UC DAVIS EXTENSION
CENTER FOR HUMAN SERVICES

NORTHERN CALIFORNIA TRAINING ACADEMY

ADVANCED ISSUES OF ADULT MENTAL HEALTH

PARTICIPANT GUIDE

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ADVANCED ISSUES OF ADULT AND CHILD MENTAL HEALTH

NORTHERN CALIFORNIA TRAINING ACADEMY

Pre-requisite: Participants must have attended Introduction to Mental Health: The DSM and Child Welfare Practice or The DSM 5 Update.

This two-day, advanced, clinically oriented course focuses on child and adult mental health diagnoses from a neurobiological viewpoint, including evidence-based therapeutic practices and psychopharmacological treatments.

After attending this training, participants will be able to:

- Understand the significant changes to and the controversies of the new DSM 5 diagnostic classification system
- Recognize the symptoms of commonly diagnosed disorders in children such as ADHD, autism spectrum, disruptive and conduct disorders and adjustment disorders
- Identify new diagnostic categories in children and adults, including trauma- and stressor-related disorders, and redesigned areas such as anxiety disorders, obsessive-compulsive disorders, and substance-related and addictive disorders
- Recognize medications prescribed for mental health disorders, review common side effects, and explore educational materials and resources for staff, clients and families

Successful participants will have a better understanding of mental health treatment issues and common promising practices of mental health partner providers. Further, participants can use this understanding to make better informed decisions when facilitating access to mental health services for adults, youth and children.

Course meets the qualifications for 12 hours of continuing education credit for MFTs or LCSWs as required by the California Board of Behavioral Sciences. BBS Provider Number PCE 577

Provider approved by the California Board of Registered Nursing, Provider Number 00046 for 12 contact hours.

INSTRUCTOR(S)

Margaret Cornish, LCSW
Renee Sievert, R.N., MFT

PROFESSIONAL CREDIT

1.2 CEUs, 12 BBS, 12 BRN

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About the Academy

Child welfare workers in public agencies serve some of the most vulnerable people in society—families and children in crisis. A consistently high-level of professional conduct in this work is essential for favorable outcomes, yet public agencies face substantial challenges in hiring and retaining professionally trained child welfare workers and supervisors.

The Northern California Training Academy' purpose is to aid counties by bringing to the region a training program designed to develop a uniformly high level of competence in services for families and children.

Professional Credit

CEU: Northern California Training Academy participants receive continuing education units (CEU) from the University of California, Davis. One CEU is awarded for each 10 hours of class time: 8.5 units for Core.

BBS: Core courses meet the qualification for the designated number of hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences, provider number PCE-577: 84.5 hours.

BRN: Core courses are approved by the California Board of Registered Nursing, provider number BRN00046. Students must enroll for credit and attend the entire course: 84.5 hours.

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Northern California Training Academy

About Your Instructors

Meg Cornish, LCSW has devoted over 30 years to working with children and families. A graduate of Smith College School for Social Work in 1988, she has focused on counseling for people with physical and emotional problems including cancer, diabetes, anxiety and depression. For the past 18 years, Meg has traveled throughout California providing training for Social Workers, Public Health Nurses, Case Managers, therapists and paraprofessionals. Her areas of training expertise include Interviewing skills, Attachment, Separation and Loss, Trauma Focused Practice, and DSM 5 and Advanced Mental Health Issues classes. Meg brings a creative, hands-on, solutions-focused approach to her live training sessions which are also integral parts of her online courses.

Renee Sievert, RN, MFT is an author, consultant, and master coach. She offers clinical training, leadership coaching, team building, strategic planning and experiential learning with horses (Equus Coaching). Renee has over 40 years of experience as a registered nurse with advanced certification in psychiatric and mental health nursing and HIV /AIDS. She has been a licensed therapist (MFT) in California for over 30 years and is certified in Gestalt Therapy, Domestic Violence Treatment and Addiction Treatment. She is a Certified Daring Way™ and Dare to Lead™ Facilitator, and a member of the International Motivational Interviewing Network of Trainers (MINT) and the International Coaching Federation. Renee was named *Mental Health Nurse of the Year* by the San Diego North County Civic Association in 2006 was honored at the *Tribute to Women in Industry (TWIN) Awards* in 2009.

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Northern California Training Academy

Advanced Issues of Adult Mental Health Table of Contents

Competencies

Safety 1

Children are, first and foremost, protected from abuse and neglect.

Permanency 1

Children have permanency and stability in their living situations without increasing reentry to foster care.

Well-being 1

Families have enhanced capacity to provide for their children's needs.

Well-being 2

Children receive services appropriate to their educational needs.

Well-being 3

Children receive services adequate to their physical, emotional, and mental health needs.

California Outcome 5F

Authorized for psychotropic medication

Learning Objectives

Knowledge:

K1. The participant will be able to recognize how commonly occurring mental disorders can affect a person's ability to parent safely.

K2. The participant will be able to recognize that there is a range of functioning among children, adolescents, and adults who experience mental and emotional disorders.

K3. The participant will be able to recognize that biological, psychological, cultural, environmental and behavioral (i.e. substance abuse) factors may influence the mental health functioning of family members.

K4. The participant will be able to describe the case management role of the child welfare worker working with health care and mental health professionals, including:

a) facilitating access to mental health services for adults, youth and children;
b) actively collaborating with mental health and medical professionals regarding mental health assessment; diagnostic testing; medication recommendations and management; and ongoing services for parents, youth and children;
c) ensuring ongoing court approval for use of psychotropic medication is in place for children and youth in placement;
d) advocating on behalf of parents, youth and children regarding the mental health services they receive.

K5. The participant will be able to recognize common case plan interventions that are used by child welfare workers to engage and assist children, youth and adults who experience mental and emotional disorders.

Skills:

S1. Utilizing a case scenario, the participant will be able to identify possible symptoms, warning signs, and behaviors that could indicate a mental health concern.

S2. Utilizing a case example, the participant will be able to identify cultural factors that may influence behavior and articulate how such behavior may be misconstrued as symptomatic of a mental disorder.

S3. Utilizing a case example, the participant will be able to develop case plan objectives, client responsibilities and planned services that meet the individual mental health needs of adults and children.

Values:

V1. The participant will value the child welfare worker's role in educating families, collaterals, service providers, and colleagues about common

misperceptions associated with certain mental disorders.

V2. The participant will value awareness of and sensitivity to cultural differences and their implications when working with families with mental health issues.

V3. The participant will value seeking out clinical case consultations and thinking critically when working with children, youth and families regarding mental health concerns and diagnoses.

V4. The participant will value customizing mental health interventions to meet individual and family needs.

Related Title IV-E MSW Curriculum Competencies

CP 1.1.
Interact positively with clients, colleagues and supervisors and demonstrate skill in seeking out suitable client services and ensuring client access to those services.

CP 1.2.
Maintain professional demeanor and boundaries in practice situations, demonstrate skill in articulating professional knowledge and effective use of self, and utilize appropriate resources to ensure professional growth.

CF 6.b.
Demonstrate knowledge of how to consult and utilize research evidence to inform ongoing practice and policy at all levels.

CA 7.1.
Integrate knowledge and theory of human behavior and the social environment from diverse perspectives to conduct reliable and valid assessments, comprehensive service plans, effective interventions, and meaningful evaluations in child welfare.

CF 10(a).a.
Demonstrate the knowledge base and affective readiness to intervene constructively with individuals and groups.

CA 10(a).1.

Demonstrate the ability to develop relationships and manage power differentials in routine and challenging client and partner situations, in a manner that reflects core social work values in child welfare practice.

CF 10(b).d.
Demonstrate ability to critically determine the most appropriate intervention strategies to implement a plan.

Classifying Mental Disorders

Why classify psychiatric diagnoses?

- **Communication** - between mental health professionals and with their patients
- **Framework** - for study of the outcome of mental illnesses
- **Treatmen**t - to predict the effects on the patient
- **Research** - into the causes of mental illness

Classification systems

The DSM 5

American Psychiatric Association: Diagnostic and statistical manual of mental disorders, Fifth Edition.

Published by the American Psychiatric Association (APA)

- A comprehensive manual of mental disorders that will be referenced throughout this course.
- The DSM 5 is a guide, an aide to assist clinicians to help facilitate treatment.

Three major sections of the DSM-5
Section I. Introduction and clear information on how to use the DSM.
Section II. Provides information and categorical diagnoses.
Section III. Provides self-assessment tools, as well as categories that require more research.

New to DSM 5

- Throughout the entire manual, disorders are framed in age, gender and developmental characteristics.
- Multi-axial system has been eliminated in the DSM 5.
- GAF (Global Assessment of Functioning) has been eliminated and the use severity scales added.
- DSM 5 removes artificial distinctions between medical and mental disorders.

In addition, the clinician can add the following to the diagnosis:

- Subtypes
- Specifiers and Severity Index
- Provisional Diagnosis

The ICD 10

International Classification of Diseases, 10th edition, 1992 (ICD-10)
The International Classification of Diseases, Ninth Revision (ICD-9) has been used in the United States for over 30 years and is extremely limited in the level of specificity it can provide in clinical diagnoses within health care. On October 1, 2014, ICD-10 coding will allow for a greater level of detail with its seven (7) alphanumeric characters instead of the 5-digit ICD-9 code set. This massive overhaul of the national coding system, going from roughly 17,000 codes to about 140,000, will be the most significant change to health care in decades.

DSM-5: Relevant disorders for Adults in Child Welfare

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar disorders
- Depressive Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Substance-Related and Addictive Disorders
- Personality Disorders
- Other Conditions That May Be a Focus of Clinical Attention

Considerations

- Mental Illness in the Parent or Caregiver
    - Effects on the children in the home
        - Trauma
        - Neglect
        - Attachment

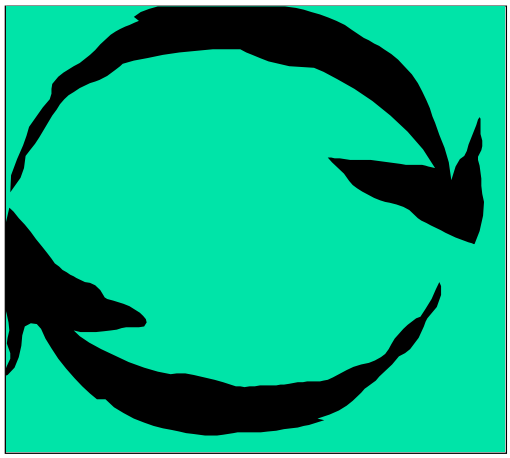
Modalities of Treatment

Cognitive behavioral therapy (CBT) with adults

- Maladaptive behavior is the result of maladaptive thinking patterns
- Thoughts drive behaviors

EVENT

FEELINGS



THOUGHTS

CBT Techniques

- Self-monitoring
- Self-talk
- Thought stopping
- Cognitive restructuring

CBT Effective Treatment for. . .

- Depression
- Anxiety disorders

Additional Modalities

- Eye Movement Desensitization Reprocessing (EMDR)
- Hypnotherapy
- Acceptance and Commitment Therapy
- Mindfulness-based Treatment
- Dialectical Behavior therapy
- Motivational Interviewing
- Solutions Focused Brief Therapy

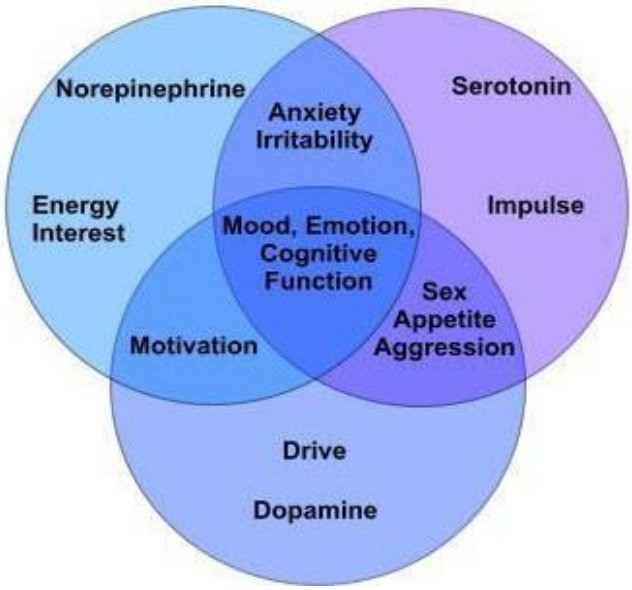
Psychopharmacology Principles

- Accurate assessment and diagnosis
- Choice of a therapeutic agent based on
  - ✓ Presenting Symptoms
  - ✓ History of previous treatment
  - ✓ Family history of treatment
  - ✓ Medical history and current status
- Desired effect, duration of action
- Maximize improvement in function
- Minimize negative side effects while taking advantage of positive secondary effects
- Minimize burden of medication administration
- Monitor compliance, side effects, response
- FDA Approval of Medications
  - "Off Label" use

Neurotransmitters

- *Dopamine* (DA)
- *Serotonin* (5HT)
- *Norepinephrine* (NE)
- *Acetylcholine* (AcH)
- *Glutamate* (Glu)

Neurotransmitters and the brain



From: Medscape.com

Mechanisms of Action of Psychotropic Medications

Agonist

Antagonist

- Blocks action of Neurotransmitter at receptor site

Inhibitor

- Inhibits production or activity of regulatory enzymes thereby influencing amount of neurotransmitter

Schizophrenia Spectrum and Other Psychotic Disorders

Schizotypal (Personality) Disorder (PD section)

Delusional Disorder

Erotomanic, Grandiose, Jealous, Persecutory, Somatic,

Mixed or Unspecified

Brief Psychotic Disorder

Schizophreniform Disorder

Schizophrenia

Schizoaffective Disorder

Bipolar Type

Depressive Type

Substance / Medication Induced Psychotic Disorder

Psychotic Disorder Due to Another Medical Condition

Catatonia

Other Specified Schizophrenia Spectrum and Other Psychotic Disorder

New in DSM-5

The 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 DSM-5 Section III to capture the important heterogeneity in symptom type and severity expressed across individuals with psychotic disorders.

Delusional Disorder

Criterion A for delusional disorder no longer has the requirement that the delusions must be nonbizarre. A specifier for bizarre type delusions provides continuity with DSM-IV. 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.

Schizoaffective Disorder

The 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. This change was made on both conceptual and psychometric grounds. 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. The change was also made to improve the reliability, diagnostic stability, and validity of this disorder, while recognizing that the characterization of patients with both psychotic and mood symptoms, either concurrently or at different

points in their illness, has been a clinical challenge.

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 the 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 the DSM-5, all contexts require three catatonic symptoms (from a total of 12 characteristic symptoms). Additionally, 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 another specified diagnosis.

From: Highlights of Changes from DSM-IV-TR to DSM-5 APA 2013

Schizophrenia

Etiology – According to the Surgeon General

- The cause of schizophrenia has not yet been determined, although research points to the interaction of genetic factors and environmental contributions during development of the brain.
- Problems with certain naturally occurring brain chemicals, including the neurotransmitters dopamine and glutamate, also may contribute to schizophrenia.
- Neuroimaging studies show differences in the brain structure and central nervous system of people with schizophrenia. While researchers aren't certain about the significance of these changes, they support evidence that schizophrenia is a brain disease.

DSM-5 criteria for Schizophrenia

Two or more of the following symptoms, each present for a significant period of time for a one-month period (at least one must be 1, 2, or 3):

1. Delusions
2. Hallucinations
3. Disorganized speech
4. Disorganized behavior
5. Negative symptoms

Level of functioning in one or more major areas is markedly below the level prior to the onset.

- R/O
- Schizoaffective disorder
- Depressive disorder
- Manic episodes

Continuous signs of the disturbance persist for at least 6 months.

Schizophrenia is **not** the result of medication or a medical condition.

If there is a history of autism spectrum disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, are present for at least 1 month.

Specifiers

- 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
- With catatonia

Current severity of Schizophrenia:

See clinician rated-dimensions of Psychosis Symptoms: 8-item measure that assesses the severity of mental health symptoms that are important across psychotic disorders, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, negative symptoms (i.e., restricted emotional expression or avolition), impaired cognition, depression, and mania.

Treatment of Schizophrenia

Pharmacotherapy

Medications are the cornerstone of schizophrenia treatment. But because medications for schizophrenia can cause serious but rare side effects, people with schizophrenia may be reluctant to take them.

Antipsychotic medications are the most commonly prescribed to treat schizophrenia. They're thought to control symptoms by affecting the brain neurotransmitters dopamine and serotonin.

A person's willingness to cooperate with treatment may affect medication choice. Someone who is uncooperative may need to be given injections instead of taking a pill. Someone who is agitated may need to be calmed initially with a benzodiazepine such as lorazepam (Ativan), which may be combined with an antipsychotic.

Psychosocial treatments

Once psychosis recedes, psychosocial treatments also are important. These may include:

- **Social skills training.** This focuses on improving communication and social interactions.

- **Family therapy.** This provides support and education to families dealing with schizophrenia.

- **Vocational rehabilitation and supported employment.** This focuses on helping people with schizophrenia find and keep jobs.

- **Individual therapy.** Learning to cope with stress and identify early warning signs of relapse can help people with schizophrenia manage their illness.

- Many communities have programs to help people with schizophrenia with jobs, housing, self-help groups and crisis situations. A case manager or someone on the health care team can help find one. With appropriate treatment, most people with schizophrenia can manage their condition.

- **Coping and support**. Coping with an illness as serious as schizophrenia can be challenging, both for the person with the condition and for friends and family.

Psychopharmacology

Atypical Antipsychotics – First Line Treatment Choice

- Preferred use in schizophrenia
  - First-line treatment of positive symptoms
  - First-line treatment of negative symptoms
  - Treatment of relapses
  - Re-stabilization of patients with side effects from conventional antipsychotics
  - Long-term maintenance

- **Potential clinical benefits**
  - Better compliance, fewer EPS and less TD
  - Better efficacy for both positive and negative Symptoms
  - Fewer hospitalizations

- Less disruptive downhill course

- **Serotonin-dopamine antagonists**
- **Anti-anxiety medication**

Conventional Antipsychotic Medications
(No longer considered 1st Treatment Choice)

- Neuroleptics and Sedative-antipsychotics
- Affect dopamine levels in the brain and reduce anxiety and emotional symptoms
- Side Effects
  - Anticholinergic: Dry mouth, blurred vision,
  - GI/GU: Constipation, mild to severe problems with urination
  - Greater risk of sunburn, hypotension, possible agranulocytosis
  - Extrapyramidal Side Effects

Extrapyramidal (EPS) Side Effects

- Parkinson-like side effects
  - Muscle rigidity, flat affect, tremor, bradykinesia
- Akathisia
  - Uncontrolled sense of inner restlessness
- Acute Dystonias
  - Muscle spasms and prolonged contractions
- Tardive Dyskinesia (TD)
  - Late onset EPS symptom
  - Very serious, can be irreversible
  - Involuntary sucking, smacking movements
  - Rigidity of the trunk and extremities
  - No cure

Patient Education

- Side effects to report to MD
  - Tremors, muscle rigidity or spasms, inner restlessness

- Most side effects can be treated or medication can be adjusted
- Education about TD
- Schizophrenia is a chronic, relapsing disorder
- Medication may be needed for a year or longer
- Avoid exposure to high temperatures and sunlight
- Avoid amphetamines and cocaine

Bipolar and Related Disorders

- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder
- Substance/Medication-Induced Bipolar and Related Disorder
- Bipolar and Related Disorder Due to Another Medical Condition
- Other Specified Bipolar and Related Disorder
- Unspecified Bipolar and Related Disorder

The disorders in this category refer to disturbances in mood in which the client cycles through stages of mania or mania and depression. Both children and adults can be diagnosed with bipolar disorder, and the clinician can work to identify the pattern of mood presentation, such as rapid-cycling, which is more often observed in children.

To enhance the accuracy of diagnosis and facilitate earlier detection in clinical settings, Criterion A for manic and hypomanic episodes now includes an emphasis on changes in activity and energy as well as mood. The DSM-IV diagnosis of bipolar I disorder, mixed episode, requiring that the individual simultaneously meet full criteria for both mania and major depressive episode, has been removed. Instead, a new specifier, "with mixed features," has been added that can be applied to episodes of mania or hypomania when depressive features are present and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present.

The DSM-5 allows the specification of particular conditions for other specified bipolar and related disorder, including categorization for individuals with a past history of a major depressive disorder who meet all criteria for hypomania except the duration criterion (i.e., at least 4 consecutive days). A second condition constituting another specified bipolar and related disorder is that too few

symptoms of hypomania are present to meet criteria for the full bipolar II syndrome, although the duration is sufficient at four or more days.

Anxious Distress Specifier

In the chapter on bipolar and related disorders and the chapter on depressive disorders, a specifier for anxious distress is delineated. This specifier is intended to identify patients with anxiety symptoms that are not part of the bipolar diagnostic criteria.

From: Highlights of Changes from DSM-IV-TR to DSM-5 APA 2013

Etiology of bipolar disorders

- Environmental factors
- Genetic Factors

Conservative estimate of risk

- One parent with BPD 15% to 30%
- Both parents with BPD 50% to 75%
- Siblings and fraternal twins 15% to 25%
- Identical twins 70%

DSM-5 - Definitions for Bipolar and Related Disorders

Manic episode
A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy for at least one week.

Three or more of the following symptoms (four if the mood is only irritable) and are a noticeable change in functioning:

- Inflated self-esteem or grandiosity
- Reduced need for sleep
- Increased talkativeness or pressured speech
- Flight of ideas or racing thoughts

- Distractible
- Increased goal-directed activity or psychomotor agitation
- Excessive involvement in activities that have a high potential for painful consequences (buying sprees, sexual indiscretions)

Additional factors related to the symptoms of a manic episode:

- The symptoms cause marked impairment, cause hospitalization, or there are psychotic features. The episode is not caused by a substance or a medical condition.

- A full manic episode that emerges during antidepressant treatment but persists beyond that treatment is sufficient evidence for a manic episode and therefore a Bipolar I diagnosis.

Hypomanic episode

A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy for at least four days.

Three or more of the following symptoms (four if the mood is only irritable) and are a noticeable change in functioning:

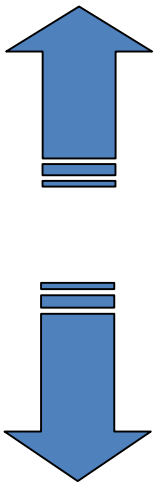
- Inflated self esteem
- Decreased need for sleep
- More talkative than usual
- Distractibility
- Increase in goal directed activity
- Less severe symptoms than in manic episode
- Excessive involvement in activities that have a high potential for painful consequences (buying sprees, sexual indiscretions)

Additional factors to consider in the context of a hypomanic episode:

- The episode is an unequivocal change in functioning that is uncharacteristic for the individual.
- The change in mood and functioning are observable by others.
- The episode is not severe enough to cause hospitalization.
- Not due to effects of a substance.

Note: use caution in diagnosing when starting on antidepressant treatment. Full hypomanic episode that emerges during treatment is still allowed but only if more than irritable, edgy or agitated following antidepressant use.

Spectrum of Mood States



Severe mania / irritability

Hypomania (mild to moderate mania)

Normal/balanced mood

Mild to moderate depression

Severe depression

Bipolar I

Criteria met for at least one manic episode

R/O
Substance Abuse
Schizoaffective disorder
Schizophrenia spectrum disorders

Note current episode:
Depressed
Manic

Specify if:
With anxious distress
With mixed features
With rapid cycling
With melancholic features

With atypical features
With mood-congruent psychotic features
With mood-incongruent psychotic features
With catatonia
With peripartum onset
With seasonal pattern

In partial remission
In full remission
Unspecified

Bipolar II

Criteria met for current or past hypomanic episode but history of hypomanic episode and a current or past major depressive episode.
No history of full manic episode

Specifiers

- Note current episode:
  Depressed
- Manic

Specify if:

- With anxious distress
- With mixed features
- With rapid cycling
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern
- In partial remission
- In full remission

Severity:

- Mild
- Moderate
- Severe

Cyclothymic Disorder

Symptoms

Multiple occurrences of hypomanic symptoms and depressive symptoms over a two year period (one year for children) that do not meet criteria for full episodes.

Symptoms present for at least half the time in the 2 year period with the longest time period free of mood symptoms is two months
Have not met criteria for manic, major depressive or hypomanic episode

The episode is not caused by a substance or a medical condition.

R/O
Schizoaffective disorder
Schizophrenia spectrum disorders

Specifier:
With anxious distress

Treatment of Bipolar Disorders

Crucial components

Accurate and early diagnosis
Prescribing the right medications for stabilizing
Incorporating family-focused treatment

- In adults on meds, 60% BPD's stay in remission for 9 months
- If family-focused treatment is added, 90% stay in remission for 9months

Treatment of bipolar disorder

Pharmacotherapy/monitor Symptoms
Individual therapy
- Anger management
- Self monitoring and self talk
- Problem solving

Play/Art Therapy
Family therapy
Parent training/parent education

Good nutrition
Regular sleep and exercise

Positive outcome indicators in bipolar disorder

- Access to competent medical care
- Early diagnosis and treatment
- Adherence to medication and treatment plan
- A flexible, low-stress home and school environment
- A supportive network of family and friends

Pharmacotherapy

Mood stabilizers

Mood stabilizers, neuroleptics, atypical

Depressive Disorders

- Disruptive Mood Dysregulation Disorder (covered in Advanced Issues of Children's Mental Health class)
- Major Depressive Disorder, Single and Recurrent Episodes
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Substance/Medication-Induced Depressive Disorder
- Depressive Disorder Due to Another Medical Condition
- Other Specified Depressive Disorder
- Unspecified Depressive Disorder

Bereavement Exclusion Removal

In the DSM-IV, if you were grieving the loss of a loved one, technically you couldn't be diagnosed with major depression disorder in the first 2 months of your grief. This exclusion was removed in the DSM-5. Here are the reasons they gave:

- The first is to remove the implication that bereavement typically lasts only two months when both physicians and grief counselors recognize that the duration is more commonly 1–2 years.
- Second, bereavement is recognized as a severe psychosocial stressor that can precipitate a major depressive episode in a vulnerable individual, generally beginning soon after the loss. When major depressive disorder occurs in the context of bereavement, it adds an additional risk for suffering, feelings of worthlessness, suicidal ideation, poorer somatic health, worse interpersonal and work functioning, and an increased risk

for persistent complex bereavement disorder, which is now described with explicit criteria in Conditions for Further Study in DSM-5 Section III.

- Third, bereavement-related major depression is most likely to occur in individuals with past personal and family histories of major depressive episodes. It is genetically influenced and is associated with similar personality characteristics, patterns of comorbidity, and risks of chronicity and/or recurrence as non–bereavement-related major depressive episodes.
- Lastly, the depressive symptoms associated with bereavement-related depression respond to the same psychosocial and medication treatments as non–bereavement-related depression. In the criteria for major depressive disorder, a detailed footnote has replaced the more simplistic DSM-IV exclusion to aid clinicians in making the critical distinction between the symptoms characteristic of bereavement and those of a major depressive episode.

Specifiers for Depressive Disorders

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. A new specifier to indicate the presence of mixed symptoms has been added across both the bipolar and the depressive disorders, allowing for the possibility of manic features in individuals with a diagnosis of unipolar depression. A substantial body of research conducted over the last two decades points to the importance of anxiety as relevant to prognosis and treatment decision making. The "with anxious distress" specifier gives the clinician an opportunity to rate the severity of anxious distress in all individuals with bipolar or depressive disorders.

From: Highlights of Changes from DSM-IV-TR to DSM-5 APA 2013

Major depressive disorder
DSM-5 criteria

The core criteria of major depressive disorder are unchanged in the new DSM-5 . However, the specifier "with mixed features" can be affixed to a diagnosis of

major depressive disorder to indicate symptoms of mania without meeting the full criteria for a manic or hypomanic episode.

Symptoms: five or more of the following symptoms, not attributable to another medical condition, occur in the same two-week period and represent a change from previous functioning; at least one is either

- Depressed mood
- Loss of interest or pleasure

Others symptoms can include:

- Depressed mood most of the day, nearly every day (in children and adolescents can be irritable mood)
- Markedly diminished pleasure in all, or almost all activities most of the day, nearly every day
- Significant weight loss or weight gain when not dieting
- Insomnia or excessive sleep
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating, or indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation or plans, or a suicide attempt or a specific plan

The symptoms cause clinically significant distress or impairment.

The episode is not caused by a substance or a medical condition.

Specifiers and severity codes

- Recurrent
- Single episode
- Mild
- Moderate
- Severe without psychotic features
- With psychotic features
- In partial remission
- In full remission
- Unspecified

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

R/O
Schizoaffective disorder
Schizophrenia
There has never been a manic or hypomanic episode.

Persistent Depressive Disorder (Dysthymia)

Depressed mood most of the day, nearly every day more days than not, for at least two years (1 year in children).

Presence, while depressed, of two (or more) of the following:

Poor appetite or overeating
Insomnia or hypersomnia
Low energy or fatigue
Low self-esteem
Poor concentration or difficulty making decisions
Feelings of hopelessness

During the 2 year period the individual has never been without the symptoms for more than 2 months.
Can have symptoms of major depressive disorder for 2 years
Never had manic or hypomanic symptoms
Not due to substance or medical condition

Specifiers

With anxious distress
With mixed features
With melancholic features
With atypical features
With mood-congruent psychotic features
With mood-incongruent psychotic features
With peripartum onset

Partial remission
Full remission
Early onset: before age 21
Late onset: after age 21

With pure dysthymic syndrome
With persistent major depressive episode
With intermittent major depressive episodes, with current episode
With intermittent major depressive episodes, without current episode

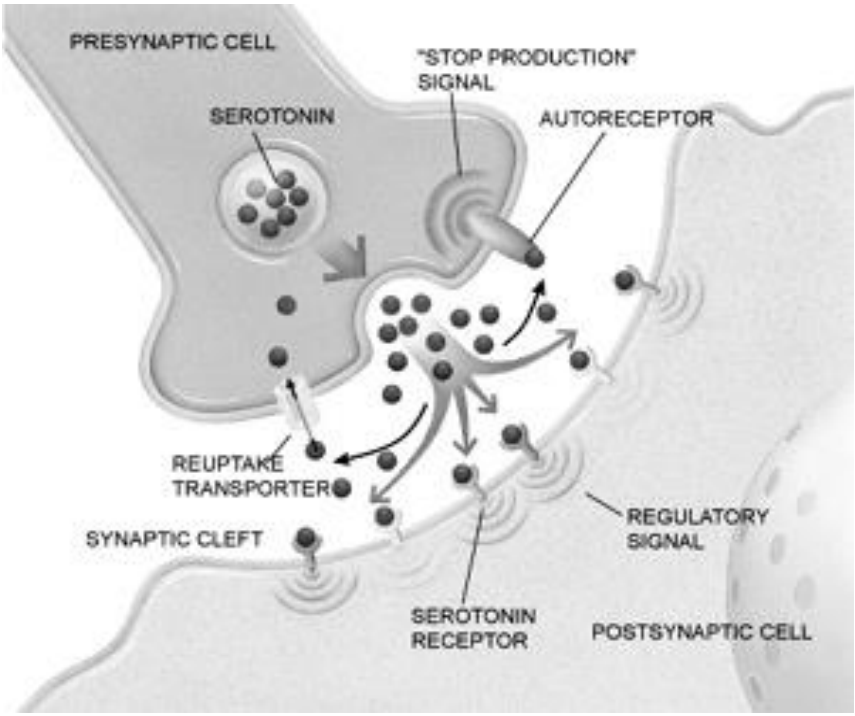
Mild
Moderate
Severe

Treatment for Depressive Disorders

- Pharmacotherapy
- Individual Therapy
- EMDR
- Behavior Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)
- Family Therapy
- Group Therapy
- Light therapy
- Magnet therapy
- Electroconvulsive therapy (ECT)

Pharmacotherapy **The content on pharmacology is for informational purposes only and should not be considered medical or treatment advice.*

The synapse and serotonin



Selective serotonin (5-HT) reuptake inhibitors (SSRIs)

- SSRIs block reuptake pumps so serotonin cannot be re-shuttled back into the synaptic neuron
- Possible Side Effects:
  GI symptoms, headaches, nervousness, insomnia, somnolence, and rashes

Novel antidepressants

Norepinephrine reuptake inhibitors

Medications derived from ketamine

Alpha-2 antagonists

Serotonin-2A antagonists / serotonin reuptake inhibitors

Trycyclic antidepressants

MAOI: Monoamine oxidase inhibitors (MAOIs)
*Not recommended for use in children or teens

What might the prescribing clinician do for treatment resistant depression?

- Start with a typical antidepressant
- Change antidepressant
- Change class of antidepressant
- Switch medication

Issues complicating treatment

- Missed Diagnosis
- Co-Morbidity
- Side Effects
- Non-compliance
- Discontinuation
- Non-response
- Partial Response
- Speed of Response
- Relapse

Anti-depressants: Family education

- Onset of clinical action (10-21 days)
- Expected improvement (which symptoms)
- Barometers of medication response
- Side effects

- Length of time for treatment
- Antidepressants are not addictive
- No alcohol while on antidepressants

Obsessive-Compulsive and Related Disorders

Obsessive-compulsive disorder
Body dysmorphic disorder
Trichotillomania (hair-pulling disorder
Hoarding disorder
Excoriation (skin-picking) disorder

The major change for obsessive-compulsive disorder is the fact that it and related disorders now have their own chapter. They are no longer considered "anxiety disorders." This is due to increasing research evidence demonstrating common threads running through a number of OCD-related disorders — obsessive thoughts and/or repetitive behaviors.

Insight & Tic Specifiers for Obsessive-Compulsive and Related Disorders

The old DSM-IV specifier with poor insight has been modified from being a black-and-white specifier, to allowing for some degrees on a spectrum of insight:
•Good or fair insight
•Poor insight
•Absent insight/delusional obsessive-compulsive disorder beliefs (i.e., complete conviction that obsessive-compulsive disorder beliefs are true)

These same insight specifiers have been included for body dysmorphic disorder and hoarding disorder as well. This change also emphasizes that the presence of absent insight/delusional beliefs warrants a diagnosis of the relevant obsessive-compulsive or related disorder, rather than a schizophrenia spectrum and other psychotic disorder.

Also, the APA notes that the new tic-related specifier for obsessive-compulsive disorder reflects the research validity (and clinical validity) of "identifying individuals with a current or past comorbid tic disorder, because **this comorbidity may have important clinical implications."**

OCD – DSM-5 criteria

Symptoms include either obsessions or compulsions (or both) that are time consuming, interfere with normal routines, or interfere with social, academic functioning.

- Obsessions
    - recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress
    - the individual attempts to ignore or suppress such thoughts with some other action (compulsion)
- Compulsions
    - are repetitive behaviors or rituals (like hand washing, keeping things in order, checking something over and over) that the individual feels driven to perform
    - mental acts aimed at preventing or reducing anxiety or distress, or preventing some dreaded event (not connected in any real way to the event
        - children may not be able to articulate the aims fo the behaviors

Time consuming: more than 1 hour per day or cause distress.
Not attributable to a substance or another medical condition.

R/O
Generalized Anxiety disorder
Body dysmorphic disorder
Hoarding disorder
Eating disorders
Illness anxiety disorder
Depression
Schizophrenia spectrum

Specifiers

With good or fair insight
With poor insight
With absent insight/delusional beliefs
Tic-related

Treatment of OCD

- Combination of
  - Psychotherapy
    - CBT
    - Behavioral
  - Pharmacotherapy
    - SSRIs
  - Family support and education

Hoarding disorder

Hoarding disorder was listed as just one symptom of obsessive-compulsive personality disorder in the DSM-IV and is now a full-blown diagnostic category in the DSM-5. After the DSM-5 OCD working group examined the research literature on hoarding, they found little support to suggest this was simply a variant of a personality disorder, or a component of another mental disorder.

Hoarding disorder is included in DSM-5 because research shows that it is a distinct disorder with distinct treatments. Using DSM-IV, individuals with pathological hoarding behaviors could receive a diagnosis of obsessive-compulsive disorder (OCD), obsessive-compulsive personality disorder, anxiety disorder not otherwise specified or no diagnosis at all, since many severe cases of hoarding are not accompanied by obsessive or compulsive behavior. Creating a unique diagnosis in DSM-5 will increase public awareness, improve identification of cases, and stimulate both research and the development of specific treatments for hoarding disorder.

The behavior usually has harmful effects — emotional, physical, social, financial, and even legal — for the person suffering from the disorder and family members. For individuals who hoard, the quantity of their collected items sets them apart from people with normal collecting behaviors.

Beyond the mental impact of the disorder, the accumulation of clutter can create a public health issue by completely filling people's homes and creating fall and fire hazards.

Prevalence

Approximately two to five percent of the population

DSM-5 Criteria

Hoarding disorder is characterized by the persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions.

Perceived need to save items and distress in discarding them.

Accumulation of a large number of possessions that often fill up or clutter active living areas to the extent that their intended use is no longer possible.

Symptoms of the disorder cause clinically significant distress or impairment in social, occupational or other important areas of functioning including maintaining an environment for self and/or others.

Not attributable to another medical condition (brain injury).

R/O

OCD
Schizophrenia spectrum disorder
Major depression
Major neurocognitive disorder
Autism spectrum disorder

Specifiers

With excessive acquisition
Specifiers
With good or fair insight
With poor insight
With absent insight/delusional beliefs

Treatment of Hoarding Disorder

Cognitive Behavioral Therapy

Intensive treatment programs or hospitalization

Psychotropic Medications: SSRI's

Trauma and Stressor-Related Disorders

Posttraumatic Stress Disorders

Reactive Attachment Disorder

Disinhibited Social Engagement Disorder

Posttraumatic Stress disorder

Acute Stress Disorder

Adjustment Disorders

Other Specified Trauma- and Stressor-Related Disorder

Unspecified Trauma- and Stressor-Related Disorder

Post-traumatic stress disorder undergoes some major changes in the DSM-5. For example, the first criteria is far more explicit in what constitutes a traumatic event. "Sexual assault is specifically included, for example, as is a recurring exposure that could apply to police officers or first responders," notes the APA. "Language stipulating an individual's response to the event — intense fear, helplessness or horror, according to DSM-IV — has been deleted because that criterion proved to have no utility in predicting the onset of PTSD."

Instead of three major symptom clusters for PTSD, the DSM-5 now lists four clusters:

- Re-experiencing the event — For example, spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.
- Heightened arousal — For example, aggressive, reckless or self-destructive behavior, sleep disturbances, hyper-vigilance or related problems.
- Avoidance — For example, distressing memories, thoughts, feelings or external reminders of the event.
- Negative thoughts and mood or feelings — For example, feelings may vary

from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.

PTSD Preschool Subtype

DSM-5 includes the addition of two new subtypes. The first is called PTSD Preschool Subtype, which is used to diagnose PTSD in children younger than 6 years. Post-traumatic stress disorder is also now developmentally sensitive, meaning that diagnostic thresholds have been lowered for children and adolescents. (see Advanced Child Mental Health Course)

PTSD Dissociative Subtype

The second new PTSD subtype is called PTSD Dissociative Subtype. It is chosen when PTSD is seen with prominent dissociative symptoms. These dissociative symptoms can be either experiences of feeling detached from one's own mind or body, or experiences in which the world seems unreal, dreamlike or distorted.

DSM-5 Criteria

Criterion A: stressor

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (1 required)
1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: intrusion symptoms

The traumatic event is persistently re-experienced in the following way(s): (1 required)
1. Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (1 required)
1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Criterion D: negative alterations in cognitions and mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event: (2 required)
1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear horror, anger, guilt or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

Criterion E: alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (2 required)
1. Irritable or aggressive behavior.
2. Self-destructive or reckless behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems in concentration.
6. Sleep disturbance.

Criterion F: duration

Persistence of symptoms (in Criteria B, C, D and E) for more than one month.

Criterion G: functional significance

Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criterion H: exclusion

Disturbance is not due to medication, substance use, or other illness.

Specify if: With dissociative symptoms.

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
1. Depersonalization: experience of being an outside observer of or detached from one (e.g., feeling as if "this is not happening to me" or one were in a dream).
2. Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").

Specify if: With delayed expression.

Full diagnosis is not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

From: http://www.ptsd.va.gov/professional/pages/dsm5_criteria_ptsd.asp

Treatment of PTSD

- Crisis intervention at time of trauma
- Cognitive-Behavioral therapy
    - Exposure
    - Self-talk and cognitive restructuring
    - Relaxation and assertiveness training
- EMDR
- Hypnotherapy
- Trauma-Focused Cognitive Behavioral Therapy
- Prolonged Exposure therapy

Substance-Related and Addictive Disorders

DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Substance use disorders are presented with 10 separate classes of drugs as well as gambling as a new disorder. For the substance use disorders, each is noted with the associated effects:

intoxication
withdrawal
substance/medication-induced disorders

The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5, and a new criterion, craving or a strong desire or urge to use a substance, has been added. In addition, the threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria, in contrast to a threshold of one or more criteria for a diagnosis of DSM-IV substance abuse and three or more for DSM-IV substance dependence.

Substance use disorders span a wide variety of problems arising from substance use, causes clinically significant impairment and covers 11 different criteria :

1. Taking the substance in larger amounts or for longer than was intended.
2. Persistent desire to cut down or stop using the substance without success.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Failure to fulfill major role obligations at work, home or school, because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational or recreational activities because of substance use.
8. Continued use in situations that are physically hazardous.
9. Continuing to use, even when person knows they have a physical or

psychological problem that could have been caused or made worse by the substance.

10. Tolerance as defined by either:
    a. Increasing amount needed to achieve desired effect
    b. Diminished effect when using same amount of substance
11. withdrawal as manifested by
    a. substance withdrawal
    b. other substance taken to relieve or avoid withdrawal

Binge drinking (new in DSM-5)

- The three leading causes of death for 15- to 24-year-olds are automobile crashes, homicides and suicides -- alcohol is a leading factor in all three.

  - Often beginning around age 13
  - Tends to increase during adolescence, peak in young adulthood (ages 18-22), then gradually decrease.
  - Individuals who increase their binge drinking from age 18 to 24 and those who consistently binge drink at least once a week during this period may have problems attaining the goals typical of the transition from adolescence to young adulthood (e.g., marriage, educational attainment, employment, and financial independence)

DSM-5 Substances – 10 Classes

- Alcohol
- Caffeine
- Cannabis
- Hallucinogens
- Inhalants
- Opioids
- Sedatives**,** Hypnotics, **or** Anxiolytics
- Stimulants
- Tobacco
- Other or unknown substances

Types of substance disorders (may have one or more types):

- Substance Use Disorder (specify class of substance)
- Substance Intoxication
- Substance Withdrawal

DSM-5 Criteria

The characteristic feature of a substance use disorder is a cluster of cognitive, behavioral and physiological symptoms signifying continued use despite considerable problems related to substance use. This diagnosis can be applied to all 10 classes of drugs, except for caffeine, and in some of the classes, certain symptoms, such as withdrawal, do not apply

Specifiers:

Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without criteria (except craving).

Additional new DSM-5 specifiers include "in a controlled environment" and "on maintenance therapy" as the situation warrants.

- In early remission
- In sustained remission
- In a controlled environment
- On maintenance therapy
- With perceptual disturbances

Severity (depends on number of symptoms)

Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed:

- Mild: 2–3 criteria

- Moderate: 4–5 criteria
- Severe: 6 or more criteria

Diagnosis and treatment

- Recognition of addiction as a bio/psycho/social disease
- Importance of psycho-education in outreach/prevention/treatment
- **Caution:** Look for co-occurring disorders that will complicate recovery

Harm reduction theory definition

"...a set of strategies and tactics that encourage users to reduce the harm done to themselves and communities by their licit and illicit substance use. In allowing users access to the tools with which to become healthier, we recognize the competency of their efforts to protect themselves, their loved ones and their communities."

Personality Disorders

The criteria for personality disorders in Section II of DSM-5 have not changed from those in DSM-IV. An alternative approach to the diagnosis of personality disorders was developed for DSM-5 for further study and can be found in Section III of the DSM-5.

Personality disorders are a group of mental health conditions in which a person has a long-term pattern of behaviors, emotions, and thoughts that is very different from his or her culture's expectations. These behaviors interfere with the person's ability to function in relationships, work, or other settings.

Causes, incidence, and risk factors

Causes of personality disorders are unknown.

Genetic and environmental factors are thought to play a role.

Symptoms vary widely depending on the type of personality disorder.

In general, personality disorders involve feelings, thoughts, and behaviors that do not adapt to a wide range of settings.

These patterns usually begin in adolescence. Often people with these disorders usually do not seek treatment on their own. They tend to seek help once their behavior has caused severe problems in their relationships or work. They may also seek help when they are struggling with another mental health problem, such as a mood or substance abuse disorder.

The severity of these conditions ranges from mild to severe.

Cluster A Personality Disorders

Paranoid Personality Disorder
Schizoid Personality Disorder

Schizotypal Personality Disorder

Cluster B Personality Disorders
Antisocial Personality Disorder (dual coded in Disruptive, Impulse-Control, and Conduct disorder section)

Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder

Cluster C Personality Disorders

Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder

Treatment of Personality Disorders

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual**.**

5 Components:

1. capability enhancement (skills training
2. motivational enhancement (individual behavioral treatment plans)

3. generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment
4. structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors

5. capability and motivational enhancement of therapists (therapist team consultation group).

Section III

Section III of the DSM-5 includes Alternative DSM-5 Model for Personality Disorders and Conditions for further Study.

Alternative DSM-5 Model for Personality Disorders

The inclusion of both models in DSM-5 reflects the decision of the APA to preserve continuity with current clinical practice, while also introducing a new approach that aims to address numerous shortcomings of the current approach to personality disorders.

DSM-5 general criteria for personality disorders

Moderate or greater impairment in personality (self /interpersonal) functioning.

One or more pathological personality traits.

The impairments in personality functioning and the individual's personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations.

The impairments in personality functioning and the individual's personality trait expression are relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood.

The impairments in personality functioning and the individual's personality trait expression are not better explained by another mental disorder.

The impairments in personality functioning and the individual's personality trait expression are not solely attributable to the physiological effects of a substance or another medical condition (e.g., severe head trauma).

The impairments in personality functioning and the individual's personality trait expression are not better understood as normal for an individual's

developmental stage or sociocultural environment.

Criterion A: Level of Personality Functioning
5 levels of functioning (continuum)

Self:
Identity
Self-direction
Interpersonal:
Empathy
Intimacy

Criterion B: Pathological Personality Traits
Trait Facets and Trait Domains

Criterion C and D: Pervasive and Stability

Citeria E, F, and G: Alternative Explanations for pathology (Differential diagnosis)

DSM-5 Section III
Conditions for further Study

These are conditions warranting more scientific research and clinical experience before they might be considered for inclusion in the main book as formal disorders. Two conditions listed here are particularly relevant for children and adolescents; both are regarded as major problems and public health issues that need to be better understood. Nonsuicidal self-injury defines self-harm without the intention of suicide. Internet gaming disorder deals with the compulsive preoccupation some people develop in playing online games, often to the exclusion of other needs and interests.

Attenuated Psychosis Syndrome
Depressive Episodes With Short-Duration
Hypomania
Persistent Complex Bereavement Disorder
Caffeine Use Disorder
Internet Gaming Disorder

Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure
Suicidal Behavior Disorder
Nonsuicidal Self-Injury

Glossary of Terms

Anhedonia - loss of pleasure in activities

Comorbidity - the co-occurrence of two or more disorders

Disorder - a syndrome consisting of particular signs and symptoms contained within a diagnostic classification system
such as the *DSM-IV*

Incidence: The term 'incidence' refers to the annual diagnosis rate, or the number of new cases of a given disorder

Lability - rapid mood swings or moodiness

Mood congruent - thoughts are of the same theme as the mood

Mood incongruent - thoughts are of a different theme than the mood

Neurotransmitter - chemical messengers that are the communication link between nerve cells

Prevalence: The term usually refers to the estimated population of people who are managing an illness or disorder at any given time.

Symptom - refers to a subjective experience; indicated by the patient of a condition

Syndrome - a group of symptoms and signs occurring together which may indicate an underlying cause or process

References and Further Reading

American Psychiatric Association: Diagnostic and statistical manual of mental disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

American Psychiatric Association: Desk Reference to the Diagnostic Criteria From DSM-5. Arlington, VA, American Psychiatric Association, 2013.

Bloch, S. and Singh, B. (2011). *Understanding troubled minds.* New York: New York University Press.

Paris, J. The Intelligent Clinician's Guide to the DSM-5. Oxford University Press: 2013.

Paris, J. and Phillips, J. (eds.) Making the DSM-5 2013 Concepts and Controversies. Springer Science + Business Media New York 2013.

Nussbaum, A. Pocket guide to the Diagnostic and statistical Manual of mental disorders-5 diagnostic exam 1st ed. Arlington, VA American Psychiatric Publishing, 2013.

Web Sites

Depression
Wings of Madness
www.wingofmadness.com

Postpartum depression
http://www.mededppd.org
http://www.depressioncenter.org/understanding/postpartum.asp

PTSD
http://www.ptsd.va.gov/professional/pages/dsm5_criteria_ptsd.asp
Nat'l Center for PTSD: http://www.ptsd.va.gov/index.asp

Balanced Mind Foundation

www.thebalancedmind.org

National Alliance on Mental Illness
www.nami.org

Mental Health America
www.mentalhealthamerica.net

American Psychiatric Association
http://www.psychiatry.org/dsm5

ADHD
The Attention Deficit Information Support Network, Inc.
www.addinfonetwork.com

Attention Deficit Disorder Association
www.add.org

Children and Adults with Attention Deficit Hyperactivity Disorder (CHADD)
www.chadd.org

American foundation for Suicide Prevention
http://www.afsp.org/

Suicide statistics
Center for Disease Control
http://www.cdc.gov/violenceprevention/suicide/statistics/aag.html#3

Autism
http://www.autismspeaks.org

Online Assessment Measures DSM-5 disorder specific
http://www.psych.org/practice/dsm/dsm5/online-assessment-measures#Disorder

Samhsa evidence based programs and practices
http://nrepp.samhsa.gov/Index.aspx

DSM-5 Classification listing

(Diagnoses in ***bold italic*** covered in this Advanced Adult Mental Health course)

Neurodevelopmental Disorders

- Intellectual Disabilities
- Intellectual Disability (Intellectual Developmental Disorder)
- Global Developmental Delay
- Unspecified Intellectual Disability (Intellectual Developmental Disorder)
- Communication Disorders
- Language Disorder
- Speech Sound Disorder (previously Phonological Disorder)
- Childhood-Onset Fluency Disorder (Stuttering)
- Social (Pragmatic) Communication Disorder
- Unspecified Communication Disorder
- Autism Spectrum Disorder
- Attention-Deficit/Hyperactivity Disorder
- Other Specified Attention-Deficit/Hyperactivity Disorder
- Unspecified Attention-Deficit/Hyperactivity Disorder
- Specific Learning Disorder
- Specific Learning Disorder
- Motor Disorders
- Developmental Coordination Disorder
- Stereotypic Movement Disorder
- Tic Disorders
- Tourette's Disorder
- Persistent (Chronic) Motor or Vocal Tic Disorder
- Provisional Tic Disorder
- Other Specified Tic Disorder
- Unspecified Tic Disorder
- Other Neurodevelopmental Disorders
- Other Specified Neurodevelopmental Disorder
- Unspecified Neurodevelopmental Disorder

Schizophrenia Spectrum and Other Psychotic Disorders

- Schizotypal (Personality) Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder

Schizophrenia
Schizoaffective Disorder
Substance/Medication-Induced Psychotic Disorder
Psychotic Disorder Due to Another Medical Condition
Catatonia
Catatonia Associated With Another Mental Disorder (Catatonia Specifier)
Catatonic Disorder Due to Another Medical Condition
Unspecified Catatonia
Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Bipolar and Related Disorders

Bipolar I Disorder
Bipolar II Disorder
Cyclothymic Disorder
Substance/Medication-Induced Bipolar and Related Disorder
Bipolar and Related Disorder Due to Another Medical Condition
Other Specified Bipolar and Related Disorder
Unspecified Bipolar and Related Disorder

Depressive Disorders

Disruptive Mood Dysregulation Disorder
Major Depressive Disorder, Single and Recurrent Episodes
Persistent Depressive Disorder (Dysthymia)
Premenstrual Dysphoric Disorder
Substance/Medication-Induced Depressive Disorder
Depressive Disorder Due to Another Medical Condition
Other Specified Depressive Disorder
Unspecified Depressive Disorder

Anxiety Disorders

Separation Anxiety Disorder
Selective Mutism
Specific Phobia
Social Anxiety Disorder (Social Phobia)
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

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

Trauma- and Stressor-Related Disorders

Reactive Attachment Disorder
Disinhibited Social Engagement Disorder
Posttraumatic Stress Disorder
Acute Stress Disorder
Adjustment Disorders
Other Specified Trauma- and Stressor-Related Disorder
Unspecified Trauma- and Stressor-Related Disorder

Dissociative Disorders

Dissociative Identity Disorder
Dissociative Amnesia
Depersonalization/Derealization Disorder
Other Specified Dissociative Disorder
Unspecified Dissociative Disorder

Somatic Symptom and Related Disorders

Somatic Symptom Disorder
Illness Anxiety Disorder
Conversion Disorder (Functional Neurological Symptom Disorder)
Psychological Factors Affecting Other Medical Conditions
Factitious Disorder
Other Specified Somatic Symptom and Related Disorder
Unspecified Somatic Symptom and Related Disorder

Feeding and Eating Disorders

Pica

Rumination Disorder
Avoidant/Restrictive Food Intake Disorder
Anorexia Nervosa
Bulimia Nervosa
Binge-Eating Disorder
Other Specified Feeding or Eating Disorder
Unspecified Feeding or Eating Disorder

Elimination Disorders

Enuresis
Encopresis
Other Specified Elimination Disorder
Unspecified Elimination Disorder

Sleep-Wake Disorders

Insomnia Disorder
Hypersomnolence Disorder
Narcolepsy
Breathing-Related Sleep Disorders
Obstructive Sleep Apnea Hypopnea
Central Sleep Apnea
Sleep-Related Hypoventilation
Circadian Rhythm Sleep-Wake Disorders
Parasomnias
Non–Rapid Eye Movement Sleep Arousal Disorders
Sleepwalking
Sleep Terrors
Nightmare Disorder
Rapid Eye Movement Sleep Behavior Disorder
Restless Legs Syndrome
Substance/Medication-Induced Sleep Disorder
Other Specified Insomnia Disorder
Unspecified Insomnia Disorder
Other Specified Hypersomnolence Disorder
Unspecified Hypersomnolence Disorder
Other Specified Sleep-Wake Disorder
Unspecified Sleep-Wake Disorder

Sexual Dysfunctions

Delayed Ejaculation
Erectile Disorder

Female Orgasmic Disorder
Female Sexual Interest/Arousal Disorder
Genito-Pelvic Pain/Penetration Disorder
Male Hypoactive Sexual Desire Disorder
Premature (Early) Ejaculation
Substance/Medication-Induced Sexual Dysfunction
Other Specified Sexual Dysfunction
Unspecified Sexual Dysfunction
Gender Dysphoria
Gender Dysphoria
Other Specified Gender Dysphoria
Unspecified Gender Dysphoria

Disruptive, Impulse-Control, and Conduct Disorders

Oppositional Defiant Disorder
Intermittent Explosive Disorder
Conduct Disorder
Antisocial Personality Disorder
Pyromania
Kleptomania
Other Specified Disruptive, Impulse-Control, and Conduct Disorder
Unspecified Disruptive, Impulse-Control, and Conduct Disorder

Substance-Related and Addictive Disorders

Substance-Related Disorders

Substance Use Disorders
Substance-Induced Disorders
Substance Intoxication and Withdrawal
Substance/Medication-Induced Mental Disorders
Alcohol-Related Disorders
Alcohol Use Disorder
Alcohol Intoxication
Alcohol Withdrawal
Other Alcohol-Induced Disorders
Unspecified Alcohol-Related Disorder
Caffeine-Related Disorders
Caffeine Intoxication
Caffeine Withdrawal
Other Caffeine-Induced Disorders
Unspecified Caffeine-Related Disorder

Cannabis-Related Disorders
Cannabis Use Disorder
Cannabis Intoxication
Cannabis Withdrawal
Other Cannabis-Induced Disorders
Unspecified Cannabis-Related Disorder
Hallucinogen-Related Disorders
Phencyclidine Use Disorder
Other Hallucinogen Use Disorder
Phencyclidine Intoxication
Other Hallucinogen Intoxication
Hallucinogen Persisting Perception Disorder
Other Phencyclidine-Induced Disorders
Other Hallucinogen-Induced Disorders
Unspecified Phencyclidine-Related Disorder
Unspecified Hallucinogen-Related Disorder
Inhalant-Related Disorders
Inhalant Use Disorder
Inhalant Intoxication
Other Inhalant-Induced Disorders
Unspecified Inhalant-Related Disorder
Opioid-Related Disorders
Opioid Use Disorder
Opioid Intoxication
Opioid Withdrawal
Other Opioid-Induced Disorders
Unspecified Opioid-Related Disorder
Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
Sedative, Hypnotic, or Anxiolytic Use Disorder
Sedative, Hypnotic, or Anxiolytic Intoxication
Sedative, Hypnotic, or Anxiolytic Withdrawal
Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders
Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder
Stimulant-Related Disorders
Stimulant Use Disorder
Stimulant Intoxication
Stimulant Withdrawal
Other Stimulant-Induced Disorders

Unspecified Stimulant-Related Disorder
Tobacco-Related Disorders
Tobacco Use Disorder
Tobacco Withdrawal
Other Tobacco-Induced Disorders
Unspecified Tobacco-Related Disorder
Other (or Unknown) Substance–Related Disorders
Other (or Unknown) Substance Use Disorder
Other (or Unknown) Substance Intoxication
Other (or Unknown) Substance Withdrawal
Other (or Unknown) Substance–Induced Disorders
Unspecified Other (or Unknown) Substance–Related Disorder
Non-Substance-Related Disorders
Gambling Disorder

Neurocognitive Disorders

Delirium
Other Specified Delirium
Unspecified Delirium
Major and Mild Neurocognitive Disorders
Major Neurocognitive Disorder
Mild Neurocognitive Disorder
Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease
Major or Mild Frontotemporal Neurocognitive Disorder
Major or Mild Neurocognitive Disorder With Lewy Bodies
Major or Mild Vascular Neurocognitive Disorder
Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury
Substance/Medication-Induced Major or Mild Neurocognitive Disorder
Major or Mild Neurocognitive Disorder Due to HIV Infection
Major or Mild Neurocognitive Disorder Due to Prion Disease
Major or Mild Neurocognitive Disorder Due to Parkinson's Disease
Major or Mild Neurocognitive Disorder Due to Huntington's Disease
Major or Mild Neurocognitive Disorder Due to Another Medical Condition
Major or Mild Neurocognitive Disorder Due to Multiple Etiologies
Unspecified Neurocognitive Disorder

Personality Disorders

General Personality Disorder
Cluster A Personality Disorders

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Cluster B Personality Disorders
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Cluster C Personality Disorders
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Other Personality Disorders
Personality Change Due to Another Medical Condition
Other Specified Personality Disorder
Unspecified Personality Disorder

Paraphilic Disorders

Voyeuristic Disorder
Exhibitionistic Disorder
Frotteuristic Disorder
Sexual Masochism Disorder
Sexual Sadism Disorder
Pedophilic Disorder
Fetishistic Disorder
Transvestic Disorder
Other Specified Paraphilic Disorder
Unspecified Paraphilic Disorder

Other Mental Disorders

Other Specified Mental Disorder Due to Another Medical Condition
Unspecified Mental Disorder Due to Another Medical Condition
Other Specified Mental Disorder
Unspecified Mental Disorder
Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Other Conditions That May Be a Focus of Clinical Attention

Section III: Emerging Measures and Models

Assessment Measures

Cross-Cutting Symptom 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
World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)
Cultural Formulation
Cultural Formulation Interview (CFI)
Cultural Formulation Interview (CFI)—Informant Version
Alternative DSM-5 Model for Personality Disorders
Conditions for Further Study

- Attenuated Psychosis Syndrome
- Depressive Episodes With Short-Duration Hypomania
- Persistent Complex Bereavement Disorder
- DSM-5 Table of Contents • 9
- Caffeine Use Disorder
- Internet Gaming Disorder
- Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure
- Suicidal Behavior Disorder
- Nonsuicidal Self-Injury