficient symptoms and less than two weeks."**
  - ***Unspecified Depressive Disorder***
  - ***DSM-5 allows multiple diagnoses to be assigned,* if both criteria are met**
  - ***Principal Diagnosis* is the focus of treatment and listed first (or designated)**
  - ***Provisional Diagnosis* can be used when there is an assumption that full criteria will eventually be met**

Differences Between DSM-IV and DSM5 (Cliff Notes Version)

- **Specific Disorders**

While most people focus on diagnostic criteria, the DSM5 has for each disorder a compilation of the current thinking on prevalence, development and course, risk and prognostic factors, culture-related diagnostic issues, gender-related diagnostic issues, suicide risks, functional consequences, differential diagnoses, and comorbidity.

- **Autism Spectrum Disorders**
  - **Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder combined into a new diagnosis of Autism Spectrum Disorder with specifiers and severity**
- **Binge Eating Disorder**
  - **Moved from further study to classification to Disorder status**
- **Conduct Disorder with Limited Prosocial Emotions Specifier guilt, empathy, performance, and affect**

Differences Between DSM-IV and DSM5 (Cliff Notes Version)

- Disruptive Mood Dysregulation Disorder (once called TDD Temper Dysregulation Disorder)
  - To address concerns about over-diagnosis of bipolar disorder in children (must be under 18)
- Excoriation (skin-picking) Disorder
  - New to DSM and in Obsessive-Compulsive Chapter
- Hoarding Disorder
  - New - Supported by extensive research
- Pedophilic Disorder
  - Simply name change from Pedophilia
- Disinhibited Social Engagement Disorder
  - RADS broken down into two disorders

Differences Between DSM-IV and DSM5 (Cliff Notes Version)

- **Personality Disorders**
  - **Maintains a categorical model and criteria for the 10 personality disorders (abandoned the proposed five trait theory classification)**
  - **New trait methodology for assessment is included in Section III (Further Study)**
- **Posttraumatic Stress Disorder (PTSD)**
  - **Four distinct diagnostic clusters** re-experiencing, avoidance, cognitions and mood, and *alterations in arousal and reactivity*
  - **Developmentally sensitive (Preschool Criteria <6) and childhood examples**
- **Specific Learning Disorder**
  - **Broadens criteria and reduces to one disorder**
- **Premenstrual Dysphoric Disorder**
  - **Adopted after extensive research**

Differences Between DSM-IV and DSM5 (Cliff Notes Version)

- **Bereavement Exclusion**
  - Removes the two month grief criteria
  - Views bereavement as a severe psychosocial stressor precipitating major depressive episode
- **Substance Use Disorder**
  - Combines abuse and dependence categories
  - Requires greater number of symptoms
- **Gambling Disorder** viewed as addiction
- **"Did Not Make The Cut"**
  - For Further Study Attenuated Psychosis, Internet Use/Gaming Disorder, Non-suicidal Self Injury, Suicidal Behavior Disorder
  - Not Accepted for DSM Anxious Depression, Hypersexual Disorder, Parental Alienation Syndrome, Sensory Processing Disorder

Module III: Highlights of Changes in DSM-5

Highlights of Changes DSM-IV-TR to DSM -5

Chapter Structure

1. Neurodevelopmental Disorders
2. Schizophrenia Spectrum and Other Psychotic Disorders
3. Bipolar and Related Disorders
4. Depressive Disorders
5. Anxiety Disorders
6. Obsessive-Compulsive and Related Disorders
7. Trauma and Stressor-Related Disorders
8. Dissociative Disorders
9. Somatic Symptoms and Related Disorders
10. Feeding and Eating Disorders
11. Elimination Disorders
12. Sleep-Wake Disorders
13. Sexual Dysfunctions
14. Gender Dysphoria
15. Disruptive, Impulse Control, and Conduct Disorders
16. Substance-Related and Addictive Disorders
17. Neurocognitive Disorders
18. Personality Disorders
19. Paraphilic Disorders

Highlights of Changes DSM-IV-TR and DSM -5

- **Chapter 1. Neurodevelopmental Disorders**
  - Intellectual Disability
  - Communication Disorders
  - Autism Spectrum Disorder
  - Attention Deficit Hyperactivity Disorder
  - Specific Learning Disorder
  - Motor Disorders

Highlights of Changes DSM-IV-TR and DSM -5

- **Intellectual Disability (Intellectual Developmental Disorder)**
  - **Removal of the terminology of *mental retardation***
  - **Consistent with advocacy groups and PL 111-256**
  - **Severity is based on *adaptive functioning and IQ***
  - **Requires deficits in both cognitive, social and adaptive behaviors (comprehensive assessment)**
  - **Intellectual Developmental Disorder included in parenthesis to prepare for ICD-11**
  - **Does not include a specific IQ score in criteria but text reflects IQ of 2sd below, or about 70**
  - **The new criteria includes severity measures (mild, moderate, severe, and profound intellectual disability)**

Highlights of Changes DSM-IV-TR and DSM -5

- **Communication Disorders**
  - Restructured to include three disorders with appropriate subtypes
  - **Language Disorders**
    - Expressive Speech Disorder
    - Expressive-receptive Disorder
  - **Speech Disorder**
    - Speech Sound Disorder (Phonological Disorder)
    - Motor Speech Disorder
    - Childhood-Onset Fluency Disorder (Stuttering)
    - Voice Disorder
    - Resonance Disorder

Highlights of Changes DSM-IV-TR and DSM -5

NEW Social (Pragmatic) Communication Disorder

- Difficulties in narrative, expository and conversational discourse.
- Difficulties using verbal and nonverbal communication for social purposes, leading to social, occupational, or academic problems
- Not explained by low cognitive ability
- Under DSM-IV was often diagnosed as PDD(NOS)
- *No restricted, repetitive behaviors*
- *ASD must be ruled out to diagnose SCD*

Highlights of Changes DSM-IV-TR and DSM -5

- **Autism Spectrum Disorder**
  - Reflects a scientific consensus, but enormous controversy
  - Combines *four disorders as a single disorder on a continuum* with levels of symptom severity (Autism, Asperger's Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder NOS)
  - Both deficits in social communication and interaction and restrictive repetitive behaviors, interests, and activities
  - *Both are required for a diagnosis of ASD, Social Communication Disorder is diagnosed if no RB's are present*
  - Allows for a number of specifiers (intellectual, genetic/medical, acquired, etc.)
  - *Three Levels of Severity* (**requiring support, requiring substantial support, requiring very substantial support**)
  - Symptoms present in "early developmental period" <24 months

Highlights of Changes DSM-IV-TR and DSM -5

- **Attention-Deficit/Hyperactivity Disorder**
  - Same 18 symptoms are used (9 Inattention and 9 Hyperactivity/Impulsivity), but examples added across the life span
  - Cross-situational requirement strengthened to include "several" symptoms in each setting
  - Onset criteria has *been increased to age 12*
  - Subtypes are replaced with *presentations*
  - Comorbid diagnosis with Autism Spectrum is allowed
  - ***Symptom threshold is different for older adolescents and adults* (5 vs. 6)**
  - Placed in neurodevelopmental category
  - *Subtypes remained the same despite earlier drafts*

    Combined Presentation: Both Criteria 1 & 2 are met for six months

    Predominately Hyperactive/Impulsive Presentation: Criteria 2 is met, and Criteria 1 is not met for past six months

    Predominately Inattentive Presentation: Criteria 1 is met, but Criteria 2 is not met and 3 or more symptoms from 2 have been present for six months
  - Severity specifiers: **mild, moderate, severe**

Highlights of Changes DSM-IV-TR and DSM -5

- **Specific Learning Disorder**
  - Combines three former diagnoses *into one category* (broadening the category)
  - *Specifiers* identify type of learning disorder
  - Text acknowledges the international diagnoses of dyslexia and dyscalculia
  - One of six symptoms for six months
  - The learning difficulties begin in school-age period, but may not manifest until later
- **Motor Disorders**
  - **Slight wording changes for existing diagnoses of Developmental Coordination Disorder, Stereotypic Movement Disorder, Tourette's Disorder, Persistent Vocal or Motor Tic Disorder, and Provisional Tic Disorder**

Highlights of Changes DSM-IV-TR and DSM -5

Chapter 2. Schizophrenia Spectrum and Other Psychotic Disorders

- **Schizophrenia**
  - ***Two criterion A symptoms are required rather than one*: hallucinations, delusions, negative symptoms (lack of affect, will, speech), and disorganized speech**
  - **Additional requirement of at least one symptom of delusions, hallucinations, and disorganized speech**
  - ***Subtypes (paranoid, disorganized, catatonic, undifferentiated, and residual) are eliminated* and instead a dimensional approach to severity (First Episode, Multiple Episodes, Continuous**

Highlights of Changes DSM-IV-TR and DSM -5

- **Schizoaffective Disorder**
  - **Primary Change is that *major mood episode is present for majority of disorder's total duration***
  - **Based on conceptual and psychometric data**
  - **Both psychotic and mood symptoms are longitudinal over course of disorder**

Highlights of Changes DSM-IV-TR and DSM -5

- **Delusional Disorder**
  - ***No longer require that delusions are non-bizarre.*** **Can be covered by specifier: With Bizarre Content**
  - **Erotomanic, grandiose, persecutory, somatic subtypes**
  - **Symptoms cannot be better explained by Obsessive-Compulsive or Body Dysmorphic Disorder**
  - ***No longer separates shared delusional*** **(Folie a Deux)**

Highlights of Changes DSM-IV-TR and DSM -5

Chapter 3:Bipolar and Related Disorders

- **Bipolar I and II**
  - **Criterion A emphasizes a change *in activity and energy* as well as mood**
  - **The requirement that full criteria for both mania and depressed mood be fully *met is removed by a new specifier, "with mixed features."* Do not have to meet full criteria for manic episode or depressive episode**
  - **A *specifier for anxious distress* is intended to cover those with anxiety symptoms, not a part of bipolar criteria**
- **Cyclothymia** remains and is relatively unchanged other than emphasizing symptom must be present half the time

Highlights of Changes DSM-IV-TR and DSM -5

Chapter 4. Depressive Disorders

- Major Depressive Disorder (wording changes)
- New – Disruptive Mood Dysregulation Disorder (for Children)
- New – Premenstrual Dysphoric Disorder
- Combined – Dysthymia and Major Depressive Disorder, Chronic into Persistent Depressive Disorder

Highlights of Changes DSM-IV-TR and DSM -5

- **Major Depressive Disorder**
  - No major Changes in symptoms or duration
  - Addition of *a "with mixed features"* with the presence of at least three manic/hypomanic symptoms, but has never reached manic or hypomanic state.
  - Specifier "**with anxious distress**" - poorer prognosis
  - **Removal of Bereavement Exclusion**
    - *Major Controversy – Pathologization of Normal Human Experience*
    1. Implication that bereavement lasts only two months – data implies 1 to 2 years
    2. A *severe stressor* that can precipitate or complicate a Major Depressive Episode
    3. Bereavement-related depression occurs more frequently in individuals with personal or family history of Major Depression
    4. Symptoms associated with *bereavement respond to the same psychosocial and medication treatments* as Major Depression
    5. Complex Bereavement Disorder Criteria in Section III

Highlights of Changes DSM-IV-TR and DSM -5

- **Premenstrual Dysphoric Disorder**
  - Graduated from the Further Study Category of DSM-IV-TR
  - A history of depressed mood, anxiety, affective lability, irritability, or loss of interest during the last week of the luteal phase (post ovulation)
  - *Symptoms include lethargy, appetite change, sleep difficulties, overwhelmed and out of control, weight gain, and bloating*
  - Approximately 2% of women will meet criteria
  - Concerns about the "*pathologization*" of women
  - Fears of implication that women are not capable of performing functions during premenstrual cycle

Highlights of Changes DSM-IV-TR and DSM -5

- **Persistent Depressive Disorder** NEW
  - Combines *Dysthymia and Major Depressive Disorder, Chronic*
  - *Chronicity* is a significant factor in treatment outcome
  - First step to conceiving mood disorders as a *spectrum* of severity and chronicity *(Dimensional Model)* rather than arbitrary categories (cleaving meatloaf)

Highlights of Changes DSM-IV-TR and DSM -5

Chapter 5. Anxiety Disorders

Obsessive Compulsive Disorder, Posttraumatic Stress Disorder, and Acute Stress Disorder are no longer considered anxiety disorders. They are moved to their own chapters

- **Panic Attacks**
  - Removal of the requirement that *recognition that anxiety is excessive*
  - Different types (cued and uncued) are now replaced by *"**expected**" and "**unexpected.**"*
  - Panic Attacks can also be *listed as a specifier* for all DSM5 Disorders

Highlights of Changes DSM-IV-TR and DSM -5

- **Panic Disorder and Agoraphobia**
  - Panic Disorder and Agoraphobia are *uncoupled* in DSM5
  - *Three categories are reduced to two*: 1) Panic Disorder and 2) Agoraphobia
  - Co-occurrence of Panic Disorder and Agoraphobia *is coded with two diagnoses*
  - Changed to require *two or more agoraphobic situations*. Robustness to distinguish agoraphobia vs. specific phobias
  - Duration of *six months* or more

Highlights of Changes DSM-IV-TR and DSM -5

- **Specific Phobia**
  - Essentially the same criteria, but duration of recognition has *time criteria*
  - Duration criteria (6 months) also applies to *all ages*
  - *Types are now referred to as specifiers* (animal, environmental, blood/injection, situational)
- **Social Anxiety Disorder**
  - Essentially the same criteria, but duration of recognition has *time criteria*
  - Duration criteria (6 months)also applies to *all ages*
  - *Generalized specifier deleted* and replaced by ***"performance only."***

Highlights of Changes DSM-IV-TR and DSM -5

- **Separation Anxiety Disorder**
  - Moved from Chapter on Infancy, Childhood, and Adolescence to Anxiety
  - Criteria are essentially unchanged, but wording is modified to *reflect adults who also have disorder*
  - *Onset prior to age 18 is removed*
  - *Duration criteria (6 months) added for adults* to prevent over-diagnosis of transient fears

Highlights of Changes DSM-IV-TR and DSM -5

Chapter 6. Obsessive-Compulsive and Related Disorders (New Chapter)

- NEW Disorders include Hoarding Disorder, Excoriation (skin picking) Disorder, Substance/medication-induced Obsessive-Compulsive Disorder, and Obsessive-Compulsive Disorder Due to a Medical Condition
- Trichotillomania moved to this Chapter

Highlights of Changes DSM-IV-TR and DSM -5

- **Obsessive-Compulsive and Related Disorders**
  - *Specifiers for level of insight have been refined* to distinguish insight. "absent" (feel compelled), "good" (probably will happen) "delusional" convinced
  - Improve differential diagnosis of obsessive-compulsive versus a schizophrenia spectrum
  - *"Tic Related" specifier* identifies a high co-morbidity factor at work.
- **Body Dysmorphic Disorder**
  - Moved from Somatoform Chapter
  - Respond better to SSRI's than antipsychotics
  - Should not be coded as a Delusional Disorder, but with specifiers ***"with muscle dysmorphia"*** and ***"absent insight/delusional beliefs"*** added

Highlights of Changes DSM-IV-TR and DSM -5

- **Hoarding Disorder**
  - New Diagnosis - In the past most were diagnosed OCD, but most *do not exhibit OCD or respond to medication*
  - *Hoarding may be a symptom* of OCD, but data indicate that hoarding can be a separate dynamic
  - Persistent difficulty discarding or parting with possessions
  - Distorted need to save items and *extreme distress* associated with discarding them
  - *Quantity of items* sets them apart
  - Not particularly distressed by the behavior, *others are*
  - Indications of a *unique neurological correlate* different from OCD (PET Scans)
  - Public health and safety issues
  - Level of Insight Specifier

Highlights of Changes DSM-IV-TR and DSM -5

- **Trichotillomania (Hair-Pulling Disorder)**
  - Essentially same criteria as DSM-IV, but moved to a new section to emphasize tension-release dynamic
- **Excoriation (Skin-Picking) Disorder**
  - New Category with substantial evidence base
  - Must have been repeated attempts to decrease or stop picking
  - Estimated that 2-4 percent of general population
- **Substance/Medication-Induced Obsessive-Compulsive Disorder** (formerly Anxiety disorders due to a General Medical Condition, with obsessive-compulsive symptoms)

Highlights of Changes DSM-IV-TR and DSM -5

- **Obsessive-Compulsive Disorder Due to Another Medical Condition** (formerly Substance-induced Anxiety Disorder, with obsessive-compulsive symptoms)
- **Other Specified and Unspecified Obsessive-Compulsive and Related Disorders**
  - Old Anxiety Disorder NOS
  - ***Body focused repetitive behavior*** **(other than hair pulling or skin-picking) e.g.** nail-biting, lip biting
  - ***Obsessional jealousy*** (non-delusional preoccupation with partner's fidelity)

Highlights of Changes DSM-IV-TR and DSM -5

Chapter 7. Trauma and Stressor Related Disorders – NEW Chapter

Brings together anxiety disorders that are preceded by a distressing or traumatic event

- **Acute Stress Disorder**
  - Criterion A requires being explicit as to whether trauma were *experienced directly, witnessed, or indirectly experienced*
  - Eliminates the *subjective reaction* to event (first resp)
  - *Must exhibit 9 of 14 symptoms (3/4)*
  - Categorizes symptoms *as intrusion, negative mood, dissociation, avoidance, and arousal*

Highlights of Changes DSM-IV-TR and DSM -5

- **Adjustment Disorder**
  - Included in Trauma and Stressor Chapter
  - Re-conceptualized from a clinically significant distress that does not meet criteria for another disorder to *a stress response to a distressing event*
  - Subtypes have been *retained unchanged*

Highlights of Changes DSM-IV-TR and DSM -5

- **Posttraumatic Stress Disorder**
  - Significant changes and re-conceptualization
  - Criterion A requires being explicit as to whether trauma were experienced *directly, witnessed, or indirectly experienced*
  - *Clearer line* as to what constitutes traumatic events
  - Criterion A2 *subjective reaction has been eliminated* (fear, helplessness, horror) Military, First Responders may have no subjective distress
  - Requires that a disturbance continues for *one month* and eliminates the distinction between acute and chronic stages

Highlights of Changes DSM-IV-TR and DSM -5

- **Posttraumatic Stress Disorder**
  - Three major symptom clusters have been *expanded to four*: re-experiencing, avoidance, **persistence negative alterations in cognitions and mood**, and alterations in arousal and reactivity
    - Re-experiencing includes spontaneous memories, recurrent dreams, flashbacks, and intense distress
    - Avoidance refers to distressing memories, thoughts, feelings, or external reminders
    - Negative Cognition and Mood reflects a myriad of feelings, including: self-blame, estrangement, diminished interests, and inability to remember
    - Arousal is marked by aggressive, reckless/self-destructive behaviors, sleep disturbances, and hyper vigilance. Fight/Flight,

Highlights of Changes DSM-IV-TR and DSM -5

- Posttraumatic Stress Disorder (continued)
  - **PTSD Preschool Differences**
    - Eliminates the criteria for repeated or extreme exposure
    - Provides example of ways of re-enactment
    - May or may not display same negative alterations in cognitions and emotions (fear, guilt, sadness, shame or confusion) but are manifested behaviorally (social withdrawal, constriction of play, expression of positive emotions)
    - Marked physiological reactions to reminders of the event
    - Avoidance is to concrete stimuli and not memories
  - **PTSD Dissociative Subtype**
    - Depersonalization or Derealization

Highlights of Changes DSM-IV-TR and DSM -5

Chapter 8. Dissociative Disorders

- **Depersonalization Disorder**
  - Now also includes derealization and name has been changed to Depersonalization/Derealization Disorder
- **Dissociative Fugue**
  - *Eliminated as a Disorder* and now is a specifier for **Dissociative Amnesia**
- **Dissociative Identity Disorder**
  - *Cultural pathological possession* and neurological symptoms covered
  - Transitions in identity may be *observable or self-reported*
  - Recall gaps may be for everyday events and not just trauma

Highlights of Changes DSM-IV-TR and DSM -5

Chapter 9. Somatic Symptom and Related Disorders (formerly Somatoform Disorders)

- Overlap and lack of clarity was particularly problematic for *primary care settings*
- Emphasis *in holistic care and removes mind-body separation*
- Categories are combined and eliminated, including: Somatization Disorder, Hypochondriasis, Pain Disorder, and Undifferentiated Somatoform Disorder

◦ **Medically Unexplained Symptoms** (New)

- Defines on the basis of *positive symptoms rather than absence of medical explanation* (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors

Highlights of Changes DSM-IV-TR and DSM -5

- **Somatic Symptom Disorder** (new)
  - Hybrid diagnosis combining Somatization Disorder and Undifferentiated Somatoform Disorder
  - Diagnosis for Somatoform Disorder was based on an unrealistically high symptom count (4 pain, 2 GI, 1 sex, and 1 neurological), now the focus is on ***abnormal thoughts, feelings, and behaviors*** *that* ***may or may not*** *have a medical condition*
  - *No specific number of symptoms* is required, but they must be persistent *(six months)*
  - No longer requires that medical symptoms are *unexplainable*
- **Conversion Disorder (Functional Neurological Symptom Disorder)**
  - *Emphasizes neurological* exam and recognizes that *psychological factors may not be identified immediately*

Highlights of Changes DSM-IV-TR and DSM -5

- **Illness Anxiety Disorder**
  - *Hypochondriasis was eliminated due to pejorative connotation and interference with therapeutic bond*
  - Those previously diagnosed *with Hypo and high symptoms will fall into Somatic Symptom Diagnosis*
  - This category covers those with *high health anxiety, but low symptoms*
- **Pain Disorder**
  - *Eliminates the distinction between psychological factors, disease and injury, or both.*
  - Chronic pain is viewed as a combination of *somatic, psychological, and environmental influences*

Highlights of Changes DSM-IV-TR and DSM -5

- **Psychological Factors Affecting Other Medical Conditions and Factitious Disorder**
  - A hybrid combination of two disorders with *predominant somatic symptoms*
  - The specific psychological factors are removed as they are covered in the stem diagnosis
  - *No external gain is obvious*

Highlights of Changes DSM-IV-TR and DSM -5

- **Chapter 10. Feeding and Eating Disorders**
- **Binge-Eating Disorder** –NEW Diagnosis
  - Graduated from *Further Study to a Disorder* after extensive research
  - Typically addressed in past by diagnosis of Eating Disorder NOS
  - Recurring episodes of *eating more food than normal in a short period of time, with feelings of loss of control, guilt, embarrassment, and disgust*
  - Only change from DSM-IV proposal was the reduction in frequency of binge eating from twice weekly for 6 months to *weekly for 3 months*
  - Distinguishes between *binge eating and overeating*

Highlights of Changes DSM-IV-TR and DSM -5

- **Pica and Rumination Disorder**
  - Reworded and extended to all ages
- **Avoidant/Restrictive Food Intake Disorder**
  - Feeding Disorder of Infancy and Childhood has been *renamed and criteria significantly expanded*
  - Adults and adolescents also restrict food intake and experience physiological/psychological issues
  - *Broad Category intended to capture a variety and range of presentations*

Highlights of Changes DSM-IV-TR and DSM -5

- **Anorexia Nervosa**
  - Core concepts are unchanged, *but drops amenorrhea*
  - Criterion A focuses on behaviors, but still requires the person to be at a significantly *low body weight, no longer 85%* and wording clarifications
  - Criterion B is expanded to include *not only overtly expressed fear of weight gain, but behavior* that interferes with normal weight gain
- **Bulimia Nervosa**
  - Only change is a *reduction from twice to average of once weekly* for binge eating

Highlights of Changes DSM-IV-TR and DSM

Chapter 11. Elimination Disorders

- Free-standing Category with no major changes

Chapter 12. Sleep-Wake Disorders

- Sleep disorders can occur in isolation or with other disorders (multiple diagnosis)
- **Narcolepsy** *(hypocretin deficiency)* separated from other Hypersomnolence Disorders
- **Breathing Related Sleep Disorders** – *obstructive sleep apnea, central sleep apnea, sleep-related hypoventilation*
- ***Restless Leg Syndrome*** included in DSM-5

Highlights of Changes DSM-IV-TR and DSM

Chapter 13. Sexual Dysfunction

- *Gender specific* sexual dysfunctions
- Female Sexual Desire and Female Arousal combined into **Female Sexual Interest/Arousal Disorder**
- Paraphilias now *have their own chapter*

Chapter 14. Gender Dysphoria

- *Replaces Gender Identity Disorder*
- Emphasizes gender *incongruence*
- Developmentally appropriate criteria

Highlights of Changes DSM-IV-TR and DSM

Chapter 15. Disruptive, Impulse Control Disorders

- Problems associated with *emotional and behavioral self-control are grouped in their own chapter*
- ***Externalizing Disorders*** as compared to ***Internalizing Disorders***
  - **Oppositional Defiant Disorder**
    - Symptom list remains the same, but is now clustered into three groups: ***Angry/Irritable Mood, Argumentative/Defiant Behavior, and Vindictiveness***
    - *Frequency of symptoms* is addressed through coding note:
    - ≥ 6 *must be more than once a week for 6 month*
    - ≤ *5 occurs on most days for 6 months*
    - Sibling exclusion
    - Can now *be diagnosed with both ODD and CD*
    - *Severity rating based on pervasiveness of relationships and settings:* **Mild –** one setting; **Moderate –** two settings; and **Severe –** three or more settings

Highlights of Changes DSM-IV-TR and DSM

- **Conduct Disorder**

  Callous and Unemotional Specifier replaced by " With Limited Prosocial Emotions

  **Limited Prosocial Emotions specifier" 1)Lack of remorse or guilt ,2)Callous-Lack of Empathy , 3)Unconcerned about Performance , 4)Shallow or Deficient Affect –typical patterns in emotional and interpersonal functioning*

  A more severe form of the disorder requiring a different treatment response

  Specifier attempts to avoid stigmatizing language and focus on a limited display of prosocial emotions such as empathy and guilt

  - *Older than 10*

- **Intermittent Explosive Disorder**
  - Now also includes *verbal aggression and nondestructive physical aggression*
  - Must be above *the age of 6*
- **Pyromania and Kleptomania *****DROPPED*******
  - Insufficient evidence to retain them as distinct disorders and are better accounted for by other disorders ODD, CD, ASPD

Highlights of Changes DSM-IV-TR and DSM

Chapter 16. Substance Use and Addictive Disorders

- ***Major Change is the elimination of the distinction between Abuse and Dependence and the formulation of Use Disorder***
  - Empirical evidence that *Abuse and Dependence exist on a continuum*
  - Abuse is different from Dependence *by degree, but not by kind*
  - Eliminates an "arbitrary distinction" that is addressed by *focusing on "Use" rather than a false dichotomy*
  - *Craving is a new concept* introduced

Highlights of Changes DSM-IV-TR and DSM

- Phencyclidene Disorders (PCP, Ketamine, angel Dust) are now covered under **Hallucinogen Disorders**
- Sedative, Hypnotic, or Anxiolytic Disorders are renamed **Sedative/Hypnotic-Related Disorders**
- Amphetamine and Cocaine Disorders are renamed **Stimulant Disorders**
- **Gambling Addiction** - Major Controversy
  - Justified on basis of *tolerance, dependence, and withdrawal*
  - *Similar genetic markers* as substance abusers
  - Brain Imaging shows *similar changes in neural circuitry*
- **Severity Specifiers**
- **Remission Specifiers**
- **Prenatal Alcohol Exposure, Caffeine Use Disorder, and Internet Use Disorder** are assigned to the Further Research Chapter III

Highlights of Changes DSM-IV-TR and DSM

Chapter 17. Neurocognitive Disorders

- Head Trauma now called *Traumatic Brain Injury*
- *Dementia* is eliminated and is now **Major Neurocognitive Disorder Due to……**
- ***Dementia*** can be used as a descriptor.
- **Mild Neurocognitive Disorder** (New) Recognition and Level of Severity

Chapter 18. Personality Disorders

- **Original 11 Personality Disorder Categories were retained *after major controversy***
- Group originally recommended *reducing to seven categories*: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal, and Personality Disorder-Trait Specified pshd
- Now in Section III For Further Study *is a "hybrid" (categorical and dimensional)* approach Criteria A *(Impairment of self or interpersonal functioning)* and Criteria B five traits *(negative affectivity, detachment, antagonism, disinhibition, and psychoticism)*
- *Rating scale to assess impairment on a four point scale*

Chapter 19.Paraphillic Disorders

- Wording changes and developmental perspective

Module III: Specific Disorders

AFFECTIVE DISORDERS

BIPOLAR DISORDERS

SCHIZOPHRENIA

DSM-5 Diagnostic Criteria for Major Depressive Disorder (Paraphrased)

296.21 (F32.0) For period of 2 weeks five or more are present and either 1) depressed mood 2) anhedonia

1. depressed mood most of day (children can be irritable)

2. loss of interest in pleasurable activities

3. 5% weight gain or loss, or decrease/increase in appetite

4. insomnia or hypersomnia

5. psychomotor agitation or retardation

6. fatigue or loss of energy

7. feelings of worthlessness or excessive guilt

8. problems thinking or concentrating

9. recurrent thoughts of death, suicide attempts, or suicide plan

Major Depressive Disorder

- No substantial changes to criteria were made other than the omission of the "Bereavement Exclusion" and a specifier of Mixed Features
  - Major Depression Episode must have at least three manic/hypomanic symptoms (two weeks)
  - Manic or Hypomanic Episode must have at least three depressive symptoms in Manic Episode or four depressive symptoms in Hypomanic Episode (one week)

Major Depressive Disorder

- Bereavement Exclusion - Criterion E under DSM-IV is eliminated
  - **Removal of Bereavement Exclusion**
    - *Major Controversy – Pathologization of Normal Human Experience*

1. Implication that bereavement lasts only two months – data implies 1 to 2 years
2. A *severe stressor* that can precipitate or complicate a Major Depressive Episode
3. Bereavement-related depression occurs more frequently in individuals with personal or family history of Major Depression
4. Symptoms associated with *bereavement respond to the same psychosocial and medication treatments* as Major Depression
5. Complex Bereavement Disorder Criteria in Section III

- Rationale for opposing removal of Bereavement Exclusion
  - In grief, painful feelings come in waves, and interspersed positive feelings, in depression feelings are constant and negative
  - In grief, self-esteem is preserved, in MDD corrosive feelings of self-loathing and worthlessness
  - MDD should not be diagnosed in the context of bereavement, since it would label a normal process as pathological
  - When grief and MDD co-exist, grief is more severe and prolonged
  - Misconception that grief symptoms are identical to those of MDD
  - Suicidal ideation and wanting to join a deceased loved one are conceptually distinct.

DSM5 Persistent Depressive Disorder (Paraphrased)

300.4 DSM-IV Dysthymia (paraphrased)

A. Depressed mood, most of the day, more days than not for two years
B. Two or more of six symptoms
   1. Poor appetite
   2. Insomnia/hypersomnia
   3. Low energy/fatigue
   4. Low Self-Esteem
   5. Poor concentration/decision making
   6. Feelings of hopelessness
C. Never without symptoms for 2 months
D. No Major Depressive Episode
E. Never a Manic Episode
F. No psychosis
G. Not physiological
H. Significant Impairment

Specify Early Onset or Late Onset

300.4 (F34.1) DSM5 (paraphrased)

A. Depressed mood, most of the day, more days than not for two years
B. Two or more of six symptoms
   1. Poor appetite
   2. Insomnia/hypersomnia
   3. Low energy/fatigue
   4. Low Self-Esteem*
   5. Poor concentration/decision making
   6. Feelings of hopelessness*
C. Never without symptoms for 2 months
D. Criteria for Major Depression present for two years
E. Never a Manic Episode
F. No psychosis
G. Not physiological
H. Significant Impairment

DSM5 Persistent Depressive Disorder (Paraphrased)

Note: Four symptoms of MD are same as PDD . Some individuals will have MD symptoms for two years, but will not meet PDD criteria. If criteria for MD are met diagnosis of MD should be used.

Specify if: with **anxious distress, mixed features, melancholic, atypical, mood-congruent psychotic, mood-incongruent psychotic, postpartum onset**

Specify if: **partial remission, full remission**

Specify if: **Early Onset <21**

Late Onset >21

DSM5 Persistent Depressive Disorder (Paraphrased)

Specify if: **pure dysthymic syndrome** (MD have not been met in prior two years)

persistent major depressive, intermittent (MD have been met throughout prior two years)

Intermittent MD episodes, current episode (full criteria are presently met, but periods of 8 weeks in prior two years where symptoms were below threshold)

Intermittent MD episode, without current episode (full criteria are not presently met, but one or more times symptoms were met in two years)

Specify if: **Mild, Moderate, Severe**

DSM5 Premenstrual Dysphoric Disorder

625.4 (N954.3) (paraphrased

A. Most cycles, **five** symptoms must be present week before menses, improve after onset of menses, and absent one week post menses

B. One or more of symptoms:
   1. Affective Lability
   2. Irritability, anger, personal conflict
   3. Depressed mood, hopelessness
   4. Anxiety, tension, on edge

C. One or more of following present to reach a total of five symptoms
   1. Decreased interest in activities
   2. Difficulty in concentration
   3. Lethargy, fatigue, lack of energy
   4. Change in appetite, overeating
   5. Hypersomnia or Insomnia
   6. Out of control, overwhelmed
   7. Unusual physical symptoms

DSM5 Premenstrual Dysphoric Disorder (paraphrased)

Note: Symptoms for A-C must have been present for most menstrual cycles in the prior year

D. Significant distress

E. Not result of another disorder

F. Criterion A should be confirmed by daily ratings for two cycles

G. Not attributable to medical issues

DSM-5 Diagnostic Criteria for Manic Episode (Summary)

The presence of a distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally increased activity or energy for a period of 1 week. Three or more of following are present

1. **inflated self esteem or grandiosity**
2. **decreased need for sleep**
3. **excessively talkative or pressured speech**
4. **flight of ideas, racing thoughts**
5. **extreme distractibility**
6. **increased goal directed activity; psychomotor agitation**
7. **excessive involvement in activities that have potential for painful consequences**

Severe disruption in functioning typically requiring hospitalization

DSM5 Manic Episode

Minor changes

- Inclusion of language to reflect increased energy/ activity is a core symptom of a manic episode
- Added language to reflect "lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
- Added language in B to reflect "and represent a noticeable change from usual behavior."
- Delete the word "pleasurable in #7.

DSM-5 Diagnostic Criteria for Hypomanic Episode (Summary)

The presence of a distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistent increased activity or energy for a period of at least four days most of the day nearly every day. Three or more of following are present

Atypical mood lasting 4 days

1. inflated self esteem or grandiosity
2. decreased need for sleep
3. excessively talkative or pressured speech
4. flight of ideas; racing thoughts
5. extreme distractibility
6. increased goal directed activity; psychomotor agitation
7. excessive involvement in pleasurable activities

*Not sufficiently severe to cause marked impairment in functioning or to necessitate **hospitalization***

DSM5 Hypomanic Episode

Minor changes are enacted

- Inclusion of language to reflect increased energy/ activity is a core symptom of a manic episode
- Added language to reflect "lasting at least 4 days and present most of the day, nearly every day."
- Added language to reflect "and represent a noticeable change from usual behavior."
- Delete the word "pleasurable in #7.
- If psychotic features are present it is a manic episode and not hypomanic

DSM5 Cyclothymia

DSM-IV 301.13 (paraphrased)

A. For two years, numerous periods with hypomanic symptoms and periods with depressive symptoms that do not meet criteria for MD. (one year for children)
B. During two year period has not been without symptoms for more than two months.
C. Criteria for MD, Mania, or Hypomania have never been met
D. Not better accounted for

DSM5 301.13 (F34.0) (para.)

A. For two years, numerous periods with hypomanic symptoms and periods with depressive symptoms that do not meet criteria for MD. (one year for children)
B. During two year period, hypomanic and depressed symptoms have been present at least half the time and individual has not been without symptoms for more than two months.
C. Criteria for MD, Mania, or Hypomania have never been met
D. Not better accounted for

DSM5 Schizophrenia

DSM-IV 295.xx (paraphrased)

A. One or more of the following for one month
   1. Delusions
   2. Hallucinations
   3. Disorganized Speech
   4. Disorganized or Catatonic Behavior
   5. Negative Symptoms (lack of emotions or will)

Only one symptom is required if delusions are bizarre or if hallucinations are a voice with running commentary or two voices conversing

DSM5 295.90 (F20.9) (paraphr.)

A. Two or more of the following for one month. At least one must be (1), (2), (3)
   1. Delusions
   2. Hallucinations
   3. Disorganized Speech
   4. Disorganized or Catatonic Behavior
   5. Negative Symptoms (lack of emotions or will)

Only one symptom is required if delusions are bizarre or if hallucinations are a voice with running commentary or two voices conversing

DSM5 Schizophrenia

B. Interferes with Social/Occupational Functioning

C. Disturbance persists for six months

D. Schizoaffective and Depressive Disorder with psychotic features have been ruled out because either 1) no MD or Manic Episodes or 2) mood episodes have been present a minority of time

E. Not better accounted for

F. If Autism or PDD, only use if hallucinations > one month

B. Interferes with Social/Occupational Functioning

C. Disturbance persists for six months

D. Schizoaffective and Depressive Disorder with psychotic features have been ruled out because either 1) no MD or Manic Episodes or 2) mood episodes have been present a minority of time

E. Not better accounted for

F. If Autism or Communication Disorder, only use if hallucinations > one month

DSM5 Schizophrenia

295.30 Paranoid Type, 295.10 Disorganized Type, 295.20 Catatonic Type, 295.90 Undifferentiated, 295.60 Residual

Specifiers:

Episodic with Interepisode Symptoms, w/ wo prominent negative symptoms

Episodic with Interepisode Symptoms, w/wo prominent negative symptoms

Continuous, w/wo negative symptoms

Single Episode partial/full remission

All subtypes of schizophrenia have been eliminated

Specifiers:

First Episode, acute

First Episode, partial remission

First Episode, full remission

Multiple Episodes, acute

Multiple Episodes, partial remiss.

Multiple Episodes, full remission

Continuous

Severity Specifiers:

Rate on 0 to 5 point scale (See Section III) (optional)

DSM5 Delusional Disorder

DSM-IV 297.1 (paraphrased)

A. Nonbizarre delusions for one month
B. Criterion A for Schizophrenia have never been met
C. Functioning is not markedly impaired
D. If mood episodes present, relatively brief
E. Not better accounted for

Specifiers: erotomanic, grandiose, jealous, persecutory, somatic, mixed, unspecified

DSM5 297.1 (F22) (paraphrased)

A. One or more delusions for one month, if hallucinations present, not prominent
B. Criterion A for Schizophrenia have never been met
C. Functioning is not markedly impaired
D. If mood episodes present, relatively brief
E. Not better accounted for

Specifiers: erotomanic, grandiose, jealous, persecutory, somatic, mixed, unspecified

DSM5 Delusional Disorder

Specifiers:

With Bizarre Content

First Episode, acute episode

First Episode, partial remission

First Episode, full remission

Multiple Episodes, acute

Multiple Episodes, partial remiss.

Multiple Episodes, full remission

Continuous

Severity Specifiers:

Rate on 0 to 5 point scale (See Section III) (optional)

DSM5 Schizoaffective Disorder

DSM-IV 295.70 (paraphrased)

A. An uninterrupted period of illness in which a major mood episode is concurrent with Criterion A of Schizophrenia
B. During same period, delusions or hallucinations for two weeks
C. Symptoms of mood episode are present for a substantial portion of total duration
D. Not better accounted for

DSM5 295.70 (F25.0) or (F25.1)

A. An uninterrupted period of illness in which a major mood episode is concurrent with Criterion A of Schizophrenia
B. During lifetime duration, delusions or hallucinations for two weeks absent mood
C. Symptoms of mood episode are present for the majority of the total duration
D. Not better accounted for

DSM5 Schizoaffective Disorder

Specify if:

Bipolar Type

Depressive Type

Specifiers:

295.70 (F25.0) Bipolar Type

295.70 (F25.1) Depressive Type

With Catatonia

First Episode, acute episode

First Episode, partial remission

First Episode, full remission

Multiple Episodes, acute

Multiple Episodes, partial remission

Multiple Episodes, full remission

Continuous

Severity Specifiers:

Rate on 0 to 5 point scale (See Section III) (optional

Module IV: Case Studies 1 - 4 and Questions and Answers

Symptoms and Dysfunctions

Differential Diagnoses

DSM5 Formatted Diagnosis

Case Study #1

CASE STUDY #1

MS. D, A 55-YEAR OLD REAL ESTATE EXECUTIVE REPORTS A HISTORY OF PAST PERIODS OF HOPELESSNESS, SADNESS, DESPAIR, AND MELANCHOLY, WHICH ULTIMATELY WENT AWAY WITHOUT HOSPITALIZATION OR THE USE OF PSYCHOTROPIC MEDICATIONS. SHE STATES THAT SHE CAN HARDLY REMEMBER A PERIOD IN HER LIFE, BEGINNING IN ADOLESCENCE, WHERE SHE FELT GOOD ABOUT THINGS. SHE BEGAN TO FEEL POORLY AFTER THE RECENT HOUSING CRISIS. HER HOPELESSNESS BECAME MORE AND MORE PRONOUNCED UNTIL SHE HAS NOT BEEN ABLE TO REPORT TO WORK FOR FOUR WEEKS. SHE FEELS VERY GUILTY THAT SHE HAS LET HER PARTNERS AND CO-WORKERS DOWN, BY "NOT BEING WITH IT." SHE SPENDS HER DAYS AND NIGHTS LYING IN BED AWAKE AND STARING AT THE CEILING. "IT'S AS IF I DON'T HAVE ENOUGH ENERGY TO MOVE."

MS. D REPORTS THAT, IF SHE EVER IS ABLE TO FALL ASLEEP, SHE WAKES UP AT TWO OR THREE IN THE MORNING AND THEN BECOMES ANGRY AND IRRITATED THAT SHE CAN'T FALL BACK ASLEEP. THE WORST TIME FOR HER IS RIGHT BEFORE DAWN AND THAT SHE MAY HAVE THOUGHTS OF KILLING HERSELF AT THAT TIME, JUST TO BE "OUT OF MY MISERY." SHE HAS STOPPED EATING, "BECAUSE IT IS TOO MUCH TROUBLE TO COOK AND I DON'T FEEL LIKE GOING OUT." SHE REPORTS DROPPING FROM 140 POUNDS TO 115 POUNDS, "WITH NO END IN SIGHT."

HER FACE SHOWS NO EMOTION AS SHE TALKS ABOUT THIS AND "THERE IS NOTHING IN LIFE THAT IS ENJOYABLE OR WORTH LIVING FOR." MS. D REPORTS THAT THERE ARE TIMES THAT SHE IS OVERWHELMED WITH GUILT, BUT CANNOT IDENTIFY ANYTHING SPECIFIC THAT SHE SHOULD BE GUILTY ABOUT. SHE FEELS THAT SHE HAS LET EVERYONE DOWN AND THAT IT WILL BE HER FAULT IF THE BUSINESS COLLAPSES. HER BUSINESS PARTNER HAS STARTED TO MAKE RUMBLINGS OF WANTING TO DISSOLVE THE PARTNERSHIP. MS. D. REPORTS THAT FOR THE LAST THREE YEARS SHE CAN HARDLY REMEMBER ANY DAYS WHERE SHE FELT NORMAL, LET ALONE HAPPY. SHE DENIES ANY HALLUCINATIONS OR DELUSIONS, BUT "I DO FEEL LIKE I AM DEAD INSIDE AND HAVE FELT THAT WAY FOR ABOUT THREE YEARS." SHE STATES THAT SHE HAS FELT A SIMILAR EMPTINESS RIGHT AFTER HER MOTHER DIED SEVERAL YEARS AGO," BUT IT WAS NEVER ANYTHING LIKE THIS." SHE SAYS THAT IT IS DIFFICULT TO DESCRIBE HER FEELINGS AND THAT SHE HAS AN EMOTIONAL ACHE THAT IS "HORRID BEYOND WORDS."

Case Study #1

- Case #1: Symptoms:
- Differential Diagnoses:
- Diagnosis:

Case Study #2

Melissa is a 23 year old, recently married woman who was referred for evaluation after a suicide attempt by an overdose of pills. On the night of the attempt, she had a fight with her husband of three months about his ongoing contact with a female friend. Her husband stormed out of the house, and she later wrote a note saying that she couldn't deal with his attitude and that her jewelry should be given to her sister. When her husband returned home he found her comatose and called 911.

During the last couple of months, Melissa has been crying frequently, and has lost interest in her friends, school, and work. Her grades have taken a real nose dive and she is considering dropping all her classes as "I'm so far behind it is hopeless." She has been eating constantly and has gained 20 pounds since the wedding. Her husband constantly criticizes her weight. He complains that all she ever wants to do is sleep and they never go anywhere or hang out with friends like they did before they were married. Melissa states that she is too tired to go out and that there is nothing that is of interest to her. She is struggling with adjusting to being married and states that "I had no idea being married would be so hard."

Since early adolescence Melissa has had a pattern getting too quickly involved in relationships and "absolutely freaking out if the guy showed any loss of interest in me, which of course ultimately led to him being annoyed and abandoning me." All of her relationships were "filled with heat initially, but then they get bored and leave me." Usually after a breakup, she reported going on spending sprees and buying a new wardrobe and then playing the bar scene to get attention. Melissa reports that she always had a "hot red-headed temper" and can go off on people. This is not her first suicide attempt, but in the past she "told people ahead of time that she was going to do something and they stopped me."

She views herself as dumb, boring, and uninteresting and that no one wants to spend time with her. She feels ignored and rejected by her husband and spends most of her time alternating between crying and being angry. Melissa states that she constantly feels tense, can't concentrate because "I'm worried that my marriage is already on the rocks, and I'm afraid that I might lose total control of myself." She notes that these mood swings seem to tie in to her menstrual cycle, but present almost all the time, even after she has completed her period. "I don't want to be this way, but I just can't help it. It's just not worth continuing to live."

Case Study #2

- Case #2:
- Differential Diagnoses:
- Diagnosis:

- Case Study #3

Zeke is a 45-year-old married accountant who was recently admitted to a psychiatric hospital for evaluation for depression. He has had four prior psychiatric consultations for depression and suicidal ideation during the preceding year. At the time of admission, as in earlier admissions, he denies having any psychiatric difficulties but according to him, is "dying" from a mysterious illness that no one has been able to diagnose. "I'm going blind, my bowels don't work, my skin is coming off, and I'm losing my hair." During the two weeks before his admission Zeke spent most of his time lying in bed and not being able to work. His wife reports that his mood has been persistently gloomy and pessimistic and that he is frequently irritable with her.

According to his wife, throughout their marriage Zeke has always fluctuated between periods of alternating depression and sudden bursts of excessive energy, that usually only last for a few days. During his energetic periods, he stays late at work, keeping several secretaries busy with his production. He also suddenly becomes involved in volunteer activities and begins extensive exercise programs, which he quickly abandons. During his most recent energetic period, he announced that he had made arrangements for a trip to Australia in place of the family beach vacation and they were leaving in four days. While his wife accompanies him on these impromptu trips, they are usually not a pleasant experience due to the whirlwind pace and his overscheduling everything. She reports that this pattern of behavior was well established when she met him in college. He did fairly well in school but would fluctuate between "glum" periods when he would sleep all day and miss classes, and then go on to a three-day all-nighter study binge.

Zeke's wife says that his brief outburst of energy tend to vanish as suddenly as they come. Then he fails to follow through on activities, becoming irritable, sad, moody, and pessimistic. His wife reports that his depressive episodes have tended to "go on forever" in the fall and winter, whereas his really energetic periods have been especially common in summer. When questioned about his energetic periods, Zeke says that he realizes that he sometimes goes too far and lose his control, but that he much prefers these to the "down times, "as he feels intensely alive, fun-loving, energetic, and can accomplish so much. He says that he can remember having these brief outburst of productivity since he was in his early teens and that he's always been a "flighty" person whose moods fluctuate quickly. "I'm just like my father in that way.

Case Study #3

Case #3:

Differential diagnoses:

Diagnosis:

- Case Study #4

Kelli is a 30 year old single woman who lives at home with her parents. She was brought to the hospital by her parents, with each one holding an arm and dragging her into the admissions area. She is loudly singing the "Battle Hymn of the Republic" at full volume when the psychologist enters the room. She consoles the psychologist about his misfortune of having blue eyes, but reassures him that he can change their color by trying to look through the top of his head. She rapidly switches from topic to topic in an incoherent ramble.

She reports that she recently broke up with her "dog of a boyfriend" who was secretly a Bishop in the church who tried to sexually abuse her. Since that time, she hasn't slept in four days, has lost 8 pounds, and ordered thousands of dollars of merchandise from the Home Shopping Network, "since I was awake anyway." She reported that has booked a flight to Paris that is scheduled to leave in three hours, "so make this fast." She reports being troubled by both male and female voices in her head that call her a "dumb whore." She reports that she hears these voices in her "down" phase.

Her parents report that Kelli was an only child who was "spoiled and pampered." She was a difficult child who could have tantrums that could last for hours. She was able to get her degree and teaches in a local kindergarten. Kelli's parents report that their daughter "drinks too much," has wrecked two cars while drinking, has been fired for drinking on the job, and always says that she is going to quit, but never does. She has an outstanding warrant and is due in court Friday for arraignment on a DUI. Relationships with men in the past have been intensely emotional at first, but eventually deteriorate into mutual hatred. "All men are "heartless SOB's" who take advantage of her sexually. On several occasions, when relationships have ended, she made suicidal gestures, but always called her parents. She has had long bouts of depression when these relationships have ended and has acted out sexually by having unprotected sex with strangers who she meets in bars. During these periods after a breakup she tends to be unhappy, lethargic, tearful, and suicidal. These feelings tend to lift immediately after she meets a new man.

Case Study #4

- Case #4: Symptoms:
- Differential Diagnoses:
- Diagnosis:

Module V: Specific Disorders

ADHD

SUBSTANCE USE

EATING DISORDERS

Evolution Of ADHD in DSM5

- Proposal to add 4 Impulsivity Criteria
- Age of onset to age 12
- Reduce number of symptoms for adults
- Inclusion of PDD
- Add subtype of ADHD Inattentive Restrictive Type
- In Remission
- Removal of Restrictive Type

Attention Deficit Hyperactivity Disorder

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) 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 impact **directly on social and academic/occupational activities**. **Note:** symptoms are not a manifestation of oppositional behavior, defiance, or hostility. **For >17 years of age, at least 5 symptoms are required**

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 reading lengthy writings).**

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

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; fails to finish schoolwork, household chores, or tasks in the workplace).**

e. Often has difficulty organizing tasks and activities **(e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized, work; poor time management; tends to fail 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, or reviewing lengthy papers).**

g. Often loses things necessary for tasks or activities **(e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, or 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., chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).**

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 **impact directly on social and academic/occupational activities**.
Note: symptoms are not a manifestation of oppositional behavior, defiance, or hostility.
For >17 years of age, at least 5 symptoms are required

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, office or other workplace, or in other situations that require remaining seated).**

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

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 or uncomfortable being still for an extended time, as in restaurants, meetings, etc; may be experienced by others as being restless and difficult to keep up with).**

f. Often talks excessively.

g. Often blurts out an answer before a question has been completed **(e.g., completes people's sentences and "jumps the gun" in conversations, cannot wait for next 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, adolescents or adults may intrude into or take over what others are doing).**

Attention Deficit Hyperactivity Disorder

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

C. Criteria for the disorder are met **in two or more settings** (e.g., at home, school or work, with friends or relatives, or in other activities).

D. There must be 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 accounted for** by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).

Specify Based on **Current Presentation**

314.01 (F90.2) Combined Presentation: A1 and A2 are met for past six months

314.00 (F90.0) Predominately Inattentive Presentation: A1 is met but A2 is not met for the past six months

314.01 (F90.1) Predominately Hyperactive/Impulsive Presentation: A2 is met but A1 is not met for the past six months

Coding note: If criteria were met previously, but fewer than symptoms than criteria have been met in past six months, but symptoms still impair functioning, Specify: **In Partial Remission**

Severity Specifier: Mild, Moderate, or Severe

Substance-Related and Addictive Disorders

Caffeine Withdrawal - elevated to Disorder status from DSM-IV-TR

Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure - Included in section III for further study (Fetal Alcohol Syndrome)

Internet Gaming Disorder - Included in section III for further study

Caffeine Use Disorder – To be included in section III for further study

Combining Substance Abuse and Dependence Into One Disorder
Substance Use Disorder

DSM-IV categories of substance abuse and substance dependence are replaced with the category of "substance use disorder." Dependence, is not a proposed disorder for DSM-5.

*The criteria are minimally changed. The symptoms listed in DSM-IV under "substance abuse" and "substance dependence" were **combined to create the list for substance use disorders**. The only change to the list was the removal of legal problems, since these are not included in the World Health Organization's (ICD)—because of marked variations in international as well as in local U.S. jurisdiction standards.*

Behavioral Addictions – **Gambling Disorder** formerly pathological gambling

Substance Use Disorder

Combining Substance Abuse and Dependence Into One Disorder Substance Use Disorder

Rationale: 1) Difficulty making the distinction, 2) Dependence = High Reliability, Abuse= Low Reliability, 3) Diagnosis on single criteria (legal issues) Single Disorder of graded severity

Amphetamine and Cocaine combined into Stimulant Related Disorder

Cannabis Use and Cannabis Withdrawal added in DSM5

Nicotine renamed Tobacco Related Disorder

Specifiers

- early remission = 3 to 12 months
- sustained remission = 12+ months (can still have symptom of craving)
- maintenance therapy (opioid and tobacco)
- controlled environment (not applicable to Gambling Disorder)

Behavioral Addictions – Gambling Disorder formerly pathological gambling

- Episodic (symptoms ease between episodes) versus Persistent (continuous symptoms for years)

Substance Use Disorders

- All disorders have common feature of direct activation of brain reward system
- Distinguished from Substance-Induced Disorders (anxiety, affective, or psychotic) which are transitory and temporary
- Most Substance Use Disorders are broken into Substance Intoxication, Substance Use Disorder, and Substance Withdrawal, but there are exceptions:
  - No Caffeine Use Disorder
  - No Hallucinogen-Related Withdrawal (Hallucinogen Persisting Perception Disorder)
  - No Inhalant Withdrawal
  - No Tobacco Intoxication
  - No Gambling Intoxication or Withdrawal

Substance Use Disorders

- Coding has become very complex and elaborate
  - Use the code that applies to a class of substances, but record the name of the specific substance e.g. F13.20 Moderate Aprazolam Use Disorder instead of F13.20 Moderate Sedative, Hypnotic, or Anxiolytic Disorder
  - If Criteria are met for more than one Substance Use Disorder, all disorders should be listed as part of the diagnosis
  - Coding also changes if there is a co-morbid Substance-Induced Disorder
  - If Intoxication, Withdrawal, or Substance-Induced Disorder is present, do not use the code for a Substance Use Disorder, but change the fourth digit of the Intoxication, Withdrawal, or Substance-Induced disorder to reflect the presence or absence of a co-morbid Substance Use Disorder.
  - Coding also changes depending on the presence or absence of perceptual disturbances

Substance Use Disorder

Each Substance (Alcohol, Caffeine, Cannabis, Phencyclidine, Inhalants, Opoids, Sedative, Stimulants, and Tobacco) has it's own codes and remission, environment, and severity specifiers

Alcohol Use Disorder (Coding based on severity)

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress as manifested by two (or more) of the following in 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 effort to cut down or control alcohol use
3. A great deal of time is spent in activities necessary to obtain alcohol, use the substance, 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.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use
8. Recurrent alcohol use in situations in which it is physically hazardous

Substance Use Disorder

9. Alcohol 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

10. Tolerance, as defined by either or both of the following:

    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect

    b. Markedly diminished effect with continued use of the same amount of alcohol

11. Withdrawal, as manifested by either of the following:

    a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for Alcohol Withdrawal)

    b. Alcohol (or a closely related substance, such as benzodiazepine is taken to relieve or avoid withdrawal symptoms

Severity Scale:

The Severity of each Substance Use Disorder is based on:

- 0-1 symptoms: No diagnosis
- 2-3 symptoms: Mild Alcohol Use Disorder **305.00 (F10.10)**
- 4-5 symptoms: Moderate Alcohol Use Disorder **303.90 (F10.20)**
- 6 or more symptoms: Severe Alcohol Use Disorder **303.90 (F10.20)**

Substance-Related and Addictive Disorders

F63.0 Gambling Disorder (Paraphrased)

A. **Persistent and recurrent problematic gambling as indicated by four or more for a 12 month period**

1. Gambling for **increased amounts**
2. **Restless or irritable** when attempting to stop
3. Repeated **unsuccessful efforts** to control or cut back
4. **Preoccupied** with gambling
5. Gambles when **distressed** (helpless, anxious, or depressed)
6. After losing, **returns to get even (chasing)**
7. **Lies to conceal** the extent of gambling
8. Has jeopardized or **lost relationships, education, jobs** because of gambling
9. Relies on **others to provide money to cover losses.**

B. Not better explained by a manic episode

Specify if : episodic or persistent

Severity Specifier: Mild (4-5 criteria met), Moderate (6-7 criteria met), or Severe (8-9 criteria met)

Binge Eating Disorder

307.51 (F50.8) Binge-Eating Disorder)paraphrased)

A. **Recurrent episodes of binge eating**. An episode of binge eating is characterized by both of the following:

1. Eating, in a **discrete period of time** (e.g., within any 2-hour period), an amount of food that is **definitely larger** than most people would eat in a similar period of time under similar circumstances

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

B. The binge-eating episodes are associated with **3 (or more)** of the following:

1. Eating much more **rapidly** than normal

2. Eating until feeling **uncomfortably full**

3. Eating large amounts of food when **not feeling physically hungry**

4. Eating **alone** because of feeling embarrassed by how much one is eating

5. Feeling **disgusted** with oneself, **depressed**, or very **guilty** after overeating

C. Marked **distress** regarding binge eating is present.

D. The binge eating occurs, on average, at least **once a week for 3 months.**

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior and does not occur exclusively during the course Bulimia Nervosa or Anorexia Nervosa.

Specify if : partial remission or full remission

Severity Specifier: Mild, Moderate, Severe, Extreme

DSM5 Anorexia Nervosa

DSM-IV 307.1 (paraphrased)

A. Refusal to maintain body weight for age and height (less than 85% of expected
B. Fear of gaining weight or becoming fat, despite underweight
C. Disturbance in way body is experienced, denial of seriousness
D. Amenorrhea, absence of three cycles

Restricting Type

Binge-Eating/ Purging Type

DSM5 307.1 (F50.01) (F50.02)(para)

A. Restriction of energy intake relative to age, sex, history
B. Fear of gaining weight or becoming fat, despite underweight
C. Disturbance in way body is experienced, denial of seriousness

(F50.01) Restricting Type

(F50.02) Binge-Eating/Purging Type

Specify: Partial Remission, Full Remission

Severity: Mild (BMI >17kg/m2), Moderate (BMI 16 to 16.99), Severe (BMI 15 to 15.99), Extreme (BMI < 15kg/m2)

DSM5 Bulimia Nervosa

DSM-IV 307.51 (paraphrased)

A. Episodes of Binge Eating characterized by
   1. Eating an amount definitely larger in discrete period of time
   2. Lack of control
B. Recurrent Compensatory Behaviors
C. Twice a week for 3 months
D. Self-Evaluation impacted
E. No Anorexia Nervosa

Purging Type, Nonpurging Type

DSM-IV 307.51 (F50.2)(paraph)

A. Episodes of Binge Eating characterized by
   1. Eating an amount definitely larger in discrete period of time
   2. Lack of control
B. Recurrent Compensatory Behaviors
C. Once a week for 3 months
D. Self-Evaluation impacted
E. No Anorexia Nervosa

Partial Remission, Full Remission

Mild (1-4 compensatory/week)

Moderate (4-7) Severe (8-13)

Extreme (14 or more)

Module VI: Case Studies 5 - 8 and Questions and Answers

Symptoms and Dysfunctions

Differential Diagnoses

DSM5 Formatted Diagnosis

- Case Study #5

Annabelle is a 44-year old woman whose twenty year marriage recently fell apart after the discovery that her husband and her sister had been having an ongoing sexual relationship for about 15 years. Her husband is actually the father of her niece. Annabelle was told by her sister that the father of her child was a "one night stand." Her niece's health issues triggered the search for a compatible donor and paternity was established. Upon learning the truth Annabelle "threw the rat out." She also has nothing to do with her sister who she was formerly close with, and "shared everything."

Annabelle almost immediately began having feelings of overwhelming fear and moments where she was emotionally and physically paralyzed. She became jittery and would sit at a stoplight unable to move because she was shaking so badly. " I'm always waiting for the other shoe to drop" and she wonders what else has gone on in her marriage that she will ultimately find out about. Her soon to be ex-husband travels for work and she is afraid that he might have another family somewhere. Annabelle reports that she is "crushed" and so overwhelmingly sad that she can hardly function. She has lost weight and has no appetite. She denies hallucinations, delusions, or suicidal ideation. She sees the situation as hopeless and that she can never trust another human being.

Partly as a result of the discovery and partly as a result of "I just don't give a damn any more," Annabelle began to purchase pain medications on the street, but finds that she can't afford enough to kill the pain. As a result she has increased her drinking and has gotten a DUI. She also has gone through a series of male "drinking buddies" and occasionally brings them home to smoke weed and to use for sex "when the mood suits me." "The weed has become a real problem since I have asthma, but I do it anyway." On a recent morning, she awoke to find one of these men going through her purse and he had removed her credit cards from her wallet. She states that this isn't really her, but "I just don't give a crap about my life any more."

Case Study #5

- Case #5: Symptoms:
- Differential Diagnoses:

- Diagnosis:

- Case Study #6

Terri is a 28 year old insurance executive who presents herself at the local weight loss clinic for "eating problems." She grew up in a family where both mother and father were high priced corporate attorneys. Her mother placed a great deal of emphasis on "looking good" and was on all of her daughters to avoid getting fat. At 14 Terri went to a boarding school in Boston to greater insure that she would have a chance at being accepted into an "Ivy League" school. At boarding school, she excelled both academically and athletically. She was particularly impacted by a coach's remark that if she wanted to get into an "Ivy League" school, she could guarantee her admission as a field hockey player if she would just lose some weight. At the time she was 5'7" and weighed 128 pounds.

Terri began a vigorous program of exercise and diet including 10 aerobic classes per week and eliminating all red meat and sweets. Her social relationships suffered because "she was always exercising, practicing, or studying." She dropped from 128 pounds to 90 pounds, and her menstrual cycle, which had been regular since age 13, ceased. Her body mass index was measured by her coach at 16.5 kg/m^2 who praised her dedication. At home during the summer she found her appetite uncontrollable and would set her alarm for 3:00 am to raid the refrigerator where she consumed an entire half gallon of ice cream three or four times per week and then make herself throw up. Her weight gradually returned and she was at 125 pounds by the time she returned for her sophomore year.

Upon graduation she was accepted into an Ivy League school, but was not recruited for field hockey. During college, her weight increased to 150 pounds and her mother was very critical of her weight when she came home for Christmas Break. During that vacation she began to induce vomiting after her eating bouts. This pattern of eating and purging has continued fairly consistently for approximately 10 years. Terri now shares an apartment with her best friend from college, but has never told her about her eating and purging rituals. On nights when she knows her roommate will not be home, about twice a week, she usually stops at the market and buys, cookies, candy and ice cream and then eats everything quickly before her roommate gets home and then purges. Terri spoke with great shame about this "disgusting habit" and has tried to stop, but has never gone for more than 2 weeks without purging.

Case Study #6

- Case #6: Symptoms:
- Differential:

- Diagnosis:

- Case Study #7

Betty is a 17-year-old girl who lives with her parents and is seeking therapy because her parents found her hanging from her closet door with a belt around her neck. Her parents came to her rescue only because they heard her violently kicking the door. Betty states that she changed her mind about wanting to die "and the belt hurt my neck." Betty has a history "eating when she is upset" but no history of purging or other compensatory efforts Her weight has ranged from 160 pounds at age 14 to the current low of 125. She has a tendency to be slightly heavy but is five feet six inches call. She's an excellent athlete, jogs 6 miles a day, and plays competitive basketball on her high school team.

There are periods when she feels depressed, because of the way she looks and the friction at home between her parents. " I can't take it any more." She is more likely to binge during these times, eating in secret, rapidly devouring huge quantities of food, usually junk food, even though she is not hungry. She has been known to eat an entire chicken at one setting, only to later purge through self-induced vomiting. She then becomes depressed about how fat she looks and refuses dates because of her embarrassment. She has been binging several times a week for months. She reports having a "stash" of junk food hidden in her closet, which her father does not know anything about. She is afraid that if he discovers the "stash," he'll constantly pull room checks and increase his anger at her daily "weigh ins." She feels a great deal of pressure from her father to win an athletic scholarship.

She is a good student and is curious about the psychological basis for bingeing. She says she now understands how an alcoholic must feel because she knows that bingeing is bad for her but she simply can't stop when she starts to eat. "Something must be terribly wrong with me. Sometimes I am amazed that any human can eat that much" She has kept her bingeing a secret from her parents and only one of her friends knows about her habits.

Case Study #7

- Case #7: Primary Symptoms/Dysfunctions:
- Differential Diagnoses:
- Diagnosis:

- Case Study #8

Wanda is a 28 year old mortgage banker who is married and the mother of a six year old child. Her mother who is an AA member convinced her to get into counseling for drinking too much and having "an enlarged liver." Wanda is the oldest of four girls and her youngest sister was diagnosed with Fetal Alcohol Syndrome. She reports that both of her parents, one of her grandfathers, and several aunts and uncles are alcoholics. "I've been around drinking my whole life and I can handle my booze."

Wanda began drinking at age 13 and by the time she was in college "I spent every weekend drunk, but would then sober up on Sunday and study like hell to get a 3.8 gpa." She knows that she drinks too much, "but compared to my mother and my fiancee, I don't have a problem. As a young couple "we continued to drink and party every weekend until I found out I was pregnant and then I stopped for about 10 months." She had great difficulty not drinking during her pregnancy, but got through it by reminding herself of her younger sister and not wanting to harm the baby. Wanda reports that she started drinking again after the baby was born to deal with the pressure of a new baby and a demanding job during the height of the mortgage crisis. Her drinking escalated to 5 to 10 drinks a day during the work week and 10 to 15 drinks on weekend days. She frequently called in sick on Mondays, was frequently hung over, was arrested for a DUI. "If I get another DUI, I'll have to serve time and lose my job." Her physician diagnosed her with gastritis and has insisted that she quit drinking, but she has continued to drink. She feels terribly guilty about her child who has seen her drunk on many occasions and who begs her "Mommy don't drink."

During the interview Wanda reports that she has not had a drink in 12 hours, but is really craving a drink. She reports insomnia and drinks to fall asleep. At one point she began to cry and said that it was hopeless and "I just can't quit." Wanda reports that she has tried marijuana, but "it just doesn't do it for me." She does report smoking two packs of cigarettes per day for 10 years, "but I can't quit those either." She denies any depressive symptoms, panic attacks, or hallucinations or delusions. She reports that she has many friends at work and in the neighborhood who think she is a lot of fun to be around.

Case Study #8

- Case #8: Symptoms:
- Differential Diagnoses:
- Diagnosis:

Module VII: Specific Disorders

SEXUAL DISORDERS

POSTTRAUMATIC STRESS DISORDER

ANXIETY DISORDERS

Sexual Dysfunctions

Delayed Ejaculation (Formerly Male Orgasmic Disorder)

Erectile Disorder

Female Orgasmic Disorder

Female Sexual Interest/Arousal Disorder

Genito-pelvic Pain/ Penetration Disorder

Male Hypoactive Sexual Desire Disorder

Premature (Early)Ejaculation Disorder

Delayed Ejaculation

DSM-IV 302.74 Male Orgasmic Disorder (paraphrased)

A. Recurrent delay or absence of orgasm
B. Marked interpersonal difficulty
C. Not better accounted

Lifelong Type

Acquired Type

Generalized Type

Situational Type

Due to Psychological Factors

Due to Combined Factors

302.74 (F52.32) Delayed Ejaculation (paraphrased)

A. Non-desired delay or lack of ejaculation 75 -100% of time
B. Six months in duration
C. Marked interpersonal difficulty
D. Not better accounted

Lifelong, Acquired, Generalized,

Situational

Mild, Moderate Severe

Erectile Disorder

302.72 Male Erectile Disorder

A. Inability to attain or maintain an adequate erection
B. Marked interpersonal difficulty
C. Not better accounted

Lifelong Type

Acquired Type

Generalized Type

Situational Type

Due to Psychological Factors

Due to Combined Factors

DSM5 302.72 (F52.21) Erectile Disorder

A. At least one of three symptoms experienced 75-100% of time 1) obtaining, erection, 2)maintaining erection, or 3) decrease in rigidity
B. Six months in duration
C. Marked interpersonal difficulty
D. Not better accounted for

Lifelong , Acquired, Generalized, Situational

Mild, Moderate Severe

Female Orgasmic Disorder

DSM-IV 302.73 Female Orgasmic Disorder (paraphrased)

A. Persistent delay or absence of orgasm in a woman considering age, experience, and adequacy of stimulation

B. Marked interpersonal difficulty

C. Not better accounted

Lifelong Type

Acquired Type

Generalized Type

Situational Type

Due to Psychological Factors

Due to Combined Factors

DSM5 302.73 (F52.31) Female Orgasmic Disorder (paraph.)

A. Marked delay, infrequency, intensity, or absence of orgasm 75-100% of the time

B. Six months in duration

C. Marked interpersonal difficulty

D. Not better accounted

Lifelong, Acquired, Generalized,

Situational

Never experienced an orgasm in any situation

Mild, Moderate Severe

Female Sexual Interest/Arousal Disorder

DSM-IV 302.71 Hypoactive Sexual Desire Disorder (paraphrased)

A. Persistently deficient sexual fantasies and sexual desire, age, life context

B. Marked interpersonal difficulty

C. Not better accounted

DSM-IV 302.72 Female Sexual Arousal Disorder (paraphrased)

A. Persistent inability to attain or maintain adequate lubrication of sexual excitement

B. Marked interpersonal difficulty

C. Not better accounted

Lifelong, acquired, generalized, situational, psychological, combined

DSM5 302.72 (F52.22) Female Sexual Interest/Arousal Disorder

A. Lack of sexual interest/arousal by at lest 3

1. Absent reduced interest
2. Absent/reduced erotic thoughts
3. Reduced initiation or unreceptive to partner
4. Absent sexual excitement in 75-100% of sexual encounters
5. Absent any interest/arousal to internal/external erotic cues
6. Absent/reduced genital sensations in 75-100% of sexual encounters

Female Sexual Interest/Arousal Disorder

B. Six months in duration

C. Marked interpersonal difficulty

D. Not better accounted

Lifelong, Acquired, Generalized,

Situational

Never experienced an orgasm in any situation

Mild, Moderate Severe

Genito-pelvic Pain/ Penetration Disorder

DSM-IV 302.76 Dyspareunia (paraphrased)

A. Recurrent genital pain associated with intercourse, male or female
B. Marked interpersonal difficulty
C. Not better accounted for

DSM-IV 306.51 Vaginismus (para)

A. Persistent involuntary spasm of the musculature of the outer third of the vagina
B. Marked interpersonal difficulty
C. Not better accounted

Lifelong, acquired, generalized, situational, psychological, combined

DSM5 302.76 (F52.6)Genito-Pelvic/Penetration Disorder

A. Persistent difficulty with one
   1. Vaginal penetration
   2. Marked vaginal or pelvic pain
   3. Fear or anxiety about vaginal or pelvic pain in anticipation of or during penetration
   4. Tensing or tightening of pelvic floor muscles with penetration
B. Six months in duration
C. Marked interpersonal difficulty
D. Not better accounted

Lifelong, Acquired, Generalized, Situational

Mild, Moderate Severe

Male Hypoactive Sexual Desire Disorder

DSM-IV 302.71 Hypoactive Sexual Desire Disorder (paraphrased)

A. Persistently deficient sexual fantasies and sexual desire, age, life context
B. Marked interpersonal difficulty
C. Not better accounted

Lifelong, acquired, generalized, situational, psychological, combined

DSM5 302.71 (F52.0 Male Hypoactive Sexual Desire Disorder (paraphrased)

A. Recurrently absent sexual/erotic thoughts and desire for sexual activity given age and life context
B. Six months in duration
C. Marked interpersonal difficulty
D. Not better accounted

Lifelong, Acquired, Generalized,

Situational

Mild, Moderate Severe

Premature (Early) Ejaculation

DSM-IV 302.75 Premature Ejaculation (paraphrased)

A. Persistent ejaculation with minimal sexual stimulation, before, on, or after penetration and before wished. Account for age, novelty, and recent sexual activity
B. Marked interpersonal difficulty
C. Not due to the effects of chemicals

Lifelong, acquired, generalized, situational, psychological, combined

DSM5 302.75 (F52.4) Premature (Early) Ejaculation (paraph.)

A. Recurrent pattern of ejaculation during partnered sexual activity within one minute of penetration and before wished
B. Present for six months and experienced 75-100% of time
C. Causes clinically significant distress in individual
D. Not better accounted for

Lifelong, Acquired, Generalized, Situational

Mild: 30 sec to 1 min, Moderate: 15 to 30 sec, Severe: prior to sexual activity, at the start of sexual activity, or 15 seconds of vaginal penetration

Posttraumatic Stress Disorder

309.81 (F43.10) Posttraumatic Stress Disorder Differences are in Bold (paraphrased)

A. **Over 6 years of age,** exposure to actual or threatened death, serious injury, or sexual violence, in one or more of the following ways:

1. Directly experiencing the traumatic event(s) 2. Witnessing in person, the event(s) as it occurred to others, **3. *Learning that the event(s) occurred to a close family member or friend 4. Experiencing repeated exposure to details of traumatic event***

NOTE: *A(4) does not apply to exposure through electronic media, TV, movies or pictures unless work related*

B. Presence of one or more of the following intrusion symptoms associated with the traumatic events, beginning after the traumatic event.

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event**. Note: memories may not necessarily appear distressing and may be expressed as play reenactment.**
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event (**Note: in children/adolescents it may be frightening dreams without recognizable content**
3. **Dissociative reactions(flashbacks) in which the individual 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 re-enactment 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 reactions to reminders of the traumatic event(s).

Posttraumatic Stress Disorder

C. Persistent Avoidance of Stimuli as evidenced by one or both:

1. **Avoidance or efforts to avoid distressing memories, thoughts, or memories associated with the trauma**
2. **Avoidance of or efforts to avoid external reminders that arouse memories of the traumatic event**

D. Negative alterations in cognitions and moods as evidenced by two or more of the following:

1. **Inability to remember important aspects of trauma**
2. **Persistent and exaggerated negative beliefs**
3. **Persistent distorted cognitions leading to self-blame**
4. **Persistent negative emotional state**
5. **Diminished interest/participation in important activities**
6. **Feelings of detachment or estrangement**
7. **Persistent inability to experience positive emotions**

Posttraumatic Stress Disorder

E. Alterations in arousal and reactivity that associated with the traumatic event (that began or worsened after the traumatic event), as evidenced by 2 or more of the following:

1. **Irritable behavior and angry outbursts with no provocation, with verbal or physical aggression**
2. **Reckless or self-destructive behavior**
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep Disturbance

F. Duration of the disturbance is more than one month.

G. The disturbance causes clinically significant distress or impairment in relationships

H. **The disturbance is not attributable to effects of substances.**

Specify Whether: **With or Without Dissociative Symptoms**

1. Depersonalization 2. Derealization

Specify if: **With Delayed Expression** (full criteria are not met for 6 months)

Adjustment Disorder

DSM-IV (paraphrased)

A. Symptoms in response to an identifiable stressor in 3 month
B. Either distress that is out of proportion or functional impairment or both
C. Does not meet criteria for other disorder/preexisting
D. Does not represent bereavement
E. Once stressor has been relieved symptoms do not persist beyond 6 months

Specify: Acute or Chronic

DSM5 (paraphrased)

A. Symptoms in response to an identifiable stressor in 3 month
B. Either distress that is out of proportion or functional impairment or both, for context and culture
C. Does not meet criteria for other disorder/preexisting
D. Does not represent normal bereavement
E. Once stressor has been relieved symptoms do not persist beyond 6 months

Adjustment Disorder

309.0 With depressed mood

309.24 With Anxiety

309.28 With Mixed anxiety and depressed mood

309.3 With disturbance in conduct

309.4 With mixed disturbance of emotions and conduct

309.9 Unspecified

309.0 (F43.21) With depressed mood

309.24 (F43.22) With Anxiety

309.28 (F43.23) With Mixed anxiety and depressed mood

309.3 (F43.24) With disturbance in conduct

309.4 (43.25) With mixed disturbance of emotions and conduct

309.9 (F43.20) Unspecified

Separation Anxiety Disorder

- **Separation Anxiety Disorder**
- A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
- 1. Recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
- 2. Persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
- 3. Persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
- 4. Persistent reluctance or refusal to go to school or elsewhere because of fear of separation
- 5. Persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
- 6. Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
- 7. Repeated nightmares involving the theme of separation
- 8. Repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated

309.21 (F93.0) **Separation Anxiety Disorder**

A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three 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 possible harm to them, such as illness, injury, disasters, or death.
3. persistent and excessive worry about experiencing an untoward event that could lead to separation from a major attachment figure (e.g., getting lost, being kidnapped, dying)
4. persistent reluctance or refusal to go out, away from home, to school, work, or elsewhere because of fear of separation
5. persistent and excessive fear or reluctance about being alone or without major attachment figures at home or in other settings
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, or vomiting) when anticipating or experiencing separation from major attachment figures

Separation Anxiety Disorder

- B. The duration of the disturbance is at least 4 weeks.
- C. The onset is before age 18 years.
- D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.
- *Specify* if:
- *Early Onset:* if onset occurs before age 6 years

B. The fear, anxiety or avoidance is persistent, lasting at least 4 weeks in children and adolescents and six months or more in adults.

- AGE OF ONSET CRITERIA DROPPED

C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

- The disturbance is not better accounted for by another mental disorder such as refusing to leave home in Autism Spectrum Disorder; delusions or hallucinations concerning separation in Psychotic Disorders; or anxiety about having Panic Attacks in Panic Disorder, or agoraphobia situations in Agoraphobia, worries about ill health or others in Generalized Anxiety Disorder, having an illness in Illness Anxiety Disorder,
- EARLY ONSET MODIFIER IS DROPPED

Generalized Anxiety Disorder

300.02 (F41.1)Generalized Anxiety Disorder

Essentially unchanged from DSM-IV-TR other than cleaning up some of the language and requiring only one symptom for children rather than three

Social Anxiety Disorder (Social Phobia)

300.23 (F40.10) Social Anxiety Disorder (Social Phobia)

In general, criteria are combined or separated in more meaningful ways with some subtlety of language.

A. Marked fear or anxiety about social situations where person is exposed to scrutiny (eliminates unfamiliar people). i.e. social interactions, being observed, or performing for others

B. Fears that he or she will act in a way that will be negatively evaluated

C. The social situations consistently provoke fear or anxiety (In children, may be expressed through crying, tantrums, freezing, clinging, or refusal to speak.

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 danger

F. The duration is at least six months

G. The fear, anxiety, and avoidance cause impairment in social, occupational, or other important areas of functioning

Specify if: Performance Only – fear is restricted to speaking or performing in public

Obsessive Compulsive Disorder

300.3 (F42) Obsessive Compulsive Disorder

Essentially as in DSM-IV-TR, with wording changes and the removal of the need for recognition that obsessions or compulsions are excessive Criterion B

New Specifiers

Specify if:

with good or fair insight – recognizes that the beliefs are definitely or probably not true, or may or may not be true

with poor insight – thinks beliefs are probably true

with absent insight/delusional beliefs – convinced that obsessive-compulsive beliefs are true

Specify if: Tic-Related – current or past history of a Tic Disorder

Module VII:
Case Studies 9-12

Symptoms and Dysfunctions
Differential Diagnoses
DSM5 Formatted Diagnosis

- Case Study #9

David is a 32 year old graduate student who is seeking therapy because he feels that he is getting nowhere in his career or love life. He has been trying to complete his dissertation for five years and has amassed thousands of references and extensive data, but has not been able get himself organized enough to complete the document. He works part-time as a barrista and is afraid that he will "be at Starbucks for the rest of my life." This is particularly painful for him because he dislikes his job, is constantly criticized by customers for mistakes, and is frequently threatened by his boss with termination.

David is painfully shy and has trouble in conversations because he is afraid that he will say something stupid and embarrass himself. He has difficulty with "small talk," fearing that something that will lead to embarrassment, rejection, and ridicule. When asked to attend social events at the University he will make up excuses , or if required to go he feels miserable and obsesses about being awkward and "blushing constantly." He often finds an excuse to leave early without having really engaged with anyone.

Very occasionally, David has had a brief involvement with a woman, "but they are usually a fix up arranged by a friend or a significantly older and more aggressive woman." Women in general are surprised at his lack of aggressiveness which they typically ascribe to him as a lack of interest in the relationship. Sexually, when the relationship has reached that point, David has become very self conscious, fears that the woman will make fun of his lack of experience, becomes anxious about performing badly, and ultimately has a premature ejaculation. "Sometimes I'm not even inside before I've already come" and then I'm totally ashamed and embarrassed.

David grew up as the oldest of five boys, and "I always knew that I was the apple of my mother's eye, but she had very high expectations for me, and I know I am a disappointment to her." His father was an extremely religious man whose favorite saying was "pride is the greatest of all sins," which David heard whenever he felt like he accomplished anything. Despite the tension with his parents, David continues to live at home and socializes with his parents and their friends who treat David like a "mascot." David has some insight into his family situation and feels like his problems of self-consciousness and fear of criticism may stem from his parents tracking his behaviors. He relates an incident when he was about five, when his father caught him "playing doctor" with the six year old girl next door. His father beat him mercilessly. He was required to meet with a minister once a week for a year "who preached hell and brimstone." These lectures about the sinfulness of sex would be the topic of conversation at the supper table in front of his brothers, "for their own good." When asked about how he sees this impacting him, he laughed and said, "sometimes when I'm with a woman, it's like my father is in the room watching me and telling me that I'm going to hell."

Case Study #9

- Case #9: Symptoms:
- Differential Diagnoses:

- Diagnosis:

- Case Study #10

Jeremy is a 30 year old married real estate broker who introduces himself as "I'm Jeremy and I'm having a nervous breakdown." "I've always been a big worrier, but this is totally out of control." Jeremy insists that his wife is in on the interview because he is falling apart and can't think straight. His wife reports that Jeremy is always keyed up and acts as if driven by a motor. He complains that he has chronic diarrhea , a chronically upset stomach, and can't concentrate at work. At work, he misses important details, his mind is elsewhere, starts projects and doesn't finish, misses appointments, and fails to return calls. He is constantly losing things and becomes very angry at others when this happens.

Jeremy grew up "as a caboose child" as the son of older parents in an affluent, privileged, and steeped in southern tradition, family. His father and grandfather attended a Northeastern Ivy League school, and Jeremy felt compelled to continue the tradition, but was an average student with average ability. He became a "legacy admission" who felt tremendous pressure to achieve and he began obsessing about grades, the right social activities, and at times would become overwhelmed and literally paralyzed, to the point of inaction. "Somehow I got through, but college took a toll on me."

Once he married "the right girl" and moved back home to be employed in his parents' real estate firm, the pressure and worry lifted. Things were fine until two years ago when his father was caught in a long-term affair and was divorced by Jeremy's mother. The business, which Jeremy was running by this time almost went bankrupt in the divorce. While the company is back on its feet, Jeremy has been unable to suppress his nervousness and worry. He lies awake at night worrying about how he would support himself if the company goes "belly-up." He is obsessed about the fact that his daughter, who has significant medical issues, might not be able to get health insurance if the company goes broke and he has to take another job. He acknowledges that he comes home at night and "has a couple of beers to take the edge off," but does not feel he has a problem with alcohol. His wife agrees with this assessment, but is concerned that he could develop a drinking problem in the future if he doesn't get control of his worry.

Case Study #10

- Case #10: Symptoms:
- Differential Diagnosis:
- Diagnosis

- Case Study #11

Larry, a 43 year old airplane flight engineer is seeking therapy after his wife discovered a phot album of him dressed in women's clothes and a "stash of women's clothing" that he acknowledges wearing when his wife is out of town. He reports that he has episodically cross-dressed since adolescence, but has kept this behavior secret from his parents and his wife of 13 years. When his wife caught him she demanded that he seek psychiatric help or she was filing for divorce.

Larry remembers beginning to wear his mother's panties and bra at about age seven. He was very close to his mother, but she was a harsh demanding woman who "brooked no nonsense." By adolescence he would wear his mother's clothing and make-up on a regular basis, usually accompanied by sexual excitement and masturbation. In college he began ordering women's clothes through catalogues and via the internet. After college he joined the military and received many awards and citations for service and bravery. In his twenties, he would often have to travel for extended periods overseas due to his occupation and would go out in public dressed as a woman, "but I've never had the courage to do that at home for fear of getting caught." Larry describes his wife as "extremely gentle and caring person who takes care of everything around the house and makes sure I have whatever I need." He expressed sorrow at being caught and the pain he has caused his wife. He denies any marital infidelity and does not feel that there is any problem with their sex life, which is mutually satisfying and consists of intercourse once or twice a week.

Cross-dressing provides Larry with extreme sexual excitement, much more than does actual sex with his wife or any women before his wife. He describes his fetish as "overpowering and preoccupying, particularly after I have had a few drinks." He enjoys that his job puts him on the road several times per month which gives him free reign to dress up and masturbate five or six times a night. He denies any homoerotic fantasies, homosexual experiences, and "feels quite comfortable being a man who is attracted to women, but has a 'quirk'." He has never considered gender reassignment, and the thought of surgery is "extremely frightening." He has no anxiety or guilt about his behavior, but "wishes his wife hadn't found out about it because it caused her so much pain." He became very upset when his wife discovered him and had a "nervous breakdown" where his heart was racing uncontrollably and he couldn't catch his breath. He reports that it was like there was a blockage in his throat and his thoughts became jumbled and fuzzy. "It was like I was having a heart attack. I worry constantly that it could happen again." He wants to stop feeling the urge to dress up and wants desperately to continue his marriage, "but I'm not sure that I can give up the women's clothes."

Case Study #11

- Case #11:Symptoms:
- Differential Diagnoses:
- Diagnosis:

- Case Study #12

Fred is a 37-year-old fireman who was hospitalized for second and third degree burns over a third of his body. During the month he spent on the burn unit, he was the model stoic patient, always cracking jokes and making the nursing staff smile. At its first follow-up appointment with the clinic, staffed unity. Shaking, stuttering, and generally unresponsive. The head of the clinic called in the staff psychiatrist to consult. Upon being introduced, Fred mumbled I sort of expected that you'd call in the "shrink."

At first he continued to joke around and then suddenly burst into tears. After calming down he explained that he cannot stop thinking about how, for the first time in his career, he entered a building alone, totally against all procedures, and nearly killed himself. "You see before you the wreck of what used to be a pretty good man." He states that while he was in the hospital he was troubled by frequent nightmares about the fire, but kept it to himself since it was his fault. He assumed they would stop once he got back home, but since being home he is "jumpy" and nervous and the "only thing that seems to help is if I drink until I pass out. Now it takes more and more alcohol to achieve that." He feels humiliated that he made a mistake at the fire, and cannot help replaying it over and over in his mind. He is having difficulty going to sleep for fear that the recurrent nightmares, in which he is burned over and over, will start.

His co-workers invited him back to the firehouse where he was given a hero's welcome, "but I know what they were thinking, and I'm sure they were saying it was my own fault." While at the firehouse, the buzzer sounded to call out the engine in response to an alarm, and "I jumped out of my skin and started shaking all over." I left quickly saying I was sick at my stomach, but I was really just scared. I'm sure my brothers could see right through me." He voices doubt that he will ever be able to go back to work again. "I don't know if I can ever trust my judgment again, and I don't want to be responsible for one of my brothers getting hurt."

At home, he paces the floor, won't leave the house by himself, and feels dizzy, numb, and detached from reality. When I try to concentrate it feels like I'm walking around in a fog, my whole life after the fire feels like a horrible dream that I'm going to wake up from, but I never do." He expresses a sense of total helplessness and is appalled by the way he looks. "I can't find any reason to go on living."

Case Study #12

- Case #12: Symptoms:
- Differential Diagnoses:
- Diagnosis:

Evaluation

- Complete evaluation form
- Place Evaluations in box on front desk
- Case Study handouts are available
- Certificates available in hallway??

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