DSM5: How to Understand It and How to Help

Additional Notes:

Introduction:

The DSM5 is a foreign language!

Three Questions:

I. The first was, "What the key assumptions made to determine the organization of the DSM5?"

A. Mental Disorders.

B. Reliability

C. The inability to validate

D. This book has nothing to do with Treatment.

II. The Second Question: "When a person says they are depressed/bipolar/schizophrenic, what does the DSM5 say that is true about them and their behavior?

A. Depression. The question is whether or not the following description of depression is accurate and does this always represent disease?

1. The Criteria: Five or more of the following symptoms present for 2 weeks. This represents a change in function. Either a depressed mood or loss of interest or pleasure in activities must be present.

   a. Depressed mood most of the day, almost every day, indicated by your own subjective report or by the report of others. This mood might be characterized by sadness, emptiness, or hopelessness.

   b. Markedly diminished interest or pleasure in all or almost all activities most of the day nearly every day.

   c. Significant weight loss when not dieting or weight gain.

   d. Inability to sleep or oversleeping nearly every day.

   e. Psychomotor agitation or retardation nearly every day.

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f. Fatigue or loss of energy nearly every day.

g. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.

h. Diminished ability to think or concentrate, or indecisiveness, nearly every day.

i. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

2. Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

3. The episode is not due to the effects of a substance or to a medical condition

4. The occurrence is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders

5. There has never been a manic episode or a hypomanic episode

B. Bipolar Disorder: What is true in Bipolar Disorder 1? Mania.

1. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

2. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior

   a. Inflated self-esteem or grandiosity.

   b. Decreased need for sleep (eg. feels rested after only three hours of sleep).

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c. More talkative than usual or pressure to keep talking.

d. Flight of ideas or subjective experience that thoughts are racing.

e. Distractibility (ie, attention too easily drawn to unimportant or irrelevant external stimuli), as reported

f. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (ie. purposeless non-goal-directed activity).

g. Excessive involvement in activities that have a high potential for painful consequences (eg. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

3. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

4. The episode is not attributable to the physiological effects of a substance (eg. a drug of abuse, a medication, other treatment) or to another medical condition.

   NOTE: A full manic episode that emerges during antidepressant treatment (eg. medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

C. Hypomania: What is less true?

1. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least four consecutive days and present most of the day, nearly every day

2. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

   a. Inflated self-esteem or grandiosity.

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b. Decreased need for sleep (eg. feels rested after only three hours of sleep).

c. More talkative than usual or pressure to keep talking.

d. Flight of ideas or subjective experience that thoughts are racing.

e. Distractibility (ie, attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed

f. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.

g. Excessive involvement in activities that have a high potential for painful consequences (eg. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

3. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

4. The disturbance in mood and the change in functioning are observable by others.

5. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

6. The episode is not attributable to the physiological effects of a substance (eg. a drug of abuse, a medication, or other treatment).

   NOTE: A full hypomanic episode that emerges during antidepressant treatment (eg. medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant

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use) are not taken as sufficient for a diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Additional Notes:

D. Schizophrenia.

1. Two or more of the characteristic symptoms below are present for a significant portion of time during a one-month period (or less if successfully treated):

    a. Delusions

    b. Hallucinations

    c. Disorganized speech (eg. frequent derailment or incoherence)

    d. Grossly disorganized or catatonic behavior

    e. Negative symptoms, ie. affective flattening, alogia, or avolition

2. For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset. When the onset is in childhood or adolescence: failure to achieve expected level of interpersonal, academic, or occupational achievement.

3. Continuous signs of the disturbance persist for at least six months. The six-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A (ie. active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A that present in an attenuated form (eg. odd beliefs, unusual perceptual experiences).

4. Schizoaffective disorder and mood disorder with psychotic features have been ruled out because either: (1) no major depressive, manic, or mixed episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their

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Additional Notes:

total duration has been brief relative to the duration of the active and residual periods.

5. The disturbance is not due to the direct physiological effects of a substance (eg. a drug of abuse or medication) or a general medical condition.

6. If the patient has a history of autistic disorder or another pervasive developmental disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

III. Third Question: Since we counsel people and not labels how does knowing these labels help us become better data gatherers?

A. The labels are reliable, but not always correct, but reliable. Use them as a signpost!

B. There are not always correctly applied. The sign may be pointing in the wrong direction!

C. I would say they tell you where to start looking!

References:

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5 5th Edition, American Psychiatric Association

DSM-5® Made Easy: The Clinician's Guide to Diagnosis 1st Edition, James Morrison MD

The Christian's Guide to Psychological Terms, 2nd Edition, Marshall and Mary Asher

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