

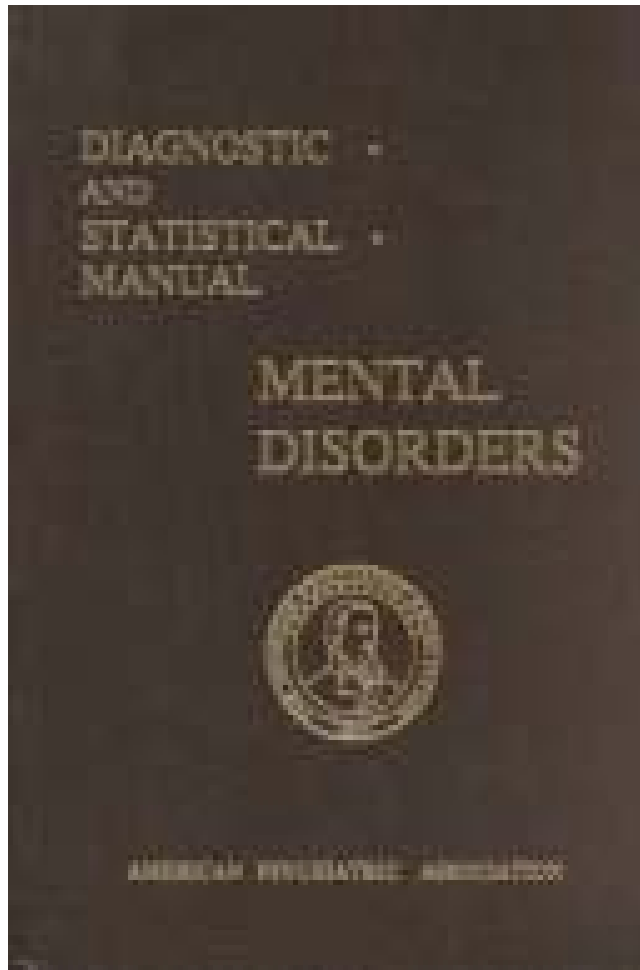
The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)

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HISTORY OF THE DSM



- **1840 1 Dx – U.S. Census – Idiocy/Insanity**
 - Also in the 1840s, southern alienists discovered a malady called **Drapetomania** - the inexplicable, mad longing of a slave for freedom.
- **1880 7 Dx's – U.S. Census**
 - **Mania** – mostly as defined today, a condition characterized by severely elevated mood.
 - **Melancholia** – would be noted as depression today.
 - **Monomania** - Pathological obsession with a single subject or idea. Excessive concentration of interest upon one particular subject or idea. *The difference between monomania and passion can be very subtle and difficult to recognize.*
 - **Paresis** – general or partial paralysis. (This would not be the last time that a physical affliction crept into the psychological arena; among the disorders described in the DSM-IV –TR is snoring, or Breathing Related Sleep Disorder 780.59, pp. 615-622).
 - **Dementia** – as described today as characterized by multiple cognitive deficits that include impairment in memory (most common Alzheimer's).
 - **Dipsomania** - An insatiable craving for alcoholic beverages.
 - **Epilepsy**

HISTORY OF THE DSM

- **1940 – 26 Dx's (ICD-6; WHO)**

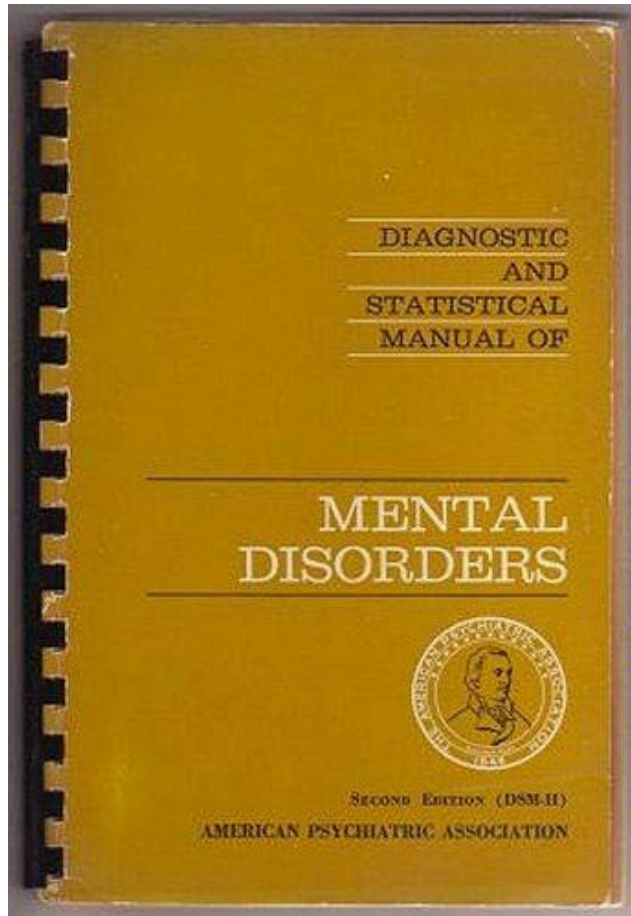
- Which took its nomenclature from the US Army and Veterans Administration nomenclature. The WHO system included 10 categories for psychoses, 9 for psychoneuroses, and 7 for disorders of character, behavior, and intelligence)

- **1952 DSM – 106 Dx's**

- DSM-I included 3 categories of psychopathology: organic brain syndromes, functional disorders, and mental deficiency. These categories contained 106 diagnoses. Only one diagnosis, Adjustment Reaction of Childhood/Adolescence, could be applied to children.

- **1968 DSM-II – 185 Dx's (revised DSM-II, 1974)**

- It had 11 major diagnostic categories. Increased attention was given to the problems of children and adolescence with the categorical addition of Behavior Disorders of Childhood-Adolescence.
- This category included Hyperkinetic Reaction, Withdrawing Reaction, Overanxious Reaction, Runaway Reaction, Unsocialized Aggressive Reaction, and Group Delinquent Reaction.



HISTORY OF THE DSM

patient seems neither physically nor mentally deficient, he does manifest inadaptability, ineptness, poor judgment, social instability, and lack of physical and emotional stamina.

301.89* Other personality disorders of specified types (Immature personality)*

301.9 [Unspecified personality disorder]

302 Sexual deviations

This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them.

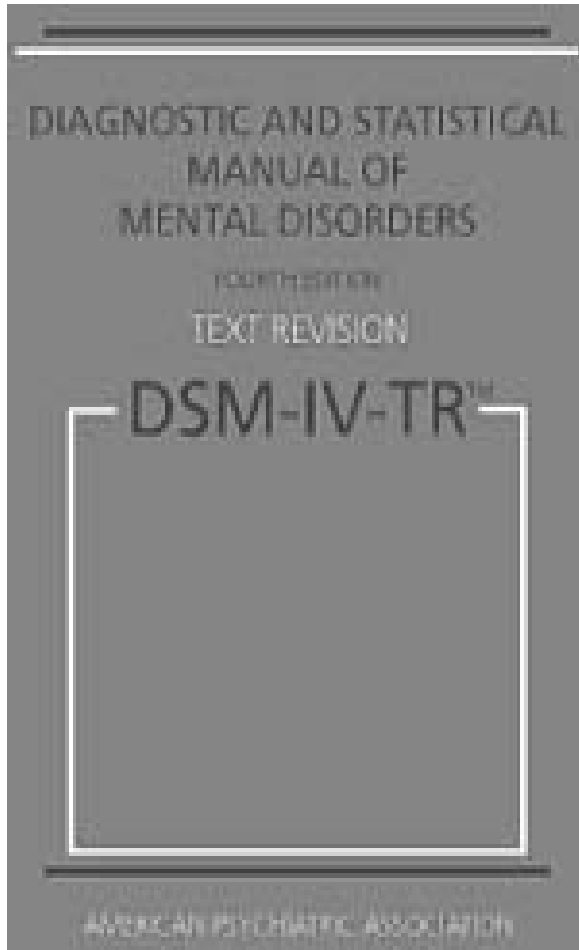
302.0 Homosexuality

302.1 Fetishism

302.2 Pedophilia

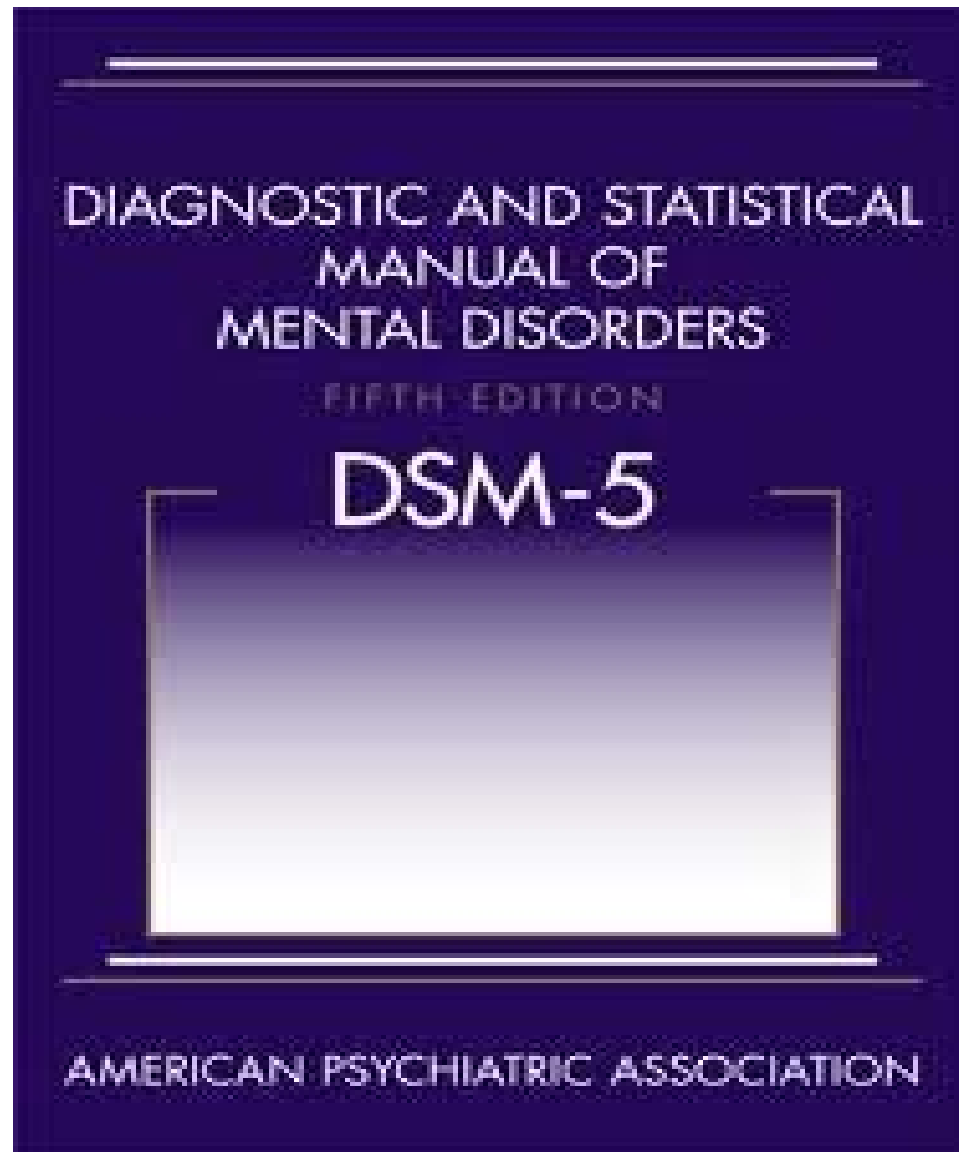
Up until December 26, 1974 Homosexuality was considered a form of deviant behavior and was a psychiatric condition.

HISTORY OF THE DSM



- **1980 DSM-III – 265 Dx’s** (roughly coincided with ICD-9, but differed from the ICD-9 which still listed disorders for statistical reasons as opposed to clinical utility).
 - DSM-III included multiaxial system.
 - Explicit diagnostic criteria.
 - Descriptive approach neutral to etiology theory.
 - Unlike its predecessors, DSM-III, it was based on scientific evidence. Its reliability was improved with the addition of explicit diagnostic criteria and structured interviews.
 - Although ICD and DSM were similar in terms of criteria, their codes were very different.
- **1987 DSM-III-R – 297 Dx’s**
 - Occurred because DSM-III revealed a number of inconsistencies in the system and a number of instances in which the criteria were not entirely clear.
- **1994 DSM-IV – 365 Dx’s –**
 - DSM-III nomenclature allowed more precise research of disorders for the DSM-IV and DSM-IV-TR.
- **2000 DSM-IV-TR – 365 Dx’s**

HISTORY OF THE DSM



DSM-5

- **SECTION I-BASICS**
 - Includes organizational structure
- **SECTION II-DIAGNOSTIC CRITERIA AND CODES**
- **SECTION III-EMERGING MEASURES AND MODELS**
 - Alternative Model for Personality Disorders
 - Conditions for Further Study
- **APPENDIX**

DSM-5

- **SECTION I-BASICS**

- “...the boundaries between many disorder ‘categories’ are more fluid over the life course than DSM-IV recognized, and many symptoms assigned to a single disorder may occur, at varying levels of severity, in many other disorders.”
- Scientific evidence places many, if not most, disorders on a spectrum with closely related disorders that have shared symptoms

DSM-5

- **SECTION I-BASICS**

- **Organizational Structure**

- “DSM is a *medical* classification of disorders and as such serves as a historically determined cognitive schema imposed on clinical and scientific information to increase its comprehensibility and utility.”
 - “Conditions for Further Study,” described in Section III, are those for which it was determined that the scientific evidence is not yet available to support clinical use.

DSM-5

- **SECTION I-BASICS**

- **Organizational Structure**

- **Personality Disorders are included in both Sections II and III. Section II represents an update of the text associated with the same criteria found in DSM-IV-TR, whereas Section III includes the proposed research model for personality disorder diagnosis and conceptualization**

DSM-5

- **SECTION I-BASICS**

- **Organizational Structure**

- *Harmonization with ICD-11 (International Classification of Disease)*

- DSM-5 and proposed structure of ICD-11 are working toward consistency
 - ICD-10 is scheduled for US implementation in October 2014
 - ICD-9 codes are used in DSM-5

- *Dimensional Approach to Diagnosis*

- Previous DSM's considered each diagnosis categorically separate from health and other diagnoses
 - Doesn't capture the widespread sharing of symptoms and risk factors (why we had some many NOS diagnoses)

Dimensional Approach to Diagnosis

- **Shared neural substrates**
- **Family traits**
- **Genetic risk factors**
- **Specific environmental risk factors**
- **Biomarkers**
- **Temperamental antecedents**
- **Abnormalities of emotional or cognitive processing**
- **Symptom similarity**
- **Course of illness**
- **High comorbidity**
- **Shared treatment response**

Dimensional Approach to Diagnosis

- **It is demonstrated that the clustering of disorders according to *internalizing* and *externalizing* factors represent an empirically supported framework. Within both the internalizing group (*anxiety, depression and somatic*) and externalizing group (*impulsive, disruptive conduct and substance use*), the sharing of genetic and environmental risk factors likely explains the comorbidities**

DSM-5

- **SECTION I-BASICS**

- **Organizational Structure**

- *Developmental and Lifespan Considerations*

- Begins with diagnoses that occur early in life (neurodevelopmental and schizophrenia spectrum), followed by diagnoses that more commonly manifest in adolescence and young adulthood (bipolar, depressive and anxiety disorders and ends with diagnoses relevant to adulthood and later life (neurocognitive disorders)
 - After neurodevelopmental disorders, see groups of internalizing (emotional and somatic) disorders, externalizing disorders, neurocognitive disorders and other disorders

DSM-5

- **SECTION I-BASICS**

- **Organizational Structure**

- *Developmental and Lifespan Considerations*

- Cultural Issues

- Gender Differences

- Use of Other Specified and Unspecified Disorders

- » Replaces NOS designation

- » *Other Specified* used when clinician wishes to communicate the specific reason the presentation does not meet criteria for diagnoses

- » If clinician does not choose to specify the reason *Unspecified Disorder* is used

DSM-5

- **SECTION I-BASICS**

- **Organizational Structure**

- *The Multiaxial System*

- DSM-5 has moved to a nonaxial documentation system
 - DSM-5 has combined Axis III with Axes I and II. Clinicians should continue to list medical conditions that are important to the understanding or management of an individual's mental disorder
 - Axis IV psychosocial and environmental problems utilize a selected set of ICD-9-CM V codes and the new Z codes contained in ICD-10
 - Axis V GAF is dropped but a global measure of disability the WHO Disability Assessment Schedule (WHODAS) is included in Section III

DSM-5

- **SECTION I-BASICS**

- *Provisional Diagnosis*

- When strong presumption that full criteria will ultimately be met

- Examples

- » *When a extremely depressed individual is unable to give an adequate history*

- » *When differential diagnosis depends exclusively on duration of illness such as schizophreniform disorder where duration is over one month but less than six*

DSM-5

- **SECTION I-BASICS**

- *Coding and Reporting*

- Identifying diagnostic and statistical codes established by WHO, the US Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention
 - Example
 - *Opioid Withdrawal 292.0 (F11.23)*
 - » 292.0 is ICD-9-CM
 - » F11.23 is ICD-10-CM code for adoption in October 2014

DSM V

- **SECTION II-DIAGNOSTIC CRITERIA AND CODES**
 - **Neurodevelopmental Disorders**
 - **Schizophrenia Spectrum and Other Psychotic Disorders**
 - **Bipolar and Related Disorders**
 - **Depressive Disorders**
 - **Anxiety Disorders**
 - **Obsessive-Compulsive and Related Disorders**

DSM V

- **SECTION II-DIAGNOSTIC CRITERIA AND CODES**
 - **Trauma- and Stressor-Related Disorders**
 - **Dissociative Disorders**
 - **Somatic Symptom and Related Disorders**
 - **Feeding and Eating Disorders**
 - **Elimination Disorders**
 - **Sleep-Wake Disorders**
 - **Sexual Dysfunctions**

DSM V

- **SECTION II-DIAGNOSTIC CRITERIA AND CODES**
 - **Gender Dysphoria**
 - **Disruptive, Impulse-Control, and Conduct Disorders**
 - **Substance-Related and Addictive Disorders**
 - **Neurocognitive Disorders**
 - **Personality Disorders**

DSM V

- **SECTION II-DIAGNOSTIC CRITERIA AND CODES**
 - **Paraphilic Disorders**
 - **Other Mental Disorders**
 - **Medication-Induced Movement Disorders and Other Adverse Effects of Medication**
 - **Other Conditions That May Be a Focus of Clinical Attention**

NEURODEVELOPMENTAL DISORDERS

- ***INTELLECTUAL DISABILITIES***
- ***COMMUNICATION DISORDERS***
- ***AUTISM SPECTRUM DISORDER***
- ***ATTENTION-DEFICIT/HYPERACTIVITY DISORDER***
- ***SPECIFIC LEARNING DISORDER***
- ***MOTOR DISORDERS***
 - ***TIC DISORDERS SUCH AS TOURETTES***

Autism Spectrum Disorder

- Using DSM-IV, patients could be diagnosed with four separate disorders: *autistic disorder*, *Asperger's disorder*, *childhood disintegrative disorder*, or the catch-all diagnosis of *pervasive developmental disorder not otherwise specified*. Researchers found that these separate diagnoses were not consistently applied across different clinics and treatment centers. Anyone diagnosed with one of the four pervasive developmental disorders (PDD) from DSM-IV should still meet the criteria for ASD in DSM-5 or another, more accurate DSM-5 diagnosis.

Autism Spectrum Disorder

- **People with ASD tend to have communication deficits, such as responding inappropriately in conversations, misreading nonverbal interactions, or having difficulty building friendships appropriate to their age. In addition, people with ASD may be overly dependent on routines, highly sensitive to changes in their environment, or intensely focused on inappropriate items. Again, the symptoms of people with ASD will fall on a continuum, with some individuals showing mild symptoms and others having much more severe symptoms.**

Attention Deficit/Hyperactivity Disorder

- ***Changes from DSM IV***
 - Age of onset of impairing symptoms by age 7 to age 12
 - Increase number of adult diagnoses
 - Changes the three subtypes to three current presentations
 - Add a fourth presentation for restrictive inattention
 - Change to accommodate a lifespan relevance of each symptom (change in examples without changing the DSM IV wording)

Attention Deficit/Hyperactivity Disorder

- ***Changes from DSM IV***
 - **Modify to indicate the information must be obtained from two different informants**
 - **Parents**
 - **Teachers**
 - **Significant other adult**
 - **The ADHD diagnosis in previous editions of DSM was written to help clinicians identify the disorder in children. Almost two decades of research conclusively show that a significant number of individuals diagnosed with ADHD as children continue to experience the disorder as adults.**

Attention Deficit/Hyperactivity Disorder

- Presentations

- Combined Presentation: Inattention and Hyperactivity-Impulsivity criteria met
- Predominantly Inattentive: Inattention criteria met and Hyperactivity-Impulsivity criteria not met but 3 or more symptoms present for the last 6 months
- Inattentive Presentation (Restrictive): Inattentive criteria met but no more than 2 symptoms from Hyperactivity-Impulsivity criteria present for the past 6 months
- Predominantly Hyperactive/Impulsive: Hyperactivity-Impulsivity criteria met but Inattentive is not met

Schizophrenia Spectrum and Other Psychotic Disorders

- ***SCHIZOTYPAL (PERSONALITY) DISORDER***
- ***DELUSIONAL DISORDER***
- ***BRIEF PSYCHOTIC DISORDER***
- ***SCHIZOPHRENIFORM DISORDER***
- ***SCHIZOPHRENIA***
- ***SCHIZOAFFECTIVE DISORDER***
- ***SUBSTANCE/MEDICATION INDUCED
PSYCHOTIC DISORDER***

Schizophrenia Spectrum and Other Psychotic Disorders

- 
- **BRIEF PSYCHOTIC DISORDER**
 - **MORE THAN ONE DAY, LESS THAN A MONTH**

- 
- **SCHIZOPHRENIFORM DISORDER**
 - **LASTS ONE TO SIX MONTHS WITH RECOVERY**

- 
- **SCHIZOPHRENIA**
 - **LASTS AT LEAST SIX MONTHS**

Schizophrenia Spectrum and Other Psychotic Disorders

- **Substance/Medication-Induced Psychotic Disorder**
 - **Presence of one or both of the following symptoms:**
 - **Delusions**
 - **Hallucinations**
 - **Evidence of both**
 - **Delusions and/or hallucinations developed soon after substance intoxication or withdrawal or after exposure to a medication**
 - **Involves substances/medications capable of producing these symptoms (sedative, hypnotics or anxiolytics)**

Bipolar and Related Disorders

- **Placed between schizophrenia spectrum and depressive disorder recognizing their place as a bridge between the two categories**
- **Includes not only changes in mood but also changes in activity in Criteria A**
 - **Increase in goal directed activity or psychomotor agitation**
 - **Excessive involvement in activities with high incidence for painful consequences**

Bipolar and Related Disorders

- **Bipolar and Related Disorders include...**
 - ***Bipolar I Disorder***- must have a manic episode with abnormally, persistently elevated, expansive or irritable mood and persistently increased activity or energy present most of the day, nearly every day for a period of at least one week; generally there also exists major depressive episodes
 - ***Bipolar II Disorder***- must have at least one episode of major depression and at least hypomanic episode

Bipolar and Related Disorders

- **Bipolar and Related Disorders include...**
 - ***Cyclothymic Disorder***- given to adults who experience at least two years (children, one) of both hypomanic and depressive episodes without ever fulfilling the criteria for an episode of mania, hypomania or major depression
- ***Numerous specifiers such as rapid cycling, with melancholic features (despondency, despair), atypical features (weight gain, hypersomnolence), seasonal pattern and with psychotic features***

Bipolar and Related Disorders

- **Addition of an anxious specifier(also added to depressive disorders)**
 - *With anxious distress*
 - **The presence of at least two of the following symptoms during the majority of days of the current or most recent episode of mania, hypomania or depression**
 - Feeling keyed up or tense
 - Feeling unusually restless
 - Difficulty concentrating because of worry
 - Fear that something awful may happen
 - Feeling that the individual might lose control of himself or herself
 - **Higher levels of anxiety associated with higher suicide risk, longer duration of illness and greater likelihood of treatment nonresponse**

Bipolar and Related Disorders

- ***Substance/Medication-Induced Bipolar and Related Disorder***
 - **Develop during or soon after substance intoxication or withdrawal or after exposure to a medication**
 - **Sedative, hypnotic or anxiolytic**
 - **Amphetamine**
 - **Cocaine**
 - **Alcohol**
 - **Phencyclidine**
 - **Hallucinogens**

DEPRESSIVE DISORDERS

- **Depressive Disorders include...**
 - *Disruptive Mood Dysregulation Disorder*
 - *Major Depressive Disorder*
 - *Persistent Depressive Disorder (dysthymia)*
 - *Premenstrual Dysphoric Disorder*
 - *Substance/Medication-Induced Depressive disorder*
- **Common feature is the presence of sad, empty or irritable mood, accompanied by somatic and cognitive changes that impact function**

DEPRESSIVE DISORDERS

- **Addresses concerns about childhood bipolar disorder and potential overdiagnosis by creating a new diagnosis, *Disruptive Mood Dysregulation Disorder***
 - **Children up to the age of 18**
 - **Exhibits persistent irritability and frequent episodes of extreme verbal (verbal rages) and behavioral dyscontrol (physical aggression) toward people or property out of proportion to the situation and inconsistent with developmental level occurring on average three or more times per week.**

DEPRESSIVE DISORDERS

- ***Premenstrual Dysphoric Disorder*** moved from “Criteria Sets and Axes Provided for Further Study” into Section II of DSM-5
 - In majority of cycles symptoms present in final week before menses, start to improve within a few days after onset and become minimal or absent in the week postmenses
- What was diagnosed as *Dysthymia* in DSM-IV is called *Persistent Depressive Disorder* which includes chronic major depression and dysthymic disorder

DEPRESSIVE DISORDERS

- **In DSM-IV there was an exclusion criteria for major depressive episode that applied to symptoms lasting less than 2 months following death of a loved one**
- **This is omitted in DSM-5 because...**
 - **Bereavement is a severe psychosocial stressor that can precipitate major depression in vulnerable individuals**
 - **The duration is more commonly 1-2 years**

DEPRESSIVE DISORDERS

- *“Although such symptoms (bereavement) may be understood or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered.”*
 - With grief the predominant affect is feelings of emptiness and loss while with MDE it is persistent depressed mood and an inability to anticipate happiness or pleasure

ANXIETY DISORDERS

- **Anxiety Disorders include...**
 - *Separation Anxiety Disorder*
 - *Selective Mutism*
 - *Specific Phobia*
 - *Social Anxiety Disorder*
 - *Panic Disorder*
 - *Agoraphobia*
 - *Generalized Anxiety Disorder*
 - *Substance/Medication-Induced Anxiety Disorder*

ANXIETY DISORDERS

- Share features of *fear* and *anxiety* and related behavioral disturbances
 - Fear is an autonomic response to real or perceived threat
 - Anxiety is muscle tension and vigilance in preparation for future danger
- Differ from one another in the types of situations or objects that induce fear, anxiety and/or avoidance plus the cognitive ideation
- Highly comorbid with one another

ANXIETY DISORDERS

- **No longer includes obsessive-compulsive disorder (OCD), acute stress disorder and posttraumatic stress disorder (PTSD)**
 - *Obsessive-Compulsive and Related Disorders*
 - *Trauma and Stressor-Related Disorders*
- **Panic attacks can now be listed as a specifier applicable to all DSM-5 disorders**
 - **Panic attack and agoraphobia are unlinked**

ANXIETY DISORDERS

- **Former DSM-IV diagnosis of panic attack with or without agoraphobia and agoraphobia without history of panic attack is now two distinct disorders**
 - *Panic Disorder*
 - *Agoraphobia*
- ***Selective Mutism* (consistent failure to speak in social situations where speaking is expected) and *Separation Anxiety Disorder* (fear or anxiety concerning separation from an attachment figure) are now listed under Anxiety Disorders**
 - Under childhood and adolescent disorders in DSM-IV

ANXIETY DISORDERS

- ***Substance/Medication-Induced Anxiety Disorder***
 - ***Example-*** heavy coffee consumption with severe anxiety
 - ***Caffeine-induced Anxiety Disorder***
 - ***Example-*** panic attacks during or after use of a stimulant such as cocaine
 - ***Cocaine-induced Panic Disorder***
- **Medical conditions such as *pheochromocytoma* and *hyperthyroidism (Graves Disease)***

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

- **Obsessive-Compulsive and Related Disorders**
 - *Obsessive-Compulsive Disorder (OCD)*
 - *Body Dysmorphic Disorder*
 - *Hoarding Disorder*
 - *Excoriation Disorder*
 - *Substance/Medication Induced Obsessive-Compulsive and Related disorders*
 - *Trichotillomania*

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

- **New Disorders**
 - *Hoarding Disorder*
 - *Excoriation (skin picking) Disorder*
 - *Substance/Medication-Induced Obsessive-Compulsive Disorder and Related Disorder*
- **DSM-IV “with poor insight” specifier for OCD refined to “good or fair insight”, “poor insight”, or “absent insight/delusional”**

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

- ***OCD*** has both compulsions and obsessions
- ***Body Dysmorphic Disorder*** and ***Hoarding Disorder*** are characterized by cognitive obsessive symptoms such as perceived defects or flaws in physical appearance or the perceived need to save possessions
- ***Trichotillomania*** and ***Excoriation Disorder*** are characterized by recurrent body-focused repetitive behaviors

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

- ***OCD*** specific content of compulsions and obsessions vary and include themes such as cleaning, symmetry, forbidden or taboo thoughts (sexual and religious) and harm
- ***Substance/Medication-Induced Obsessive-Compulsive and Related Disorders***
 - ***Cocaine***
 - ***Amphetamine***
 - ***Specifiers “with onset during intoxication”, “with onset during withdrawal”, and “with onset after medication use”***

TRAUMA-AND STRESSOR-RELATED DISORDERS

- **Disorders in which exposure to traumatic or stressful events is listed explicitly as a diagnostic criterion**
 - ***REACTIVE ATTACHMENT DISORDER***
 - ***DISINHIBITED SOCIAL ENGAGEMENT DISORDER***
 - ***POSTTRAUMATIC STRESS DISORDER (PTSD)***
 - ***ACUTE STRESS DISORDER***
 - ***ADJUSTMENT DISORDERS***

TRAUMA-AND STRESSOR-RELATED DISORDERS

- **These disorders share a close relationship with Anxiety Disorders, Obsessive-Compulsive and Related Disorders and Dissociative Disorders**
- **Psychological distress following trauma yields a heterogeneous response (often mixed)**
 - *In some cases the response can be understood in an anxiety or fear-based context*
 - *In others the clinical presentation is one of anhedonia and dysphoria, externalizing anger and aggression or dissociation*

TRAUMA-AND STRESSOR-RELATED DISORDERS

- **Social neglect-inadequate caregiving-** is a diagnostic requirement of both *Reactive Attachment Disorder* and *Disinhibited Social Engagement Disorder*
 - *Reactive Attachment Disorder* expressed as an *internalizing disorder with depressive symptoms* (inhibited, emotionally withdrawn, minimal responsiveness to others)
 - *Disinhibited Social Engagement Disorder* expressed as *disinhibited and externalizing behaviors* (approaches and interacts with strangers, etc.)

TRAUMA-AND STRESSOR-RELATED DISORDERS

- ***Acute Stress Disorder***
 - **Explicit as to whether stress was...**
 - **Experienced directly**
 - **Witnessed in person**
 - **Experienced indirectly**
 - **Learning about event that happened to close friends or family members (including threats of violence)**
 - **Experienced repeated or extreme exposure to aversive details of traumatic event (e.g. first responders collecting human remains, police officers repeatedly exposed to child abuse)**
 - **NOTE: does not apply to exposure through electronic media unless exposure is work related**

TRAUMA-AND STRESSOR-RELATED DISORDERS

- ***Adjustment Disorder***
 - Stress response syndromes occurring after exposure to a distressing (traumatic or nontraumatic) event rather than a residual category when do not meet criteria for more discrete disorder
- ***Posttraumatic Stress Disorder***
 - Stressor criterion (Criterion A) more explicit with regard to events qualifying as traumatic
 - Subjective reaction (DSM-IV Criterion A2) has been eliminated

TRAUMA-AND STRESSOR-RELATED DISORDERS

- ***Posttraumatic Stress Disorder***
 - Three major symptom clusters in DSM-IV now four symptom clusters
 - ***Intrusion symptoms***
 - Includes dissociative reactions (flashbacks) where individual feels or acts as if the traumatic event were reoccurring
 - ***Persistent avoidance of stimuli***
 - Includes avoidance of memories, thoughts, people and places that remind the individual of the trauma

TRAUMA-AND STRESSOR-RELATED DISORDERS

- Three major symptom clusters in DSM-IV now four symptom clusters (continued)
 - *Negative alterations in cognition and mood associated with the traumatic event*
 - Includes inability to remember aspects of the trauma, altered world view and anhedonia
 - *Marked alterations in arousal and reactivity (includes irritable behavior or angry outbursts and reckless or self-destructive behavior)*
 - Includes irritable and angry outbursts, hypervigilance and exaggerated startle response

TRAUMA-AND STRESSOR-RELATED DISORDERS

- ***Posttraumatic Stress Disorder***
 - **Separate criteria added for children under 6 years of age**
 - **Diagnostic thresholds lowered for both children and adolescents**

DISSOCIATIVE DISORDERS

- **Dissociative Disorders include...**
 - *Dissociative Identity Disorder*
 - *Dissociative Amnesia*
 - *Depersonalization/Derealization Disorder*
- **Characterized by a disruption of an/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation ,motor control and behavior**

DISSOCIATIVE DISORDERS

- Symptoms are experienced as a) unbidden intrusions into awareness and behavior with losses of continuity in subjective experience (i.e. *“positive” dissociative symptoms* such as fragmentation of identity, depersonalization and derealization) and/or b) inability to access information or to control mental functions that normally are readily amenable to access or control (i.e. *“negative” dissociative symptoms* such as amnesia)

DISSOCIATIVE DISORDERS

- There may be embarrassment or confusion and attempts to hide the symptoms
- *Depersonalization/Derealization Disorder*
 - DSM-IV Depersonalization Disorder
 - Consistent or recurrent depersonalization
 - Experiences of unreality or detachment from one's mind, self or body
 - Accompanied by intact reality testing

DISSOCIATIVE DISORDERS

- ***Dissociative Amnesia***

- Inability to recall autobiographical information
- May be *localized* (an event or period of time), *selective* (a specific aspect of an event) or *generalized* (identity and life history)
 - Localized and selective are most common while generalized is a rare occurrence
- May or may not involve purposeful travel or bewildered wandering (fugue state)
 - Fugue is rare in dissociative amnesia but common in Dissociative Identity Disorder
 - Fugue is a specifier and not a separate diagnosis as in DEM-IV
- Most are initially unaware of their amnesia

DISSOCIATIVE DISORDERS

- ***Dissociative Identity Disorder*** is characterized by a) presence of two or more distinct personality states or an experience of possession and b) recurrent episodes of amnesia
 - Fragmentation may vary by culture (*possession-form presentations*)
- Persons with DID experience a) *recurrent intrusions into conscious functioning and sense of self* (voices; dissociated actions and speech; intrusive thoughts, emotions and impulses)

DISSOCIATIVE DISORDERS

- ***DID*** experiences **b) *alterations of sense of self*** (attitudes, preferences and feeling like one's body or actions are not their own **c) *odd changes of perception*** (depersonalization or derealization-detached from one's body while cutting) and **d) *intermittent functional neurological symptoms*** (seizure like symptoms, hippocampal shrinking, etc.)
 - Symptoms may be observed by others or reported by patient which is a change from DSM-IV
- **70% suicide attempt rate-many multiple attempts**

SOMATIC SYMPTOM AND RELATED DISORDERS

- **Includes the diagnoses of**
 - *Somatic Symptom Disorder*
 - *Illness Anxiety Disorder*
 - *Conversion Disorder* (functional neurological symptom disorder)
 - *Psychological Factors Affecting Other Medical Conditions*
 - *Factitious Disorder*
- **Share a common feature: the prominence of somatic symptoms with significant distress and impairment**

SOMATIC SYMPTOM AND RELATED DISORDERS

- ***Somatic Symptom Disorder*** emphasizes diagnosis made on basis of positive symptoms and signs (distressing somatic symptoms plus abnormal thoughts, feelings and behaviors)
 - *Distinctive characteristic is not the somatic symptom but the way they present and interpret them*
- **Replace somatoform disorders in DSM-IV**

SOMATIC SYMPTOM AND RELATED DISORDERS

- Individuals previously diagnosed with hypochondriasis who have high health anxiety but no somatic symptoms will receive DSM-5 *Illness Anxiety Disorder*
- *Psychological Factors Affecting Other Medical Conditions* is new and was formerly listed in DSM-IV under “Other Conditions That May Be the Focus of Clinical Attention”
- This and *Conversion Disorder* have somatic symptoms and are more often encountered in a medical setting

FEEDING AND EATING DISORDERS

- A persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning
 - Pica
 - *Rumination Disorder*
 - *Avoidant/Restrictive Food Intake Disorder*
 - *Anorexia Nervosa*
 - *Bulimia Nervosa*
 - *Binge-eating Disorder*

FEEDING AND EATING DISORDERS

- DSM-IV-TR chapter “Disorders Usually First Diagnosed During Infancy, Childhood or Adolescence” has been eliminated
- DSM-5 has *Pica* and *Rumination Disorder* (regurgitation of food) during infancy, etc. falling under *Avoidant/Restrictive Food Intake Disorder*
- Diagnoses are mutually exclusive and therefore only one diagnosis can be assigned
 - *Pica* can be present with any other eating disorder

FEEDING AND EATING DISORDERS

- **Obesity is not considered a mental disorder in DSM-5**
- ***PICA***
 - **Eating nonnutritive, nonfood substances over a period of at least one month**
- ***RUMINATION DISORDER***
 - **Repeated regurgitation of food which can be re-chewed, re-swallowed or spit out for at least one month**

FEEDING AND EATING DISORDERS

- ***AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER***
 - Eating or food disturbance such as lack of interest in food or eating, avoidance based upon sensory characteristics of food or concern about aversive effects of eating
- ***ANOREXIA NERVOSA***
 - Restriction of energy intake leading to significantly lowered body weight (defined as less than minimally normal)
 - Amenorrhea requirement is eliminated

FEEDING AND EATING DISORDERS

- ***ANOREXIA NERVOSA*** Subtypes

- ***RESTRICTING TYPE***

- No recurrent episodes of binge eating or purging. Weight loss accomplished by dieting, fasting and excessive exercise

- ***BINGE-EATING/PURGING TYPE***

- Recurrent binge eating or purging

- ***BULIMIA NERVOSA***

- Binge eating with inappropriate compensatory measures to prevent weight gain

FEEDING AND EATING DISORDERS

- ***BINGE-EATING DISORDER***
 - Was in Appendix B of DSM-IV
 - Recurrent episodes of binge eating with loss of control during the episode associated with...
 - Rapid eating
 - Eating when uncomfortably full
 - Eating when not feeling hungry
 - Eating alone due to embarrassment
 - Feelings of disgust or depression after an episode

ELIMINATION DISORDERS

- No significant changes from DSM-IV
- Previously classified under disorders first diagnosed in childhood, infancy and adolescence
- ***ENURESIS***
 - Repeated voiding of urine into bed or clothes either voluntarily or involuntarily when at least 5
- ***ENCOPRESIS***
 - Passage of feces into inappropriate places whether involuntary or intentional when at least 4

SLEEP-WAKE DISORDERS

- **Sleep-Wake Disorders**
 - *Narcolepsy*
 - *Breathing-Related Sleep Disorders*
 - *Circadian Rhythm Sleep-wake Disorders*
 - *Non-rapid Eye Movement (NREM) Sleep Arousal Disorders*
 - *Nightmare Disorder*
 - *Rapid Eye Movement (REM) Sleep Behavior Disorder*
 - *Restless Legs Syndrome*
 - *Substance/Medication-Induced Sleep Disorder*

SLEEP-WAKE DISORDERS

- **Intended to be used by general mental health and medical clinicians**
- **Sleep Disorder Related to Another medical condition and Sleep Disorder Related to Another Mental Disorder have been removed**
- **Primary Insomnia has been renamed *Insomnia Disorder***
- ***Narcolepsy* is distinguished from other forms of hypersomnolence**

SLEEP-WAKE DISORDERS

- ***Rapid Eye Movement Sleep Behavior Disorder*** and ***Restless Legs Syndrome*** have been elevated to independent disorders
- **Sleep-wake complaints about the quality, timing and amount of sleep**
- **Sleep-wake Disorders**
 - ***Insomnia Disorder***
 - ***Hypersomnolence Disorder***

SEXUAL DYSFUNCTIONS

- **Sexual dysfunctions...**
 - *Delayed Ejaculation*
 - *Erectile Disorder*
 - *Female Orgasmic Disorder*
 - *Female Sexual Interest/arousal Disorder*
 - *Genito-pelvic Pain/penetration Disorder*
 - *Male Hypoactive Sexual Desire Disorder*
 - *Premature Ejaculation*
 - *Substance/medication-induced Sexual dysfunction*

SEXUAL DYSFUNCTIONS

- In DSM-5 some gender-specific sexual dysfunctions have been added
- For females sexual desire and arousal disorders have been combined into *Female Sexual Interest/Arousal Disorder*
- All of the dysfunctions except *Substance/Medication-induced Sexual Dysfunction* require a minimum duration of 6 months

SEXUAL DYSFUNCTIONS

- ***Genito-pelvic Pain/penetration Disorder*** has been added and represents a merging of vaginismus and dyspareunia
- **Only two subtypes:**
 - *Lifelong versus Acquired*
 - *Generalized versus Situational*
- **Sexual dysfunctions are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure**

GENDER DYSPHORIA

- ***Gender Dysphoria*** is a new diagnostic class in DSM-5
- Looks at “gender incongruence” as opposed to cross-gender identification as did DSM-IV gender identity disorder
- ***Gender Dysphoria*** has separate sets of criteria for children, adolescents and adults
- ***Posttransition Specifier*** for those who have undergone at least one medical procedure or treatment to support a new gender assignment

GENDER DYSPHORIA

- There is one overarching diagnosis of *Gender Dysphoria* with separate developmentally appropriate criteria sets (*child, adolescent and adult*)
- Refers to an individual's affective/cognitive discontent with the assigned gender
- *Transgender* refers to an individual who transiently or persistently identify with a gender different from their natal gender

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

- **New chapter in DSM-5**
- **ADHD is frequently comorbid**
- **Combines disorders previously included in DSM-IV in chapter “Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence**
 - **Oppositional Defiant Disorder(ODD)**
 - **Conduct Disorder**
 - **Disruptive Behavior Disorder NOS**

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

- **Also combines Chapter “Impulse-control Disorders Not Elsewhere Classified”**
 - Intermittent Explosive /disorder
 - Pyromania
 - Kleptomania
- ***These disorders distinguished by problems of emotional and behavioral self-control***
- ***Unique in that the problems violate the rights of others***

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

CD

- POORLY CONTROLLED BEHAVIORS
- VIOLATE THE RIGHTS OF OTHERS

ODD

- BEHAVIORS (DEFIANCE)
- EMOTIONS (ANGER AND IRRITATION)

IED

- POORLY CONTROLLED EMOTIONS
- DISPROPORTIONATE ANGRY OUTBURSTS

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

- **Because of close association both ASPD and Conduct Disorder are listed in this chapter**
- **Criteria for ODD now grouped into three types**
 - **Angry/irritable mood**
 - **Argumentative/defiant behavior**
 - **Vindictiveness**

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

- **FIRST ONSET TENDS TO BE IN CHILDHOOD OR ADOLESCENCE**
- **More often diagnosed in males**
- **A developmental relationship between ODD and CD**
- **In most cases of CD, criteria was met for ODD**
- **However, most children with ODD do not develop CD**

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

- **Linked to a common *externalizing spectrum* associate with the personality dimensions labeled as**
 - *Disinhibition*
 - *Constraint* (inversely)
- **May account for comorbidity with *Substance Use Disorders* and *Antisocial Personality Disorder***

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- Expanded to include *Gambling Disorder*
- *Cannabis Withdrawal* and *Caffeine Withdrawal* are new disorders
- *Caffeine Withdrawal* was in DSM-IV Appendix B “for further study”
- DSM-5 does not separate abuse and dependence but criteria is provided for *Substance Use Disorder*

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- **Recurrent substance-related legal problems criteria deleted**
- ***Threshold for diagnosis is set at two or more criteria while in DSM-IV it one or more for abuse and three or more for dependence***
- **Diagnosis of polysubstance dependence in DSM-IV is eliminated**
- **Criteria for *intoxication, withdrawal, substance-induced disorders and unspecified substance-related disorders***

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- ***Early remission*** for a DSM-5 substance use disorder is defined as at least 3 months but less than 12 months without meeting criteria (except craving)
- ***Sustained remission*** is defined as over 12 months
- **Additional DSM-5 specifiers include**
 - ***“In a controlled environment”***
 - ***“On maintenance therapy”***

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- ***“The essential feature of a substance use disorder is a cluster of cognitive, behavioral and physiological symptoms indicating the individual continues using the substance despite significant substance-related problems.”***
- **The diagnosis of *substance use disorder* can be applied to all 10 classes with the exception of caffeine**

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- **10 Classes of Substances in DSM-5**
 - ALCOHOL
 - CAFFEINE
 - CANNABIS
 - HALLUCINOGENS (includes phencyclidine)
 - INHALANTS
 - OPIOIDS
 - SEDATIVES, HYPNOTICS OR ANXIOLYTICS
 - STIMULANTS
 - TOBACCO
 - OTHER OR UNKNOWN

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- *“The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli. These persistent drug effects may benefit from long-term approaches to treatment.”*
- **The diagnosis is based upon a pathological pattern of behaviors**

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- ***Pathological pattern of behaviors***
 - **CRITERION A**
 - ***Criteria 1-4- Impaired control over substance use***
 - **Criterion 4- Craving**
 - ***Criteria 5-7-Social impairment***
 - ***Criteria 8-9- Risky use of the substance***
 - ***Criterion 9- Failure to abstain despite the difficulties caused by the usage***
 - ***Criteria 10-11- Pharmacological criteria***
 - **Criterion 10- Tolerance**
 - **Criterion 11- Withdrawal**

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- **Neither tolerance nor withdrawal is necessary to diagnose a substance-use disorder**
- **Symptoms of tolerance and withdrawal from prescribed medications taken as directed is not substance use disorder**
- **Broad range of severity based upon number of symptom criteria**

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- **General estimate of severity**
 - ***MILD***- 2 or 3 symptoms
 - ***MODERATE***- 4 or 5 symptoms
 - ***SEVERE***- 6 or more symptoms
- **Recording Procedure**
 - **305.70 (F15.10)- Moderate Alprazolam Use Disorder (not sedative, hypnotic or anxiolytic disorder)**

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- **EXAMPLE: *OPIOID-RELATED DISORDERS***
 - **Opioid Use Disorder**
 - **Opioid Intoxication**
 - **Opioid Withdrawal**
 - **Other Opioid-Induced Disorders**
 - **Unspecified Opioid-Related Disorders**

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- **Opioid Use Disorder**
 - Based upon the 11 criteria and specifiers
 - 305.50 (F11.10)-MILD Opioid Use Disorder
 - 304.00 (F11.20)-MODERATE Opioid Use Disorder
 - 304.00 (F11.20)-SEVERE Opioid Use Disorder
- **Opioid Intoxication 292.89 (F11.129)**
 - Based upon criteria for recent use, clinically significant behavioral or psychological changes, pupillary constriction and other signs of opioid use not attributable to other medical conditions

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- **Opioid Withdrawal 292.0 (F11.23)**
 - Based upon cessation or reduction in dose or administration of an antagonist plus three or more of symptoms associated with opioid withdrawal producing distress or impairment
- **Other Opioid-Induced Disorders**
 - Opioid-induced depressive disorder (see under Depressive Disorders)
- **Unspecified Opioid-Related Disorder 292.9 (F11.99)**
 - Where symptoms of an Opioid-Related Disorder exist causing significant distress but not meeting full criteria

NON-SUBSTANCE-RELATED DISORDERS

- ***Gambling Disorder 312.31 (F63.0)***
 - **Gambling behavior leading to significant impairment or distress as indicated by four or more criteria within a 12 month period**
 - **Need to gamble with increasing amounts of money**
 - **Restless and irritable when try to cut down or stop**
 - **Repeated unsuccessful efforts**
 - **Preoccupation**
 - **Gambles when feeling distressed**
 - **“Chases” one’s losses**
 - **Lies**
 - **Jeopardizes relationships**
 - **Relies on others for money to relieve desperate financial situations**
 - **Not explained by manic episode**

NEUROCOGNITIVE DISORDERS

- DSM-IV diagnoses of dementia and amnesic disorder are subsumed under the newly named entity *Major Neurocognitive Disorder (NCD)*
- DSM-5 also recognizes a less severe level of cognitive impairment *Mild NCD*
- Unique in that the underlying pathology can be determined
- Traumatic Brain Injury is classified here

NEUROCOGNITIVE DISORDERS

- Primary clinical deficit is in cognitive functioning that is acquired rather than developmental
- *Delirium* is specified as due to intoxication, withdrawal, medication induced or due to another medical condition
 - Acute versus persistent
 - Hyperactive, hypoactive or mixed

NEUROCOGNITIVE DISORDERS

- ***Major or Mild NCD etiological subtypes:***
 - ***Alzheimer's Disease***
 - ***Frontotemporal Lobar Degeneration***
 - ***Lewy Body Disease***
 - ***Vascular Disease***
 - ***Traumatic Brain Injury***
 - ***Substance/Medication Induced***
 - ***HIV Infection***
 - ***Parkinson's Disease***

PERSONALITY DISORDERS

- An updated version of DSM-IV
- New conceptualization is in Section III as *Alternative DSM-5 Model for Personality Disorders*
- A *Personality Disorder* is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment

PERSONALITY DISORDERS

- **Cluster A-odd or eccentric**
 - *Paranoid Personality Disorder*
 - *Schizoid Personality Disorder*
 - *Schizotypal Personality Disorder*
- **Cluster B-dramatic, emotional and erratic**
 - *Antisocial Personality Disorder*
 - *Narcissistic Personality Disorder*
 - *Histrionic Personality Disorder*
 - *Borderline Personality Disorder*

PERSONALITY DISORDERS

- **Cluster C-anxious or fearful**
 - *Avoidant Personality Disorder*
 - *Obsessive-compulsive Personality Disorder*
 - *Dependent Personality Disorder*

PARAPHILIC DISORDERS

- **Paraphilic Disorders...**
 - ***Voyeuristic Disorder*** (spying on others in private activities)
 - ***Exhibitionistic Disorder*** (exposing the genitals)
 - ***Frotteuristic Disorders*** (touching or rubbing against a nonconsenting individual)
 - ***Sexual Masochism disorder*** (undergoing humiliation, bondage, or suffering)
 - ***Pedophilic Disorder*** (sexual focus on children)

PARAPHILIC DISORDERS

- **Paraphilic Disorders...**
 - *Fetishistic Disorder* (using nonliving objects or having a highly specific focus on nongenital body parts)
 - *Transvestic Disorder* (engaging in sexually arousing cross-dressing)
- ***Denotes an intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners***

PARAPHILIC DISORDERS

- **Mostly unchanged since DSM-III with exception of specifiers and distinction between paraphilia's and Paraphilic Disorder (must also include Criterion B which states the individual acted on a nonconsenting person or the actions created significant distress or impairment)**
- **Specifiers**
 - *In a controlled environment*
 - *In full remission (5 years in an uncontrolled environment)*

OTHER MENTAL DISORDERS

- **Other Specified Mental Disorder Due to Another Medical Condition**
 - Example- *Dissociative Symptoms Secondary to Complex Partial Seizures*
- **Unspecified Mental Disorder Due to Another Medical Condition**
 - Example- Like in an emergency room where psychiatric symptoms are observed but not specified due to lack of information and evidence

OTHER MENTAL DISORDERS

- **Other Specified Mental Disorder**
 - Example-Full criteria is not met for a mental disorder and clinician chooses to communicate the specific reason the presentation does not meet full criteria
- **Unspecified Mental Disorder**
 - Example-Full criteria is not met for a mental disorder and clinician chooses *not* to communicate the specific reason the presentation does not meet full criteria

MEDICATION-INDUCED MOVEMENT DISORDERS AND OTHER ADVERSE EFFECTS OF MEDICATION

- ***Neuroleptic-Induced Parkinsonism***
- ***Neuroleptic Malignant Syndrome***
 - Usually secondary to a dopamine antagonist
 - Hyperthermia and profuse diaphoresis
 - Generalized rigidity (“lead pipe”)
 - Catatonic stupor
- **Tardive Dyskinesia**
 - Involuntary movements generally of the tongue, lower face and jaw and extremities

MEDICATION-INDUCED MOVEMENT DISORDERS AND OTHER ADVERSE EFFECTS OF MEDICATION

- ***Antidepressant Discontinuation Syndrome***
 - Abrupt cessation of an antidepressant (Paxil and Effexor as examples)
 - Usually begin 2-4 days after discontinuation
 - Somatic and sensory such as flashes of light “electric shock sensations, hyperresponsiveness to light and sound
 - Vivid nightmares

OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

- **V Codes (ICD-9-CM) or Z Codes (ICD-10-CM)**
- **RELATIONAL PROBLEMS**
 - *Parent-Child Relational Problem*
- **ABUSE AND NEGLECT**
 - *Child Physical Abuse*
 - *Child Sexual Abuse*
 - *Child Neglect*
 - *Child Psychological Abuse*
 - *Adult Maltreatment and Neglect Problems*

OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

- **EDUCATIONAL AND OCCUPATIONAL PROBLEMS**
- **HOUSING AND ECONOMIC PROBLEMS**
- **PROBLEMS RELATED TO CRIME OR INTERACTION WITH THE LEGAL SYSTEM**
- **PROBLEMS RELATED TO ACCESS TO MEDICAL AND OTHER HEALTH CARE**
 - *Nonadherence to Medical Treatment*

DSM-5

- **SECTION III EMERGING MEASURES AND MODELS**
 - **Assessment Measures**
 - **Cultural Formulation**
 - **Alternative DSM-5 Model for Personality Disorders**
 - **Conditions For Further Study**

ALTERNATIVE DSM-5 MODEL FOR PERSONALITY DISORDERS

- *Antisocial Personality Disorder*
- *Avoidant Personality Disorder*
- *Borderline Personality Disorder*
- *Narcissistic Personality Disorder*
- *Obsessive-Compulsive Personality Disorder*
- *Schizotypal Personality Disorder*

ALTERNATIVE DSM-5 MODEL FOR PERSONALITY DISORDERS

- In this model personality disorders are characterized by impairments in personality *functioning* and pathological personality *traits*
- In the Alternative Model for Personality Disorders histrionic and schizoid personality disorders are excluded
- In the *Alternative Model Criterion A: Level of Personality Functioning* and *Criterion B: Pathological Personality Traits* make up the diagnostic model

ALTERNATIVE DSM-5 MODEL FOR PERSONALITY DISORDERS

- **Criterion A: Level of Personality Functioning**
 - **SELF:**
 - ***Identity***: Clear boundaries, stability of self-esteem and accuracy of self-appraisal, good emotional range
 - ***Self-direction***: Coherent and meaningful short-term and life goals, prosocial internal standards of behavior, ability to self-reflect

ALTERNATIVE DSM-5 MODEL FOR PERSONALITY DISORDERS

- **Criterion A: Level of Personality Functioning**
 - **INTERPERSONAL:**
 - ***Empathy:*** Appreciation of others experiences and motivations, tolerance for different perspectives, understanding the effects of one's behavior on others
 - ***Intimacy:*** of connection with others, desire and capacity for closeness, mutuality of regard reflected in interpersonal behavior

ALTERNATIVE DSM-5 MODEL FOR PERSONALITY DISORDERS

- **Criterion B: Pathological Personality Domains**
 - *NEGATIVE AFFECTIVITY vs. EMOTIONAL STABILITY*
 - *DETACHMENT vs. EXTRAVERSION*
 - *ANTAGONISM vs. AGREEABLENESS*
 - *DISINHIBITION vs. CONSCIENTIOUSNESS*
 - *PSYCHOTICISM vs. LUCIDITY*

ALTERNATIVE DSM-5 MODEL FOR PERSONALITY DISORDERS

- Each personality domain has numerous traits
 - Example: *Negative Affectivity vs. Emotional Stability*
 - Emotional lability
 - Anxiousness
 - Separation insecurity
 - Submissiveness
 - Hostility
 - Perseveration

ALTERNATIVE DSM-5 MODEL FOR PERSONALITY DISORDERS

- **This model also includes a diagnosis of *Personality Disorder-Trait Specified (PD-TS)* that can be made when a personality disorder is considered present but the criteria for a specific disorder are not met**

CONDITIONS FOR FURTHER STUDY

- Proposed criteria sets for which future research is encouraged
- *Cannot be used as a diagnostic category (only Section II)*
 - *Attenuated Psychosis Syndrome*
 - *Depressive Episodes With Short-Duration Hypomania*
 - *Persistent Complex Bereavement Disorder*

CONDITIONS FOR FURTHER STUDY

- *Caffeine Use Disorder*
- *Internet Gaming Disorder*
- *Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure*
- *Suicidal Behavior Disorder*
- *Nonsuicidal Self-Injury*

BIBLIOGRAPHY

- **American Psychiatric Association. (1952). Diagnostic and statistical manual of mental disorders. Washington, DC: Author.**
- **American Psychiatric Association. (1968). Diagnostic and statistical manual of mental disorders (2nd ed.). Washington, DC: Author.**
- **American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.**
- **American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders, (3rd ed., rev.). Washington, DC: Author.**
- **American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author**
- **American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: Author.**

BIBLIOGRAPHY

- <http://psychcentral.com/blog/archives/2012/12/02/final-dsm-5-approved-by-american-psychiatric-association/> - Final DSM-5 Approval by the American Psychiatric Association. Online – Accessed March 10, 2013.
- <http://www.clinicalpsychiatrynews.com/news/practice-trends/single-article/dsm-5-expected-to-be-more-user-friendly/c15c9ec460b6f43dbc73b7a3a776fa43.html> - DSM-5 Expected to be More User Friendly. Online – Accessed March 10, 2013.
- Axelson, D. (2013). Taking Dysruptive Mood Dysregulation Disorder Out for a Test Drive. Psychiatry Online. <http://ajp.psychiatryonline.org/article.aspx?articleid=1566892> - Accessed March 13, 2013.