Module 4: Substance Use Disorders, Impulse Control Disorders, Conduct Disorders, and Personality Disorders
Your Presenters

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Course Objectives

Upon completion of this program trainees will:

- Learn the etiology of substance use disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining substance use, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing substance use diagnoses
- Comprehend differential diagnosis from other disorders with similar presentations
- Apply common specifiers for substance use disorders
- Learn appropriate treatment strategies based upon diagnosis
- Learn the etiology of impulse control and conduct disorders based on current research
Course Objectives

Upon completion of this program trainees will:

- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining impulse control and conduct disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing impulse control and conduct disorders diagnoses
- Comprehend differential diagnosis from other disorders with similar presentations
- Apply common specifiers for impulse control and conduct disorders
- Learn appropriate treatment strategies based upon diagnosis
- Learn the etiology of personality disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
Course Objectives

Upon completion of this program trainees will:

- Grasp appropriate assessment processes for determining personality disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing personality disorders diagnoses
- Comprehend differential diagnosis with other disorders with similar presentations
- Apply common specifiers for personality disorders
- Learn appropriate treatment strategies based upon diagnosis
Purposes Behind Diagnosis

• Accurate diagnosis allows for **consistency and standardization** throughout all disciplines that address mental health concerns: medical, nursing, psychiatric, psychological, counseling, social work, marriage and family therapy.

• Accurate diagnosis allows for **common ground** to be established in terms of research concerning the **effectiveness of various kinds of treatment**.

• Accurate diagnosis can be used for **shaping the client's treatment plan**, aligning the treatment approaches research has determined to be most effective with the various diagnostic categories.
Section One

Assessment and Diagnosis of Substance Use and Related Disorders
Substance Abuse Problems
(NIMH as applied to 2007)

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

2. Drug abuse over lifetime – 7.7% of adult Americans
   Drug Dependence over lifetime – 2.6%
Important Reformulations of Diagnoses in the DSM-5

• Substance-Related and Addictive Disorders

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

Replaced by:

Substance Use Disorders with specifiers to rate the level of severity from mild to severe.
Important Reformulations of Diagnoses in the DSM-5

• Substance-Related and Addictive Disorders

No more use of polysubstance abuse.

Replaced by:

Substance Use Disorder listing each individual substance for which there is a use disorder.
New Diagnostic Terms and Categories in this Diagnostic Section Added in the DSM-5

- Caffeine Withdrawal (ICD-10: F15.93)
- Cannabis Withdrawal (ICD-10: F12.288)
- Tobacco Use Disorder (ICD-10: Z72.0)
- Gambling Disorder (ICD-10: F63.0)
Complications of Substance Abuse Assessment

Substance abuse is a disorder with neurological, psychological, cultural and social contributors. A thorough assessment and diagnosis process must cover all of these areas.
- **Pharmacological factors** refer to the ingredients of a particular drug that affect the functions of the body and the nervous system and in turn affect social behavior.

- **Cultural factors** are society’s views of drug use, as determined by custom and tradition, and these affect the initial approach and use of a particular drug.

- **Social factors** refers to the belief that attitudes about drug use develop from the values and attitudes of other drug users, the norms in the community, subcultures, peer groups, friends, and families, as well as the drug user’s need for, and personal experiences with, using drugs.

- **Contextual factors** are the physical surroundings where drug use takes place and these contexts influence the attitudes toward drug use and the types and amount of drug use.
Three Factors

• Tolerance
• Physical dependence
• Psychological dependence
The Neurobiology of Addiction

- Conditioning from pleasure centers
- Physical changes to neurons
- Changes in brain metabolism
- Withdrawal avoidance
Neurotransmitters

Neurotransmitter released into synapse

Neurotransmitter attached to receptor

Neurotransmitter stored in vesicles

Enzyme that destroys neurotransmitter
4 Main chemicals related to mood change…

- Dopamine
- Serotonin
- Norepinephrine
- Gamma aminobutyric acid (GABA)
Dopamine

Pathway is concentrated in the front of the brain

- Involved in regulating awareness of the environment and other higher information processing tasks

- Abnormal functioning may lead to...
  - difficulties in relating to others
  - social isolation
  - distorted perceptions of the world
Serotonin

Pathways are widespread covering all major areas of the brain

- Involved in regulating mood and aggressive, impulsive and suicidal behaviors
- Abnormal levels related to...
  - diminished ability to control impulses
  - depressed moods
  - heightened risk of suicide
Norepinephrine

Pathways travel to many areas of the brain, including the cerebral cortex and spinal cord…chemical transmitter for Autonomic Nervous System (ANS)

❖ Excitatory - enhancing the responsiveness of nerve cells
❖ Major role in creating and maintaining mood states

Low levels…
>>> depression
Excessive amounts may
>>> mania
>>> anxiety
Gamma aminobutyric acid (GABA)

Functions in the Central Nervous System (CNS) to prevent the excessive firing of neurons by blocking impulses from one cell to another

- Calming, helps to block anxiety and stress related impulses

- Shortage linked with panic attacks (intake of tranquilizers increases the body’s GABA levels)
Contributors to Problem Use

- Genetic factors
- Personality factors
- Life circumstances
- History of physical, emotional or psychological pain or distress
- Peer environments
- Other mental disorders
Components of Assessment: Methods of Gathering Information

- Patient self-report and self-monitoring
- Self-anchored and rating scales
- Questionnaires
- Direct behavioral observation
- Role play and analogue situations
- Behavioral by-products
- Psycho-physiological measures
- Goal attainment scaling
Gathering Information During Assessment of Substance Use Disorder

• All components of a thorough biopsychosocial assessment should be addressed
• Careful gathering of the client’s substance use history, present and past, with thorough exploration of where the client may minimize or deny actual substance use
• Family history of problems with substance misuse, mental illness, or traumatic events
• Where possible, gathering history from other parties: family members, significant others, work and social relationships where possible
• Use of screening tools specifically designed to uncover substance use: e.g., MAST, SASSI
• Where appropriate, laboratory screening of substance presence
Psychological Tests and Screening Tools

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

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

Mental health clinicians must remember to use only those tools that fall within their area of competence.
Gathering Information During Assessment of Substance Use Disorder

• Use of Motivational Interviewing techniques, where needed, to reduce resistance and diminish the likelihood of treatment dropout
• Building motivation for treatment as the development of the therapeutic process begins
Complications of Substance Abuse Diagnosis

- Is the substance use culturally syntonic?
- Is substance use problematic enough to warrant a diagnosis of substance use disorder?
- Is substance use the primary problem or secondary to another medical or mental disorder?
- Is the use of substances obscuring the presence of another disorder or responsible for the development of another disorder?

Without conducting a thorough biopsychosocial assessment, it is not possible to answer these questions.
Substance Abuse...

Co-morbidity rate...
• 21% for mild-to–moderate depression and substance abuse
• 19% with drug abuse apart from alcohol

Depression may be...
• consequence of drug or alcohol withdrawal
• commonly seen after cocaine and amphetamine use

Many with depression self-medicate with alcohol and street drugs >>> *actually worsens a Major Depressive Disorder*
>>> making diagnosis and treatment difficult

Many with alcohol or drug addictions have a high rate of depression.
Dual Diagnosis Disorders

Coexistence of substance use and mental disorder often diagnosed/treated as *Dual Diagnosis Disorders*

These manifest in four possible ways:

- **Primary mental illness with subsequent substance abuse**
  - self-medication to cope with symptoms of primary mental illness
  - usually have poor coping skills, impaired judgment, and poor impulse control.
Dual Diagnosis Disorders

**Primary substance use disorder with psychopathologic sequelae**
- psychiatric symptoms manifest due to intoxication, withdrawal, or chronic drug/ETOH abuse

**Dual primary diagnosis**
- mental illnesses and substance abuse exist together and exacerbate each other
Dual Diagnosis Disorders

Common etiology
- one factor causing both disorders
  - genetics
  - dopamine dysfunction
  - cholinergic activity dysfunction (HPA axis)

Predispose clients/patients to affective disorders and substance abuse through their own body chemistry
Proficiency in Diagnosis:
The Biopsychosocial Assessment
The Biopsychosocial Perspective

Source: Ross, DE
A Method for Developing a Biopsychosocial Formulation
Components of Assessment:
Biological, Psychological, Social

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

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

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

- Generalized Anxiety
- Phobias
- Panic Attacks
- Depersonalization
- Obsessions/Compulsions
- Depression
- Psychomotor retardation
- Low energy
- Fatigue
- Withdrawal
- Hopelessness
- Sleep disturbance
- Weight change
- Impaired memory
- Irritability
- Anger control problems
- Aggressiveness
- Impulsiveness
- Focus/concentration problems
- Distractibility
- Negative Self Image
- Disorientation
- Mania/Hypomania
- Tremors
- Suspiciousness
- Paranoid ideation
- Bizarre Behaviors
- Tangential/Circumstantial thinking
- Confusion
- Delusions
- Agitation
- Dissociation
- Hallucinations
- Loose Associations
- Flight of Ideas
- Intrusive thoughts
**Mental Status Checklist**

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

<table>
<thead>
<tr>
<th>Mood</th>
<th>__ Normal __Anxious __Depressed __Irritable __Euphoric __Expansive __Dysphoric __Calm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affect</td>
<td>__Normal __Unconstrained __Blunted/Restricted __Inappropriate __Labile __Flat</td>
</tr>
<tr>
<td>Behavior</td>
<td>__Normal __Aggressive __Impulsive __Angry __Oppositional __Agitated __Explosive</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Eye Contact</th>
<th>__Normal __Fleeting __Avoidant __Staring __Other: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial Expression</td>
<td>__Responsive __Flat __Tense __Anxious __Sad __Angry</td>
</tr>
<tr>
<td>Attitude Toward Clinician</td>
<td>__Normal/Cooperative __Uninterested __Passive __Guarded __Dramatic</td>
</tr>
<tr>
<td>__Manipulative __Suspicious __Rigid __Sarcastic __Resistant __Critical __Irritable __Hostile __Threatening</td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td>__Normal __Disheveled __Unclean __Inappropriate __Unhealthy looking</td>
</tr>
<tr>
<td>Insight</td>
<td>__Good __Impairments in insight</td>
</tr>
<tr>
<td>Decision Making</td>
<td>__Good __Impairments in decision making</td>
</tr>
<tr>
<td>Reality Testing</td>
<td>__Good __Impairments in reality testing</td>
</tr>
<tr>
<td>Judgment</td>
<td>__Good __Impairments in judgment</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>__Normal __Impaired __Intelect</td>
</tr>
</tbody>
</table>
Example of Detailed Mental Status Checklist

Generalized Anxiety as manifested by:

___Feelings of apprehension or dread
___Trouble concentrating
___Feeling tense and jumpy
___Anticipation of negative outcomes
___Heightened irritability
___Restlessness or unsettled feeling
___Vigilance for signs of danger
___Muscle fatigue associated with tenseness
**Example of Detailed Substance Abuse Assessment**

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

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

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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Current use</th>
<th>Past use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>Marijuana</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>Cocaine</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>Other (list):</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>Other (list):</td>
<td>__________</td>
<td>__________</td>
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<tr>
<td>Other (list):</td>
<td>__________</td>
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<td>Other (list):</td>
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</tr>
<tr>
<td>Other (list):</td>
<td>__________</td>
<td>__________</td>
</tr>
</tbody>
</table>
## Example of Detailed Substance Abuse Assessment

<table>
<thead>
<tr>
<th>Substance Use Problem Effects</th>
<th>Current use</th>
<th>Past use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used alcohol/drugs more than intended</td>
<td>____</td>
<td>____</td>
</tr>
<tr>
<td>Spent more time using/drinking than intended</td>
<td>____</td>
<td>____</td>
</tr>
<tr>
<td>Neglected some usual responsibilities because of alcohol or drugs</td>
<td>____</td>
<td>____</td>
</tr>
<tr>
<td>Wanted or needed to cut down on drinking or drug use in past year</td>
<td>____</td>
<td>____</td>
</tr>
<tr>
<td>Someone has objected to client’s drinking/drug use</td>
<td>____</td>
<td>____</td>
</tr>
<tr>
<td>Preoccupied with wanting to use alcohol or drugs</td>
<td>____</td>
<td>____</td>
</tr>
<tr>
<td>Used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom</td>
<td>____</td>
<td>____</td>
</tr>
</tbody>
</table>

**Comments:**
Common Specifiers for Substance Use Disorders

1) Level of severity: Mild, moderate, severe

2) Remission status: In early remission or sustained remission

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

4) With other symptoms: With perceptual disturbances
Common Specifiers

Mild: Presence of 2-3 symptoms

Moderate: Presence of 4-5 symptoms

Severe: Presence of 6 or more symptoms
Substance Use Disorder Symptoms

- Taken in larger amounts or over a longer period than intended
- Persistent desire or unsuccessful attempts to control
- Much time spent in obtaining, using, or recovering from use
- Craving or strong desire to use
- Use resulting in failure to fulfill major life roles
- Continued use despite persistent problems from use
- Social, occupational, or recreational activities abandoned in order to use
- Recurrent use in situations that create hazards or risks
- Continued use in spite of knowledge of problems resulting from use
- Development of tolerance, marked by a need for increased amount of substance to achieve intoxication or diminished response to use of same amount of substance
Components of Assessment:
Methods of Gathering Information

- Projective measures
- Standardized measures
- Coordination of care with medical, psychiatric, psychological, and other providers
Who Makes the Diagnosis?

Boundaries around Assessment
Value: *Competence*

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

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

1.04 Competence

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

O.C.G.A. 377 states:

“‘Psychological testing’ means the use of assessment instruments to both:

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

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

Diagnostic criteria and differential diagnosis
Alcohol Related Disorders

Diagnostic Features

• Alcohol use disorder defined by a cluster of behavioral and physical symptoms including withdrawal, tolerance, and craving

• Alcohol withdrawal is characterized by symptoms that develop approximately 4-12 hours after the reduction of intake following prolonged, heavy alcohol ingestion. Because withdrawal can be unpleasant and intense, clients may continue to consume despite adverse consequences, often to avoid or relieve withdrawal symptoms. Some withdrawal symptoms (e.g., sleep problems) can persist for months and can contribute to relapse.

• Once a pattern of repetitive and intense use develops, individuals with alcohol use disorder may devote significant periods of time to consuming alcohol. Craving is indicated by a strong desire to drink that makes it difficult to think of anything else and often results in the onset of drinking. School and job performance may also suffer either from the aftereffects of drinking or from actual intoxication at school or on the job; responsibilities may be neglected; and alcohol-related absences may occur
Alcohol Use Disorder

A. A problematic pattern of alcohol use leading to clinically significant impairment, as manifested by at least two of the following, within a 12-month period:
   1. Alcohol often taken in larger amounts or over a longer period than intended.
Substance Related Disorders
Alcohol Use Disorder

Criteria:

2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use
3. A great deal of time is spent in activities to obtain or use alcohol or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
Substance Related Disorders
Alcohol Use Disorder

Criteria:

9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem likely to have been caused or exacerbated by alcohol.

10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
   b. A markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal).
   b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.
Alcohol Intoxication  F10.129

A. Recent ingestion of alcohol.
B. Clinically significant problematic behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment) that developed during, or shortly after, alcohol ingestion.
C. One (or more) of the following signs or symptoms developing during, or shortly after, alcohol use:
   1. Slurred speech.
   2. Incoordination.
   3. Unsteady gait.
Substance Related Disorders
Alcohol Intoxication

Criteria:

5. Impairment in attention or memory.
6. Stupor or coma.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.
Substance Related Disorders

Criteria:
Alcohol Withdrawal

A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
B. Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) alcohol use described in Criterion A:
   1. Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm).
   2. Increased hand tremor.
   3. Insomnia.
   4. Nausea or vomiting.
   5. Transient visual, tactile, or auditory hallucinations or illusions.
   6. Psychomotor agitation.
   7. Anxiety.
Substance Related Disorders

Criteria:

**Alcohol Withdrawal**  
F10.239 without perceptual disturbance
F10.232 with perceptual disturbance

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Specify if: With perceptual disturbances. This specifier applies in the rare instance when hallucinations (usually visual or tactile) occur with intact reality testing, or auditory, visual, or tactile illusions occur in the absence of a delirium.
Criteria:

**Caffeine Intoxication F15.929**

A. Recent consumption of caffeine (typically a high dose well in excess of 250 mg).

B. Five (or more) of the following signs or symptoms developing during, or shortly after, caffeine use:

1. Restlessness.
2. Nervousness.
3. Excitement.
4. Insomnia.
5. Flushed face.
Caffeine Related Disorders

Diagnostic Features

- The essential feature of caffeine withdrawal is the presence of a characteristic withdrawal syndrome that develops after the abrupt cessation of (or substantial reduction in) prolonged daily caffeine ingestion.

- Headache is the hallmark feature of caffeine withdrawal and may be diffuse, gradual in development, throbbing, severe, and sensitive to movement. However, other symptoms of caffeine withdrawal can occur in the absence of headache. Caffeine is the most widely used behaviorally active drug in the world and is present in many different types of beverages, foods, energy aids, medications, and dietary supplements. Because caffeine ingestion is often integrated into social customs and daily rituals, some caffeine consumers may be unaware of their physical dependence on caffeine.

- The probability and severity of caffeine withdrawal generally increase as a function of usual daily caffeine dose. However, there is large variability among individuals and within individuals across different episodes in the incidence, severity, and time course of withdrawal symptoms. Caffeine withdrawal symptoms may occur after abrupt cessation of relatively low chronic daily doses of caffeine.
Substance Related Disorders

Caffeine Related Disorders

Criteria:

**Caffeine Intoxication**

6. Diuresis.
7. Gastrointestinal disturbance.
8. Muscle twitching.
9. Rambling flow of thought and speech.
10. Tachycardia or cardiac arrhythmia.
11. Periods of inexhaustibility.
Criteria:

**Caffeine Withdrawal**  
F15.93

A. Prolonged daily use of caffeine.

B. Abrupt cessation of or reduction in caffeine use, followed within 24 hours by three (or more) of the following signs or symptoms:

1. Headache.
2. Marked fatigue or drowsiness.
3. Dysphoric mood, depressed mood, or irritability.
4. Difficulty concentrating.
5. Flu-like symptoms (nausea, vomiting, or muscle pain/stiffness).
Substance Related Disorders
Caffeine Related Disorders

Criteria:

**Caffeine Withdrawal**

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The signs or symptoms are not associated with the physiological effects of another medical condition (e.g., migraine, viral illness) and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.
Cannabis Related Disorders
Diagnostic Features

• Cannabis use disorder and the other cannabis-related disorders include problems that are associated with substances derived from the cannabis plant and chemically similar synthetic compounds. Individuals who regularly use cannabis can develop all the general diagnostic features of a substance use disorder. Cannabis use disorder is commonly observed as the only substance use disorder experienced by the individual; however, it also frequently occurs concurrently with other types of substance use disorders (i.e., alcohol, cocaine, opioid). In cases for which multiple types of substances are used, many times the individual may minimize the symptoms related to cannabis, as the symptoms may be less severe or cause less harm than those directly related to the use of the other substances.

• New to DSM-5 is the recognition that abrupt cessation of daily or near-daily cannabis use often results in the onset of a cannabis withdrawal syndrome. Common symptoms of withdrawal include irritability, anger or aggression, anxiety, depressed mood, restlessness, sleep difficulty, and decreased appetite or weight loss. Although typically not as severe as alcohol or opiate withdrawal, the cannabis withdrawal syndrome can cause significant distress and contribute to difficulty quitting or relapse among those trying to abstain.
Substance Related Disorders

Cannabis Related Disorders

Criteria:

**Cannabis Use Disorder**

F12.10 Mild presence of 2-3 symptoms

F12.20 Moderate presence of 4-5 symptoms

F12.20 Severe presence of 6 or more symptoms

A. A problematic pattern of cannabis use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Cannabis is often taken in larger amounts or over a longer period than was intended.

2. There is a persistent desire or unsuccessful efforts to cut down or control cannabis use.

3. A great deal of time is spent in activities necessary to obtain cannabis, use cannabis, or recover from its effects.
Substance Related Disorders

Cannabis Related Disorders

Criteria:

**Cannabis Use Disorder**

4. Craving, or a strong desire or urge to use cannabis.
5. Recurrent cannabis use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis.
7. Important social, occupational, or recreational activities are given up or reduced because of cannabis use.
8. Recurrent cannabis use in situations in which it is physically hazardous.
9. Cannabis use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by cannabis.
Criteria:

Cannabis Use Disorder

10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of cannabis to achieve intoxication or desired effect.
   b. Markedly diminished effect with continued use of the same amount of cannabis.

11. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for cannabis (refer to Criteria A and B of the criteria set for cannabis withdrawal).
   b. Cannabis (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.
Criteria:

**Cannabis Use Disorder**

Specify if: **In early remission**: After full criteria for cannabis use disorder were previously met, none of the criteria for cannabis use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use cannabis,” may be met).

**In sustained remission**: After full criteria for cannabis use disorder were previously met, none of the criteria for cannabis use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use cannabis,” may be present).

Specify if: **In a controlled environment**: This additional specifier is used if the individual is in an environment where access to cannabis is restricted.
Substance Related Disorders
Cannabis Related Disorders

Criteria:

**Cannabis Intoxication**  
F12.129 without perceptual disturbance  
F12.122 with perceptual disturbance

A. Recent use of cannabis.
B. Clinically significant behavioral or psychological changes (impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgment, social withdrawal) that developed during, or shortly after, cannabis use.
C. Two or more of the following symptoms develop within 2 hours of cannabis use:
   1. Conjunctival injection.
   2. Increased appetite.
   3. Dry mouth.
   4. Tachycardia.
D. The symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Specify if: With perceptual disturbances: Hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium.
Substance Related Disorders

Cannabis Related Disorders

Criteria:

**Cannabis Withdrawal**  F12.288

A. Cessation of cannabis use that has been heavy and prolonged (daily or almost daily over a period of at least a few months).

B. Three or more of the following symptoms develop within approximately 1 week after Criterion A:
   1. Irritability, anger, or aggression.
   2. Nervousness or anxiety.
   3. Sleep difficulty (e.g., insomnia, disturbing dreams).
   4. Decreased appetite or weight loss.
   5. Restlessness.
   6. Depressed mood.
   7. At least one of the following physical symptoms causing significant discomfort:
      abdominal pain, shakiness/tremors, sweating, fever, chills, or headache.

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.
Hallucinogen Related Disorders
Diagnostic Features

- The phencyclidines (or phencyclidine-like substances) include phencyclidine (e.g., PCP, "angel dust") and less potent but similarly acting compounds such as ketamine, cyclohexamine, and dizocilpine. These substances were first developed as dissociative anesthetics in the 1950s and became street drugs in the 1960s. They produce feelings of separation from mind and body (hence "dissociative") in low doses, and at high doses, stupor and coma can result. These substances are most often smoked or taken orally, but may also be snorted or injected. Although the main psychoactive effects last a few hours, the total elimination rate from the body typically extends 8 days or longer. The hallucinogenic effects in vulnerable individuals may last weeks and may precipitate a psychotic episode resembling schizophrenia. Ketamine has been observed to have utility in the treatment of major depressive disorder. Withdrawal symptoms have not been clearly established in humans, and therefore the withdrawal criterion is not included in the diagnosis of phencyclidine use disorder.
Substance Related Disorders
Hallucinogen Related Disorders

Criteria:

**Phencyclidine Use Disorder**
- **F16.10** Mild, presence of 2-3 symptoms
- **F16.20** Moderate, presence of 4-5 symptoms
- **F16.20** Severe, presence of 6 or more symptoms

A. clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Phencyclidine is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control phencyclidine use.
3. A great deal of time is spent in activities necessary to obtain phencyclidine, use the phencyclidine, or recover from its effects.
4. Craving, or a strong desire or urge to use phencyclidine.
5. Recurrent use resulting in a failure to fulfill role obligations.
6. Continued use despite social or interpersonal problems caused or exacerbated by effects of the phencyclidine
Substance Related Disorders
Hallucinogen Related Disorders

Criteria:

Phencyclidine Use Disorder

6. Continued use despite social or interpersonal problems caused or exacerbated by effects of the phencyclidine
7. Important social, occupational, or recreational activities are given up or reduced because of phencyclidine use.
8. Recurrent phencyclidine use in situations in which it is physically hazardous
9. Phencyclidine use is continued despite knowledge of having a persistent or recurrent physical or psychological problem likely to have been caused by the phencyclidine.
10. Tolerance, as defined by either of the following:
    a. A need for increased amounts of the phencyclidine to achieve desired effect.
    b. A markedly diminished effect with continued use of the same amount.
Substance Related Disorders

Hallucinogen Related Disorders

Criteria:

**Phencyclidine Use Disorder**

Note: Withdrawal symptoms and signs are not established for phencyclidines, so this criterion does not apply. (Withdrawal from phencyclidines has been reported in animals but not documented in humans.)

Specify if: In early remission: After full criteria for phencyclidine use disorder were previously met, none of the criteria for phencyclidine use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use the phencyclidine,” may be met).

In sustained remission: After full criteria for phencyclidine use disorder were previously met, none of the criteria for phencyclidine use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use the phencyclidine,” may be met).

Specify if: In a controlled environment: This additional specifier is used if the individual is in an environment where access to phencyclidines is restricted.
Substance Related Disorders
Hallucinogen Related Disorders

Criteria:

**Phencyclidine Intoxication   F16.129**

A. Recent use of phencyclidine (or a pharmacologically similar substance).

B. Clinically significant problematic behavioral changes (e.g., belligerence, impulsiveness, unpredictability, psychomotor agitation, impaired judgment) that developed during, or shortly after phencyclidine use.

C. Within 1 hour, two or more of the following symptoms:

Note: When smoked, “snorted,” or used intravenously, onset may be more rapid.

1. Vertical or horizontal nystagmus.
2. Hypertension or tachycardia.
3. Numbness or diminished responsiveness to pain.
4. Ataxia.
5. Dysarthria.
7. Seizures or coma.
8. Hyperacusis.
Criteria:

**Hallucinogen Persisting Perception Disorder  F16.983**

A. Following cessation of use of a hallucinogen, the reexperiencing of one or more of the perceptual symptoms that were experienced while intoxicated with the hallucinogen (e.g., geometric hallucinations, false perceptions of movement in the peripheral visual fields, flashes of color, intensified colors, trails of images of moving objects, positive afterimages, halos around objects, macropsia and micropsia).

B. The symptoms in Criterion A cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The symptoms are not attributable to another medical condition (e.g., anatomical lesions and infections of the brain, visual epilepsies) and are not better explained by another mental disorder (e.g., delirium, major neurocognitive disorder, schizophrenia) or hypnopompic hallucinations.
Inhalant Related Disorders
Diagnostic Features

• Features of inhalant use disorder include repeated use of an inhalant substance despite the individual's knowing that the substance is causing serious problems. Those problems are reflected in the diagnostic criteria.

• Missing work or school or being unable to perform responsibilities, and continued use of the inhalant even though it causes arguments with family or friends, fights, and other social or interpersonal problems, may be seen in inhalant use disorder. Limiting family contact, work or school obligations, or recreational activities may also occur

• Tolerance and mild withdrawal are reported by about 10% of individuals who use inhalants, and a few individuals use inhalants to avoid withdrawal. However, because the withdrawal symptoms are mild, this manual neither recognizes a diagnosis of inhalant withdrawal nor counts withdrawal complaints as a diagnostic criterion for inhalant use disorder.
**Substance Related Disorders**

Inhalant Related Disorders

Criteria

**Inhalant Use Disorder**

F18.10  Mild, presence of 2-3 symptoms  
F18.20  Moderate, presence of 4-5 symptoms  
F18.20  Severe, presence of 6 or more symptoms

A. A pattern of use of a hydrocarbon-based inhalant substance leading to clinically significant impairment, as manifested by at least two of the following within a 12-month period:

1. The inhalant is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control use of the inhalant.
3. A great deal of time is spent in activities necessary to obtain the inhalant, use it, or recover from its effects.
Criteria:

**Inhalant Use Disorder**

4. Craving, or a strong desire or urge to use the inhalant.
5. Recurrent use of the inhalant resulting in a failure to fulfill obligations.
6. Continued use of the inhalant despite having social or interpersonal problems caused by its use.
7. Important social, occupational, or recreational activities are given up or reduced because of use of the inhalant.
8. Recurrent use of the inhalant in situations in which it is physically hazardous.
9. Use of the inhalant is continued despite knowledge of having a physical or psychological problem likely to have been caused by the substance.
10. Tolerance, as defined by either of the following:
   a. A need for increased amounts of the inhalant to achieve intoxication or desired effect.
   b. A markedly diminished effect with continued use of the same amount of the inhalant.
Criteria:

Inhalant Use Disorder

Specify the particular inhalant: When possible, the particular substance involved should be named (e.g., “solvent use disorder”).

Specify if: in early remission: After full criteria for inhalant use disorder were previously met, none of the criteria for inhalant use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use the inhalant substance,” may be met). In sustained remission: After full criteria for inhalant use disorder were previously met, none of the criteria for inhalant use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use the inhalant substance,” may be met).

Specify if: In a controlled environment: This additional specifier is used if the individual is in an environment where access to inhalant substances is restricted.
Substance Related Disorder
Inhalant Related Disorders

Criteria:

**Inhalant Intoxication**

F18.129 Mild comorbid Inhalant Use Disorder
F18.229 Moderate/ Severe comorbid Inhalant Use Disorder
F18.929 No comorbid Inhalant Use Disorder

A. Recent intended or unintended short-term, high-dose exposure to inhalant substances, including volatile hydrocarbons such as toluene or gasoline.

B. Clinically significant problematic behavioral or psychological changes that developed during, or shortly after, exposure to inhalants.
Substance Related Disorders

Inhalant Related Disorders

Criteria:

**Inhalant Intoxication**

C. Two (or more) of the following signs or symptoms developing during, or shortly after, inhalant use or exposure:

1. Dizziness.
2. Nystagmus.
3. Incoordination.
4. Slurred speech.
5. Unsteady gait.
7. Depressed reflexes.
8. Psychomotor retardation.
11. Blurred vision or diplopia.
12. Stupor or coma.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.
Opioid Related Disorders

Diagnostic Features

- Opioid use disorder includes signs and symptoms that reflect compulsive, prolonged self administration of opioid substances that are used for no legitimate medical purpose or, if another medical condition is present that requires opioid treatment, that are used in doses greatly in excess of the amount needed for that medical condition.

- The essential feature of opioid intoxication is the presence of clinically significant problematic behavioral or psychological changes (e.g., initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgment) that develop during, or shortly after, opioid use. Intoxication is accompanied by pupillary constriction (unless there has been a severe overdose with consequent anoxia and pupillary dilation) and one or more of the following signs: drowsiness (described as being "on the nod"), slurred speech, and impairment in attention or memory; drowsiness may progress to coma. Individuals with opioid intoxication may demonstrate inattention to the environment, even to the point of ignoring potentially harmful events.
Substance Related Disorders

Opioid Related Disorders

Criteria:

**Opioid Use Disorder**

F11.10 Mild, presence of 2-3 symptoms
F11.20 Moderate, presence of 4-5 symptoms
F11.20 Severe, presence of 6 or more symptoms

A. A pattern of opioid use leading to clinically significant impairment as manifested by at least two of the following within a 12-month period:

1. Opioids are taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities to obtain the opioid, use, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
Substance Related Disorders

Opioid Related Disorders

Criteria

**Opioid Use Disorder**

5. Recurrent use resulting in a failure to fulfill major role obligations.
6. Continued use despite having persistent or recurrent problems caused by the effects of opioids.
7. Important activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a physical or psychological problem that is likely to have been caused by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve desired effect.
    b. A markedly diminished effect with continued use of the same amount.

**Note:** This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
Substance Related Disorders

Opioid Related Disorders

Criteria:

**Opioid Use Disorder**

11. Withdrawal, as manifested by either of the following:
   a. The characteristic opioid withdrawal syndrome (Criteria A and B of the criteria for opioid withdrawal).
   b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

**Note**: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

**Specify if**: In early remission: After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met for at least 3 months but for less than 12 months (with the exception that, “Craving, or a strong desire or urge to use opioids,” may be met).

In sustained remission: After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met at any time during a period of 12 months or longer (with the exception that, “Craving, or a strong desire or urge to use opioids,” may be met).
Substance Related Disorders
Opioid Related Disorders

Criteria
Opioid Intoxication

F11.129 with no perceptual disturbances, with mild comorbid opioid disorder
F11.229 with no perceptual disturbances, with moderate/ severe comorbid opioid disorder
F11.929 with no comorbid opioid disorder
Section Two

Assessment and Diagnosis of Impulse Control and Conduct Disorders
Impulse Control and Conduct Disorders

Diagnostic criteria and differential diagnosis
Disruptive, Impulse Control and Conduct Disorder—Diagnostic Features

• These problems are manifested in behaviors that violate the rights of others (e.g., aggression, destruction of property) and/or that bring the individual into significant conflict with societal norms or authority figures. The underlying causes of the problems in the self-control of emotions and behaviors can vary greatly across the disorders in this section and among individuals within a given diagnostic category.
Disruptive, Impulse Control and Conduct Disorder—Diagnostic Features

- The disruptive, impulse-control, and conduct disorders all tend to be more common in males than in females, although the relative degree of male predominance may differ across disorders and within a disorder at different ages. The disorders in this group tend to have first onset in childhood or adolescence. It is very rare for either conduct disorder or oppositional defiant disorder to first emerge in adulthood. There is a developmental relationship between oppositional defiant disorder and conduct disorder. Most cases of conduct disorder previously would have met criteria for oppositional defiant disorder, at least in those cases in which conduct disorder emerges prior to adolescence. However, most children with oppositional defiant disorder do not eventually develop conduct disorder.
Disruptive, Impulse Control and Conduct Disorder—Diagnostic Features

- The disruptive, impulse-control, and conduct disorders have been linked to a common externalizing spectrum associated with the personality dimensions labeled as disinhibition and (inversely) constraint and, to a lesser extent, negative emotionality. These shared personality dimensions could account for the high level of comorbidity among these disorders and their frequent comorbidity with substance use disorders and antisocial personality disorder.
Important Reformulations of Diagnoses in the DSM-5

• Intermittent Explosive Disorder

1) Verbal aggression and non-destructive/noninjurious physical aggression now can be considered valid criteria to warrant this diagnosis. In the DSM-IV-TR physical aggression was a required criterion.
Important Reformulations of Diagnoses in the DSM-5

• Oppositional Defiant Disorder

1) Symptoms are now grouped in three types: a) angry/irritable mood, b) argumentative/defiant behavior, and c) vindictiveness.
2) A severity rating has been added to help describe the pervasiveness and severity of the symptoms.
Oppositional Defiant Disorder

Two key changes

1) Symptoms are now grouped in three types: a) angry/irritable mood, b) argumentative/defiant behavior, and c) vindictiveness.
2) A severity rating has been added to help describe the pervasiveness and severity of the symptoms.
Important Reformulations of Diagnoses in the DSM-5

- Conduct Disorder

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

• Change in criteria

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

Criteria:
A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.
Disruptive, Impulse Control and Conduct Disorders

Criteria:

**Angry/Irritable Mood**

1. Often loses temper.
2. Is often touchy or easily annoyed.
3. Is often angry and resentful.
4. Often argues with authority figures or, for children and adolescents, with adults.
5. Often actively defies or refuses to comply with requests from authority figures or with rules.
Disruptive, Impulse Control and Conduct Disorders

Oppositional Defiant Disorder

Criteria:

**Argumentative/Defiant Behavior**

6. Often deliberately annoys others.
7. Often blames others for his or her mistakes or misbehavior.
   Vindictiveness.
8. Has been spiteful or vindictive at least twice within the past 6 months.
Disruptive, Impulse Control and Conduct Disorders
Oppositional Defiant Disorder

**Note**: The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children younger than 5 years, the behavior should occur on most days for a period of at least 6 months unless otherwise noted. For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months, unless otherwise. While these frequency criteria provide guidance, other factors should also be considered, such as whether the frequency and intensity are outside a range that is normative for the individual’s developmental level, gender, and culture.
Disruptive, Impulse Control and Conduct Disorders

Oppositional Defiant Disorder

Criteria:

B. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.

C. The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.
Disruptive, Impulse Control and Conduct Disorders
Oppositional Defiant Disorder

Criteria:

Specify current severity:

Mild: Symptoms are confined to only one setting.

Moderate: Some symptoms are present in at least two settings.

Severe: Some symptoms are present in three or more settings.
Disruptive, Impulse Control and Conduct Disorders

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<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
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<tbody>
<tr>
<td>F63.81</td>
<td>Intermittent Explosive Disorder</td>
<td>Disruptive, Impulse Control and Conduct Disorders</td>
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</table>

Criteria:
A. Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by either of the following:
Disruptive, Impulse Control and Conduct Disorders

Criteria:

1. Verbal aggression or physical aggression toward property, animals, or other individuals, occurring twice weekly, on average, for a period of 3 months. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals.

2. Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period.
Disruptive, Impulse Control and Conduct Disorders
Intermittent Explosive Disorder

Criteria:
B. The magnitude of aggressiveness expressed during the outbursts is out of proportion to the provocation or to any precipitating psychosocial stressors.
C. The aggressive outbursts are not premeditated, they are impulsive and/or anger-based.
D. The aggressive outbursts cause either marked distress in the individual or impairment in functioning, or are associated with financial or legal consequences.
E. Chronological age is at least 6 years.
Disruptive, Impulse Control and Conduct Disorders

Intermittent Explosive Disorder

Criteria:
F. The aggressive outbursts are not better explained by another mental disorder and are not attributable to another medical condition or to the physiological effects of a substance. For children ages 6-18 years, aggressive behavior that occurs as part of an adjustment disorder should not be considered for this diagnosis.

Note: This diagnosis can be made in addition to the diagnosis of attention-deficit/hyper-activity disorder, conduct disorder, oppositional defiant disorder, or autism spectrum disorder when recurrent aggressive outbursts are in excess of those usually seen in these disorders and warrant independent clinical attention.
# Disruptive, Impulse Control and Conduct Disorders

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<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
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<tbody>
<tr>
<td>F91.1</td>
<td>Conduct Disorder, Childhood Onset</td>
<td>Disruptive, Impulse Control and Conduct Disorders</td>
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<tr>
<td>F91.2</td>
<td>Conduct Disorder, Adolescent Onset</td>
<td>Disruptive, Impulse Control and Conduct Disorders</td>
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<tr>
<td>F91.9</td>
<td>Conduct Disorder, Unspecified Onset</td>
<td>Disruptive, Impulse Control and Conduct Disorders</td>
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Criteria:
6. Fatigue or regular loss of energy.
7. Feelings of worthlessness or excessive guilt nearly every day (not merely self-reproach or guilt about being.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either subjective account or observed by others).
9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
Disruptive, Impulse Control and Conduct Disorders

Conduct Disorder

Criteria:
A. A repetitive pattern of behavior in which the basic rights of others or major societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:

Aggression to People and Animals
1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim
7. Has forced someone into sexual activity.

Destruction of Property
8. Has deliberately engaged in fire setting
9. Has deliberately destroyed others’ property
Disruptive, Impulse Control and Conduct Disorders

Conduct Disorder

Criteria:

**Deceitfulness or Theft**

10. Has broken into someone else’s house, building, or car.
11. Often lies to obtain goods or favors or to avoid obligations
12. Has stolen items of nontrivial value without confronting a victim

**Serious Violation of Rules**

13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
15. Is often truant from school, beginning before age 13 years.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.
Specify if: **With limited prosocial emotions**: To qualify for this specifier, an individual must have displayed at least two of the following characteristics persistently over at least 12 months and in multiple relationships and settings. These characteristics reflect the individual’s typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. Thus, to assess the criteria for the specifier, multiple information sources are necessary. In addition to the individual’s self-report, it is necessary to consider reports by others who have known the individual for extended periods of time (e.g., parents, teachers, co-workers, extended family members, peers).
Specify if: **Lack of remorse or guilt**: Does not feel bad or guilty when he or she does something wrong (exclude remorse when expressed only when caught and/or facing punishment). The individual shows a general lack of concern about the negative consequences of his or her actions. For example, the individual is not remorseful after hurting someone or does not care about the consequences of breaking rules.

Callous—lack of empathy: Disregards and is unconcerned about the feelings of others. The individual is described as cold and uncaring. The person appears more concerned about the effects of his or her actions on himself or herself, rather than their effects on others, even when they result in substantial harm to others.
Disruptive, Impulse Control and Conduct Disorders

Conduct Disorder

**Unconcerned about performance**: Does not show concern about poor/problematic performance at school, at work, or in other important activities. The individual does not put forth the effort necessary to perform well, even when expectations are clear, and typically blames others for his or her poor performance.

**Shallow or deficient affect**: Does not express feelings or show emotions to others, except in ways that seem shallow, insincere, or superficial or when emotional expressions are used for gain.
Specify current severity:

**Mild:** Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others

**Moderate:** The number of conduct problems and the effect on others are intermediate between those specified in “mild” and those in “severe”.

**Severe:** Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others
Disruptive, Impulse Control and Conduct Disorders

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<tr>
<td>F63.1</td>
<td>Pyromania</td>
<td>Disruptive, Impulse Control and Conduct Disorders</td>
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Criteria:

A. Deliberate and purposeful fire setting on more than one occasion.
B. Tension or affective arousal before the act.
C. Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, consequences).
D. Pleasure, gratification, or relief when setting fires or when witnessing or participating in their aftermath.
Disruptive, Impulse Control and Conduct Disorders

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<td>Pyromania</td>
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Criteria:

E. The fire setting is not done for monetary gain, to conceal criminal activity, to express anger or vengeance, to improve one’s living circumstances, in response to a delusion or hallucination, or as a result of impaired judgment.

F. The fire setting is not better explained by conduct disorder, a manic episode, or antisocial personality disorder.
Disruptive, Impulse Control and Conduct Disorders

Criteria:

A. Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.
B. Increasing sense of tension immediately before committing the theft.
C. Pleasure, gratification, or relief at the time of committing the theft.
D. The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination.
E. The stealing is not better explained by conduct disorder, a manic episode, or antisocial personality disorder.

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<tr>
<td>F63.3</td>
<td>Kleptomania</td>
<td>Disruptive, Impulse Control and Conduct Disorders</td>
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Section Three

Assessment and Diagnosis of Personality Disorders
Notable Mental Health Problems
(NIMH as applied to 2004)

Personality Disorders – 9.1% of adult Americans
- Avoidant Personality Disorder: 5.2% of adults
- Antisocial Personality Disorder: 1.0% of adults
- Borderline Personality Disorder: 1.6%
Personality Disorders
Diagnostic Features

• The personality disorders are grouped into three clusters based on descriptive similarities. It should be noted that this clustering system, although useful in some research and educational situations, has serious limitations and has not been consistently validated.

• Individuals frequently present with co-occurring personality disorders from different clusters.
Reasoning Behind Clusters

The division of personality disorders into three clusters in DSM-5 is intended to reflect the tendency of any given personality disorder to be most likely to be difficult to distinguish from other personality disorders within its cluster, as there is symptom overlap and considerable similarity of important signs and symptoms.
Personality Disorders: Three Clusters

- Cluster A
- Cluster B
- Cluster C
Cluster A Personality Disorders

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
Cluster A Personality Disorders

Common Features:

• Social awkwardness
• Social withdrawal
• Odd, bizarre, eccentric behaviors
Cluster B Personality Disorders

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
Cluster B Personality Disorders

Common Features:

• Dramatic behaviors
• Erratic behaviors
• Self-centeredness
Cluster C Personality Disorders

- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder
Cluster C Personality Disorders

Common Features:

• Fearfulness
• Anxiety
• Avoidance
Etiology of Personality Disorders

The exact cause of these disorders is not yet known. They may be created by a number of different, interactive causative factors, including underlying genetic predisposing factors, combined with a history of other psychiatric problems, as well as possible contributions for poor parenting, poor fit between the patient as a child and parenting style of parents, and/or a history of abuse and/or other childhood trauma.
Assessment of Personality Disorders

An accurate diagnosis of these disorders will generally require gathering a thorough history of the client, including a detailed family history of the person’s early childhood experiences, especially with regard to a history of violence, abuse, neglect and disturbed parental interactions. Because there may be genetic and/or neurological injury contributors to these diagnoses, a history of illness, injury, pre- and perinatal problems, and family history of similar disorders should be gathered. When possible, history taking should be gathered from other family members with knowledge of the patient’s history, as history gathering from the patient may present challenges due to the defining features of these disorders.
Components of Assessment: Biological, Psychological, Social

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

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

Personality disorders may require extensive courses of therapy over many years, combining supportive talk therapy, interventions to support problems with major life roles, skill building, and medications, where warranted, to address secondary effects of living with these disorders, which may include anxiety, depression, substance abuse, eating disorders, chronic stress, and other mental health problems.

A substantial percentage of persons with personality disorders never seek and never receive treatment.
Complications in Diagnosis of Personality Disorders
Difficulties in Arriving at an Accurate Diagnosis of Personality Disorders

• Patients with these disorders may present with a high degree of reluctance to enter treatment, provide accurate information, and to confirm presence and nature of problems
• Blurring with other PDs within same cluster can make it difficult to settle on a single diagnosis
• Patients may present with more than one personality disorder
• High degree of comorbidity with other disorders: substance abuse, depression, anxiety, eating disorders, other mental health conditions
Defining Features of Personality Disorders

The defining characteristic of the signs and symptoms that present in personality disorders is concerned with persistent, durable and long-term patterns of thinking, feeling, behaving and interacting that have caused ongoing distress or problems in relationships and life situations, and that have been integrated into the personality organization of the person who presents with the problems.
### Personality Disorders

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<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
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<tbody>
<tr>
<td>F60.0</td>
<td>Paranoid Personality Disorder</td>
<td>Cluster A Personality Disorders</td>
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</table>

Criteria:
A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four or more of the following:
1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
4. Reads hidden demeaning or threatening meanings into benign remarks or events.
5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).
Personality Disorders

Criteria:

6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.

7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

Note: If criteria are met prior to the onset of schizophrenia, add “premorbid,” i.e., “paranoid personality disorder (premorbid).”
Personality Disorders

Criteria:
A. A pattern of detachment from relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four or more of the following:
1. Neither desires nor enjoys close relationships, including being part of a family.
2. Almost always chooses solitary activities.
3. Has little, if any, interest in sexual experiences with another person.
4. Takes pleasure in few activities.
5. Lacks close friends other than first-degree relatives.
6. Appears indifferent to the praise or criticism of others.
7. Shows emotional coldness, detachment, or flattened affectivity.

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<tbody>
<tr>
<td>F60.1</td>
<td>Schizoid Personality Disorder</td>
<td>Cluster A Personality Disorders</td>
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Personality Disorders

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<tr>
<td>F60.1</td>
<td>Schizoid Personality Disorder</td>
<td>Cluster A Personality Disorders</td>
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</table>

Criteria:
B. Does not occur exclusively during the course of schizophrenia, bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder; is not attributable to the physiological effects of another medical condition.

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," i.e., "schizoid personality disorder (premorbid)."
Personality Disorders

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<tr>
<td>F21</td>
<td>Schizotypal Personality Disorder</td>
<td>Cluster A Personality Disorders</td>
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Criteria:
A. A pattern of social and interpersonal deficits marked by acute discomfort with close relationships as well as cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, indicated by five or more of the following:
   1. Ideas of reference
   2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms
   3. Unusual perceptual experiences, including bodily illusions.
   4. Odd thinking and speech
   5. Suspiciousness or paranoid ideation.
   6. Inappropriate or constricted affect.
   7. Behavior or appearance that is odd, eccentric, or peculiar.
   8. Lack of close friends or confidants other than first-degree relatives.
   9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.
Personality Disorders

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<tbody>
<tr>
<td>F21</td>
<td>Schizotypal Personality Disorder</td>
<td>Cluster A Personality Disorders</td>
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Criteria:

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder.

Note: If criteria are met prior to the onset of schizophrenia, add “premorbid,” e.g., “schizotypal personality disorder (premorbid).”
Personality Disorders

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<tr>
<td>F60.2</td>
<td>Antisocial Personality Disorders</td>
<td>Cluster B Personality Disorders</td>
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Criteria:
A. A pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three or more of the following:
   1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
   2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
   3. Impulsivity or failure to plan ahead.
   4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
   5. Reckless disregard for safety of self or others.
   6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
   7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.
B. The individual is at least age 18 years.
C. There is evidence of conduct disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.
## Personality Disorders

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<tr>
<td>F60.3</td>
<td>Borderline Personality Disorder</td>
<td>Cluster B Personality Disorders</td>
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### Criteria:

A. A pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging.
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger.
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.
Personality Disorders

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<tr>
<td>F60.4</td>
<td>Histrionic Personality Disorder</td>
<td>Cluster B Personality Disorders</td>
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Criteria:

A. A pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
1. Is uncomfortable in situations in which he or she is not the center of attention.
2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
3. Displays rapidly shifting and shallow expression of emotions.
4. Consistently uses physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
7. Is suggestible (i.e., easily influenced by others or circumstances).
8. Considers relationships to be more intimate than they actually are.
Personality Disorders

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<tr>
<td>F60.81</td>
<td>Narcissistic Personality Disorder</td>
<td>Cluster B Personality Disorders</td>
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Criteria:
A. A pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:
1. Has a grandiose sense of self-importance
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. Believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.
5. Has a sense of entitlement
6. Is interpersonally exploitative.
7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of him or her.
9. Shows arrogant, haughty behaviors or attitudes.
Personality Disorders

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<td>F60.6</td>
<td>Avoidant Personality Disorder</td>
<td>Cluster C Personality Disorders</td>
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Criteria:

A. A pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
   1. Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.
   2. Is unwilling to get involved with people unless certain of being liked.
   3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.
   4. Is preoccupied with being criticized or rejected in social situations.
   5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
   6. Views self as socially inept, personally unappealing, or inferior to others.
   7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.
Personality Disorders

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<tr>
<td>F60.7</td>
<td>Dependent Personality Disorder</td>
<td>Cluster C Personality Disorders</td>
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Criteria:
A. An excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:
1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of his or her life.
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval.
4. Has difficulty initiating projects or doing things on his or her own
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
7. Urgently seeks another relationship as a source of care and support when a relationship ends.
8. Is preoccupied with fears of being left to take care of himself or herself
Personality Disorders

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<td>F60.5</td>
<td>Obsessive-Compulsive Personality Disorder</td>
<td>Cluster C Personality Disorders</td>
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Criteria:

A. A pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
2. Shows perfectionism that interferes with task completion
3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships
4. Is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
## Personality Disorders

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**Criteria:**

A. A pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

5. Is unable to discard worn-out or worthless objects even when they have no sentimental value.

6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.

7. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.

8. Shows rigidity and stubbornness
Examples of Differential Diagnosis of Personality Disorders
Bipolar Disorder versus Borderline Personality Disorder
Bipolar Disorders versus BPD

• Key diagnostic symptoms of BPD

- Extreme efforts to avoid abandonment (real or imagined)
- Intense and unstable relationships, and individual alternates between idealizing and devaluing others in relationships.
- Sense of self is unstable showing an identity disturbance.
- Impulsive in at least two areas of behavior that are harmful to self (overspending, overeating, inappropriate or unsafe sexual behavior, substance abuse, etc.). Does not include suicidal thoughts of self-mutilation covered in next criterion.
Bipolar Disorders versus BPD

- Recurrent self-mutilating behavior or suicidal behaviors or threats.
- Intense affective instability, lasting only a few hours possibly up to a few days.
- Chronic feelings of emptiness
- Intense, inappropriate expression of anger.
- Transient paranoid or dissociative ideation, linked with stress.

Key diagnostic symptoms of BPD
Borderline Personality Disorder versus PTSD
BPD versus PTSD

• Attachment security and PTSD

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

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

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

• Key differentiating features

-Symptoms of excessive emotional expressiveness pursuant to traumatic incident as opposed to durable expression of symptoms
**Schizophrenia versus Paranoid Personality**

- **Key differentiating features**

  - Paranoid personality disorders present with longer term suspiciousness without the presence of clear delusional or hallucinogenic breakthroughs.
Schizoid versus Other Personality Disorders

- Key differentiating features

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

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

- Schizoid PD is different from Avoidant PD in that social isolation in Avoidant PD is due to fear of embarrassment or rejection.
Dependent versus Other Personality Disorders

- Key differentiating features

- Suicide attempts, identity diffusion, and numerous chaotic relationships occur less frequently with a diagnosis of HPD than with Borderline PD.

- Dependent PD exhibits greater submissiveness in relationships than Histrionic PD, where seductiveness is used to secure attention.

- Narcissistic PD exhibits much more confidence, albeit fragile and potentially false, than Dependent PD, where the primary mode is submissiveness or passive-aggressive manipulation.

- Dependent PD is different from Avoidant PD in that social isolation occurs with Avoidant PD while relationships are sought out with Dependent PD.
Narcissistic Personality Disorder versus Bipolar

- Key differentiating features

- During manic phase of bipolar disorder, grandiosity is less fragile and more delusional than the grandiosity exhibited with Narcissistic PD

- Precipitants more reliably tied to changes in mood in Narcissistic PD, where mood shifts can occur without clear precipitant with Bipolar Disorder