DSM5 WORKSHOP PRESENTATIONS
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>09h00-09h15</td>
<td>General changes</td>
<td>Milligan</td>
</tr>
<tr>
<td>09h15-09h30</td>
<td>Developmental disorders</td>
<td>Vogel / de Vries</td>
</tr>
<tr>
<td>09h30-09h45</td>
<td>Neurocognitive disorders</td>
<td>Lewis</td>
</tr>
<tr>
<td>09h45-10h00</td>
<td>Mood disorders</td>
<td>Horn</td>
</tr>
<tr>
<td>10h00-10h15</td>
<td>Anxiety disorders</td>
<td>Louw</td>
</tr>
<tr>
<td>10h15-10h30</td>
<td>Psychotic disorders</td>
<td>Timmermans</td>
</tr>
<tr>
<td>10h30-10h45</td>
<td>Tea break</td>
<td></td>
</tr>
<tr>
<td>10h45-11h00</td>
<td>Personality disorders</td>
<td>Kaliski</td>
</tr>
<tr>
<td>11h15-11h30</td>
<td>PTSD</td>
<td>Benson-Martin</td>
</tr>
<tr>
<td>11h30-11h45</td>
<td>Eating disorders</td>
<td>Hoare</td>
</tr>
<tr>
<td>11h45-12h00</td>
<td>Substance Abuse</td>
<td>de Clercq</td>
</tr>
<tr>
<td>12h00-12h15</td>
<td>Intellectual disability</td>
<td>Ganasen</td>
</tr>
<tr>
<td>12h15-12h45</td>
<td>General Discussion</td>
<td></td>
</tr>
</tbody>
</table>
Introduction to the DSM-5

Dr Pete Milligan
January 2014
History

- DSM-I (1952)
- DSM-II (1968)
- DSM-III (1980)
- DSM-III-R (1987)
- DSM-IV (1994)
- DSM-5 (2013)
Predicting the DSM-V

- Year of publication – 2007
- 31 member task force
- 25 advisory committees
- Chairperson’s surname begins with “T”
- 1026 pages
- 415 000 words
- Brown cover
- 390 disorders
- 1 800 diagnostic criteria
- 11 appendices
- Will sell 1 140 000 copies
- Generate $40 000 000 in revenue for the APA

Blashfield and Fuller (1996), Journal of Nervous & Mental Disease, Vol 184(1), pp 4-7
Predicting the DSM-V

• Year of publication – 2007 (2013)
• 31 member task force (35)
• 25 advisory committees (22)
• Chairperson’s surname begins with “T” (David Kupfer)
• 1026 pages (DSM-IV = 900) (947)
• 415 000 words (DSM-IV = 324 000) (?)
• Brown cover (Purple)
• 390 disorders (DSM-IV = 357) (348)
• 1 800 diagnostic criteria (DSM-IV = 1 500) (?)
• 11 appendices (DSM-IV = 10) (7)
• Will sell 1 140 000 copies (?)
• Generate $40 000 000 in revenue for the APA (?)$230 000 000)

Blashfield and Fuller (1996), Journal of Nervous & Mental Disease, Vol 184(1), pp 4-7
Organisational Structure

• Harmonization with ICD-11
  – Includes ICD-9-CM and ICD-10-CM codes

• Developmental and Lifespan Considerations
  – Sequential Order starting with Neurodevelopmental disorders
  – Also used within chapters

• Dimensional approach
  – Internalizing (eg. anxiety, depressive, somatic) vs Externalizing (eg. impulsive, disruptive conduct and substance use)
Organisational Structure

• Neurodevelopmental Disorders
• Internalizing Disorders
• Externalizing Disorders
• Neurocognitive Disorders
• Other Disorders

• New groups:
  Eg. Obsessive – Compulsive and Related Disorders,
       Trauma and Stressor-Related Disorders
Chapters

- Neurodevelopmental Disorders
- Schizophrenia-Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Elimination Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
Chapters

• Gender Dysphoria
• Disruptive, Impulse-Control, and Conduct Disorders
• Substance-Related and Addictive Disorders
• Neurocognitive Disorders
• Personality Disorders
• 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
Cultural Issues

• Expanded Chapter on Cultural Formulation including a cultural formulation interview (CFI).
• Culture-bound syndrome replaced by:
  1. Cultural Syndrome: a cluster or group of co-occurring, relatively invariant symptoms found in a specific cultural group, community, or context.
  2. Cultural idiom of distress: a linguistic term, phrase, or way of talking about suffering among individuals of a cultural group.
  3. Cultural explanation or perceived cause: a label, attribution, or feature of an explanatory model that provides a culturally conceived aetiology or cause for symptoms, illness, or distress.
Gender Differences

• Refers to ‘gender differences’ rather than ‘sex differences’ throughout
• Gender-specific symptoms added to the diagnostic criteria
• Gender-related specifiers used where relevant
• Other issues pertinent to diagnosis and gender considerations included in most chapters in a section labelled “Gender-Related Diagnostic Issues”
Other Specified and Unspecified Disorders and Disorders

• Previous NOS designation replaced with:
  – Other Specified Disorder: Name of category followed by the specific reason
    • eg. Clinically significant depressive episode, but falls short of diagnostic threshold for MDE = “other specified depressive disorder, depressive episode with insufficient symptoms”.
  – Unspecified Disorder: Name of category, reason not given
    • eg. Acute admission to casualty with a depressive episode, but final diagnosis not yet clear = “unspecified depressive disorder”.
Disorders due to Another Medical Condition

• Indicate if due to *another medical condition*.  
  – Include the name of the other medical condition in the name of the mental disorder  
    • eg. Bipolar disorder due to hyperthyroidism.  
  – Code other medical condition first, then mental disorder due to the medical condition
The Multiaxial System

• Nonaxial documentation of diagnosis (formerly Axis I, II and III)
  – Principal Diagnosis: The condition chiefly responsible for current admission.
  – List principal diagnosis first followed by others in order of focus of attention and treatment.
  – Can use “provisional” as a specifier where there is a strong presumption that full criteria will be met.
• Record important psychosocial and contextual factors (formerly Axis IV) using ICD-9-CM V codes or ICD-10-CM Z codes
• Disability (formerly Axis V): GAF dropped. WHODAS 2.0 included for further study.
  – 36 item, self-administered scale.
  – Rates difficulty in specific areas of functioning in past 30 days.
  – Simple or complex methods for calculating summary score.
Emerging Measures and Models

• Assessment Measures
  – DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult
  – Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure – Child Age 6-17
  – Clinician-Rated Dimensions of Psychosis Symptom Severity
  – WHODAS 2.0

• Cultural Formulation
  – Cultural Formulation Interview (CFI)
Emerging Measures and Models

• Alternative DSM-5 Model for Personality Disorders
• Conditions for further study
  – Attenuated Psychosis Syndrome
  – Depressive Episodes with Short-Duration Hypomania
  – Persistent Complex Bereavement Disorder
  – Caffeine Use Disorder
  – Internet Gaming Disorder
  – Neurobehavioural Disorder Associated with Prenatal Alcohol Exposure
  – Suicidal Behavior Disorder
  – Nonsuicidal Self-Injury
Transition from the DSM-IV-TR to the DSM-5

Examinations administered in 2014:

Candidates sitting the FC Psych(SA) Part II examination in 2014 (March/May and August/October) will be required to have a good understanding of DSM-5 terminology and of the conceptual and category changes from the DSM-IV-TR for both the written and clinical/oral examinations. The long case presentation and the diagnostic formulation may, however, follow DSM-IV-TR nosology and criteria.
Transition from the DSM-IV-TR to the DSM-5
Examinations administered in 2015:

As of March/May 2015, candidates sitting the FC Psych(SA) Part II examinations will be required to be fully versed in the DSM-5 classification system for both the written and clinical/oral examinations. Candidates will be required to familiarise themselves with DSM-5 criteria and compare and cross-reference them with DSM-IV-TR criteria. The long case presentation and diagnostic formulation should conform to the DSM-5. A suggested format for the case presentation is being prepared and will be made available by June 2014.
Dr Pete Milligan
Valkenberg Hospital
Department of Psychiatry and Mental Health
University of Cape Town
Peter.milligan@westerncape.gov.za
DSM-IV to DSM-5 in Child & Adolescent Psychiatry

Prof Petrus de Vries
Sue Struengmann Professor of Child & Adolescent Psychiatry
DSM in Child & Adolescent Psychiatry

Neurodevelopmental Disorders

- Number of changes
- New terms, new groupings, new subdivisions, new specifiers, some changes in criteria
Test (True or False)

1. We no longer use the term mental retardation. We diagnose intellectual disability.
2. The correct DSM-5 term for a child with autism is autistic spectrum disorder.
3. Asperger no longer exists in DSM-5.
4. ADHD has had a change in the age of onset criterion.
5. ODD and Conduct disorders are not neurodevelopmental disorders in DSM-5.
6. Selective Mutism is classified as an anxiety disorder in DSM-5.
7. To have Tourette’s you no longer need to have evidence of impairment or distress caused by the disturbance.
Disorders usually first diagnosed in infancy, childhood or adolescence (DSM-IV)

- Mental Retardation
- Learning Disorders
- Motors Skills Disorder
- Communication Disorders
- Pervasive Developmental Disorder
- Attention deficit and disruptive behaviour disorders
- Feeding and eating disorders of infancy and early childhood
- Tic disorders
- Elimination Disorders
- Other – separation anxiety disorder

Selective mutism
Reactive Attachment Disorder of I/early Childhood
Stereotypical movement disorder
NOS

Neurodevelopmental Disorders (DSM-5)
Disorders usually first diagnosed in infancy, childhood or adolescence (DSM-IV)

- Mental Retardation
- Learning Disorders
- Motors Skills Disorder
- Communication Disorders
- Pervasive Developmental Disorder
- Attention deficit and disruptive behaviour disorders
- Feeding and eating disorders of infancy and early childhood
- Tic disorders
- Elimination Disorders
- Other – separation anxiety disorder

Selective mutism
Reactive Attachment Disorder of I/early Childhood
Stereotypical movement disorder
NOS

Neurodevelopmental Disorders (DSM-5)

- Intellectual (developmental) disability
- Communication disorders
- Autism Spectrum Disorders
- ADHD
- Specific Learning Disorder
- Motor Disorders
  - Developmental coordin. dis
  - Stereotypical movement dis
  - Tic disorders

Other Specified Neurodevelopmental Disorder

Unspecified Neurodevelopmental Disorder
Communication Disorders

- **Language Disorder**
  Combination of DSM-IV Expressive Language Disorder and Mixed Receptive-Expressive Language Disorder
- **Speech Sound Disorder**
  Phonological Disorder in DSM-IV
- **Childhood-onset fluency Disorder (stuttering)**
  Stuttering in DSM-IV
- **Social (Pragmatic) Communication Disorder**
  Not in DSM-IV
- **Unspecified Communication Disorder**
Autism Spectrum Disorder
Autistic Disorder
Rett’s Disorder
Childhood Disintegrative Disorder
Asperger’s Disorder
PDD NOS

Specifiers:
With or without ID
With or without language impairment
Associated with a known medical or genetic condition or environmental factor
Associated with another NDD or other Dis.
With Catatonia
Severity (3 clinical levels)

Lord & Jones, JCPP, 2012
Attention-Deficit/Hyperactivity Disorder

A. Inattention Criteria – similar, more developmental examples; Hyperactivity/Impulsivity Criteria – similar, more developmental examples
• Requires 6+ in childhood; 5+ after age 17
B. Age-of-onset: before 12y (DSM-IV <7)
C. Several (vs ‘some’) inattentive and h-l symptoms in two or more settings
D. Evidence of interference or reducing quality of functioning
E. Context of other disorders (ASD no longer exclusion)
Specifiers – (vs subtypes): Combined; Pred Inatt; Pred H/Impul
Specifiers – partial remission
Specifiers – severity: mild, moderate, severe
Specific Learning Disorder

• Difficulties learning and using academic skills; reworded criteria, more developmental and less ‘measurement’ focused
• Grouped all together vs DSM-IV (reading disorder, maths disorder, disorder of written expression)
• Specifiers: impairment in reading, written expression, mathematics
• Specifier: severity
Motor Disorders

• Developmental Coordination Disorder
• Stereotypical Movement Disorder
• Tic disorders*
  – Tourette’s Disorder
  – Persistent (Chronic) Motor or Vocal Tic disorder
  – Provisional (vs Transient) tic disorder
  – Other specified tic disorder
  – Unspecified Tic disorder

* ‘disturbance causes marked distress or significant impairment in social, occupational or other important areas of functioning’ – removed in DSM-5
Disorders usually first diagnosed in infancy, childhood or adolescence (DSM-IV)

- Mental Retardation
- Learning Disorders
- Motors Skills Disorder
- Communication Disorders
- Pervasive Developmental Disorder
- Attention deficit and disruptive behaviour disorders
- Feeding and eating disorders of infancy and early childhood
- Tic disorders
- Elimination Disorders
- Other — separation anxiety disorder
  Selective mutism
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  Stereotypical movement disorder
  NOS

Neurodevelopmental Disorders (DSM-5)

- Intellectual (developmental) disability
- Communication disorders
- Autism Spectrum Disorders
- ADHD
- Specific Learning Disorder
- Motor Disorders
  - Developmental coordin. dis
  - Stereotypical movement dis
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Other Specified Neurodevelopmental Disorder
Unspecified Neurodevelopmental Disorder
Disorders usually first diagnosed in infancy, childhood or adolescence (DSM-IV)

- Mental Retardation
- Learning Disorders
- Motors Skills Disorder
- Communication Disorders
- Attention deficit and disruptive behaviour disorders
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- Tic disorders
- Elimination Disorders
- Other – separation anxiety disorder

Selective mutism
Reactive Attachment Disorder of I/early Childhood
Stereotypical movement disorder
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Neurodevelopmental Disorders (DSM-5)

- Intellectual (developmental) disability
- Communication disorders
- Autism Spectrum Disorders
- ADHD
- Specific Learning Disorder
- Motor Disorders
  - Developmental coordin. dis
  - Stereotypical movement dis
  - Tic disorders

Other Specified Neurodevelopmental Disorder

Unspecified Neurodevelopmental Disorder
Not in Neurodevelopmental Disorders

- **Disruptive Behaviour Disorders** = Disruptive, Impulse-Control, and Conduct Disorders
- **Feeding and eating disorders of infancy and early childhood** = Feeding and Eating Disorders
- **Elimination Disorders** = Elimination Disorders
- **Separation anxiety disorder and selective mutism** = Anxiety Disorders
- **Reactive attachment disorder of infancy/early childhood** = Trauma- and Stressor-Related Disorders
Test (True or False)

1. We no longer use the term mental retardation. We diagnose intellectual disability.
2. The correct DSM-5 term for a child with autism is autistic spectrum disorder.
3. Asperger no longer exists in DSM-5.
4. ADHD has had a change in the age of onset criterion.
5. ODD and Conduct disorders are not neurodevelopmental disorders in DSM-5.
6. Selective Mutism is classified as an anxiety disorder in DSM-5.
7. To have Tourette’s you no longer need to have evidence of impairment or distress caused by the disturbance.
Test (True or False)

1. We no longer use the term mental retardation. We diagnose intellectual disability. **TRUE**
2. The correct DSM-5 term for a child with autism is autistic spectrum disorder. **FALSE**
3. Asperger no longer exists in DSM-5. **TRUE**
4. ADHD has had a change in the age of onset criterion. **TRUE**
5. ODD and Conduct disorders are not neurodevelopmental disorders in DSM-5. **TRUE**
6. Selective Mutism is classified as an anxiety disorder in DSM-5. **TRUE**
7. To have Tourette’s you no longer need to have evidence of impairment or distress caused by the disturbance. **TRUE**
DSM-5
Neurocognitive Disorders

Ian Storm Lewis
Neurocognitive Disorders

Replaces “Delirium, dementia, amnesic and other cognitive disorders”

Delirium
Mild Neurocognitive disorder
Major Neurocognitive disorder
Subtypes

Major Neurocognitive disorder due to Alzheimer’s disease

Alzheimer’s disease
Frontotemporal lobar degeneration
Lewy body disease
Vascular disease
Traumatic brain injury
Substance/medication use
Three Advances in DSM-5

Delirium
Mild NCD
Major NCD

‘Major Neurocognitive disorder ’ replaces ‘Dementia’
  e.g. Major NCD due to TBI

Criteria for Specific Aetiology
  e.g. Mild NCD with Lewy Bodies
Three Advances:
1. Clear Structure

Exclude delirium

Mild or Major NCD

Likely Aetiology
Delirium (1)

- Disturbance in attention and awareness [consciousness] (reduced orientation to the environment).
  - develops over short period,
  - change from baseline attention and awareness
  - fluctuates

- Additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception).
Delirium (2)

- Not better explained by another [...] neurocognitive disorder
- Evidence [...] direct consequence of:
  - Medical condition
  - Substance intoxication or withdrawal
  - Toxin
  - Multiple aetiologies.
Major [mild] Neurocognitive Disorder (1)

Significant [modest] cognitive domains

– complex attention
– executive function
– learning and memory
– Language
– perceptual-motor, or,
– social cognition
Major [mild] Neurocognitive Disorder (2)

Substantial [modest] impairment in cognitive performance
The cognitive deficits
  [do not] Interfere with independence in everyday activities
• Not part of a delirium.
• Not better explained by another mental disorder
Cognitive Domains

Significant [modest] cognitive decline in one or more cognitive domains

– complex attention
– executive function
– learning and memory
– Language
– perceptual-motor, or,
– social cognition
### MEMORY
Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

<table>
<thead>
<tr>
<th>1st trial</th>
<th>FACE</th>
<th>VELVET</th>
<th>CHURCH</th>
<th>DAISY</th>
<th>RED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd trial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ATTENTION
Read list of digits (1 digit/sec.). Subject has to repeat them in the forward order: [ ] 2 1 8 5 4.

Subject has to repeat them in the backward order: [ ] 7 4 2.

Read list of letters. The subject must tap with his hand at each letter. A. No points if ≥ 2 errors.

[ ] FBACMNAJLKBFAKDDEAAAJAMOFAB

### LANGUAGE
Repeat: I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ]

Fluency: Name maximum number of words in one minute that begin with the letter F [ ] ____ (N ≥ 11 words)

### ABSTRACTION
Similarity between e.g. banana - orange = fruit [ ]

[ ] train - bicycle [ ]

[ ] watch - ruler

### SERIAL 7 SUBTRACTION
Starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt

### DELAYED RECALL
Has to recall words WITH NO CUE

<table>
<thead>
<tr>
<th>FACE</th>
<th>VELVET</th>
<th>CHURCH</th>
<th>DAISY</th>
<th>RED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ORIENTATION
[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

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Total: ___/30

Add 1 point if ≤ 12 yr edu

Administered by: ____________________________
Perceptual-motor (construction)
Language (naming)

Montreal Cognitive Assessment (MOCA)

Visuospatial / Executive

- Copy cube
- Draw clock (Ten past eleven) (3 points)

Points

Naming

- Lion
- Rhinoceros
- Camel

Contour Numbers Hands

1/5

NAME:
Education:
Sex:
Date of birth:
DATE:

[ ]
### Language (repetition, fluency)

**Memory**
- Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

<table>
<thead>
<tr>
<th></th>
<th>FACE</th>
<th>VELVET</th>
<th>CHURCH</th>
<th>DAISY</th>
<th>RED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st trial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd trial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Attention**
- Read list of digits (1 digit/sec.). Subject has to repeat them in the forward order.
- Subject has to repeat them in the backward order.
- Read list of letters. The subject must tap with his hand at each letter.

<table>
<thead>
<tr>
<th></th>
<th>2 1 8 5 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2</td>
<td></td>
</tr>
</tbody>
</table>

Serial 7 subtraction starting at 100

<table>
<thead>
<tr>
<th></th>
<th>93</th>
<th>86</th>
<th>79</th>
<th>72</th>
<th>65</th>
</tr>
</thead>
<tbody>
<tr>
<td>/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt

**Language**
- Repeat: I only know that John is the one to help today. [ ]
- The cat always hid under the couch when dogs were in the room. [ ]

<table>
<thead>
<tr>
<th></th>
<th>(N ≥ 11 words)</th>
</tr>
</thead>
<tbody>
<tr>
<td>/2</td>
<td></td>
</tr>
</tbody>
</table>

Fluency / Name maximum number of words in one minute that begin with the letter F

<table>
<thead>
<tr>
<th></th>
<th>______</th>
</tr>
</thead>
<tbody>
<tr>
<td>/1</td>
<td></td>
</tr>
</tbody>
</table>
## Learning and Memory

### Memory

- **Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.**

<table>
<thead>
<tr>
<th></th>
<th>FACE</th>
<th>VELVET</th>
<th>CHURCH</th>
<th>DAISY</th>
<th>RED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st trial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd trial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No points

### Attention

- **Read list of digits (1 digit/sec.). Subject has to repeat them in the forward order:** [ ] 2 1 8 5 4
- **Subject has to repeat them in the backward order:** [ ] 7 4 2
- **Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors:** [ ] FBACMNAAJKLBAFKDEAAMOFAAB
- **Serial 7 subtraction starting at 100:** [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
  - 4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt

### Language

- **Repeat:** I only know that John is the one to help today. [ ]
- **The cat always hid under the couch when dogs were in the room.** [ ]
- **Fluency / Name maximum number of words in one minute that begin with the letter F:** [ ] _____ (N ≥ 11 words)

### Abstraction

- **Similarity between e.g. banana - orange = fruit:** [ ]
- **train – bicycle** [ ]
- **watch – ruler** [ ]

### Delayed Recall

- **Has to recall words WITH NO CUE:**
  - FACE [ ]
  - VELVET [ ]
  - CHURCH [ ]
  - DAISY [ ]
  - RED [ ]

Points for UNCUEd recall only

### Optional

- **Category cue**
- **Multiple choice cue**

### Orientation

- **Date** [ ]
- **Month** [ ]
- **Year** [ ]
- **Day** [ ]
- **Place** [ ]
- **City** [ ]

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Normal ≥ 26 / 30

TOTAL [ ] /30

Add 1 point if ≤ 12 yr edu
### Complex Attention

#### MEMORY
Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

<table>
<thead>
<tr>
<th>Trial</th>
<th>FACE</th>
<th>VELVET</th>
<th>CHURCH</th>
<th>DAISY</th>
<th>RED</th>
<th>No points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### ATTENTION
Read list of digits (1 digit/sec.). Subject has to repeat them in the forward order. Subject has to repeat them in the backward order.

1. Forward order: [ ] 2 1 8 5 4
2. Backward order: [ ] 7 4 2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors.

- [ ] FBACMNAAJKLBAFAKDEAAAALAMOFAAB

Serial 7 subtraction starting at 100:

- [ ] 93
- [ ] 86
- [ ] 79
- [ ] 72
- [ ] 65

4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt

#### LANGUAGE
- Repeat: I only know that John is the one to help today.
- The cat always hid under the couch when dogs were in the room.

#### ABSTRACTION
Similarity between e.g. banana - orange = fruit
- [ ] train - bicycle
- [ ] watch - ruler

#### DELAYED RECALL
Has to recall words WITH NO CUE

<table>
<thead>
<tr>
<th>Category cue</th>
<th>FACE</th>
<th>VELVET</th>
<th>CHURCH</th>
<th>DAISY</th>
<th>RED</th>
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#### ORIENTATION
- [ ] Date
- [ ] Month
- [ ] Year
- [ ] Day
- [ ] Place
- [ ] City

© Z.Nasreddine MD  Version 7.1  www.mocatest.org  Normal ≥26 / 30  TOTAL __/30

Add 1 point if ≤ 12 yr edu
Social cognition

Recognition of emotions
images with positive or negative emotions

Theory of mind
story cards – why is the boy sad?

Perceptual Motor

Apraxia
wave goodbye
use hammer

Agnosia
recognise faces
colours
Apraxia

• Inability to make movements when ordered
• Nature of request is understood
• No significant weakness, sensation intact
Agnosia

Alert patient, virtually normal sensation
Unable to recognise familiar objects
Three Advances:

2. ‘Major NCD’ replaces ‘Dementia’

Matches clinical practice for patients with NCD due to head injury, HIV, HD etc.

Broader category is helpful (esp. in DSV-IV Amnestic disorder)

Still option to use ‘dementia’
Three Advances:
3. Criteria for Specific Aetiology

Characterises less common causes of NCD

E.g.

NCD with Lewy Bodies
Frontotemporal NCD
NCD due to Traumatic brain injury
Major or Mild Neurocognitive Disorder with Lewy Bodies (1)

A. The criteria are met for major or mild neurocognitive disorder.

B. The disorder has an insidious onset and gradual progression.

C. The disorder meets a combination of core diagnostic features and suggestive diagnostic features for either probable or possible neurocognitive disorder.
Major or Mild Neurocognitive Disorder with Lewy Bodies (2)

1. Core diagnostic features:
   a. Fluctuating cognition with pronounced variations in attention and alertness.
   b. Recurrent visual hallucinations that are well formed and detailed.
   c. Spontaneous features of parkinsonism with onset subsequent to the development of cognitive decline

2. Suggestive diagnostic features:
   a. Meets criteria for REM sleep behaviour disorder
   b. Severe neuroleptic sensitivity
Summary: Three Advances in DSM-5

Clear structure
  Delirium
  Mild NCD
  Major NCD

‘Major Neurocognitive disorder ’ replaces ‘Dementia’
  e.g. Major NCD due to TBI

Criteria for Specific Aetiology
  e.g. Mild NCD with Lewy Bodies
DSM 5
Anxiety Disorders
DSM-IV Anxiety Disorders

- Panic attack
- Panic Disorder With or Without Agoraphobia
- Agoraphobia Without History of Panic Disorder
- Specific Phobia
- Social Phobia
- Obsessive-Compulsive Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Generalized Anxiety Disorder
- Anxiety Disorder Due to a General Medical Condition
- Substance-Induced Anxiety Disorder
- Anxiety Disorder Not Otherwise Specified
DSM 5 Anxiety Disorders

• No longer includes obsessive-compulsive disorders- moved to Obsessive-Compulsive and Related Disorders
• No longer includes posttraumatic stress disorder and acute stress disorder- moved to Trauma-and Stressor-Related Disorders
• Sequential chapters reflects close relationship
• Now includes Separation Anxiety Disorder and Selective Mutism- moved from DSM-IV Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence
Panic Attack Specifier

• Essential features remain the same
• DSM-IV terminology (situationally bound/cued, situationally predisposed, unexpected/cued) is replaced with terms unexpected and expected
• Can be listed as a specifier that is applicable to all DSM 5 disorders e.g. posttraumatic stress disorder with panic attacks
Panic Disorder and Agoraphobia

• Panic disorder and agoraphobia are unlinked
• Two separate diagnoses with separate criteria
• Co-occurrence is now coded as two separate diagnoses
• Panic disorder: essential features remain the same
• Agoraphobia: marked fear or anxiety about 2/5 situations (using public transportation, being in open spaces), agoraphobic situations provoke fear and anxiety and are avoided, clinician judges the fear to be out of proportion to actual danger in cultural context, duration of more than 6 months
Specific Phobia

• Core features remain the same
• No longer a requirement that individuals over the age of 18 years must recognize that fear is excessive or unreasonable instead the clinician judges the anxiety to be out of proportion to the actual danger or threat in the situation, after considering cultural and contextual factors
• Duration requirement (> 6 months) applies to all ages
• The different types of specific phobia are unchanged, referred to as specifiers and have their own codes
Social Anxiety Disorder

- Formally called Social Phobia
- No longer a requirement that individuals over the age of 18 years must recognize that fear is excessive or unreasonable instead the clinician judges the anxiety to be out of proportion to the actual danger or threat in the situation, after considering cultural contextual factors
- Duration requirement (> 6 months) applies to all ages
- Generalized specifier has been deleted and replaced with a Performance only specifier
Generalized Anxiety Disorder

• Essentially unchanged
Separation Anxiety Disorder

• Moved from Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence
• Core features unchanged
• Wording modified to represent symptoms in adults as well as children
• Attachment figures may include the children of adults
• Avoidance behaviours may occur in work place as well as school
• Onset may be after age 18 years
• Duration 4 weeks in children, 6 months in adults
Selective Mutism

- Moved from Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence
- Large majority of children with selective mutism are anxious
- Diagnostic criteria unchanged
Others

- Substance/Medication Induced Anxiety Disorder: Criteria essentially unchanged, specifiers changed in keeping with changes to substance related disorders
- Anxiety Disorder Due to Another Medical Condition: essentially unchanged
- Other Specified Anxiety Disorder (record the specific reason that presentation does not meet criteria)
- Unspecified Anxiety Disorder
Obsessive- Compulsive and Related Disorders

• New chapter
• Obsessive-Compulsive Disorder has been moved from DSM-IV Anxiety Disorders
• Trichotillomania (hair-pulling disorder) has moved from DSM-IV impulse-control disorders not elsewhere classified
• Body Dysmorphic Disorder has moved from DSM-IV Somatoform Disorders, criterion related to repetitive behaviours or mental acts in response to preoccupation with perceived deficit has been added
Obsessive-Compulsive and Related Disorders
New Disorders

• Hoarding disorder
• Excoriation (skin-picking) disorder
• Substance-/medication-induced obsessive compulsive and related disorder
• Obsessive-compulsive and related disorder due to another medical condition
• Other Specified Obsessive-Compulsive and Related Disorder (body dysmorphic-like disorder with actual flaws, body-focused repetitive behaviour disorder, obsessional jealousy)
• Unspecified Obsessive-Compulsive and Related Disorders
Specifiers for Obsessive-Compulsive and Related Disorders

- DSM-IV with *poor insight specifier* had been refined- *with good or fair insight, with poor insight, with absent insight/delusional beliefs*
- Insight specifiers included for obsessive-compulsive disorder, body dysmorphic disorder and hoarding disorder
- Obsessive-compulsive disorder has a *tic-related* specifier if the individual has a current or past history of a tic disorder
- Body dysmorphic disorder has a *with muscle dysmorphia* specifier if the individual is preoccupied with the idea that body build is too small or insufficiently muscular
### In Summary...

#### DSM 5 Anxiety Disorders
- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder
- Panic Disorder
- Panic Attack Specifier
- Agoraphobia
- Generalized Anxiety Disorder
- Substance/Medication-Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition
- Other Specified Anxiety Disorder
- Unspecified Anxiety Disorder

#### DSM 5 Obsessive-Compulsive and Related Disorders
- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania (Hair-Pulling Disorder)
- Excoriation (Skin-Picking) Disorder
- Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
- Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
- Other Specified Obsessive-Compulsive and Related Disorder
- Unspecified Obsessive-Compulsive and Related Disorder
Schizoaffective Disorder – at last some sense

• a major mood episode must be present for a **majority** of the disorder’s total duration

• schizoaffective disorder is longitudinal instead of a cross-sectional diagnosis

• as with schizophrenia, bipolar disorder, and major depressive disorder
Bipolar Disorder

- Criterion A **new requirement for persistently increased activity and energy** as well as mood. (But still also a Criterion B symptom!
- Duration remain 7 (4) days unless hospitalised
- **mixed episode removed** - A new specifier, “**with mixed features**,” has been added
- can be applied to episodes of mania or hypomania when depressive features are present, and to episodes of depression when features of mania hypomania are present.
- Eg 3/6 depressive Sx required (fatigue! Dysphoria, anhedonia, PsyM retardation, worthlessness or guilt, thoughts of death.
“Other” Bipolar and Related Disorder

- Short duration hypomania + MDE (2 days)
- Subthreshold hypomania – 4 days of elevated or irritable mood and and 1 (or 2) other hypomanic Sx
- Hypomania without depression
- Short duration cyclothymia

- Jules Angst rules at 88
Anxious Distress Specifier

This specifier is intended to identify patients with 2 or more anxiety symptoms that are not part of the bipolar diagnostic criteria – occurs in either pole.

- Keyed up or tense
- Unusually restless
- Difficulty concentrating because of worry
- Fearful
- Feeling s/he might loose control
New depressive disorders

- disruptive mood dysregulation disorder in children
- to address concerns about potential overdiagnosis and overtreatment of bipolar disorder in children, up to age 18 years who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol.

- premenstrual dysphoric disorder.
- dysthymia is now called persistent depressive disorder, which includes both chronic major depressive disorder and the previous dysthymic disorder.
Major Depressive Disorder

- Criterion A in DSM-5 is identical to that of DSM-IV, as is the requirement for clinically significant distress or impairment in social, occupational, or other important areas of life, although this is now listed as Criterion B rather than Criterion C.
- major depressive episode + at least three manic symptoms is now acknowledged by the specifier “with mixed features.”
Bereavement Exclusion

- depressive symptoms lasting less than 2 months following the death of a loved one - omitted in DSM-5 for several reasons.
- the duration is more commonly 1–2 years.
- bereavement can precipitate a major depressive episode in a vulnerable individual, generally beginning soon after the loss.
- bereavement-related major depression is most likely to occur in individuals with past personal and family histories of major depressive episodes.
- depressive symptoms associated with bereavement-related depression respond to the same treatments as non–bereavement-related depression.
Suicidality

- Suicidality represents a critical concern in psychiatry. Thus, the clinician is given guidance on assessment of suicidal thinking, plans, and the presence of other risk factors in order to make a determination of the prominence of suicide prevention in treatment planning for a given individual.
DSM-5-Highlights of changes from DSM-IV

Trauma- and Stressor-Related Disorders

J.Benson-Martin
January 2014
Major Change!

No longer classified as an Anxiety disorder
List of Conditions

1. Reactive Attachment Disorder
2. Disinhibited Social Engagement Disorder
3. Acute Stress Disorder
4. Posttraumatic Stress Disorder
5. Adjustment Disorder
6. Other Specified Trauma- and Stressor-Related Disorder
7. Unspecified Trauma- and Stressor-Related Disorder
Childhood Disorders

DSM-IV
Reactive Attachment Disorder with 2 subtypes

DSM-5
Reactive Attachment Disorder

DSM-5
Disinhibited Social Engagement Disorder
Acute Stress Disorder

• Criterion A changed- the ‘stressor criterion’
  – Be explicit as to whether trauma experienced directly, witnessed or indirectly

• Criterion A2 i.e. subject’s response (‘the person’s response involved intense fear, helplessness, or horror’) is removed

• Will now meet criteria for acute stress disorder if exhibit ANY listed 9 of 14 symptoms in the categories: intrusion, negative mood, dissociation, avoidance, and arousal
Posttraumatic Stress Disorder

• Criterion A1/stressor criterion more explicit
• Criterion A2/subjective reaction removed
PTSD: Three becomes Four

**DSM-IV**
- Re-experiencing
- Avoidance/‘numbing’
- Arousal

**DSM-5**
- Intrusion/Re-experiencing
- Avoidance
- Persistent Negative Alterations in Cognitions & Mood (‘numbing’ + other)
- Alterations in arousal & reactivity
PTSD- now developmentally sensitive

• Diagnostic thresholds lowered for children & adolescents
• Separate criteria added for children ≤ 6 yrs
Adjustment disorders

• NOW -Reconceptualized as heterogenous array of stress-response syndromes

• Occurs after exposure to distressing event (traumatic or nontraumatic)

• No longer residual category for individuals that do not meet criteria for DSM-IV discrete disorder

• DSM-IV subtypes retained: depressed mood, anxious symptoms, or disturbances in conduct
Other Specified Trauma- and Stressor-Related Disorder

• When does not meet full criteria
• Allows clinician to communicate specific reason
• E.g. persistent complex bereavement
Unspecified Trauma- and Stressor-Related Disorder

• Does not meet full criteria for other dx’s
• Used when clinician chooses not to specify reason e.g. when insufficient info available
Eating Disorders DSM-V

Dr Jackie Hoare
Liaison Psychiatry GSH
Anorexia nervosa (AN)

• is an illness characterised by extreme concern about body weight
• with serious disturbances in eating behavior
• leading to a self-imposed starvation state
• Severe weight loss.
• Body image becomes the predominant measure of self-worth
• denial of the seriousness of the illness.
Important Changes in Eating Disorder Diagnoses in DSM-V

• Criterion A focuses on behaviors, like restricting calorie intake
• But no longer includes the word ‘refusal’
• in terms of weight maintenance since that implies intention on the part of the patient
• The DSM-IV Criterion requiring amenorrhea, is deleted.
• This criterion cannot be applied to males, children, OC, and post-menopausal females.
• exhibit all other symptoms and signs of anorexia nervosa but still report some menstrual activity
DSM V

• All 3 of the following:
• Energy restriction leading to significantly low body weight
• Fear of weight gain or behavior interfering with weight gain
• Disturbance in self perceived weight or shape
Subtypes and severity

• Restricting type
• Binge eating /purging type; recurrent episodes of bingeing or purging in the last 3 months

• Mild BMI > 17 kg/m²
• Moderate 16-16.9
• Severe 15-15.9
• Extreme < 15
Avoidant/restrictive food intake disorder

- Significant disturbance in eating manifested by persistent failure to meet nutritional/energy requirement associated with 1 of:
  - Significant weight loss
  - Significant nutritional deficiency
  - Dependence on enteral feeding or supplements
  - Interference with psychosocial functioning
  - NOT due to lack of food or body image disturbance
Clinically Significant Restrictive Eating Problems Are Key

• **Avoidant/Restrictive Food Intake Disorder (ARFID)** has replaced *Feeding Disorder of Infancy and Early Childhood* and EDNOS which was described in the *DSM-IV*.

• While few data on ARFID have been published, it appears that it usually presents in infancy or childhood, but it can also present or persist into adulthood.

• The course of illness for individuals relatively unknown.

• Avoidance due to sensory characteristics of food, emotional difficulties, food beliefs etc.

• **ARFID** may be associated with impaired social functioning and affect family functioning, especially if there is great stress surrounding mealtimes.
Distinguishing ARFID from Other Disorders

- The presence of other psychological disorders may be risk factors for *ARFID*, such as anxiety disorders, obsessive-compulsive disorders, attention deficit disorders, and autism spectrum disorders.

- If an individual presents with one of these illnesses and an eating problem, a diagnosis of ARFID should be given only when the feeding disturbance itself is causing significant clinical impairment.

- Individuals with a history of gastrointestinal conditions such as gastroesophageal reflux may develop feeding disturbances, but a diagnosis of *ARFID* should be assigned only when the feeding disturbances require significant treatment beyond that needed for the gastrointestinal problems.
Bulimia nervosa

- Bulimia nervosa is characterized by recurrent and frequent episodes of eating unusually large amounts of food
- feeling a lack of control over the eating.
- purging (e.g., vomiting, excessive use of laxatives or diuretics), fasting and/or excessive exercise
- DSM-5 criteria reduce the frequency of binge eating and compensatory behaviors to once a week from twice weekly as specified in DSM-IV.
Binge eating disorder

• Binge eating disorder will now have its own category as an eating disorder.
• In the DSM-IV, under the category Eating Disorder Not Otherwise Specified
• “recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes accompanied by feelings of lack of control.”
• eat quickly and uncontrollably, despite hunger signals or feelings of fullness.
• feelings of guilt, shame, or disgust
• behavior will have typically taken place at least once a week over a period of three months.
Over 7 years, the majority of women with anorexia nervosa experienced diagnostic crossover: more than half crossed between the restricting and binge eating/purging anorexia nervosa subtypes over time; one-third crossed over to bulimia nervosa but were likely to relapse into anorexia nervosa. Women with bulimia nervosa were unlikely to cross over to anorexia nervosa.
Changes in DSM 5
Intellectual Disabilities

K.A Ganasen

2014
Significant Changes 1

• Name Change: “Mental Retardation” to “Intellectual Disability (Intellectual Developmental Disorder)”

• Brings DSM terminology in alignment with that used in WHO ICD, and other medical, educational and advocacy organizations/groups eg. IASSID, AAIDD
Significant Changes 2

• Severity of impairment based on adaptive functioning rather than on IQ scores alone

• Emphasizes the need to use both clinical assessment and standardized testing of intelligence in the diagnosis
Significant Changes 3

• **Criteria improvements** to encourage a more comprehensive patient assessment

• **Assessment of severity across 3 domains:** Conceptual, Social and Practical. Ensures that the clinicians base their diagnosis on the impact on functioning needed for everyday life.

• **Important for developing a treatment plan**
<table>
<thead>
<tr>
<th>DSM IV - TR</th>
<th>DSM 5</th>
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<tbody>
<tr>
<td>Significantly subaverage intellectual functioning, IQ approximately &lt;70 on individually administered tests</td>
<td>Deficits in intellectual functions such as, reasoning, problem solving, planning, abstract thinking, judgment, academic learning, learning from experience. Confirmed by clinical assessment and individualized, standardized intelligence testing</td>
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</table>
Criterion B

**DSM IV - TR**

- Concurrent deficits/impairments in present adaptive functioning (persons effectiveness in meeting the standards expected for age in cultural group) in two of following areas: communication, self care, home living, social/interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, health, safety

**DSM 5**

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

**DSM IV - TR**
- The onset is before age 18

**DSM 5**
- Onset of intellectual and adaptive deficits is during the developmental period
Specifiers of Severity

• Defined on basis of adaptive functioning, not IQ scores because adaptive functioning determines the level of support required

• Mild
  Moderate
  Severe
  Profound
Domain - Conceptual

Academic skills involving reading, writing, time, money. Abstract thinking, executive functioning (i.e. planning, strategising, priority setting, cognitive flexibility), short term memory
Domain - Social

Domain - Practical

Age appropriate personal care. Tasks/activities of daily living. Recreational skills. Type of employment. Important decisions about health, and legal issues.
Global Developmental Delay

Reserved for individuals under age 5 when the clinical severity cannot be reliably assessed during early childhood. Fail to meet developmental milestones in several areas of intellectual functioning. Unable to undergo systematic assessments of intellect or standardized testing. Requires reassessment after a period
Unspecified Intellectual Disability (Intellectual Developmental Disorder)

Reserved for individuals over age 5 when assessment by means of locally available procedures is difficult or impossible because of sensory, physical impairments (eg. blind or deaf), severe problem behaviours or co-occurring mental disorders. Should be used in exceptional circumstances and requires reassessment after a period
Schizophrenia Spectrum and Other Psychotic Disorders

DSM V
• Schizophrenia and Other Psychotic Disorders

DSM IV
• include schizophrenia,
• other psychotic disorders,
• and **schizotypal (personality) disorder**
<table>
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<tr>
<th>DSM IV</th>
<th>DSM V</th>
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<tr>
<td>• Schizophrenia</td>
<td>• Schizotypal Disorder</td>
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<td>• Schizopreniform Disorder</td>
<td>• Delusional Disorder</td>
</tr>
<tr>
<td>• Schizoaffective Disorder</td>
<td>• Brief Psychotic disorder</td>
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<tr>
<td>• Delusional Disorder</td>
<td>• Schizopreniform Disorder</td>
</tr>
<tr>
<td>• Brief psychotic Disorder</td>
<td>• Schizophrenia</td>
</tr>
<tr>
<td>• Shared psychotic Disorder</td>
<td>• Schizoaffective Disorder</td>
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<tr>
<td>• Psychotic Disorder d/t a GMC</td>
<td>• Substance/Medication Induced Psychotic Disorder</td>
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<td>• Substance-Induced Psychotic Disorder</td>
<td>• Psychotic Disorder d/t Another Medical Condition</td>
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<tr>
<td>• Psychotic Disorder NOS</td>
<td>• Catatonia Assoc. with Another Mental Disorder</td>
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<td>• Catatonia d/t Another Medical Condition</td>
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<td></td>
<td>• Unspecified Catatonia</td>
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<tr>
<td></td>
<td>• Other Specified Schizophrenia Spectrum and Other psychotic disorder</td>
</tr>
<tr>
<td></td>
<td>• Unspecified Schizophrenia Spectrum and Other Psychotic Disorder</td>
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</tbody>
</table>
• defined by abnormalities in one or more of the following **five domains**: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behaviour (including catatonia), and negative symptoms
• organized along a gradient of psychopathology
  a) first consider conditions that do not reach full criteria for a psychotic disorder or are limited to one domain of psychopathology. (e.g. delusions or catatonia)
  b) Then consider time-limited conditions. (e.g. Brief psychotic disorder)
  c) Finally, the diagnosis of a schizophrenia spectrum disorder requires the exclusion of another condition that may give rise to psychosis.
• Two conditions are defined by abnormalities limited to one domain of psychosis: delusions or catatonia.

• Delusional Disorder

• Catatonia
Schizotypal PD

- Schizotypal personality disorder is noted within this chapter as it is considered within the schizophrenia spectrum, although its full description is found in the chapter “Personality Disorders.”

- Because it is considered part of the schizophrenia spectrum of disorders, and is labelled in this section of ICD-9 and ICD-10 as schizotypal disorder, it is listed in this chapter.
• captures a pervasive pattern of social and interpersonal deficits,
• including reduced capacity for close relationships;
• cognitive or perceptual distortions;
• and eccentricities of behaviour,
• usually beginning by early adulthood but in some cases first becoming apparent in childhood and adolescence.
• Abnormalities of beliefs, thinking, and perception are below the threshold for the diagnosis of a psychotic disorder.
Catatonia can occur in several disorders, including neurodevelopmental, psychotic, bipolar, depressive, and other mental disorders. This chapter also includes the diagnoses catatonia associated with another mental disorder (catatonia specifier), catatonic disorder due to another medical condition, and unspecified catatonia, and the diagnostic criteria for all three conditions are described together.
• Other specified and unspecified schizophrenia spectrum and other psychotic disorders are included for classifying psychotic presentations that do not meet the criteria for any of the specific psychotic disorders, or psychotic symptomatology about which there is inadequate or contradictory information
Clinician-Rated Assessment of Symptoms and Related Clinical Phenomena in Psychosis
- Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behaviour, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”)
### DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

**Name:**

**Age:**

**Sex:** [ ] Male [ ] Female

**Date:**

**If the measure is being completed by an informant, what is your relationship with the individual:**

**In a typical week, approximately how much time do you spend with the individual:**

**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.

<table>
<thead>
<tr>
<th>Domain</th>
<th>None Not at all</th>
<th>Slight Rare, less than a day or two</th>
<th>Mild Several days</th>
<th>Moderate More than half the days</th>
<th>Severe Nearly every day</th>
<th>Highest Domain Score (clinician)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>1.</td>
<td>Little interest or pleasure in doing things?</td>
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<td>2.</td>
<td>Feeling down, depressed, or hopeless?</td>
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<td>II.</td>
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<td>3.</td>
<td>Feeling more irritated, grouchy, angry than usual?</td>
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<tr>
<td>III.</td>
<td>0</td>
<td>1</td>
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<td>4.</td>
<td>Sleeping less than usual, but still have a lot of energy?</td>
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<td>5.</td>
<td>Starting lots more projects than usual or doing more risky things than usual?</td>
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<td>IV.</td>
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<td>4</td>
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<tr>
<td>6.</td>
<td>Feeling nervous, anxious, frightened, worried, or on edge?</td>
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<td>7.</td>
<td>Feeling panic or being frightened?</td>
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<tr>
<td>8.</td>
<td>Avoiding situations that make you anxious?</td>
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<tr>
<td>V.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>9.</td>
<td>Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?</td>
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<tr>
<td>10.</td>
<td>Feeling that your illnesses are not being taken seriously enough?</td>
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<tr>
<td>VI.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>11.</td>
<td>Thoughts of actually hurting yourself?</td>
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<td>VII.</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>12.</td>
<td>Hearing things other people couldn’t hear, such as voices even when no one was around?</td>
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<tr>
<td>13.</td>
<td>Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?</td>
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<tr>
<td>VIII.</td>
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<tr>
<td>14.</td>
<td>Problems with sleep that affected your sleep quality over all?</td>
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<td>IX.</td>
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<td>4</td>
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<tr>
<td>15.</td>
<td>Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?</td>
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<tr>
<td>X.</td>
<td>0</td>
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<td>3</td>
<td>4</td>
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<tr>
<td>16.</td>
<td>Unpleasant thoughts, urges, or images that repeatedly enter your mind?</td>
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<tr>
<td>17.</td>
<td>Feeling driven to perform certain behaviors or mental acts over and over again?</td>
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<tr>
<td>XI.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
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<tr>
<td>18.</td>
<td>Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?</td>
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<tr>
<td>XII.</td>
<td>0</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>19.</td>
<td>Not knowing who you really are or what you want out of life?</td>
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<tr>
<td>20.</td>
<td>Not feeling close to other people or enjoying your relationships with them?</td>
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<tr>
<td>XIII.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>21.</td>
<td>Drink at least 4 drinks of any kind of alcohol in a single day?</td>
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<tr>
<td>22.</td>
<td>Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco?</td>
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<tr>
<td>23.</td>
<td>Use any of the following medicines ON YOUR OWN, that is, without a doctor’s prescription, in greater amounts or longer than prescribed (e.g., painkillers like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?</td>
<td></td>
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</tbody>
</table>
WHODAS 2.0
World Health Organization Disability Assessment Schedule 2.0
36-item version, self-administered

Patient Name: ___________________ Age: ______ Sex: ☐ Male ☐ Female Date: __________

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the past 30 days and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

<table>
<thead>
<tr>
<th>Numeric scores assigned to each of the items:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Raw Item Score</th>
<th>Raw Domain Score</th>
<th>Average Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 30 days, how much difficulty did you have in:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Understanding and communicating</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1.1 Concentrating on doing something for ten minutes?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1.2 Remembering to do important things?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1.3 Analyzing and finding solutions to problems in day-to-day life?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1.4 Learning a new task, for example, learning how to get to a new place?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1.5 Generally understanding what people say?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1.6 Starting and maintaining a conversation?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Getting around</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2.1 Standing for long periods, such as 30 minutes?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2.2 Standing up from sitting down?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2.3 Moving around inside your home?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2.4 Getting out of your home?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>D2.5 Walking a long distance, such as a kilometer (or equivalent)?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Self-care</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>D3.1 Washing your whole body?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3.2 Getting dressed?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>D3.3 Eating?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
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<tr>
<td>D3.4 Staying by yourself for a few days?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Getting along with people</td>
<td></td>
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<td></td>
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<tr>
<td>D4.1 Dealing with people you do not know?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4.2 Maintaining a friendship?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4.3 Getting along with people who are close to you?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4.4 Making new friends?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
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<tr>
<td>D4.5 Sexual activities?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme or cannot do</td>
<td></td>
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</tbody>
</table>
The individual diagnoses and any changes from DSM IV ...
Schizotypal Personality Disorder

• Already mentioned
Delusional Disorder

• The demarcation of delusional disorder from psychotic variants of obsessive-compulsive disorder and body dysmorphic disorder is explicitly noted with a new exclusion criterion, which states that the symptoms must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs.
• DSM-5 no longer separates delusional disorder from shared delusional disorder. If criteria are met for delusional disorder then that diagnosis is made. If the diagnosis cannot be made but shared beliefs are present, then the diagnosis “other specified schizophrenia spectrum and other psychotic disorder” is used.
• Delusions no longer have to be nonbizarre (Criterion A)
• Specific types remain the same (grandiose/paranoid/religiose/etc)

Additional specifiers:
• With bizarre content
• First episode, currently in acute episode
• First episode, currently in partial remission
• First episode, currently in full remission
• Multiple episodes, currently in acute episode
• Multiple episodes, currently in partial remission
• Multiple episodes, currently in full remission
• Continuous
• Unspecified

Specify current severity
Brief Psychotic Disorder

- Criteria remain the same
- With additional specifier – with catatonia
- Severity rating as outlined before
Schizophreniform Disorder

• As before but with catatonia specifier and severity rating
Schizophrenia

• **Two changes** to Criterion A for schizophrenia.

• 1) The *elimination* of the special attribution of *bizarre delusions* and *Schneiderian first-rank auditory hallucinations* (e.g., two or more voices conversing). In DSM-IV, only one such symptom was needed to meet the diagnostic requirement for Criterion A, instead of two of the other listed symptoms. This special attribution was removed due to the nonspecificity of Schneiderian symptoms and the poor reliability in distinguishing bizarre from nonbizarre delusions. Therefore, in DSM-5, two Criterion A symptoms are required.
• 2) The addition of a requirement in Criterion A that the individual must have at least one of these three symptoms: delusions, hallucinations, and disorganized speech. At least one of these core “positive symptoms” is necessary for a reliable diagnosis of schizophrenia.
Schizophrenia subtypes

- DSM-IV subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) are eliminated due to their limited diagnostic stability, low reliability, and poor validity. These subtypes also have not been shown to exhibit distinctive patterns of treatment response or longitudinal course. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia is included in Section III to capture the important heterogeneity in symptom type and severity expressed across individuals with psychotic disorders.
Schizophrenia

• The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.
  • First episode, currently in acute episode
  • First episode, currently in partial remission
  • First episode, currently in full remission
  • Multiple episodes, currently in acute episode
  • Multiple episodes, currently in partial remission
  • Multiple episodes, currently in full remission
  • Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with sub threshold symptom periods being very brief relative to the overall course.
  • Unspecified
  • Specify if: With catatonia (refer to the criteria for catatonia associated with another mental disorder for definition).
  • Severity Rating
Schizoaffective Disorder

• primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder’s total duration after Criterion A has been met

• It makes schizoaffective disorder a longitudinal instead of a cross-sectional diagnosis—more comparable to schizophrenia, bipolar disorder, and major depressive disorder, which are bridged by this condition.
Catatonia

The same criteria are used to diagnose catatonia whether the context is a psychotic, bipolar, depressive, or other medical disorder, or an unidentified medical condition.

In DSM-IV, two out of five symptom clusters were required if the context was a psychotic or mood disorder, whereas only one symptom cluster was needed if the context was a general medical condition.

In DSM-5, all contexts require three catatonic symptoms (from a total of 12 characteristic symptoms).
1. **Stupor** (i.e., no psychomotor activity; not actively relating to environment).

2. **Catalepsy** (i.e., passive induction of a posture held against gravity).

3. Waxy flexibility (i.e., slight, even resistance to positioning by examiner).

4. **Mutism** (i.e., no, or very little, verbal response [exclude if known aphasia]).

5. **Negativism** (i.e., opposition or no response to instructions or external stimuli).

6. **Posturing** (i.e., spontaneous and active maintenance of a posture against gravity).

7. **Mannerism** (i.e., odd, circumstantial caricature of normal actions).

8. **Stereotypy** (i.e., repetitive, abnormally frequent, non-goal-directed movements).


10. **Grimacing**.

11. **Echolalia** (i.e., mimicking another’s speech).

12. **Echopraxia** (i.e., mimicking another’s movements
• In DSM-5, catatonia may be diagnosed as a specifier for depressive,
• bipolar,
• and psychotic disorders;
• as a separate diagnosis in the context of another medical condition;
• or as an other specified diagnosis
Other Specified Schizophrenia Spectrum and Other Psychotic Disorder

• symptoms characteristic of a schizophrenia spectrum and other psychotic disorder that cause clinically significant distress or impairment in functioning predominate but do not meet the full criteria for any of the disorders in the schizophrenia spectrum and other psychotic disorders diagnostic class.

• used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria
• **Persistent auditory hallucinations** occurring in the absence of any other features.

• **Delusions with significant overlapping mood episodes:** This includes persistent delusions with periods of overlapping mood episodes that are present for a substantial portion of the delusional disturbance (such that the criterion stipulating only brief mood disturbance in delusional disorder is not met).

• **Attenuated psychosis syndrome:** This syndrome is characterized by psychotic-like symptoms that are below a threshold for full psychosis (e.g., the symptoms are less severe and more transient, and insight is relatively maintained).

• **Delusional symptoms in partner of individual with delusional disorder:** In the context of a relationship, the delusional material from the dominant partner provides content for delusional belief by the individual who may not otherwise entirely meet criteria for delusional disorder.
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

- is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific schizophrenia spectrum and other psychotic disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).
Substance-related and Addictive Disorders

Highlights of Changes to DSM 5
Major changes at a glance

• Combinations
  – Substance abuse and Dependence = Substance Use Disorders

• New inclusions
  – Caffeine withdrawal
  – Cannabis withdrawal

• Eliminations
  – Polysubstance dependence

• Movers and newly named
  – Pathological gambling = Gambling disorder
Substance Related Disorders

• Substance Use Disorders
• Substance Induced Disorders
  – Intoxication
  – Withdrawal
  – Other Substance induced disorders
    • Psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, sleep disorders, sexual dysfunctions, delirium and neurocognitive disorders (described in group with whom they share phenomenology)

• Unspecified substance-related disorder
• Other (unknown) SUD
Substance Use disorders

- Diagnoses of abuse and dependence combined into single SUD’s specific to each substance of abuse
- Criteria tightened into groups
- Divided into Mild, Moderate, and Severe subtypes
- Threshold set at 2 or more criteria (1 for abuse and 3 for dependence in DSM 4)
- DSM 4 criterion of recurrent substance-related legal problems deleted
- DSM 5 new criterion of craving added
• Applied to all 10 substances except caffeine
• Diagnosis based on a combination of a pathological pattern of behaviours
• Behaviours grouped in overall groupings of:
  – Impaired control
  – Social impairment
  – Risky use
  – Pharmacological criteria
• **11 Criteria**
  
  – **Impaired control**
    • Larger amount over a longer period than intended
    • Unsuccessful efforts to cut down
    • Increased time spent with it
    • Craving
  
  – **Social impairment**
    • Major role obligations failure
    • Social and interpersonal problems
    • Other activities neglected (social, recreational, occupational)
– **Risky use**
  - In physically hazardous situations
  - Despite physical/ psychological problems

– **Pharmacological criteria**
  - Tolerance
  - Withdrawal
• Course specifiers
  – Early remission* (3-12 months)
  – Sustained remission (>12 months)
  – On maintenance* treatment (used to be agonist)
  – In a controlled environment

• Severity specifiers
  – Mild (2*-3 symptoms)
  – Moderate (4-5 symptoms)
  – Severe (>= 6 symptoms)
• Implications intended
  – **Strengthen reliability** of SUD’s by increase in # required symptoms
  – **Clarify definition** of “dependence”
    • Core-compulsive drug seeking behaviours at the core of “addiction” not a necessity
    • Mental and behavioural aspects of SUD’s more specific to SUD’s than physical domains, e.g. tolerance and withdrawal, which are not unique to addiction
• Critique
  – Chances of meeting new criteria now much greater despite new criteria requiring increased # of symptoms
  – Patients who now qualify for new diagnosis with only minor symptoms may divert scarce treatment resources away from those with more severe symptoms.
Substance-induced disorders

• Described in each of the 10 substances where applicable

• Includes:
  – Intoxication (N/A to nicotine)
  – Withdrawal (New: Caffeine and Cannabis)
  – Substance/ Medication induced Mental disorders
• Caffeine withdrawal
  – Controversial addition
  – Moved from Appendix B in DSM 4
  – Rationale: Reflects our increasing dependence on caffeine (coffee, caffeine energy/ alcoholic drinks)
  – Critique: Symptoms overlap with stress-related symptoms; underdiagnosing of other pathology
  – Proposed: Caffeine use disorder (Section 3 – condition for further study)
• **Cannabis withdrawal**

  – **Rationale:**
    • Legalization and increased use for medical reasons frequent smokers easier and better studied
    • NIH study 2012 on 384 lifetime smokers, >40% met criteria for withdrawal upon stopping
Unspecified substance-related disorder

- Unable to classify type of substance as one of the 10 named substance classes in DSM 5
- DSM 4 named 12 substances
- **PCP-related disorders moved into Hallucinogen-related disorders** (separate categories for “PCP and others”)
- **Polysubstance Dependence removed as a diagnosis**
• Such substances include: anabolic steroids, NSAID’s, cortisol, anti-parkinsonian meds, antihistamines, NO, nitrates, betel nut, kava, khat leaves
• Also: new, black market drugs OR unidentified substances (box of mixed pills)
Other (unknown) SUD

- Presentations where symptoms characteristic of certain substance-related disorders that causes clinical distress but does not meet full criteria for any SPECIFIC substance related disorder
Addictive disorders

• Non-substance-related disorders
• Disorders whose behaviours activate the reward systems similar to those activated by drugs of abuse
• Groups of repetitive behaviours or “Behavioural addictions”
• Internet gaming, Sexual activity, Shopping, Exercise
• Currently insufficient peer-reviewed evidence to establish diagnostic criteria and course descriptions needed to identify these behaviours as mental disorders (Internet use gaming disorder in Section 3 for further study)

• Hypersexual disorder/ Sex addiction rejected from the manual entirely

• For time being Gambling disorder will be included in the same chapter as SUD’s
• Gambling disorder
  – Pathological gambling moved from ICD (DSM 4)
  – 10 Criteria now 9 (committed illegal acts taken out)
  – Must meet criteria for 4 instead of 5 over 12 months
  – Specifiers added:
    • Episodic/persistent
    • In Early (3-12) or full (>12) remission
    • Severity specifiers (Mild, Moderate, Severe)
Personality Disorders in DSM 5
The Same but Also Different

• SECTION II
  – No substantial changes in criteria for routine use

• SECTION III
  – Alternative multidimensional trait model for Personality Disorders
  – = impairments in personality functioning & pathological personality traits,
  – Which lead to:
    • Antisocial, avoidant, borderline, narcissistic, obsessive-compulsive & schizotypal PD’s, and...
    • Personality disorder-trait specified (PD-TS): PD is present but criteria for specific PD not met
SECTION III: General Criteria for PD

A. Moderate or greater impairment in personality (self/interpersonal) functioning
B. One or more pathological personality traits
C. ...  
D. ...  
E. .. 
F. .. 
G. ...not better understood as normal for an individual’s development stage or sociocultural environment
Elements of personality functioning

• Self

  – **Identity**: experience of oneself as unique, with clear boundaries between self and others; stability of self esteem and accuracy of self-appraisal; ability to regulate range of emotional experience

  – **Self-direction**: pursuit of coherent and meaningful short-term and life goals, utilization of constructive and prosocial internal standards of behaviour; ability to self-reflect productively

• Interpersonal

  – **Empathy**: comprehension and appreciation of others’ experiences and motivations; tolerance of differing perspectives; understanding the effects of one’s own behaviour on others

  – **Intimacy**: Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behaviour
Pathological Personality Traits

• Five broad domains:
  – Negative Affectivity (vs Emotional Stability)
  – Detachment (vs Extraversion)
  – Antagonism (vs Agreeableness)
  – Disinhibition (vs Conscientiousness)
  – Psychotism (vs Lucidity)

• 25 specific Trait Facets (within the domains)

• Each PD assessed uniquely according to the above domains (*i.e. Increased complexity*)
Example: Domain-Negative Affectivity vs Emotional Stability - Facets

- Emotional lability
- Anxiousness
- Separation insecurity
- Submissiveness
- Hostility
- Perseveration
- Depressivity
- Suspciousness
- Restricted affectivity (lack of)
<table>
<thead>
<tr>
<th>DOMAINS (Polar Opposites) and Facets</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEGATIVE AFFECTIVITY</strong> (vs. Emotional Stability)</td>
<td>Frequent and intense experiences of high levels of a wide range of negative emotions (e.g., anxiety, depression, guilt/shame, worry, anger) and their behavioral (e.g., self-harm) and interpersonal (e.g., dependency) manifestations.</td>
</tr>
<tr>
<td>Emotional lability</td>
<td>Instability of emotional experiences and mood; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.</td>
</tr>
<tr>
<td>Anxiousness</td>
<td>Feelings of nervousness, tenseness, or panic in reaction to diverse situations; frequent worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and apprehensive about uncertainty; expecting the worst to happen.</td>
</tr>
<tr>
<td>Separation insecurity</td>
<td>Fears of being alone due to rejection by—and/or separation from—significant others, based in a lack of confidence in one’s ability to care for oneself, both physically and emotionally.</td>
</tr>
<tr>
<td>Submissiveness</td>
<td>Adaptation of one’s behavior to the actual or perceived interests and desires of others even when doing so is antithetical to one’s own interests, needs, or desires.</td>
</tr>
<tr>
<td>Hostility</td>
<td>Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behavior. See also Antagonism.</td>
</tr>
<tr>
<td>Perseveration</td>
<td>Persistence at tasks or in a particular way of doing things even after the behavior has ceased to be functional or effective; continuance of the same behavior despite repeated failures or clear reasons for stopping.</td>
</tr>
<tr>
<td>Hostility</td>
<td></td>
</tr>
</tbody>
</table>

**DETACHMENT** (vs. Extraversion) |
| Withdrawal | Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact. |
| Intimacy avoidance | Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships. |
| Anhedonia | Lack of enjoyment from, engagement in, or energy for life’s experiences; deficits in the capacity to feel pleasure and take interest in things. |
| Depression | Feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame and/or guilt; feelings of inferior self-worth; thoughts of suicide and suicidal behavior. |
| Restricted affectivity | Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference and aloofness in normatively engaging situations. |
| Suspiciousness | Expectations of—and sensitivity to—signs of interpersonal ill-intent or harm; doubts about loyalty and fidelity of others; feelings of being mistreated, used, and/or persecuted by others. |
Assessment

• Level of Personality Functioning Scale (p775)
  
  little or no impairment – some-moderate-severe-extreme

• Definitions of DSM-5 personality trait domains and facets (p779)-

• Personality Inventory for DSM-5 (PID-5)
<table>
<thead>
<tr>
<th>Level of impairment</th>
<th>Identity</th>
<th>Self-direction</th>
<th>Empathy</th>
<th>Intimacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>0—Little or no impairment</td>
<td>Has ongoing awareness of a unique self; maintains role-appropriate boundaries. Has consistent and self-regulated positive self-esteem, with accurate self-appraisal. Is capable of experiencing, tolerating, and regulating a full range of emotions.</td>
<td>Sets and aspires to reasonable goals based on a realistic assessment of personal capacities. Utilizes appropriate standards of behavior, attaining fulfillment in multiple realms. Can reflect on, and make constructive meaning of, internal experience.</td>
<td>Is capable of accurately understanding others’ experiences and motivations in most situations. Comprehends and appreciates others’ perspectives, even if disagreeing. Is aware of the effect of own actions on others.</td>
<td>Maintains multiple satisfying and enduring relationships in personal and community life. Desires and engages in a number of caring, close, and reciprocal relationships. Strives for cooperation and mutual benefit and flexibly responds to a range of others’ ideas, emotions, and behaviors.</td>
</tr>
<tr>
<td>1—Some impairment</td>
<td>Has relatively intact sense of self, with some decrease in clarity of boundaries when strong emotions and mental distress are experienced. Self-esteem diminished at times, with overly critical or somewhat distorted self-appraisal. Strong emotions may be distressing, associated with a restriction in range of emotional experience.</td>
<td>Is excessively goal-directed, somewhat goal-inhibited, or conflicted about goals. May have an unrealistic or socially inappropriate set of personal standards, limiting some aspects of fulfillment. Is able to reflect on internal experiences, but may over-emphasize a single (e.g., intellectual, emotional) type of self-knowledge.</td>
<td>Is somewhat compromised in ability to appreciate and understand others’ experiences; may tend to see others as having unreasonable expectations or a wish for control. Although capable of considering and understanding different perspectives, resists doing so. Has inconsistent awareness of effect of own behavior on others.</td>
<td>Is able to establish enduring relationships in personal and community life, with some limitations on degree of depth and satisfaction. Is capable of forming and desires to form intimate and reciprocal relationships, but may be inhibited in meaningful expression and sometimes constrained if intense emotions or conflicts arise. Cooperation may be inhibited by unrealistic standards; somewhat limited in ability to respect or respond to others’ ideas, emotions, and behaviors.</td>
</tr>
</tbody>
</table>
PD Template

• Broad brief description of PD
• A. Description of specific characteristics on *Identity, Self-direction, Empathy, Intimacy*
• B. List of specific traits
• Specifiers: additional personality features that may be present but not required for diagnosis
• *Personality Disorder-Trait Specified*: two or more difficulties in A, & one or more pathological personality domains or specific trait facets
Conclusion

• DSM IV categories can still be used
• But should be regarded as existing as dimensions
• Multidimensional model of PD is proposed, which is recommended and preferred for use, even though its clinical validity remains to be confirmed