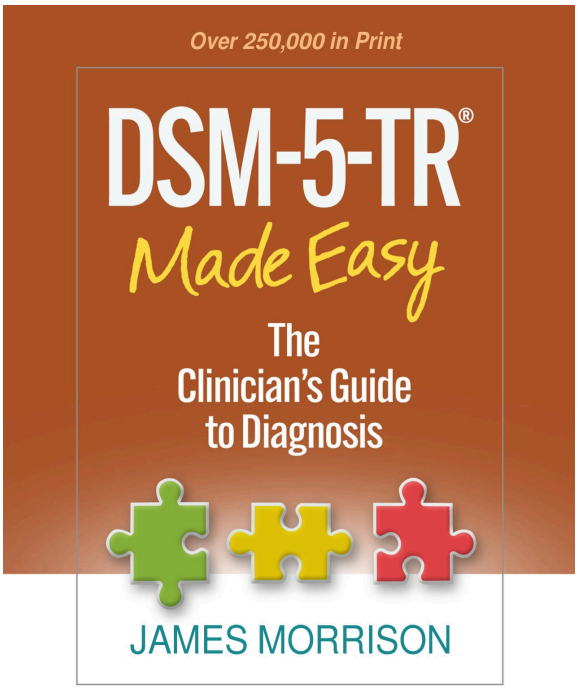


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out the Author

s Morrison, MD, is Affiliate Professor of Psychiatry at Oregon Health and Science University nd. His long career includes extensive experience in both the private and public sectors. With imed practical books—including *Diagnosis Made Easier, Second Edition; The First Intervie h Edition;* and others—Dr. Morrison has guided hundreds of thousands of mental health ssionals and students through the complexities of clinical evaluation and diagnosis.

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roduction

ummer after my first year in medical school, I visited a classmate at his home near the mental tion where his parents both worked. One afternoon, walking around the vast, open campus, we onversation with a staff psychiatrist who told us about an interesting patient.

his young woman had been admitted a few days earlier. While attending college nearby, she ha nly become agitated—speaking rapidly and rushing in a frenzy from one activity to another. Aft pulsively sold her nearly new Corvette for $500, her friends had brought her for evaluation. ive hundred dollars!" exclaimed the psychiatrist. "That kind of thinking, that's schizophrenia!"

ow, my friend and I had had just enough exposure to mental health diagnosis to recognize that th woman's symptoms and course of illness were far more consistent with an episode of mania t chizophrenia. We were too young and callow to challenge the diagnosis of an experienced clin we went on our way, we each expressed the fervent hope that this patient's care would be less d than her assessment.

or decades, the memory of that blown diagnosis has haunted me, in part because it is by no mea e in the annals of mental health. Indeed, it wasn't until many years later that the first diagnostic al to include specific criteria (DSM-III) was published. That book has since morphed into the ous fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, now a text on (DSM-5-TR) published by the American Psychiatric Association.

nyone who evaluates and treats mental health patients must understand the latest edition of what e the world standard for evaluation and diagnosis. But getting value from DSM-5-TR requires deal of concentration. Written by a committee with the goal of providing standards for research as clinical practice in a variety of disciplines, it covers nearly every conceivable subject relate l health. But you could come away from it not understanding how diagnostic criteria translate t patient.

wrote *DSM-5-TR Made Easy* to make mental health diagnosis more accessible to clinicians fro l health professions. In these pages, you will find descriptions of every mental disorder, with asis on those that occur in adults. With its careful use, today's readers would be unlikely to mis oung college student's manic symptoms for schizophrenia.

t Have I Done to Make DSM-5-TR Easy?

ductory material. Each section begins with a brief description designed to orient you to the osis. There might be a discussion of the major symptoms, perhaps a little historical information of the demographics—who is likely to have this disorder, and in what circumstances. Here, I'v to include the details that I would want to know if I were just starting out as a student.

tial Features. OK, this is the name I've given the defining symptoms in *DSM-5-TR Made Eas* e also known as *prototypes*. I've used them in hopes that they will make the official criteria mo sible. For years, working clinicians have known that when we evaluate a new patient, we don't of emotional and behavioral attributes and start ticking off boxes. Rather, we compare the data e gathered to the mind's eye picture we've formed of the various mental and behavioral disorde the data fit an image, we have an "aha!" moment and pop that diagnosis into our list of differen oses. (From long experience and conversations with countless other experienced clinicians, I c e you that this is exactly how it works.)

ome years ago, a study of mood and anxiety disorders[*] found that clinicians who make diagnose their patients against prototypes perform at least as well as, and sometimes better than, other ians who adhere to strict criteria. That is, it can be shown that prototypes have validity even gr hat of some DSM diagnostic criteria. Moreover, prototypes are reported to be usable by clinici relatively modest level of training and experience; you don't need 20 years of clinical work t ed with prototypes. Clinicians also report that prototypes are less cumbersome and more clinic . (However—and I hasten to underscore this point—the prototypes used in the studies I have ju oned were generated from the diagnostic criteria inherent in the DSM criteria.) The bottom line we need criteria, but we can adapt them so they work even better for us.

nce you've collected the data and read the prototypes, you can assign a number to indicate how ly your patient fits the ideal of any diagnoses you are considering. Here's the accepted conventi e or no match; 2 = some match (the patient has a few features of the disorder); 3 = moderate ma are significant, important features of the disorder); 4 = good match (the patient meets the stand diagnosis applies); 5 = excellent match (a classic case). Obviously, the vignettes I've provide s match at the 4 or 5 level (if not, why would I use them as illustrative examples?), so I haven' red to grade them on the 5-point scale. But, if you wish, you can do just that with each new pati terview.

here may be times you'll want to turn to the official DSM-5-TR criteria. For example, when yo arting out, DSM-5-TR will give you a picture of the exact numbers of each set of criteria that ally count the patient as "in." You'll also refer to it when doing clinical research, where you m o report that participants were all selected according to a scientifically studied, reproducible ard. Even as an experienced clinician, I return to the actual criteria from time to time. Perhaps i have fresh in my mind the complete information that allows me to communicate with other ians; sometimes it is related to my writing. (As you read through the discussions of the patients nted in this book, you will find that the evaluations are couched in terms of the official DSM-5- ia.) But mostly, whether I am with patients or talking with students, I stick to the prototype meth ke nearly every other working clinician.

ine Print. Most of the diagnostic material in these sections is what I call *boilerplate*. I suppos

ry I've dubbed *the D's*. (I started out by using "Don't disregard the D's" or similar phrases, bu got tired of all the typing; so, I eventually adopted "the D's" as shorthand.) In any event, this rplate stuff is important: It forms part of the diagnostic requirements for the condition in questio oss over it.

ifferential diagnosis. Listed here are all the disorders to consider as alternatives when evaluat mptoms. In most cases, this list starts off with substance use disorders and general medical sorders, which despite their relative infrequence you should always place first on the list of sorders competing for your consideration. Next I put in those conditions that are most treatable nce should be addressed early. Only at the end do I include conditions that have a poor progno that you can't do very much to treat. I call this the *safety principle* of differential diagnosis.

There are some disorders that DSM-5-TR lists right in the diagnostic criteria themselves. Th ve emphasized with **bold print.** Conditions mentioned in the text I have also mentioned, but not phasized.

istress or disability. Most DSM-5-TR diagnostic criteria sets require that the patient experienc stress or some form of impairment (for work, social interactions, interpersonal relations, or mething else). The purpose is to ensure that we discriminate people who are patients from thos ho, while diagnostically normal, perhaps have lives with interesting aspects.

---

e word *distress* is explained exactly once in all of DSM-5-TR. DSM-IV didn't define the term anywhere; Campbell's *ychiatric Dictionary* doesn't even list it. The DSM-5-TR sections on trichotillomania and excoriation (hair-pulling and in-picking disorders, respectively) both describe distress as including negative feelings such as embarrassment and rfeiture of control. It's unclear, however, whether the same definition is employed anywhere else, or what might be th minant thinking throughout the manual. But for me, some combination of pain, anxiety, and suffering works pretty we a definition.

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uration. Many disorders require that symptoms be present for a certain minimum length of time fore they can be ruled in. Again, this is to ensure that we don't go around indiscriminately han t diagnoses. For example, nearly everyone will feel blue or down at one time or another. To q r a diagnosis of a depressive disorder, however, symptoms must last for at least a couple of we

emographics. A few disorders are limited to certain age spans, genders, or cultural groups.

itions. I have tried to provide definitions of all the terms needed to evaluate and diagnose patie ental disorders. Mostly, those definitions are sprinkled into the text as needed. In the index I u *ized* page numbers to locate those definitions—a sort of distributed glossary.

fiers. Many DSM-5-TR diagnoses aren't content to sit there by themselves; they want us to mo in some way when we write them down. They indicate ways in which we clinicians, after settli nosis, must make further judgments about a patient's symptoms or course of illness, to cram as ation as possible into the final diagnostic product. Don't worry: After you've read a few, you' ea.

g Notes. Many of the Essential Features sections conclude with guidance on coding, which su

ars. To underscore or augment what you need to know, I have sprinkled additional bits of ation throughout the text (such as the sidebar about *distress* that you just read). Some of these y highlight information that will help you make a diagnosis quickly. Some contain historical ation and other sidelights about diagnoses that I've found interesting. Many include editorial a opinions about patients, the diagnostic process, and clinical matters in general.

ttes. I have based this book on that reliable device, the clinical vignette. As a student, I found t had trouble recalling the features of disorders. But once I had evaluated and treated a patient, I s had a mental image to help me remember important points about symptoms and differential osis. I hope that the more than 130 patients described in *DSM-5-TR Made Easy* will do the sa

ation. This section summarizes my thinking for each patient I've written into a vignette. I expla he patient fits the diagnostic criteria and why I think other diagnoses are unlikely. Sometimes I st that additional history or medical or psychological testing should be obtained before a final osis is given. The conclusions stated here allow you to compare your thinking to mine. There ar ays you can do this. One is by picking out from the vignette the Essential Features I've listed f diagnosis. But so that you can follow the thinking of the folks who wrote the actual DSM-5-TR, ncluded references (in parentheses) to the official criteria. If you disagree with any of my retations, I hope you'll email me (*morrjame@ohsu.edu*).

diagnosis. Code numbers can be assigned by clinicians or support staff. To guide staff on how ed, we need to put all the diagnostic material that seems relevant into language that conforms to ved format. The final diagnoses included in the book not only explain how I'd code each patie rovide models to use in writing up the diagnoses for your own patients.

s. I've included several tables to provide an overall picture of certain topics—specifiers that a s different diagnoses, a list of physical disorders that can produce emotional and behavioral oms, and more. Tables that are of principal use in a given chapter appear in that chapter. A few apply more generally throughout the book, you'll find in the Appendix. Some of these tables ar licated, but they consolidate into one place information that you'd have to read page after page -5-TR to unearth.

riting. Throughout, I've tried to use language that is clear and simple. Clinically relevant ation is written in declarative sentences that describe what you need to know in diagnosing a t. My goal has been to make the material sound as though it was written by a clinician to use fo ts, not by a lawyer to brandish in court. Wherever I've failed, I hope you will email me to let . I'll try to put it right in a future edition.

cture of *DSM-5-TR Made Easy*

rst 18 chapters* of this book contain descriptions and criteria for the major mental diagnoses a nality disorders. Chapter 19 comprises information concerning other terms that you may find us