LPCA, CEU Concepts,TMH Professionals, yourceus.com, EAPWorks & American College of Psychotherapy present:

PSYCHOPATHOLOGY, DIFFERENTIAL DIAGNOSIS, AND THE DSM-5: A COMPREHENSIVE OVERVIEW

Module 1: Overview and Introduction to the Diagnostic Process

Your Presenters

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Course Objectives

Upon completion of this program trainees will:

1. **Know the history, use, and structure of the fifth edition of the Diagnostic and Statistical Manual, the DSM-5**
2. **Understand the revised organization of the DSM-5**
3. **Comprehend the process of utilizing the DSM-5 for diagnosis**
4. **Learn how to organize an assessment approach that aligns successfully with the DSM-5**
5. **Grasp the ethical and clinical issues concerned with the use of appropriate assessment instruments**
6. **Comprehend the key changes and modifications from the DSM-IV-TR to the DSM-5**
7. **Understand the decision making process in moving from assessment to best practices treatment**

Purposes Behind Diagnosis

- Accurate diagnosis allows for ***consistency and standardization*** throughout all disciplines that address mental health concerns: medical, nursing, psychiatric, psychological, counseling, social work, marriage and family therapy
- Accurate diagnosis allows for ***common ground*** to be established in terms of research concerning the ***effectiveness of various kinds of treatment***
- Accurate diagnosis can be used for ***shaping the client's treatment plan***, aligning the treatment approaches research has determined to be most effective with the various diagnostic categories

Brief History of the DSM

The **International Classification of Diseases**, or **ICD**, dates to the 1890s

ICD-6 (1952) saw first attempt to classify mental and nervous disorders in 1952, coinciding with DSM-I

ICD-9 (1978) and DSM-II: detailed diagnostic criteria, a multi-axial system, and a descriptive theoretical approach. All subsequent updates to the DSM retained the multi-axial system until the DSM-5.

DSM-III (1980): medical labeling system for clinicians and researchers. Revised in 1987 (DSM-III-R).

Brief History of the DSM

The DSM-IV was created through an increased interest in research on diagnosis, and now most diagnoses have empirical literature available to confirm diagnoses. The DSM-IV coincided with the ICD-10 (APA, 1994).

Until mid 2013, clinicians used the DSM-IV-TR, the Text Revision of the DSM-IV

DSM-5, was released in March of 2013 with significant changes from the prior version, the DSM-IV-TR, including a movement away from the multi-axial system.

Brief History of the DSM

DSM-5, was released in March of 2013 with significant changes from the prior version, the DSM-IV-TR, including a movement away from the multi-axial system.

The DSM-5 was a product of 13 work groups responsible for each of the five sections. The work groups were composed of representatives from many professions, including social workers, physicians, psychiatrists, counselors and nurses to cover different perspectives on mental health assessment.

The DSM-5 was produced in accordance with ICD-9, but with ICD-10 having replaced the ICD-9 system, the DSM-5 now utilizes ICD-10 diagnostic numbers.

The Key to Useful Diagnosis

Seeking the proper balance between concision and clarity

Precautions Concerning the Use of Diagnosis

- A person is not a diagnosis and a diagnosis does not fully represent a complex human being and his/her complete state of existence within the systems of which he/she is a part
- A focus on a diagnosis can obscure as much information as it can reveal
- Diagnoses must be used cautiously in cross-cultural cases
- Diagnosis must be made based upon what is known

Precautions Concerning the Use of Diagnosis

Diagnosis must be arrived at within one's area of competence

Precautions Concerning the Use of Diagnosis

The DSM-5 has generated some controversy, as some influential clinicians feel it has been too influenced by the pharmaceutical industry.

Assessment

Assessment **is defined as the process of:**

"gathering, analyzing, and synthesizing salient data into a formulation that encompasses the following vital dimensions: (1) the *nature* of the patients' problems, including special attention to the roles that patients and significant others play in the difficulties, (2) the *functioning* (strengths, limitations, personality assets, and deficiencies) of patients and significant others, (3) the *motivation* of the patient to work on the problems, (4) the relevant *environmental* factors that contribute to the problems, and (5) the *resources* that are available or are needed to ameliorate the patients' difficulties"

(Hepworth & Larsen, 1990)

Assessment

Assessment is two-fold:

1) collecting patient data
2) monitoring case progress

Who Makes the Diagnosis?

Diagnosis by history

Diagnosis by observation

Diagnosis by psychometric tools

Assessment

1) Is the assessment empirically-based – meaning ***based on research and statistics***?

2) Has the assessment been made from ***both a systems and an ecological perspective***, capturing the full picture of the client and his/her functioning within the environment(s) in which he/she exists: biological, familial, social, cultural, societal?

3) Has the assessment been able to accurately ***measure the essential factors that shape a fully formed understanding of the case***?

Assessment

4) Have the practitioners engaged in a conscientious process of ***evaluating their practice***, and determined that their assessment processes are sufficiently well-designed to capture the right data concerning the client?

5) Are the practitioners ***sufficiently knowledgeable about the development and use of a wide variety of assessment methods***, so that the clinician may direct the process towards the use of the assessment tools and methods that produce the most precise and essential information necessary to understand the case?

6) Are the practitioners willing to ***refer the client(s) to additional parties for further assessment*** when the assessment needs fall outside of the practitioner's area of competence?

(Mary Coleman Allen, PhD, LPC)

Boundaries around Assessment:

Who Makes the Diagnosis?

Ethics in Tools and Assessment

- What are the legal and ethical boundaries for Master's level clinicians?

- How do we differentiate, ethically and legally, the diagnostic criteria in assessment?

Ethics in Tools and Assessment

- When do we refer for further testing and diagnostics?

- To whom do we refer for further assessment?

Ethics in Tools and Assessment

GA Composite Board states:

Rule 135-7-.05. Assessment Instruments

(1) When using assessment instruments or techniques, the licensee shall make every effort to promote the welfare and the best interests of the client….(see handout)

- (2) Unprofessional conduct, includes but is not limited to the following:

  (a) Failing to provide the client with an orientation to the purpose of testing or the proposed use of the test results prior to administration or assessment instruments or techniques;

  (b) Failing to consider the specific validity, reliability, and appropriateness of test measures for use in a given situation or with a particular client;

(c) Using unsupervised or inadequately supervised test-taking techniques with clients, such as testing through the mail, unless the test is specifically self-administered or self-scored.

(d) Administering test instruments either beyond the licensee’s competence for scoring and interpretation or outside of the licensee’s score of practice, as defined by law;

…and

(d) Failing to make available to the client, upon request, copies of documents in the possession of the licensee which have been prepared for and paid for by the client.

From the Social Work Code of Ethics

Value: *Competence*

Ethical Principle: *Social workers practice within their areas of competence and develop and enhance their professional expertise.*

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

From the Social Work Code of Ethics

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

Psychological Testing by Law

O.C.G.A. 377 states:

"'Psychological testing' means the use of assessment instruments to both:

(A) Measure mental abilities, personality characteristics, or neuropsychological functioning; and

(B) Diagnose, evaluate, classify, or render opinions regarding mental and nervous disorders and illnesses, including, but not limited to, organic brain disorders, brain damage, and other neuropsychological conditions."

- Example of Assessment Training in Master's Program: CACREP requirements for Professional Counseling Identity

7. Assessment and Testing:

a) Historical perspectives concerning the nature and meaning of assessment and testing in counseling
b) Methods of effectively preparing for and conducting initial assessment meetings
c) Procedures for assessing risk of aggression or danger to others, self-inflicted harm, or suicide
d) Procedures for identifying trauma and abuse and for reporting abuse
e) Use of assessments for diagnostic and intervention planning purposes

f) Basic concepts of standardized and non-standardized testing, norm referenced and criterion-referenced assessments, and group and individual assessments

g) Statistical concepts, including scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations.

h) Reliability and validity in the use of assessments

i) Use of assessments relevant to academic/educational, career, personal, and social development

j) Use of environmental assessments and systematic behavioral observations

k) Use of symptom checklists, and personality and psychological testing

l) Use of assessment results to diagnose developmental, behavioral and mental disorders

m) Ethical and culturally relevant strategies for selecting, administering, and interpreting assessment and test results

www.cacrep.org

- Determining Your Educational Eligibility

Qualifications for Ordering Tests

- Qualification Level A: There are no special qualifications to purchase these products
- Qualification Level B: Tests may be purchased by individuals with:
  - A master's degree in psychology, education, occupational therapy, social work, counseling, or in a field closely related to the use of the assessment, and formal training in the ethical administration, scoring and interpretation of clinical assessments

(www.pearsonclinical.com)

Qualification Level B, cont’d

OR

- Certification by full or active membership in a professional organization that requires training and experience in the relevant area of assessment

OR

- A degree or license to practice in the healthcare or allied healthcare field

OR

- Formal, supervised mental health, speech/language, occupational therapy, social work, counseling, and/or educational training specific to assessing children, or in infant and child development, and formal training in the ethical administration, scoring and interpretation of clinical assessments.

- Licensure or certification to practice in your state in a field related to the purchase.

OR

- Certification by or full active membership in a professional organization (such as APA, NASP, NAN, INS) that requires training and experience in the relevant area of assessment.

- Qualification Level C
  - Tests with a C qualification require a high leel of expertise in test interpretation, and can be purchased with:
  - A doctorate degree in psychology, education, or closely related field with formal training in the ethical administration, scoring, and interpretation of clinical assessments related to the intended use of the assessment.

  OR

- Certification by or full active membership in a professional organization (such as APA, NASP, NAN, INS) that requires training and experience in the relevant area of assessment.
- EXAMPLE: Minnesota Multiphasic Personality Inventory – 2

www.pearsonclinical.com

Psychological Tests and Screening Tools

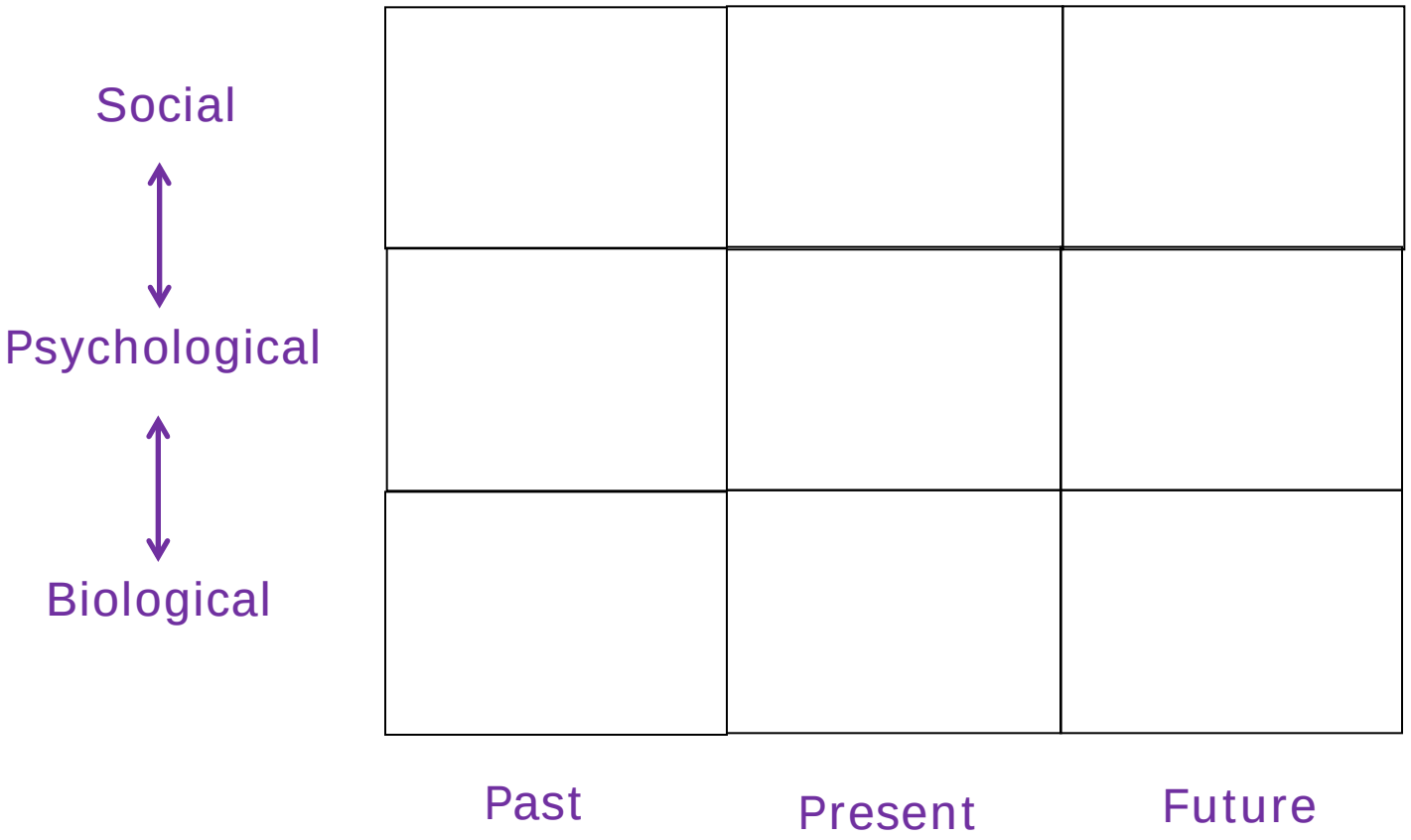
The following web site contains a substantially complete list of current psychological tests and screening tools for a wide range of mental health concerns.

http://www.scalesandmeasures.net/search.php

Proficiency in Diagnosis:

The Biopsychosocial Assessment

The Biopsychosocial Perspective



Source: Ross, DE A Method for Developing a Biopsychosocial Formulation

Components of Assessment:

Biological, Psychological, Social

- **Gather a history of past and current problems, signs and symptoms, and challenges**
- **Gather a history of past and current strengths and resources: skill based, relationship based, socially based**
- **Gather medical history, including surgeries, major injuries, medications past and present**
- **Gather mental health history, including current and prior counseling or psychiatric care**
- **Gather a wellness history: sleep, exercise, nutrition including supplements, self-care**
- **Gather a history of religious or spiritual life and its importance and relevance for the well-being of the client**

Components of Assessment:

Biological, Psychological, Social

- **Conduct a comprehensive mental status check**
- **Conduct a substance use assessment**
- **Gather a history of past and current suicidal and homicidal thoughts and actions**
- **Gather a history of past and current domestic violence and physical, emotional and/or sexual abuse**
- **Establish client goals for treatment and their vision for outcomes**

Proficiency in DSM-5 Diagnosis:

There has been a significant expansion in

Other Conditions That May Be a Focus of Clinical Attention

Z-codes and T-codes

(formerly V-codes)

Components of Assessment:

Methods of Gathering Information

- Patient self-report and self-monitoring
- Self-anchored and rating scales
- Questionnaires
- Direct behavioral observation
- Role play and analogue situations
- Behavioral by-products
- Psycho-physiological measures
- Goal attainment scaling

Mental Status Checklist

Symptom Inventory / Mental Status (0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme)

__Generalized Anxiety
__ Phobias
__ Panic Attacks
__Depersonalization
__Obsessions/Compulsions
__Depression
__Psychomotor retardation
__Low energy
__Fatigue
__Withdrawal
__Hopelessness
__Sleep disturbance

__Weight change
__Impaired memory
__Irritability
__ Anger control problems
__ Aggressiveness
__Impulsiveness
__Focus/concentration problems
__Distractibility
__Negative Self Image
__Disorientation
__Mania/Hypomania
__Tremors

__Suspiciousness
__Paranoid ideation
__ Bizarre Behaviors
__ Tangential/Circumstantial thinking
__Confusion
__Delusions
__Agitation
__ Dissociation
__ Hallucinations
__ Loose Associations
__ Flight of Ideas
__Intrusive thoughts

Mental Status Checklist

Symptom Inventory / Mental Status (0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme)

Mood: __ Normal __Anxious __Depressed __Irritable __Euphoric __Expansive __Dysphoric __Calm
Affect: __Normal __Unconstrained __Blunted/Restricted __Inappropriate __Labile __Flat
Behavior: __Normal __Aggressive __Impulsive __Angry __Oppositional __Agitated __Explosive

Social Relating / Executive Functioning (0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme)

Eye Contact: __Normal __Fleeting __Avoidant __Staring __Other: _____
Facial Expression: __Responsive __Flat __Tense __Anxious __Sad __Angry
Attitude Toward Clinician: __Normal/Cooperative __Uninterested __Passive __Guarded __Dramatic __Manipulative __Suspicious __Rigid __Sarcastic__Resistant __Critical __Irritable __Hostile __Threatening
Appearance: __Normal __Disheveled __Unclean __Inappropriate __Unhealthy looking
Insight: __Good __Impairments in insight **Decision Making:** __Good __Impairments in decision making
Reality Testing: __Good __Impairments in reality testing **Judgment:** __Good __Impairments in judgment
Interpersonal Skills: __Normal __Impaired **Intellect:** __Average or above __Impaired

Example of Detailed Mental Status Checklist

(0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme)

Generalized Anxiety as manifested by:

__Feelings of apprehension or dread
__Trouble concentrating
__Feeling tense and jumpy
__Anticipation of negative outcomes
__Heightened irritability
__Restlessness or unsettled feeling
__Vigilance for signs of danger
__Muscle fatigue associated with tenseness

Alternative Detailed Mental Status Checklist

(0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme)

Generalized Anxiety as manifested by:

Feelings of apprehension or dread	___By self-report	___By observation
Trouble concentrating	___By self-report	___By observation
Feeling tense and jumpy	___By self-report	___By observation
Anticipation of negative outcomes	___By self-report	___By observation
Heightened irritability	___By self-report	___By observation
Restlessness or unsettled feeling	___By self-report	___By observation
Vigilance for signs of danger	___By self-report	___By observation
__Muscle fatigue associated with tenseness	___By self-report	___By observation

Example of Detailed Mental Status Checklist

Panic Attack as manifested by episodes of anxiety in conjunction with:

___Sweating
___Heart pounding
___Fear of death
___Shortness of breath
___Feeling of choking
___Shaking
___Chest pain
___Nausea or stomach ache
___Dizziness
___Fear of going crazy
___Chills or hot flashes
___Derealization

Example of Detailed Mental Status Checklist

Mania as manifested by:

___Irritability
___Pressured speech/ feel urge to talk or keep talking
___Decreased need for sleep
___Inflated self esteem or grandiosity
___Racing thoughts
___Distractibility
___Increased goal directed activity or psychomotor agitation
___Excessive involvement in pleasurable activities that have a high threshold for painful consequences.

Example of Detailed Mental Status Checklist

Depression as manifested by:

___Markedly decreased interest in activities
___Significant weight loss or gain (5% or more)
___Increased or decreased need for sleep
___Psychomotor agitation or retardation
___Loss of energy
___Feelings of worthlessness or guilt
___Inability to concentrate or think
___Recurrent thoughts of death or suicidal thoughts.

Example of Detailed Substance Abuse Assessment

Drug/ETOH Use (Please rate amount and frequency, present and past: e.g., 2B = moderate, infrequent)

(Amount of use ratings: 0=No use 1=Light or limited use 2=Moderate use 3=Heavy use 4=Extreme use)

(Frequency of use modifier: A=Almost never B=Infrequent / Occasional C=Regular, not constant D=Constant)

	Current use	Past use
Alcohol	____	____
Marijuana	____	____
Cocaine	____	____
Other (list): _____	____	____
Other (list): _____	____	____
Other (list): _____	____	____
Other (list): _____	____	____

Example of Detailed Substance Abuse Assessment

Substance Use Problem Effects (0=None 1=Mild 2=Moderate 3= High 4-Severe 5-Extreme)

	Current use	Past use
Used alcohol/drugs more than intended	_____	_____
Spent more time using/drinking than intended	_____	_____
Neglected some usual responsibilities because of alcohol or drugs	_____	_____
Wanted or needed to cut down on drinking or drug use in past year	_____	_____
Someone has objected to client's drinking/drug use	_____	_____
Preoccupied with wanting to use alcohol or drugs	_____	_____
Used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom	_____	_____

Comments:

Components of Assessment:

Methods of Gathering Information

- **Projective measures**
- **Standardized measures**
- **Coordination of care with medical, psychiatric, psychological, and other providers**

Complications in Diagnosis:

How Certain are You?

Provisional, Deferred and Rule Out Diagnoses

When to use provisional diagnosis

If the clinician is inclined to believe that the final diagnosis selected will in all likelihood be Major Depressive Disorder, Recurrent, Moderate (296.32), but there remains enough uncertainty to proceed cautiously, then the word “provisional” would simply be added to the end of the diagnosis, either separated by a comma, or placed in parentheses

When to use provisional diagnosis

The specifier “provisional” may also be used when there are diagnoses where the criteria include a requirement for the symptoms to be present for a specified period of time that has not elapsed.

When to use diagnosis deferred

Diagnosis deferred is utilized when there is still a substantial amount of uncertainty about any specific diagnosis, often when the assessment session has been interrupted or too brief to allow for the formation of a reasonable idea of the patient's likely diagnosis.

This is designed to be used as a temporary measure pending resumption of the assessment process when the client returns for additional sessions.

The code for diagnosis deferred is R69

When to use unspecified mental disorder

1) when it is not expected that a more precise diagnosis will ultimately be reached either through gathering additional information or by the passage of more time.
2) when the treatment circumstances will not permit time for more clarifying assessment to occur.

No diagnosis

If no diagnosis is present, the code for “No diagnosis” is Z99.

Other Clarifying Specifiers

- "**Traits—**this person does not meet criteria, however, he or she presents with many of the features of the diagnosis (e.g., borderline traits or cluster B traits).
- **By history—**previous records (another provider or hospital) indicate this diagnosis; records can be inaccurate or outdated (e.g., alcohol dependence by history).
- **By self-report—**the client claims this as a diagnosis; it is currently unsubstantiated; these can be inaccurate (e.g., bipolar by self-report)."

Other Clarifying Specifiers: Traits

"**Traits—**this person does not meet criteria, however, he or she presents with many of the features of the diagnosis (e.g., borderline traits or cluster B traits).

Complications in Diagnosis: Getting the Specifiers Right

Specifiers

With the implementation of ICD-10-CM, code will move from a format that allows up to five digits (e.g., 296.32, Major Depressive Disorder, Recurrent Episode, Moderate) to a format that allows for up to seven digits (e.g., F40.232, Specific Phobia, Fear of Medical Care).

The new codes, with up to seven digits, will allow for the recording of additional specifiers within the code numbers.

Specifiers and Subtypes

The first, second and third number after the decimal point may indicates subtype of the disorder or specifiers for the disorder, including severity level:

e.g., F31.12 Bipolar Disorder, moderate, most recent episode manic 1=manic, 2= moderate

e.g., F17.209 Unspecified Tobacco-Related Disorder
9=Unspecified

Common Specifiers

1) Level of severity: Mild, moderate, severe

2) Onset: Early onset or late onset, with onset during intoxication, withdrawal or after medication use; with peripartum onset; with seasonal pattern

3) Remission status: In partial remission or full remission; in early remission or sustained remission

4) Duration: Lifelong or acquired; episodic, persistent, or recurrent

5) Pervasiveness: Generalized or situational

6) Prognostic features: With or without good prognostic features

Common Specifiers

7) Environment: In a controlled environment or on maintenance therapy

8a) Episode type: First, multiple, continuous, unspecified, mixed

8b) Episode type: Erotomanic, grandiose, jealous, persecutory, somatic

Common Specifiers

9) With other symptoms: With:

a) medical condition

b) perceptual disturbances

c) anxious distress

d) mixed features

e) melancholic features

f) rapid cycling

g) atypical features

h) mood congruent psychotic features

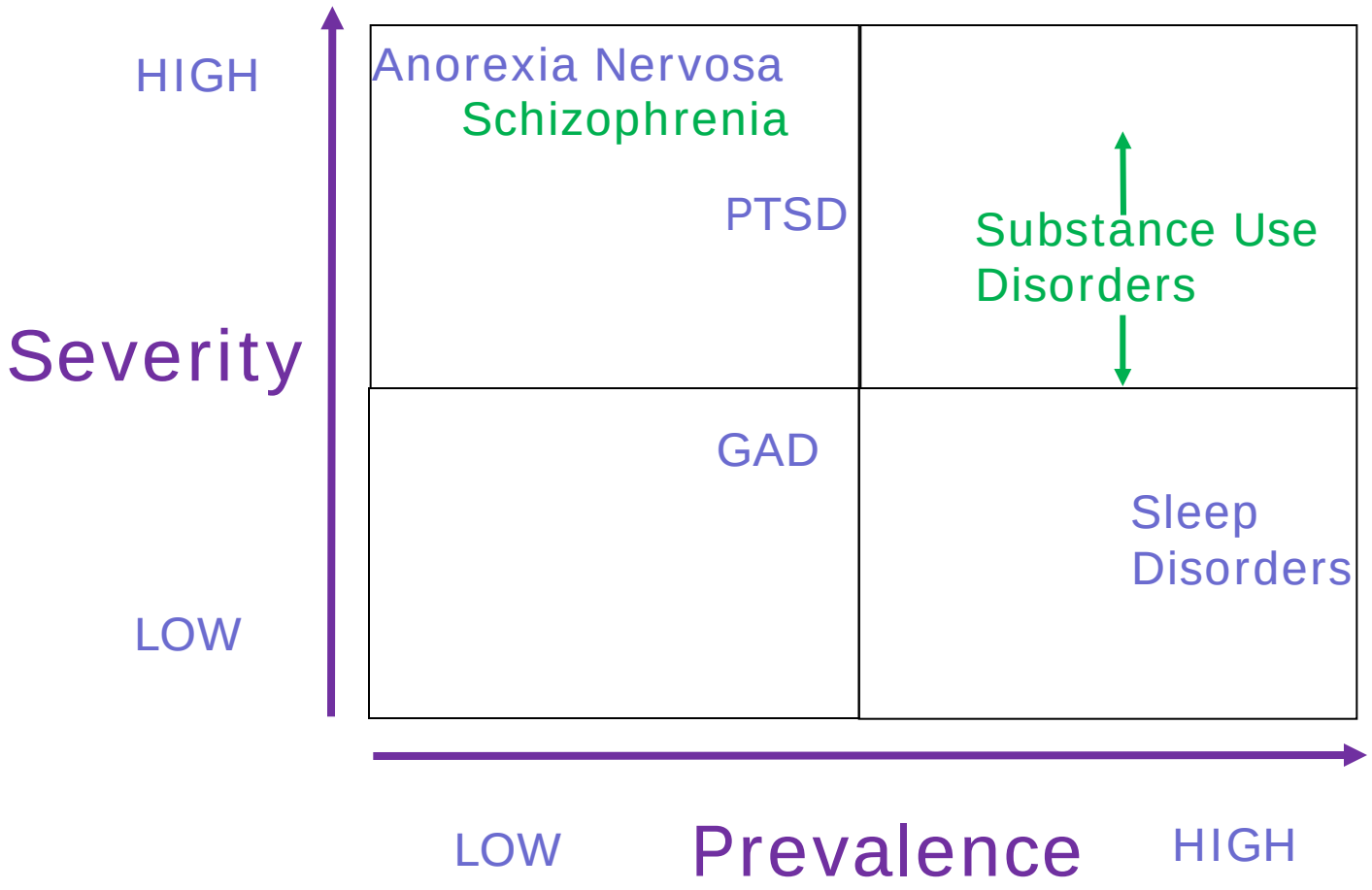
i) mood incongruent psychotic features

j) catatonia

k) delusions

l) hallucinations

Where Do We Focus



Notable Mental Health Problems
(NIMH as applied to 2004)

1. **Anxiety Disorders – 18.1% of adult Americans**
- Panic disorder: 2.7% of adults
- OCD – 1% of adults
- PTSD – 3.5% of adults
- GAD – 3.1% of adults
- Social phobia – 6.8% of adults

2. **Mood Disorders – 9.5% of adult Americans**
- Major Depressive Disorder: 6.7% of adults
- Bipolar Disorder: 2.6% of adults
- Dysthymic Disorder: 1.5%

3. **Personality Disorders – 9.1% of adult Americans**
- Avoidant Personality Disorder: 5.2% of adults
- Antisocial Personality Disorder: 1.0% of adults
- Borderline Personality Disorder: 1.6%

Notable Mental Health Problems
(NIMH as applied to 2004)

4. **Eating Disorders – 4.4% of adult Americans**
   - Binge Eating Disorder: 2.8% of adults
   - Bulimia Nervosa: 1.0% of adults
   - Anorexia Nervosa: 0.6%

5. **Attention Deficit Disorders – 4.1% of adult Americans**

6. **Schizophrenia – 1.1% of adult Americans**

7. **Autism Spectrum Disorder – 1% of adult Americans**

Substance Abuse Problems
(NIMH as applied to 2007)

1. **Alcohol abuse over lifetime – 17.8% of adult Americans**
   Alcohol dependence over lifetime – 12.5%

2. **Drug abuse over lifetime – 7.7% of adult Americans**
   Drug Dependence over lifetime – 2.6%

Sleep Problems

1. **Insomnia Disorder – 10-15% of adult Americans meet criteria**

   Signs and symptoms not meeting full criteria – 30%

2. **Obstructive sleep apnea – 3-7% of adult Americans**

   This diagnosis is growing in numbers.

3. **22-75% of alcohol use disorder in treatment report sleep disorders, 35-70% problems w/ sleep**

Learning Disorders

1. **Specific Learning Disorder: reading, writing, math – 5-15% of Americans**
2. **ADHD – Up to 6.69%**
3. **Language disorder and speech-sound disorder – 2-25%**

Important Changes from DSM-IV-TR to DSM-5

Large Scale Structural Changes

- **DSM-5: Discontinuation of the use of roman numerals**
- **Discontinuation of separation of personality disorders into separate category/axis**
- **Discontinuation of the chapter on disorders usually diagnosed in infancy, childhood, and adolescence**
- **Movement to ICD-10 coding in 2015 (delayed by Congress for one year, signed into law this past month)**
- **Discontinuation of the multi-axial system**

End of Multi-axial System: Implications

- **No separate axis for personality disorders**
- **Changes to how psychosocial codes are handled**

End of Multi-axial System: Implications

DSM-5 has created diagnostic codes for psychosocial features to utilize in shaping a comprehensive diagnostic picture. It is now considered best practices to utilize these codes, with accompanying text to provide a further degree of clarity, where indicated.

End of Multi-axial System: Implications

Diagnosis: Inadequate housing Code: Z59.1

Diagnosis: Extreme poverty Code: Z59.5

Significant psychosocial and contextual features: Financial instability and housing insecurity affect the ability of the client to access treatment on a regular basis.

ICD-10 Coding Changes

- ICD-9 Coding: Up to 5 digits ICD-10 coding: Up to 7 digits
- ICD-10 coding: All codes begin with letters
- ICD-10 coding: Codes that denote more than one diagnosis
- ICD-10 coding: Most common mental health codes will begin with the letter ‘F’
- ICD-10 coding: V codes to be replaced by Z codes and T codes

ICD-10 Coding Changes

ICD-10 coding: A few notable exceptions to F, T and T codes

- G codes for sleep problems, some neurocognitive problems, and adverse effects of psychotropic medications
- L98.1, Excoriation (Skin-Picking) Disorder
- N94.3, Premenstrual Dysphoric Disorder
- N39.498 urinary incontinence
- R15.9 fecal incontinence

Diagnostic Terms and Categories No Longer to Be Used in the DSM-5

- Polysubstance dependence
- Mental Retardation [Now: Intellectual Disability]
- Asperger's and other Sub-types of Autism Spectrum Disorders [Now: Autism Spectrum Disorder]
- Feeding Disorder of Infancy or Early Childhood [Now: Avoidant/Restrictive Food Intake Disorder]
- Sub-types of Schizophrenia
- Dysthymia [Now: Persistent Depressive Disorder (Dysthymia)]
- Panic Disorders with and Without Agoraphobia and Agoraphobia without History of Panic Disorder

Diagnostic Terms and Categories No Longer to Be Used in the DSM-5

- Dissociative Fugue [Now: Absorbed into Dissociative Amnesia]
- Depersonalization Disorder [Now: Depersonalization / Derealization Disorder]
- Shared Psychotic Disorder
- Dyspareunia not due to a Medical Condition*
- Sexual Aversion Disorder

***These diagnoses have typically been the domain of qualified psychiatrists or physicians**

Diagnostic Terms and Categories No Longer to Be Used in the DSM-5

- **Reactive Attachment Disorder Sub-types**

- Reactive Attachment Disorder Emotionally Withdrawn / Inhibited type
- Reactive Attachment Disorder Indiscriminately Social / Disinhibited type

Replaced by:

- Reactive Attachment Disorder (ICD-9: 313.89; ICD-10: F94.1)
- Disinhibited Social Engagement Disorder (ICD-9: 313.89; ICD-10: F94.2)

Diagnostic Terms and Categories No Longer to Be Used in the DSM-5

- Expressive Language Disorder* [Now: Language Disorder]
- Phonological Disorder* [Now: Speech Sound Disorder]
- Stuttering* [Now: Childhood-Onset Fluency Disorder]
- Mathematics Disorder* [Now: Specific Learning Disorder with Impairment in . . .]
- Reading Disorder*
- Disorder of Written Expression*
- Learning Disorder Not Otherwise Specified*

***These diagnoses will typically be made by qualified psychologists**

Diagnostic Terms and Categories No Longer to Be Used in the DSM-5

- Somatization Disorder*
- Hypochondriasis*
- Pain Disorder*
- Undifferentiated Somatoform Disorder/Somatoform Disorder NOS*

Replaced by: Somatic Symptom Disorder (ICD-9: 300.82; ICD-10: F45.1)

***These diagnoses have typically been the domain of qualified psychiatrists or other physicians**

Diagnostic Terms and Categories No Longer to Be Used in the DSM-5

- Sleep Disorders Related to Another Medical Condition
  - Hypersomnia type
  - Insomnia type
  - Mixed type
  - Parasomnia type

- Sleep Disorders Related to a Another Mental Disorder
  - Hypersomnia type
  - Insomnia type

- Dyssomnia Not Otherwise Specified

***These diagnoses have typically been the domain of qualified physicians who are sleep specialists**

Diagnostic Terms and Categories No Longer to Be Used in the DSM-5

- ***Replaced by:***

- Insomnia Disorder (ICD-9: 780.52; ICD-10: G47.00)

- Hypersomnolence Disorder (ICD-9: 780.54; ICD-10: G47.10)

New Diagnostic Terms and Categories Added in the DSM-5

- **Caffeine Withdrawal (ICD-9: 292.0; ICD-10: F15.93)**
- **Cannabis Withdrawal (ICD-9: 292.0; ICD-10: F12.288)**
- **Tobacco Use Disorder (ICD-9: 305.1; ICD-10: Z72.0)**
- **Binge Eating Disorder (ICD-9: 307.51; ICD-10: F50.8)**
- **Gambling Disorder (ICD-9: 312.31; ICD-10: F63.0)**
- **Disruptive Mood Dysregulation Disorder (ICD-9: 296.99; ICD-10: F34.8)**
- **Hoarding Disorder (ICD-9: 300.3; ICD-10: F42)**
- **Excoriation/Skin Picking, Disorder (ICD-9: 698.4; ICD-10: L98.1)**

New Diagnostic Terms and Categories Added in the DSM-5

- Psychological Factors Affecting Other Medical Conditions (ICD-9: 316; ICD-10: F54)
- Premenstrual Dysphoric Disorder (ICD-9: 625.4; ICD-10: N94.3)
- Substance/Medication-Induced Obsessive-Compulsive and Related Disorder (ICD-9: 292.89; ICD-10: F14.xxx and F15.xxx)
- Obsessive-Compulsive and Related Disorder Due to Another Medical Condition (ICD-9: 294.8; ICD-10: F06.8)

These diagnoses should be made by qualified medical and psychiatric personnel only

New Diagnostic Terms and Categories Added in the DSM-5

- **Premenstrual Dysphoric Disorder (ICD-9: 625.4; ICD-10: N94.3)**

This diagnosis is designed to address marked changes in mood and behaviors that occur as the result of the hormonal changes accompanying a woman's menstrual cycle.

At least five symptoms in two criterion areas (criterion areas B and C) must be present, and the onset, reduction and remission of the symptoms must coincide with a women's movement through the period leading up to and through the menstrual cycle.

This diagnosis should be made by qualified medical and psychiatric personnel only, so if it is suspected by a clinician a referral is indicated.

New Diagnostic Terms and Categories Added in the DSM-5

- **Substance/Medication-Induced Obsessive-Compulsive and Related Disorder (ICD-9: 292.89; ICD-10: F14.xxx and F15.xxx)**

Examples: L-Dopa induced obsessive-compulsive behavioral effects, including uncontrollable gambling or sexual behaviors for Parkinson's patients or cocaine induced scratching, skin picking and hair pulling due to the disruption of the neurotransmitters at specific brain sites associated with obsessive and compulsive behaviors.

For the diagnosis to be used properly, the obsessive or compulsive symptoms must appear during or soon after substance intoxication or withdrawal for drugs, and after exposure for a medication. It must also cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

These diagnoses should be made by qualified medical and psychiatric personnel only

New Diagnostic Terms and Categories Added in the DSM-5

- **Obsessive-Compulsive and Related Disorder Due to Another Medical Condition (ICD-9: 294.8; ICD-10: F06.8)**

Example: Obsessive-compulsive and related disorder ***due to cerebral infarction.***

If this condition is noted, it will be accompanied with the specifiers that clarify how the OCD behaviors are appearing. These are the options that will likely be noted:

- **With obsessive-compulsive disorder-like symptoms** (Akin to symptoms of OCD, e.g., hand washing, ritualistic behaviors)
- **With appearance preoccupations** (Akin to body preoccupation as in Anorexia or Bulimia Nervosa)
- **With hoarding symptoms** (Akin to symptoms of Hoarding Disorder which has been added as a diagnosis in the DSM-5)
- **With hair-pulling symptoms** (Akin to symptoms of trichotrillomania)
- **With skin-picking symptoms** (Akin to symptoms of Skin-Picking Disorder which has been added as a diagnosis in the DSM-5)

These diagnoses should be made by qualified medical and psychiatric personnel only

Important Reformulations of Diagnoses in the DSM-5

- **Post-traumatic Stress Disorder**
- **Acute Stress Disorder**

Key change: The client's subjective reaction to a stressful or traumatic event is no longer a criterion used in diagnosis. Instead, more objective markers are explored in order to determine the presence of these disorders.

Important Reformulations of Diagnoses in the DSM-5

- **Acute Stress Disorder**

Key change: There are now 14 listed symptoms in five categories: intrusion, negative mood, dissociation, avoidance and arousal.

Important Reformulations of Diagnoses in the DSM-5

- **Post-traumatic Stress Disorder**

Key change: In the DSM-IV-TR the three major symptom clusters were: **re-experiencing**, **avoidance/numbing**, and **arousal**. In the DSM-5, the avoidance/numbing cluster has been broken down into two separate clusters: ***1) avoidance*** and ***2) persistent negative alterations in cognitions and mood***.

Important Reformulations of Diagnoses in the DSM-5

- **Bereavement Exclusions**

Key change: In the DSM-IV-TR, depressive episodes that were believed to be precipitated by the death of a loved one could not be classified as major depression ***until the depressive symptoms had persisted beyond 2 months***, as the grieving behind the depressive episode was thought to be normal. This exclusion has been removed in the DSM-5.

Important Reformulations of Diagnoses in the DSM-5

- **Gender Identity Disorder**

Key change: A new diagnostic class, Gender Dysphoria, has been introduced in the DSM-5. This terminology is believe to express more accurately the central feature of this disorder, specifically the client's distress at having his/her physiological gender be different from his/her perceived psychological/emotional gender.

Important Reformulations of Diagnoses in the DSM-5

- **Gender Identity Disorder**

The following three diagnoses have been deleted in DSM-5:

Gender Identity Disorder in Adolescents or Adults (DSM-IV-TR 302.85),
Gender Identity Disorder in Children (DSM-IV-TR 302.6),
Gender Identity Disorder NOS (DSM-IV-TR 302.6).

They have been replaced by: Gender Dysphoria in Children (ICD-9: 302.6; ICD-10: F64.2),
Gender Dysphoria in Adolescents or Adults (ICD-9: 302.85; ICD-10: F64.1).

Important Reformulations of Diagnoses in the DSM-5

- **Substance-Related and Addictive Disorders**

All diagnoses that differentiate between 1) substance abuse and 2) substance dependence for all misused substances have been deleted.

Replaced by:

Substance Use Disorders

Important Reformulations of Diagnoses in the DSM-5

- **Substance-Related and Addictive Disorders**

All diagnoses that differentiate between 1) substance abuse and 2) substance dependence for all misused substances have been deleted.

Replaced by:

Substance Use Disorders with specifiers to rate the level of severity from mild to severe.

Important Reformulations of Diagnoses in the DSM-5

- **Paraphilias**

In the DSM-5, ***certain paraphilias are not automatically considered mental disorders*** and are not automatically considered to warrant clinical intervention. In order for a paraphilia to be considered a mental disorder under DSM-5, the paraphilia must 1) be causing distress or impairment to the person exhibiting the paraphilia, and/or 2) the paraphilia must be presenting itself in a way that can create personal harm or the risk of harm to others.

Important Reformulations of Diagnoses in the DSM-5

- **Paraphilias not involving boundary violations**

- Fetishistic Disorder (ICD-9: 302.81; ICD-10: F65.0)
- Other Specified Paraphilic Disorder (ICD-9: 302.89; ICD-10: F65.89)
- Sexual Masochism Disorder (ICD-9: 302.83; ICD-10: F65.51)
- Transvestic Fetishism Disorder (ICD-9: 302.3; ICD-10: F65.1)
- Unspecified Paraphilic Disorder (ICD-9: 302.9; ICD-10: F65.9)

Important Reformulations of Diagnoses in the DSM-5

- **Paraphilias that can / do involve boundary violations**

- Exhibitionistic Disorder (ICD-9: 302.4; ICD-10: F65.2)
- Voyeuristic Disorder (ICD-9: 302.82; ICD-10: F65.3)
- Frotteuristic Disorder (ICD-9: 302.89; ICD-10: F65.81)
- Pedophilic Disorder (ICD-9: 302.2; ICD-10: F65.4)
- Sexual Sadism Disorder (ICD-9: 302.84; ICD-10: F65.52)

Important Reformulations of Diagnoses in the DSM-5

- **Dementia and Amnestic Disorders**

All diagnoses that include the term Dementia have been deleted

Amnestic Disorder (DSM-IV-TR 294.8) has been deleted

Replaced by:

Neurocognitive Disorder

Important Reformulations of Diagnoses in the DSM-5

- **Dementia and Amnestic Disorders**

All diagnoses that include the term Dementia have been deleted

Amnestic Disorder (DSM-IV-TR 294.8) has been deleted

Replaced by:

Neurocognitive Disorder

These diagnoses should be made by qualified medical and psychiatric personnel only

Important Reformulations of Diagnoses in the DSM-5

- **Bi-Polar Disorder and Depressive Disorders**

1) A new specifier has been added to accommodate circumstances in which the full criteria for the combination of mania and major depression are not present, but where major depression is present with some features of mania or hypomania, or when mania or hypomania predominate in conjunction with some depressive features. This specifier is “With mixed features”.

Important Reformulations of Diagnoses in the DSM-5

- **Bi-Polar Disorder and Depressive Disorders**

2) A new specifier, “With anxious distress”, has been added to the list of potential specifiers under Bipolar Disorder and under Depressive Disorders. This is meant to clarify the additional presence of anxiety over and above what occurs as a manifestation of the Bipolar Disorder or the Major Depression or Persistent Depressive Disorder.

Important Reformulations of Diagnoses in the DSM-5

- **Schizophrenia**

1) Bizarre delusions and Shneiderian first-rank auditory hallucinations no longer stand as special symptoms: where either one of these standing alone will suffice to meet diagnostic requirements for Schizophrenia under Criteria A (Presence of: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms like diminished emotional expressiveness or avolition). A minimum of two symptoms in category A is now required.

2) At least one of the following three core symptoms must be present in order to warrant a diagnosis of schizophrenia under the DSM-5: delusions, hallucinations, and disorganized speech.

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Important Reformulations of Diagnoses in the DSM-5

- **Delusional Disorder**

1) It is no longer required that delusions be non-bizarre in order to meet Criteria A for this disorder.

2) DSM-5 “no longer separates delusional disorder from shared delusional disorder”.

Important Reformulations of Diagnoses in the DSM-5

- **Specific Phobia Criteria**
- **Social Anxiety Disorder (Social Phobia)**

1) For both of these diagnostic categories, there is no longer a requirement that individuals over 18 years of age recognize that their fear and anxiety are excessive or unreasonable.

2) For both of these diagnostic categories, there is now a requirement that the symptoms have a duration of 6 months or more.

Important Reformulations of Diagnoses in the DSM-5

- **Social Anxiety Disorder (Social Phobia)**

3) For Social Phobia, there is now a specifier that notes whether the social anxiety disorder/social phobia is related exclusively to performance in public. According to the APA, individuals “who fear only performance situations(i.e., speaking or performing in front of an audience) appear to represent a distinct subset of social anxiety disorder in terms of etiology, age at onset, physiological response, and treatment response.” (APA, 2013) This specifier stands in opposition to the specifier in DSM-IV-TR, in which the social phobia was “generalized” to all or most social situations. This specifier has been deleted in the DSM-5.

Important Reformulations of Diagnoses in the DSM-5

- **Separation Anxiety Disorder Criteria**

1) This diagnosis is no longer included with disorders usually first diagnosed in infancy, childhood, or adolescence, but is rather included amongst anxiety disorders because, according to the APA, “a substantial number of adults report onset of separation anxiety after age 18.” (APA, 2013) Accordingly, diagnostic criteria no longer require that symptoms appear prior to the age of 18.

2) To accommodate the reformulation, symptoms must be present in adults for more than 6 months in order to warrant this diagnosis.

Important Reformulations of Diagnoses in the DSM-5

- **Intermittent Explosive Disorder**

1) Verbal aggression and non-destructive/noninjurious physical aggression now can be considered valid criteria to warrant this diagnosis. In the DSM-IV-TR physical aggression was a required criterion.

Important Reformulations of Diagnoses in the DSM-5

- **Oppositional Defiant Disorder**

1) Symptoms are now grouped in three types: a) angry/irritable mood, b) argumentative/defiant behavior, and c) vindictiveness.

2) A severity rating has been added to help describe the pervasiveness and severity of the symptoms.

Important Reformulations of Diagnoses in the DSM-5

- **Conduct Disorder**

1) A specifier has been added to denote clients with this disorder who also present with limited pro-social emotions. This specifier is “based on research showing that individuals with conduct disorder who meet criteria for the specifier tend to have a relatively more severe form of the disorder and a different treatment response.” (APA, 2013)

Important Reformulations of Diagnoses in the DSM-5

- **Anorexia Nervosa**

1) The requirement for amenorrhea (loss of menstrual period) to be present has been deleted as a criterion for this diagnosis.

2) Persistent behavior that interferes with weight gain is another criterion that supports this diagnosis. This is an expansion of the criterion noting an overtly expressed fear of weight gain.

Important Reformulations of Diagnoses in the DSM-5

- **Elimination Disorders**

1) This class of disorders has been removed from the category of disorders first diagnosed in infancy, childhood, or adolescence and are now placed in their own category of disorders.

Important Reformulations of Diagnoses in the DSM-5

- **Attention Deficit/Hyperactivity Disorder**

1) The age of onset criteria have been changed from "symptoms that caused impairment were present prior to age 7" to "several inattentive or hyperactive-impulsive symptoms were present prior to age 12." (DSM, 2013)

2) A co-morbid diagnosis with Autism Spectrum Disorder is permitted in the DSM-5.

Important Reformulations of Diagnoses in the DSM-5

- **Obsessive-Compulsive and Related Disorders**

1) A new specifier, “With poor insight”, has been added in the DSM-5 to allow for more subtle distinctions concerning degrees of insight about OCD beliefs held by clients. In the DSM-IV-TR, the only two choices were “good or fair insight” and “absent insight/delusional”.

Important Reformulations of Diagnoses in the DSM-5

- **Body Dysmorphic Disorder**

1) A new specifier, “With muscle dysmorphia”, has been added to this diagnosis to denote individuals who maintain an excessive focus on building and maintaining muscle mass and muscle definition as a manifestation of a dysmorphic relationship with their own bodies.

Complications in Diagnosis:

Diagnostic Criteria with More Subtle Reformulations

Reformulated: Bi-Polar Disorder and Depressive Disorders

- **New Specifiers: With mixed features**

1) A new specifier, “With mixed features”, has been added to the diagnosis of bipolar disorder or major depression to accommodate circumstances in which the full criteria for the combination of mania and major depression are not present, but where major depression is present with some features of mania or hypomania, or when mania or hypomania predominate in conjunction with some depressive features.

Reformulated: Bi-Polar Disorder and Depressive Disorders

- **New Specifiers: With anxious distress**

1) A new specifier, “With anxious distress”, has been added to the diagnosis of bipolar disorder or major depression to clarify the additional presence of anxiety over and above what occurs as a manifestation of the Bipolar Disorder or the Major Depression or Persistent Depressive Disorder.

Reformulated: Schizophrenia

- **Removal of special symptoms**

1) Bizarre delusions and Shneiderian first-rank auditory hallucinations no longer stand as special symptoms: where either one of these standing alone will suffice to meet diagnostic requirements for Schizophrenia under Criteria A (Presence of: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms like diminished emotional expressiveness or avolition). A minimum of two symptoms in category A is now required.

Reformulated: Schizophrenia

- **Requirement for one of three core symptoms**

2) At least one of the following three core symptoms must be present in order to warrant a diagnosis of schizophrenia under the DSM-5: delusions, hallucinations, and disorganized speech.

Reformulated: Delusional Disorder

- **Two key changes**

1) It is no longer required that delusions be non-bizarre in order to meet Criteria A for this disorder.

2) DSM-5 “no longer separates delusional disorder from shared delusional disorder.”

Reformulated: Specific Phobia Criteria
Reformulated: Social Anxiety Disorder (Social Phobia)

- **Removal of age requirement**

1) For both of these diagnostic categories, there is no longer a requirement that individuals over 18 years of age recognize that their fear and anxiety are excessive or unreasonable.

Reformulated: Specific Phobia Criteria
Reformulated: Social Anxiety Disorder (Social Phobia)

- **Removal of 6 months duration requirement**

2) For both of these diagnostic categories, there is now a requirement that the symptoms have a duration of 6 months or more.

Reformulated: Specific Phobia Criteria
Reformulated: Social Anxiety Disorder (Social Phobia)

- **Performance in public specifier**

3) For Social Phobia, there is now a specifier that notes whether the social anxiety disorder/social phobia is related exclusively to performance in public.

Reformulated: Separation Anxiety Disorder Criteria

- **Removal of age requirement**

1) Diagnostic criteria no longer require that symptoms appear prior to the age of 18.

Reformulated: Separation Anxiety Disorder Criteria

- **6 months duration requirement**

2) To accommodate the reformulation, symptoms must be present in adults for more than 6 months in order to warrant this diagnosis.

Intermittent Explosive Disorder

- **Change in criteria**

1) Verbal aggression and non-destructive/noninjurious physical aggression now can be considered valid criteria to warrant this diagnosis. In the DSM-IV-TR physical aggression was a required criterion.

Oppositional Defiant Disorder

- **Two key changes**

1) Symptoms are now grouped in three types: a) angry/irritable mood, b) argumentative/defiant behavior, and c) vindictiveness.

2) A severity rating has been added to help describe the pervasiveness and severity of the symptoms.

Conduct Disorder

- **Limited pro-social emotions specifier**

1) A specifier has been added to denote clients with this disorder who also present with limited pro-social emotions. This specifier is “based on research showing that individuals with conduct disorder who meet criteria for the specifier tend to have a relatively more severe form of the disorder and a different treatment response.” (APA, 2013)

Anorexia Nervosa

- **Two key changes**

1) The requirement for amenorrhea (loss of menstrual period) to be present has been deleted as a criterion for this diagnosis.

2) Persistent behavior that interferes with weight gain is another criterion that supports this diagnosis. This is an expansion of the criterion noting an overtly expressed fear of weight gain.

Attention Deficit/Hyperactivity Disorder

- **Two key changes**

1) The age of onset criteria have been changed from “symptoms that caused impairment were present prior to age 7” to “several inattentive or hyperactive-impulsive symptoms were present prior to age 12.” (DSM, 2013)

2) A co-morbid diagnosis with Autism Spectrum Disorder is permitted in the DSM-5.

Obsessive-Compulsive and Related Disorders

- **With poor insight specifier**

1) A new specifier, “With poor insight”, has been added in the DSM-5 to allow for more subtle distinctions concerning degrees of insight about OCD beliefs held by clients. In the DSM-IV-TR, the only two choices were “good or fair insight” and “absent insight/delusional”.

Complications in Diagnosis of Anxiety Disorders

GAD versus PTSD

- **History of identifiable traumatic episode**

- The person experienced, witnessed, or was confronted with an event or actual events that threatened death or serious injury, or threat to physical integrity of self or others.

-The person's response involved intense fear, helplessness, or horror.

-The event is re-experienced with recurrent and intrusive recollections, or memories, of the event.

GAD versus PTSD

Both PTSD and GAD occur with alterations to HPA axis (hyopthalamus-pituitary-adrenal) and stress related changes to the hippocampus, but the rate of change is faster and more pronounced with PTSD.

Anxiety Disorder versus Attention Deficit Disorder

Anxiety Disorder versus ADHD

- **Significant symptom overlap**

- A number of studies note high percentage of children referred for ADHD were diagnosed with anxiety disorder

- Numerous children with ADHD also present with significant amounts of anxiety

- Overall, up to 30% of cases have overlap and may be practically indistinguishable one from the other

Anxiety Disorder versus ADHD

- **Differentiating features**

- ADHD tends to exhibit more externalization of behaviors

-ADHD tends to present with higher degrees of impulsiveness and distractibility

- Decreases in anxiety can lead to improvements in symptoms for children with anxiety disorders, but can lead to increases in symptoms in some children with ADHD

- ADHD distractibility often not tied to worries, but rather to causes the client cannot explain

PTSD versus Attention Deficit Disorder

Anxiety Disorder versus ADHD

- **Significant symptom overlap**

- A number of symptoms similar in both PTSD and ADHD

Anxiety Disorder versus ADHD

- **Key differentiating features**

-With PTSD symptoms, are more circumscribed and situational

- Defined traumatic source of PTSD development

- ADHD persistent and consistent from situation to situation

Complications in Diagnosis of Mood Disorders

Bipolar Disorder versus Major Depression

Bipolar Disorder versus Major Depression

- **History of manic episode**

If a client has ever experienced a full manic episode, then the correct diagnosis would be Bipolar I Disorder even if the client currently presents with depression only.

Bipolar Disorder versus Thyroid Disease

Bipolar Disorders versus Thyroid Disease

- **Neurochemical versus endocrinological versus both**

There is a high rate of overlap between thyroid disorder and bipolar and a complex relationship and not yet fully understood relationship between the two

Lithium may interfere with thyroid functioning and predispose a client towards Hashimoto

Autoimmune thyroiditis may be related to bipolar disorder

Thyroid hormone is sometimes given as part of the treatment for bipolar disorder

Bipolar Disorders versus Thyroid Disease

Every person suspected of bipolar disorder should be referred to an endocrinologist due to the degree of overlap between these two disorders

Bipolar Disorder versus Schizoaffective Disorder

Bipolar Disorders versus Schizoaffective

- **Major Mood disorder Plus Criterion A of Schizophrenia**

- Delusions
- Hallucinations
- Disorganized speech
- Grossly disorganized or catatonic behavior
-Negative symptoms (explained below)
    - Diminished emotional expression
    - Avolition

Bipolar Disorders versus Schizoaffective

- **Presence of a thought disorder with alterations in mood**

The main distinguishing features are which of these disorders has the most presence, the psychosis or the mood disturbance.

If the positive or negative symptoms only occur in the presence of the mood disturbance, the diagnosis of bipolar with psychotic features is most appropriate.

Bipolar Disorder versus Borderline Personality Disorder

Bipolar Disorders versus BPD

- **Key diagnostic symptoms of BPD**

- Extreme efforts to avoid abandonment (real or imagined)

- Intense and unstable relationships, and individual alternates between idealizing and devaluing others in relationships.

- Sense of self is unstable showing an identity disturbance.

- Impulsive in at least two areas of behavior that are harmful to self (overspending, overeating, inappropriate or unsafe sexual behavior, substance abuse, etc.). Does not include suicidal thoughts of self-mutilation covered in next criterion.

Bipolar Disorders versus BPD

- **Key diagnostic symptoms of BPD**

- Recurrent self-mutilating behavior or suicidal behaviors or threats.

- Intense affective instability, lasting only a few hours possibly up to a few days.

- Chronic feelings of emptiness

- Intense, inappropriate expression of anger.

- Transient paranoid or dissociative ideation, linked with stress.

Borderline Personality Disorder versus PTSD

BPD versus PTSD

- **Attachment security and PTSD**

- Clients with diminished attachment security appear to be more likely to develop PTSD in the face of external trauma

- Attachment security is a protective element for surviving traumatic incidents without developing PTSD

- Treatment for PTSD involves the use of efforts to increase attachment security

BPD versus PTSD

- **Key differentiating features**

-Symptoms of excessive emotional expressiveness pursuant to traumatic incident as opposed to durable expression of symptoms

Schizophrenia Spectrum Disorders

Schizophrenia versus Paranoid Personality

- **Key differentiating features**

- Paranoid personality disorders present with longer term suspiciousness without the presence of clear delusional or hallucinogenic breakthroughs.

Schizoid versus Other Personality Disorders

- **Key differentiating features**

- Schizoid PD can be differentiated from Schizotypal PD by the ***lack of perceptual and cognitive distortions***.

- Schizoid PD is differentiated from Paranoid PD by ***lack of suspicion and paranoia***.

- Schizoid PD is different from Avoidant PD in that social isolation in Avoidant PD is ***due to fear of embarrassment or rejection***.

- **Remember:**

Schizophrenia, Schizophreniform, and Schizoaffective Disorders are ***psychotic disorders***. The array of problems will have a basis in some form of neurochemical dysfunction.

Schizoid and Schizotypal Disorders are ***personality disorders***. The suspiciousness and inappropriate affect/behavior will have a basis in poor personality organization, usually due to some combination of pre-disposing personality fragility and environmental/family stresses experienced during early developmental periods.