

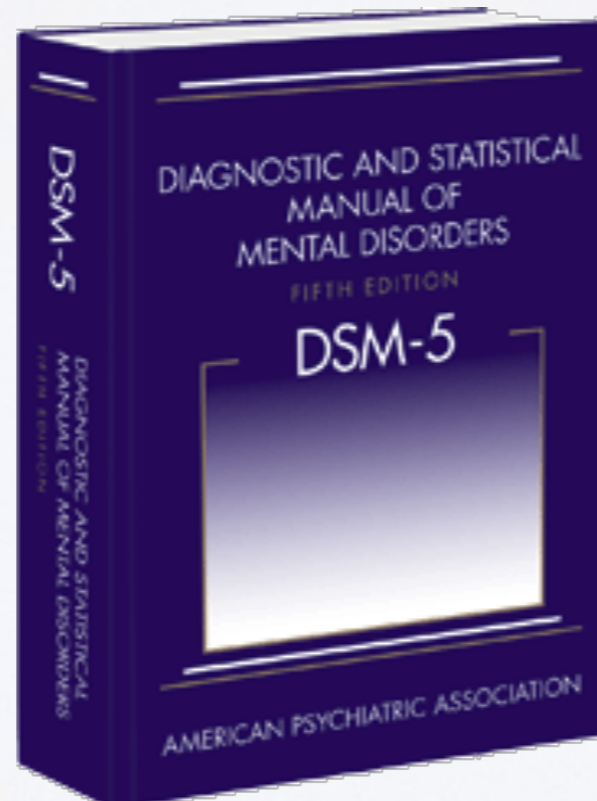
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presents

PREPARING FOR THE **DSM-5**

CONFERENCE

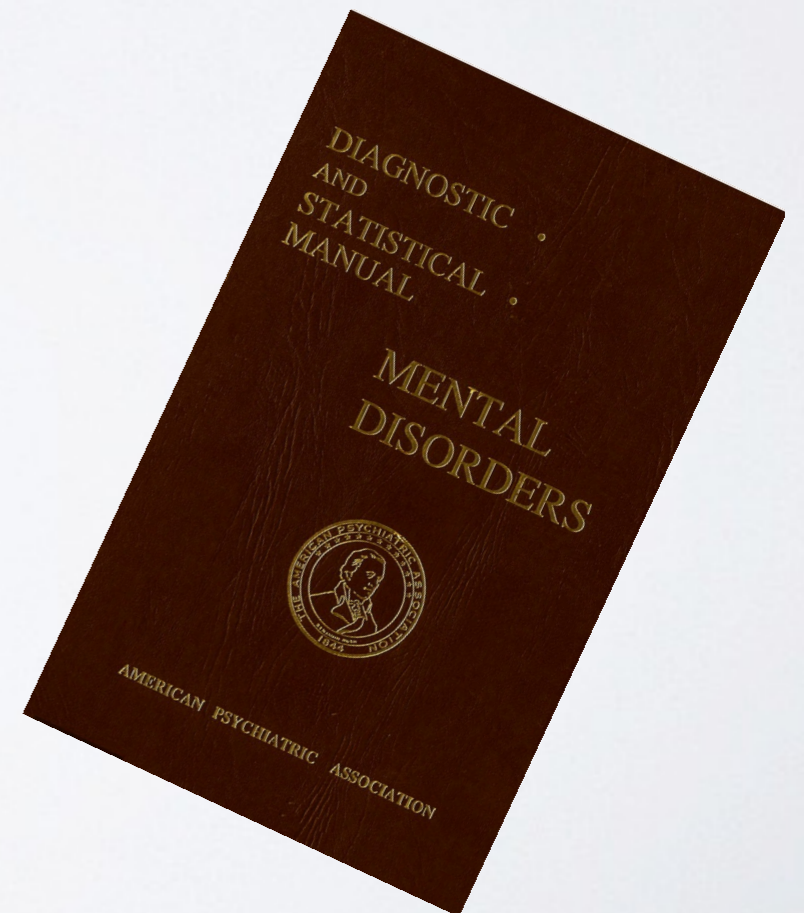
HISTORY AND CONTEXT OF DSM-5

Dr Earl Bland



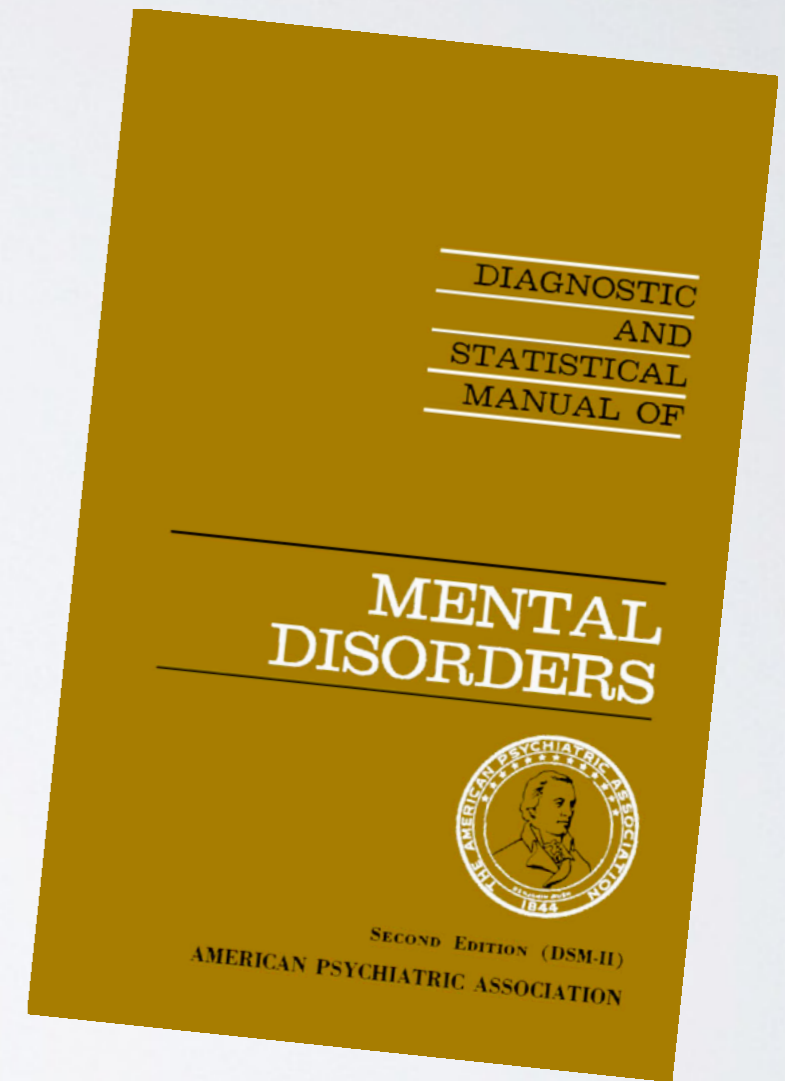
HISTORICAL PERSPECTIVE

- Post-war changes in psychiatric practice
- Need for diagnostic consistency across diverse diagnostic settings
- DSM I appeared in 1952



DSM I & II

- Functional psychiatric diagnoses were conceptualized as reactions
- Psychodynamic emphasis
- Psychological conflict in collision with environmental stressors



DSM I & II

- Diagnoses were seen in dimensional terms – a continuum of reactions

“How Neurotic are you?”

- Symptoms as disguise

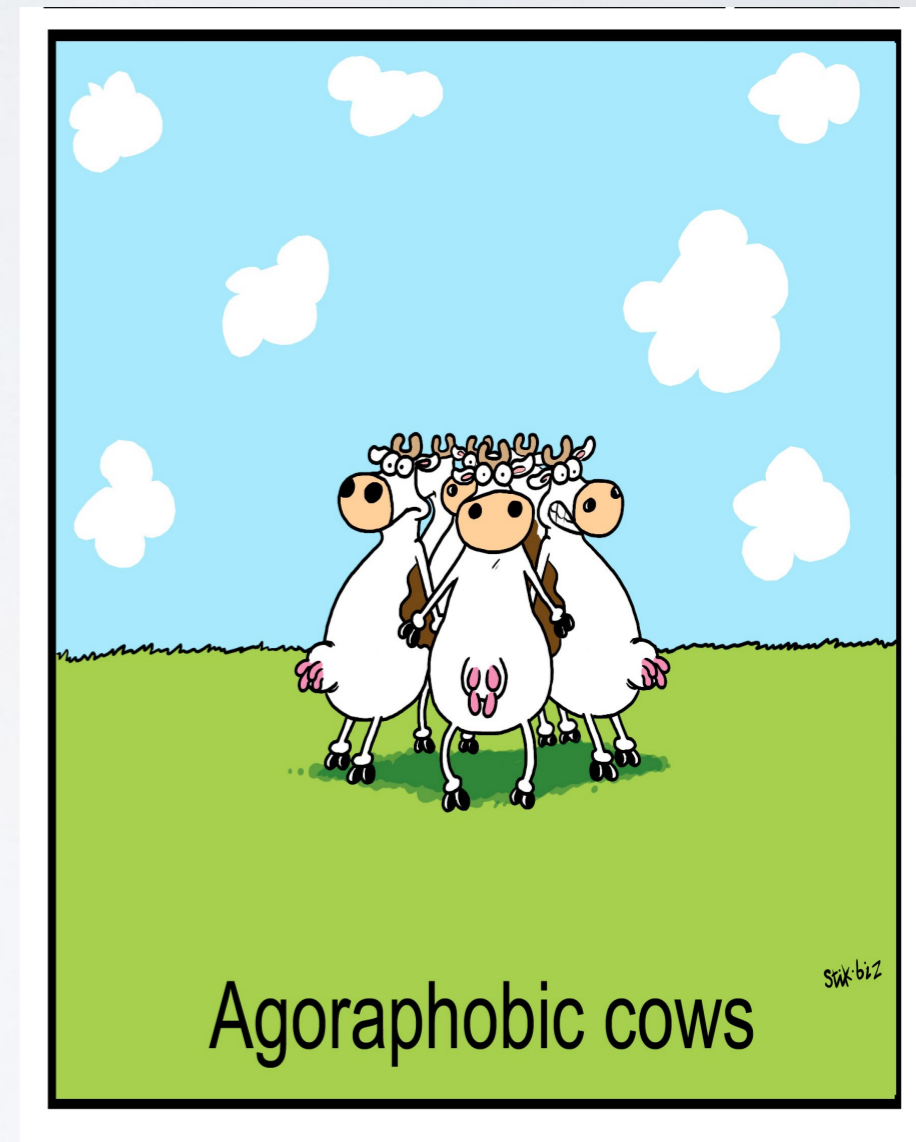


DSM III

- Advance of neo-Kraepelinian view:

Psychiatric disorders seen as discrete mental illnesses which can be explained by medical or biological research

Differentiation is based on empirical observation



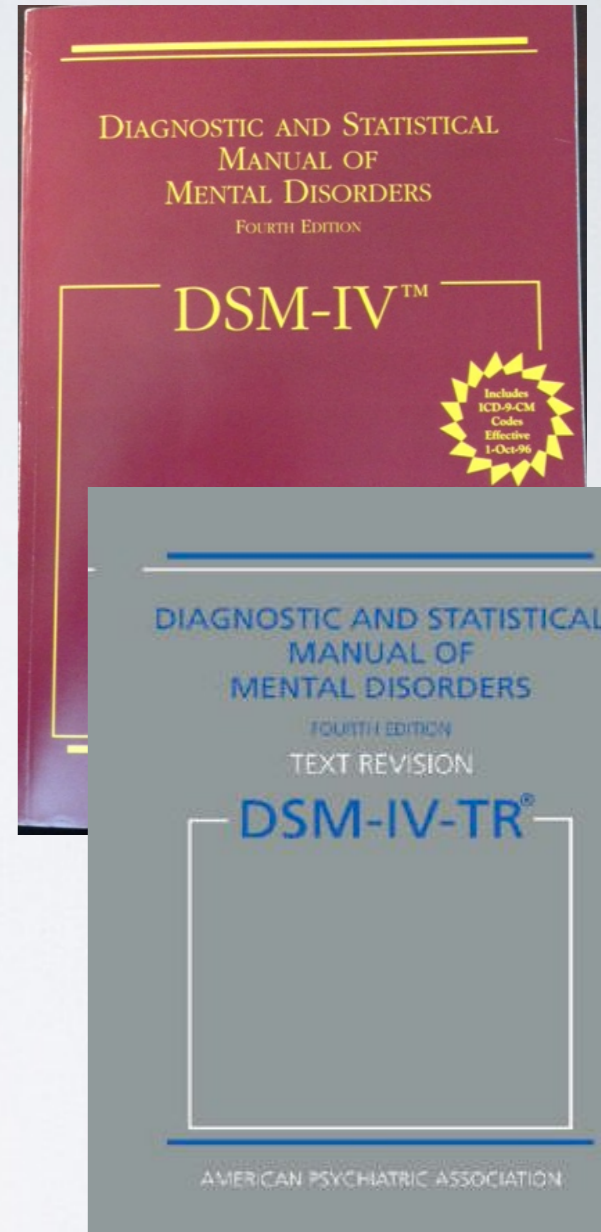
DSM III (R)

- Decoupling theories of causation from description
- Comprehensive Illness categories with discrete symptoms
- Multi axial



DSM-IV

- Largely unchanged from DSM III-R
- More rigorous use of empirical data & processes to indicate changes & thresholds for disorders
- Increased sensitivity to cultural exclusions



PROBLEMS WITH DSM

- Limitations of a descriptive categorical approach
 - Improved reliability did not necessarily increase validity
- Symptom covariation and arbitrary cutoffs
- High levels of comorbidity
- Axial confusions

DSM-5

- Work began in 1999 to address definition and classification of mental disorders
- Consider all scientific & clinical advances since 1994



“Never, ever, think outside the box.”

DSM-5

- Attempted to address the construct validity question by considering dimensional or spectrum perspectives
- Reassessment of the multi-axial system
- DSM is a clinical document - changes must be implementable

DSM-5 PROCESS

- Meetings and conferences 2004-2008 to address recent advances and gaps in knowledge.
- 2007/2008 Task Force & 13 diagnostic Work Groups were formed and constructed a research plan.
- Public comments began in 2010.

DSM-5 PROCESS

- Field trials began in 2010/2011 in a variety of settings.
- The Kappa statistic was used to measure interobserver agreement reliability.

DSM-5 PROCESS

- Work Group results were evaluated by the DSM Task Force and other APA committees
- Voted and approved by APA in December 2012



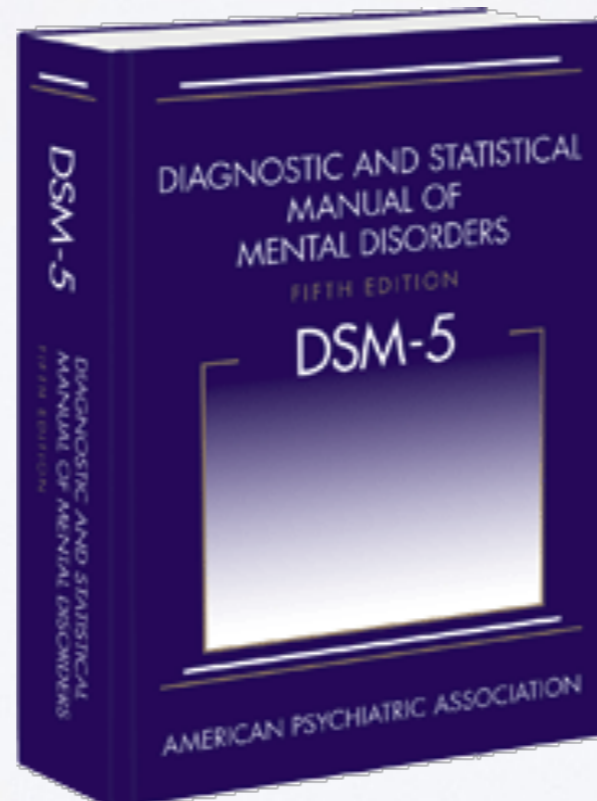
“Your prognosis is tied to the outcome of the election.”

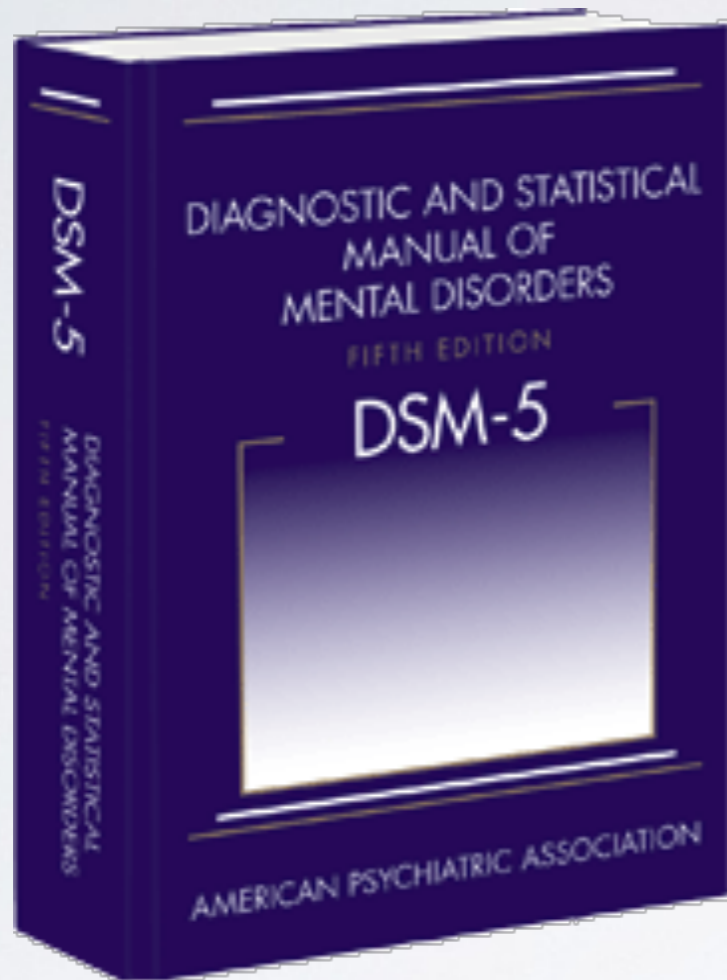


"I'm sorry. I wasn't listening."

OVERVIEW OF STRUCTURAL CHANGES OF DSM-5

Dr Todd Frye





Cost for You: \$149
Released: May 2013
Cost to APA: 25 Million

STRUCTURAL CHANGES IN THE DSM-5

ACCORDING TO THE DSM-5 TASK FORCE

- The primary goals for the manual's new frame is to
 1. Help clinicians make more accurate and consistent diagnoses.
 2. Help researchers better study how disorders relate to one another.
 3. Lead to better treatment for patients

ACCORDING TO THE DSM-5 TASK FORCE

- In addition the task force wanted to incorporate a
 1. **developmental** approach-organization of text
 2. **culture and gender influence**
 3. **dimensional** measure-rate severity
 4. **harmonize** the text with ICD-9
 5. **genetic** and **neurobiological** integration findings-by group clusters of disorders that share genetic or neurobiological substrates.

STRUCTURAL CHANGES

- Will include approximately the **same number of disorders** as in the DSM-IV.
- Focus is on disorders that have a “real impact on peoples lives, not expanding the scope of psychiatry” said Dr. Kupfer.
- Code changes will **include ICD-9 codes** for individual diagnoses.
- Will include diagnostic criteria for dozens of diseases.
- Will come with long text explanations for each diagnosis.
- Disorders will be presented in a simple 20 chapter format.

STRUCTURAL CHANGES

- **Roman numerals (DSM-IV) to alphanumeric numbers (DSM-5)**
- Reason
 - DSM 5.1 etc. allows new governance for continued change

STRUCTURAL CHANGES

- **Multi-axis diagnoses is now on one axis**
 - move to a non-axial documentation of diagnosis
 - combining former Axis I, II, & III
 - Reason
 - people weren't using it and distinctions that it generated were not clinically meaningful with no scientific basis

STRUCTURAL CHANGES

- **NOS categories are gone**

- Reason

- NOS served too much as a catchall
 - example: more than 1/2 of all eating disorders were coded for ED-NOS
 - Lose specificity for treatment with an NOS diagnoses
- Also some disorders that are now well recognized were included in NOS categories (restless legs disorder)

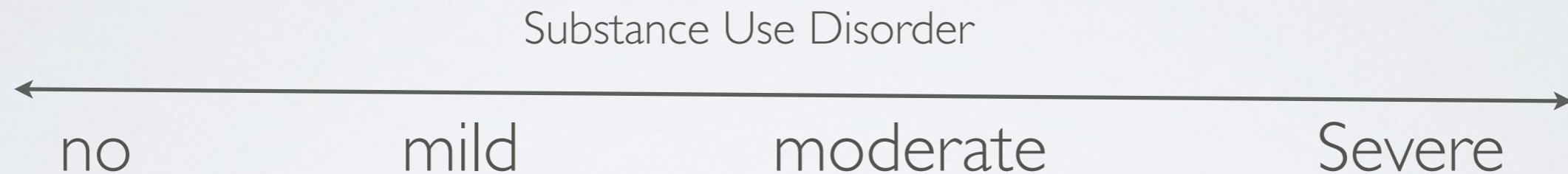
STRUCTURAL CHANGES

- **GAF scores are gone**
- Reason:
 - They weren't being used effectively and getting away from GAF scores moves clinicians to consider specifiers and spectrums of pathology.

STRUCTURAL CHANGES

Dimensional measures of severity are added for some diagnoses and expanded for others.

- these are indicators of severity for certain symptoms



- Based on number of criteria met determines the specifier

- Reason

- boundaries between many disorders “categories” are more fluid over the life course
- many symptoms assigned to a single disorder may occur at varying levels of severity

- example: autism spectrum disorder

- 3 levels of severity for two symptom categories (support, substantial support, very substantial support)

- deficit in social communication and social interaction
- restrictive and repetitive behavior patterns

STRUCTURAL CHANGES

- **Biomarkers** are added
 - results of objective testing will be a part of the formal diagnostic criteria
 - example-sleep wake disorders will require polysomnography for diagnoses
- Reason
 - a greater link between hard and soft sciences

STRUCTURAL CHANGES

- Now includes **3 Sections**

- Section I

- Introduction to the DSM-5
- How to use it

- Section II

- Outline the categorical diagnoses according to revised chapter organization (eliminates multi-axial system)

- Section III

- Conditions that require further research before their considered as formal diagnoses
- Detailed discussion of culture and diagnoses

STRUCTURAL CHANGES

- **Order of chapters in section 2 has changed**
 - From most frequently diagnosed in childhood
 - First chapters geared toward children
 - example: neurodevelopmental disorders
 - Final chapters more applicable to older adulthood
 - example: neurocognitive disorders
- Reason
 - Reflects a **Lifespan Approach**

STRUCTURAL CHANGES

Section II

Included Disorders

- NEURODEVELOPMENTAL DISORDERS
- SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS
- BIPOLAR AND RELATED DISORDERS
- DEPRESSIVE DISORDERS
- ANXIETY DISORDERS
- OBSESSIVE-COMPULSIVE AND RELATED DISORDERS
- TRAUMA-AND STRESSOR-RELATED DISORDERS
- DISSOCIATIVE DISORDERS
- SOMATIC SYMPTOM AND RELATED DISORDERS
- FEEDING AND EATING DISORDERS
- ELIMINATION DISORDERS
- SLEEP-WAKE DISORDERS
- SEXUAL DYSFUNCTIONS
- GENDER DYSPHORIA
- DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDER
- SUBSTANCE RELATED AND ADDICTIVE DISORDERS
- NEUROCOGNITIVE DISORDERS
- PERSONALITY DISORDERS
- PARAPHILIC DISORDERS
- OTHER MENTAL DISORDERS

STRUCTURAL CHANGES

Section III

RESEARCH INITIATIVES

- **Alternative DSM-5 model for personality disorders**

- Antisocial (dissocial) Personality Disorder
- Avoidant Personality Disorder
- Borderline Personality Disorder
- Narcissistic Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Schizotypal Personality Disorder
- Personality Disorder-Trait Specified
- Levels of Personality Functioning
- Personality Traits

STRUCTURAL CHANGES

Section III

FURTHER STUDY

- Attenuated Psychoses Syndrome
- Short Duration Hypomania
- Persistent Complex Bereavement Disorder
- Caffeine Use Disorder
- Internet Gaming Disorder
- Neurobehavioral Disorder Due to Prenatal Alcohol Exposure
- Suicidal Behavior Disorder
- Nonsuicidal Self-injury

WHAT IS IN AND WHAT IS OUT

Dr Scott Koeneman and Dr Todd Bowman



IN

- Section 3 will contain a listing of conditions that require further research before their consideration as formal disorders, as well as cultural formulations, glossary, the names of individuals involved in DSM-5's development and other information.

IN

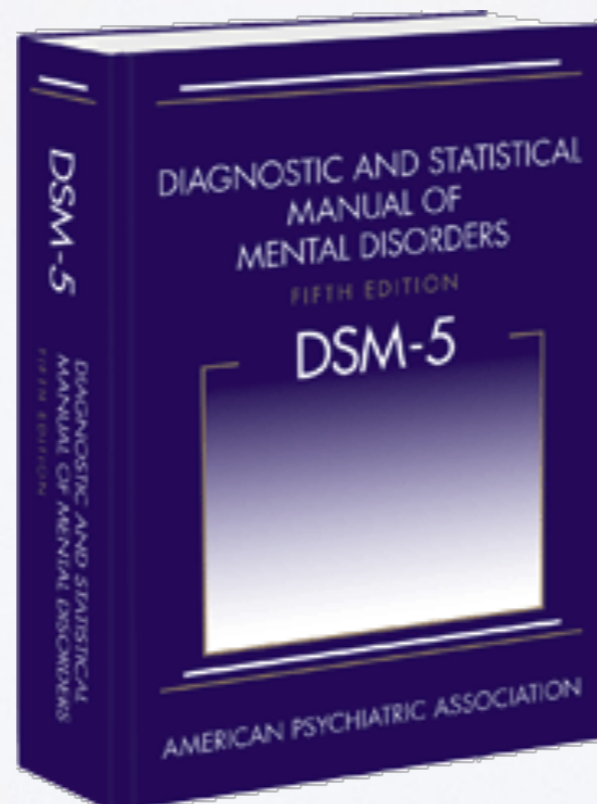
- Attenuated psychosis syndrome
- Internet use gaming disorder
- Non-suicidal self-injury
- Suicidal behavior disorder

OUT

- Hypersexual disorder
- Sensory processing disorder
- Anxious depression
- Parent alienation syndrome

PERSONALITY DISORDERS AND SCHIZOPHRENIA

Dr Earl Bland



PERSONALITY DISORDERS

Unrequited Expectations

AGENDA

- Current understanding of Personality disorders
- Limitations of the DSM IV PD Framework
- DSM-5 proposals & considerations
 - Major issues at stake
- DSM-5 PD categories

DSM IV CLASSIFICATIONS

- Paranoid Personality Disorder
- Schizoid
- Schizotypal
- Antisocial Personality Disorder
- Borderline
- Histrionic
- Narcissistic
- Avoidant Personality Disorder
- Dependent
- Obsessive-Compulsive
- Personality Disorder NOS

PERSONALITY DISORDERS ELEMENTS

- Enduring patterns deviate markedly from expectations of individuals culture and context
- Patterns are inflexible, maladaptive, and cause significant functional impairment (social, work, other)
- Involves emotional, cognition, relatedness, impulse control

DSM-IV DIAGNOSTIC LIMITATIONS

- Categorical modeling with arbitrary criterion cutoffs
- Overlapping criteria causing boundary & differential diagnosis problems
- Excessive use of NOS category
- Mixture of stable trait-like criteria and less stable state-like criteria
- Binary assessment decision – present or absent
- Suggests homogeneity of expression

DSM-5 CLASSIFICATIONS

- Paranoid Personality Disorder
- Schizoid
- Schizotypal
- Antisocial Personality Disorder
- Borderline
- Histrionic
- Narcissistic
- Avoidant Personality Disorder
- Dependent
- Obsessive-Compulsive

DSM-5 CLASSIFICATIONS

- Personality Change Due to Another Medical Condition
- Other Specified Personality Disorder
- Unspecified Personality disorder

- DROPPED:
- Personality Disorder NOS

DSM-5 CHAPTER 3

- Reduction of types
 - Antisocial/Psychopathic
 - Avoidant
 - Borderline
 - Obsessive-Compulsive
 - Schizotypal
 - Narcissistic*

DSM-5 CHAPTER 3

- Dimensional ratings:
 - Impairments in self & interpersonal functioning
 - Pathological personality traits
 - Stability across time
 - Cultural or developmental concerns
 - Medical & substance use concerns

SCHIZOPHRENIA AND PSYCHOTIC DISORDERS

DSM-IV: SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

- Schizophrenia
- Schizophreniform Disorder
- Schizoaffective Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Shared Psychotic Disorder
- Psychotic Disorder Due to a General Medical Condition
- Substance-Induced Psychotic Disorder
- Psychotic Disorder NOS

CATEGORY NAME CHANGE

Schizophrenia and Other Psychotic Disorders

to

Schizophrenia Spectrum and Other Psychotic
Disorders

DSM-5: SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS - UNCHANGED

- Schizophreniform Disorder
- Schizoaffective Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Psychotic Disorder Due to a General Medical Condition

DSM-5: SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS – CHANGED OR UPDATED

- Schizophrenia
 - Diagnostic threshold is raised to **two active symptoms**
 - Delusions, Hallucinations, Disorganized Speech and Behavior, other symptoms that cause social or occupational dysfunction
 - **Removal of subtypes** that speak to predominant symptoms
 - **Catatonia** has been moved to a **specifier** of Schizophrenia and other psychotic conditions

DSM-5: SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS – CHANGED OR UPDATED

- Addition of Schizotypal Personality Disorder to the spectrum
- Removal of Shared Psychotic Disorder
- Substance/Medication-Induced Psychotic Disorder

DSM-5: SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS – CHANGED OR UPDATED

- Catatonic Features Specifier
- Catatonic Disorder Due to Another Medical Condition
- Other Specified Catatonic Disorder

DSM-5: SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS – CHANGED OR UPDATED

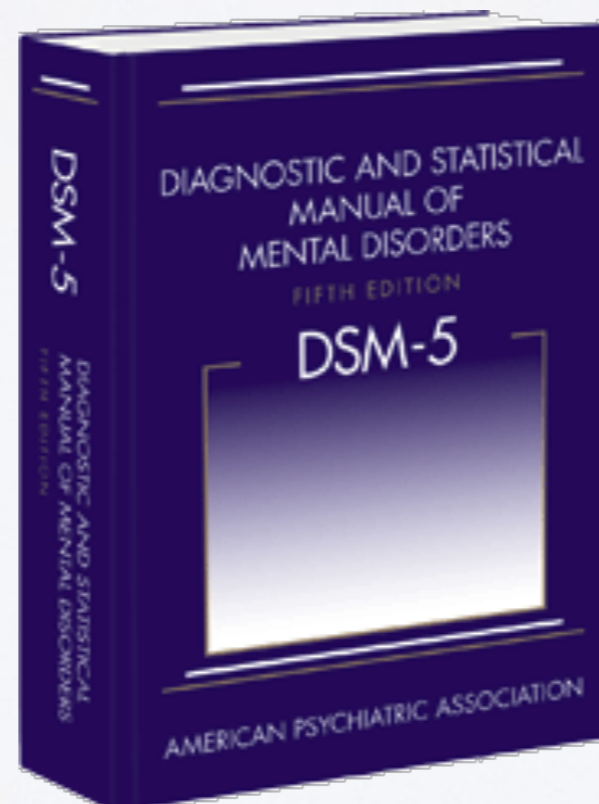
- Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
- Removal of Psychotic Disorder NOS

BIPOLAR DISORDER

- Mixed Episode diagnosis is replaced with a Mixed-Features specifier
 - Allows clinicians to diagnose mixed-features without having to meet all of the diagnostic criteria for an episode of major depression and an episode of mania
 - Now required to have at least three symptoms of alternate mood expression

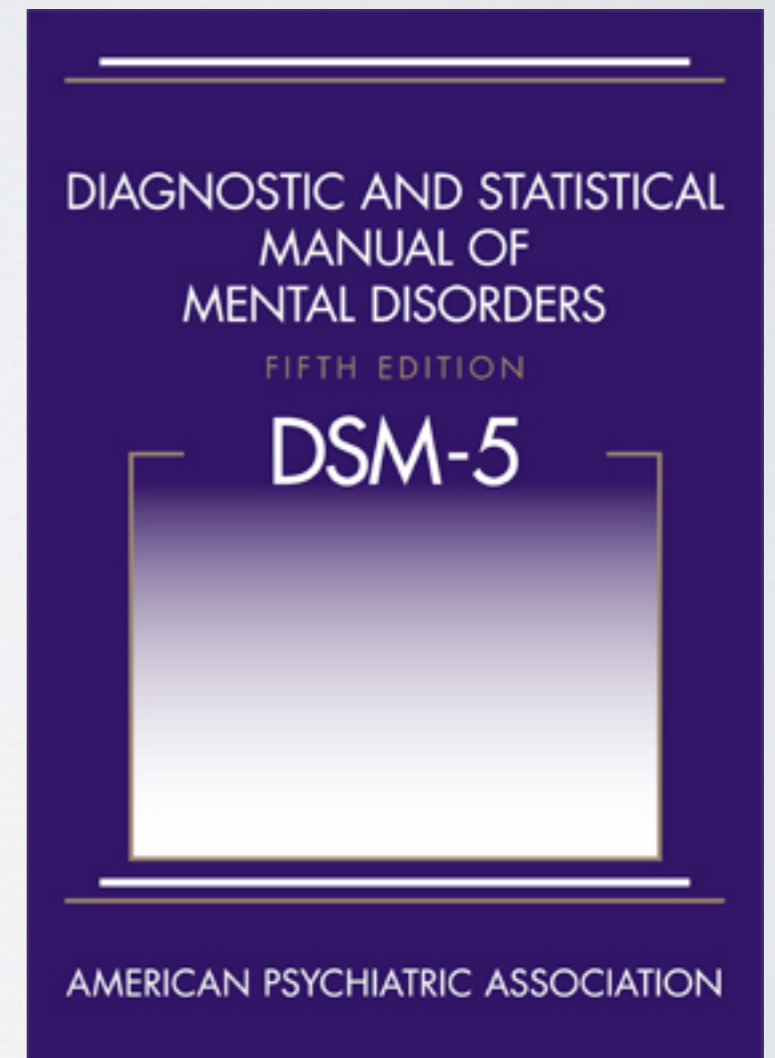
CHANGES RELEVANT TO CHILDREN

Dr Scott Koeneman



ANTICIPATED CHANGES RELEVANT TO CHILDREN

- Autism Spectrum Disorder
- Social Communication Disorder
- Attention Deficit Hyperactivity Disorder
- Intellectual Disability
- Specific Learning Disorder
- Disruptive Mood Dysregulation Disorder



DSM-5 is stirring up controversy

“It’s official: Aspergers Syndrome is no longer a thing.” - George Dvorsky

“Will the new diagnostic manual for psychiatrists go too far in labeling kids dysfunctional?” - David Dobbs **Slate**

“Just In: Aspergers Prevalence Predicted to Fall to Zero.” **Forbes**
Forbes.com

- Emily Willingham, Contributor Forbes Magazine

“New diagnosis in the DSM-5 Challenge Normal/Whacked Dichotomy. Normal is the new whacked.” - Alistair McHarg

THREE MAJOR CHANGES

- **Autism Spectrum Disorder will become a single diagnosis.**
- **Movement from three symptom domains to two.**
 - Social Communication Deficits
 - Restricted/Repetitive Behavior
 - Can be met on history alone
- **Inclusion of specifiers**
 - Primary diagnosis followed by a number of specifiers (age of onset, type of onset, intellectual and verbal impairment)

DSM-IV TR vs DSM-5

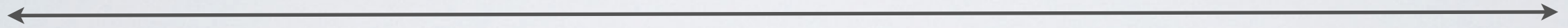
- **DSM-IV TR**

- Qualitative impairment in social interactions
- Qualitative impairment in communication
- Restricted repetitive and stereotyped patterns of behavior, interests, and activities

- **DSM-5**

- Persistent deficits in social communication and social interactions
- Restricted, repetitive patterns of behaviors, interests, or activities

SEVERITY LEVELS OF ASD



Requiring very substantial support

Requiring substantial support

Requiring support



TREATMENT IMPLICATIONS

- Will prevalence rates decline based on the new criteria?
- How will research data be impacted?
- Retraining clinicians on the new criteria.

SOCIAL COMMUNICATION DISORDER

- **Social Communication Disorder** highlights problems using verbal and nonverbal communication for social purposes, which results in impairments in their ability to:
 - Effectively communicate
 - Participate socially
 - Maintain social relationships
 - Or otherwise perform academically or occupationally

CHARACTERISTICS

- **Persistent difficulty with verbal and non-verbal communication** (can not be explained by low cognitive ability)
- **Symptoms include:**
 - impairment in acquisition and use of spoken and written language
 - problems with inappropriate responses to conversations
- The disorder limits effective communication, social relationships, academic achievement or occupational performance.
- Must be present in childhood even if the symptoms are not recognized until later.

RATIONALE

Why is this diagnosis needed?

- Increase access to service to this population.
- Increased specificity will lead to more effective treatment.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

- New behavioral descriptors based on age.
- Number of criteria required to meet threshold of diagnosis will depend on age.
- Age of onset has changed from seven to twelve.
- No exclusion criteria for ASD.

INTELLECTUAL DISABILITY

- Intellectual Disability will replace Mental Retardation.
- **Will no longer rely exclusively on IQ score.** More emphasis on measures of adaptive functioning in criteria.
- Additional language to describe impairments in general mental abilities that negatively impact adaptive functioning in three domains:
 - Conceptual
 - Social
 - Practical

TREATMENT IMPLICATIONS

- PRO-Additional emphasis on adaptive functioning will lead to increased specificity and enhanced treatment planning.
- CON-Psychologist who make a living on IQ/cognitive assessments, how will this change their practice?

SPECIFIC LEARNING DISORDER

- From four specific disorders in DSM-IV TR to one in DSM-5: **Specific Learning Disorder.**
- The criteria will include deficits in learning and achievement.
- The criteria will also include specifiers: reading, written expression, and mathematics.

TREATMENT CONSIDERATIONS

- PRO-Will make diagnosing a learning disorder easier.
- PRO-Enhanced access to service and treatment sensitivity.
- CON-How will the loss of specificity impact treatment?

DISRUPTIVE MOOD DYSREGULATION DISORDER



- A controversial new diagnosis.

“Will turn temper tantrums into a mental disorder.”

- Allan Frances in response to the proposed DMDD diagnosis

It will finally give many young patients a “diagnostic home”.

Summary of proposed diagnostic criteria for DDMD

A	Severe recurrent temper outbursts in response to common stressors, which are: <ul style="list-style-type: none">• Manifest verbally or behaviorally, such as in the form of verbal rages, or physical aggression towards people or property.• Grossly out of proportion in intensity or duration to the situation or provocation.• Inconsistent with the child's level of development.
B	Temper outbursts occur, on average, three or more times per week.
C	Mood between temper outbursts is persistently negative (irritable, angry, and/or sad) nearly every day.
D	Criteria A-C have been present for at least 12 months. Throughout that time the person has not had three or more consecutive months where they were without symptoms of Criteria A-C.
E	Symptoms in at least two settings (at home, at school, or with peers) and must be severe in at least one setting.
F	The diagnosis should not be made before the age of 6 or after the age of 18
G	Onset before the age of 10
H & I	Does not meet criteria for another mental disorder (e.g. bipolar, major depression, psychosis), but it can coexist with oppositional defiant disorder, ADHD, conduct disorder or substance use disorder

As of October 2012 Source:APA

RATIONALE

- Reduce the misuse and over diagnosis of Pediatric Bipolar Disorder.
- Differences in course, family history, and behavioral manifestations when compared to Bipolar Disorder.
- Helps ensure treatment for individuals who lag behind in emotional regulation skills.

TREATMENT CONSIDERATIONS

- PRO-Will require an astute understanding of developmental deviations and environmental stressors.
- CON-Could this additional diagnostic category result in a new fad in psychiatry and lead to the advent of new medications for children?

NOS

Dr Todd Bowman



POST-TRAUMATIC STRESS DISORDER

LINGERING QUESTIONS

- Are there significant changes to the symptoms? What about criteria?
- Will it still be considered an anxiety disorder?
- Will it be more inclusive of children and adolescents?



PTSD AND DSM-5

- Symptoms are mostly the same with some variation
- Criteria have been made more specific
- Falls in new class of disorders entitled “Trauma and stressor-related disorders”
- The criteria are more child/adolescent sensitive and allow individuals to be diagnosed across the lifespan

SIGNIFICANT CHANGES

A person was exposed to one or more event(s) that involved death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation.

In addition, these events were experienced in one or more of the following ways:

- The event was experienced by the person.

- The event was witnessed by the person as it occurred to someone else.

- The person learned about an event where a close relative or friend experienced an actual or threatened violent or accidental death.

- The person experienced repeated exposure to distressing details of an event.

CRITERION A2

- The person's response involved intense fear, helplessness or horror.
- This criteria has been removed for DSM-5
- This broadens the diagnosis; critics have suggested this will overwhelm service providers
- O'Donnell, et al (2010) demonstrated the overall prevalence remained nearly identical statistically (7% versus 8% in DSM-V-TR)

DSM-IV/TR

DSM-5

Reexperiencing	Intrusive symptoms
Avoidant/numbing	Avoidance
Hyperarousal	Negative changes in thought and mood
	Changes in arousal

CRITERION B

- A person experiences at least one the following intrusive symptoms associated with the traumatic event:

Unexpected or expected reoccurring, involuntary, and intrusive upsetting memories

Repeated upsetting dreams

The experience of some type of dissociation (for example, flashbacks)

Strong and persistent distress upon exposure to cues connected to the traumatic event

Strong bodily reactions (for example, increased heart rate)

CRITERION D

- At least three of the following negative changes in thoughts and mood that occurred or worsened following the experience of the traumatic event:

The inability to remember an important aspect

Persistent and elevated negative evaluations about one's self, others, or the world

Elevated self-blame or blame of others

A negative emotional state (for example, shame, anger, fear) that is pervasive

Loss of interest in activities that one used to enjoy

Feeling detached from others

The inability to experience positive emotions (for example, happiness, love, joy)

CRITERION G, H

Criterion G

The symptoms bring about considerable distress and/or interfere greatly with a number of different areas of a person's life.

Criterion H

The symptoms are not due to a medical condition or some form of substance use.



SUMMARY

- Shift from an anxiety disorder to more of a multidimensional construct
- Less emphasis on cognitive appraisal of trauma and more on embodied expressions of symptomology
- Increased distinction between “traumatic” events and “distressing events”

MAJOR DEPRESSIVE
DISORDER, BEREAVEMENT
EXCLUSION

CLINICAL EXAMPLE

- Mr. Smith is a 52 year-old businessman who lost his wife 3 weeks ago. He visits his family doctor and reports feeling anhedonic, “down in the dumps” and socially withdrawn during this time. He is distractible, easily fatigued and reports early waking at 4 AM daily. He has lost 10 lbs and endorses passive suicidal ideation.
- Is Mr. Smith depressed or grieving?

BEREAVEMENT EXCLUSION CRITERIA

- DSM-5 Mood Disorder Work Group has argued that there is insufficient evidence to suggest that bereavement is a unique stressor (Zisook & Kendler, 2007).



BEREAVEMENT EXCLUSIONARY CRITERIA

- First appeared in the DSM-III which encouraged clinicians to not diagnose MDD if the patient's symptoms can be better accounted for by bereavement.
- The intent of the exclusionary criteria was to control for misdiagnosis of individuals who are experiencing normal grief reactions to a loved one's death.

RATIONALE FOR REMOVAL

- The exclusion of the bereavement in the DSM-5 is proposed on the basis that the International Classification of Diseases has never had an exclusion criteria for Major Depression.
- Little to no evidence to suggest that the bereavement is different than other psychosocial stressors that could propose a depressive episode (e.g. job loss).

COUNTERPOINTS

- Major Depression- the clinical syndrome- is different than feeling “sad”, “grieving”, “feeling blue”, or “upset.”
- The Frances Assertion- false positive syndrome
- Limitations to the Zisook and Kendler (2007) article

SUBSTANCE-USE AND ADDICTIVE DISORDERS

SUBSTANCE USE DISORDERS

- Types will include alcohol, cannabis, cocaine, heroin and others
- “Addiction” is not a proposed disorder for DSM-5. The current substance abusers would not be categorized as “addicts.”
- Since early intervention can prevent more serious disorders, this is expected to be a significant public health benefit.

SUBSTANCE USE DISORDERS

- The symptoms listed in DSM-IV under “substance abuse” and “substance dependence” were combined to create the list for substance use disorders.
- Changes include the removal of legal problems, the addition of “craving” and that symptoms lead to clinically significant impairment or distress.

SUBSTANCE USE DISORDERS

- These changes strengthen the diagnosis by increasing the number of symptoms required for a mild diagnosis to two symptoms (DSM-IV required one).
- Patients would receive a diagnosis of mild, moderate, or severe substance use disorder based on how many criteria on that list they met: no disorder (0-1), mild disorder (2-3), moderate (4-5) or severe (6 or more).

SUBSTANCE USE DISORDERS

- The symptoms of people with substance use problems do not fall neatly into two discrete disorders.
- “Dependence” is misleading, often confused with “addiction.” The tolerance and withdrawal are very typical responses to some prescribed medications.

BINGE EATING DISORDER

DISORDERED EATING CONTINUUM

- Binge eating disorder moved from Section 3 of DSM-IV to Section 2 of DSM-5
- Removal of Eating Disorder NOS (Keel, et al, 2011)
- Removal of amenorrhea as a necessary symptom for diagnosis of Anorexia Nervosa



BED CRITERIA

- A. Recurrent episodes of binge eating. An episode is characterized by:
 1. Eating a larger amount of food than normal during a short period of time (within any two hour period)
 2. Lack of control over eating during the binge episode (i.e. the feeling that one cannot stop eating)

BINGE EATING DISORDER

B. Binge eating episodes are associated with three or more of the following:

1. Eating until feeling uncomfortably full
2. Eating large amounts of food when not physically hungry
3. Eating much more rapidly than normal
4. Eating alone because you are embarrassed by how much you're eating
5. Feeling disgusted, depressed, or guilty after overeating

BINGE EATING DISORDER

C. Marked distress regarding binge eating is present.

D. Binge eating occurs, on average, at least once a week for three months.

E. The binge eating is not associated with the regular use of inappropriate compensatory behavior (i.e. purging, excessive exercise, etc.) and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

COUNTERPOINTS

- False positives- Potential for pathologizing normal behavior.
- Misses- Potential for missing problematic behaviors in low insight clientele due to a lack of appraisal of “distress”.



EXCORIATION DISORDER

EXCORIATION DISORDER

- Similar to Trichotillomania which is classified as an Impulse Control Disorder Not Elsewhere Classified in DSM-IV-TR.
- Move toward dimensional model has allowed individual symptoms with sufficient statistical support to become stand alone diagnoses.
- Will fall in the Obsessive-Compulsive and Related Disorders chapter.

EXCORIATION DISORDER

- Current prevalence rates between 2-5.4% of general population.
- Typical onset is during adolescence with target of picking being the head or face.
- High shame and embarrassment which may minimize treatment seeking behavior.



EXCORIATION DISORDER

- A. Maladaptive skin excoriation (e.g. picking, digging, etc) or maladaptive preoccupation with skin excoriation as indicated by at least one of the following:
 - Preoccupation with skin excoriation and/or recurrent impulses to excoriate the skin that is/are experienced as irresistible, intrusive or senseless.
 - Recurrent excoriation of the skin resulting in noticeable skin damage.

EXCORIATION DISORDER

- B. The preoccupation, impulses, or behaviors associated with skin excoriation cause marked distress, are time-consuming, significantly interfere with social or occupational functioning, or result in medical problems (e.g. infections)
- C. The disturbance is not better accounted for by another mental disorder or general medical condition
 - Subtypes: 1) compulsive type- full awareness, excoriation alleviates dread or anxiety 2) impulsive type- minimal insight, behavior provides arousal, pleasure or reduction of tension, 3) mixed type- compulsive and impulsive features present

HOARDING DISORDER

HOARDING DISORDER

- Originally conceptualized as 1 of 8 symptoms of OCPD in DSM-IV, while more recent literature has tied it to OCD.
- Typical categories of hoarded materials: 1) inanimate objects, 2) animals



HOARDING DISORDER

- In a 2010 study, Matiax-Cols found that only 18% of participants with hoarding behaviors met criteria for OCD.
- Prevalence rate is around 4% of the general population.
- Frost, et al demonstrated that ADHD, inattentive type is the strongest co-morbid predictor of hoarding behavior.

PROPOSED NOSOLOGY FOR DSM-5

- A. Persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to those possessions.
- OR
- A. Persistent difficulty in discarding or parting with possessions regardless of their actual value.
- B. This difficulty is due to strong urges to save items and/or distress associated with discarding.

PROPOSED NOSOLOGY FOR DSM-5

- C. The symptoms result in the accumulation of a larger number of possessions that fill up and clutter active living areas of the home or workplace to the extent that the intended use is no longer possible. If all living areas are uncleared, it is only because of the intervention of third parties.
- D. The symptoms cause clinically significant distress or impairment in social occupational, or other important areas of functioning (including maintaining a safe environment for self and others).

PROPOSED NOSOLOGY FOR DSM-5

- E. The hoarding symptoms are not due to a general medical condition (e.g. brain disease).
- The hoarding symptoms are not restricted to the symptoms of another mental disorder (e.g. hoarding due to obsessions in OCD, decreased energy in MDD, delusions in Schizophrenia, etc).

SPECIFIERS

- With excessive acquisition: buying or stealing of items that are not needed or no space for.
- Good or fair insight: recognizes hoarding-related beliefs and behaviors are problematic.
- Poor insight: mostly convinced hoarding-related behaviors are not problematic despite evidence to the contrary.
- Absent insight: completely convinced that hoarding-related behaviors are not problematic despite evidence to the contrary.