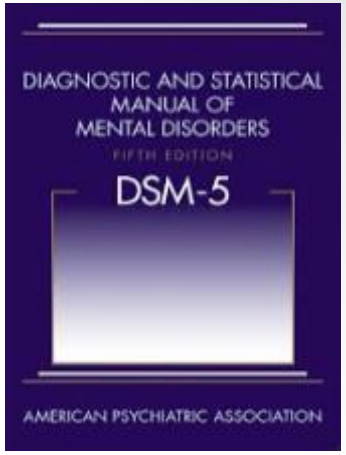


Nuevas tendencias diagnósticas del DSM 5 y sus implicaciones en la práctica de los profesionales de Terapia Ocupacional

Dr. Arnaldo Cruz, PhD., MS, MC, OTR/L
Programa de Maestría en Ciencias Terapia Ocupacional
Recinto de Ciencias Médicas Universidad de Puerto Rico

¿Pregunta?

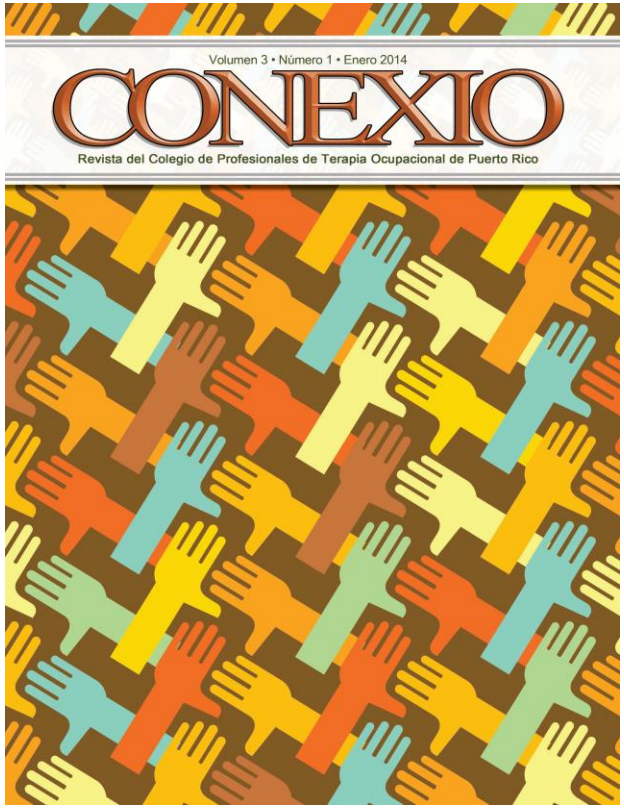
DSM 5

Datos….

- Asumo el nivel de conocimiento de la audiencia del DSM 5 es poco y básico
- Ya se incluyó en los cursos de la UCA hace dos semestres
- Yo lo incluí desde el año pasado en mis cursos estableciendo el puente entre el DSM IV TR y DSM 5
- Reválida de psicología otoño de 2014
- Aún casa aseguradoras usan DSM IV TR- viene cambio ya
- En Health South se desde oct 2014 para facturación Medicare; Veteranos

Cambios más importantes del Manual Diagnóstico y Estadístico de los Trastornos Mentales: Trayectoria del DSM IV TR al DSM 5

Vol 3, Num 1, enero 2014



Medscape Psychiatry © 2012 WebMD, LLC

- In the 21st century, when technology allows immediate electronic dissemination of information worldwide, Roman numerals are especially limiting.
- Research advances will continue to require text revisions to DSM, and a TR designation, as was done with DSM-IV-TR, can only be appended once.
- After DSM-5 is published in may 2013, future changes prior to the manual's next complete revision will be signified as DSM-5.1, DSM-5.2 and so on.


AUN NO TERMINO DE COMPRENDER DEL TODO EL DSM-IV Y YA VIENE EL DSM-5

Objetivos de la Educación Continua

Al finalizar la experiencia educativa los participantes lograrán:

- Discutir el trasfondo histórico del DSM, y los cambios principales asociados a la organización de los desórdenes psiquiátricos en el DSM-5.
- Evaluar el nuevo sistema diagnóstico y de clasificación DSM-5 y su aplicación a situaciones clínicas.
- Examinar las implicaciones del DSM-5 en el dominio y proceso de la práctica de Terapia Ocupacional en salud mental.
- Analizar el esquema de diagnóstico ocupacional sugeridos por la Asociación Canadiense de Terapia Ocupacional.
- Práctica de casos y ejercicios de aplicación del DSM-5.


DSM-5


DSM-I
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
DSM-II
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
DSM-III
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
DSM-IV
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
DSM-5
5

Datos…

- Estudio 2012
  - Más del 70% de los psiquiatras en 44 países usan el ICD
  - 23% usan el DSM- países con relación con EU- PR, INGLATERRA, FRANCIA, ESPAÑA, AUSTRALIA, COREA DEL SUR

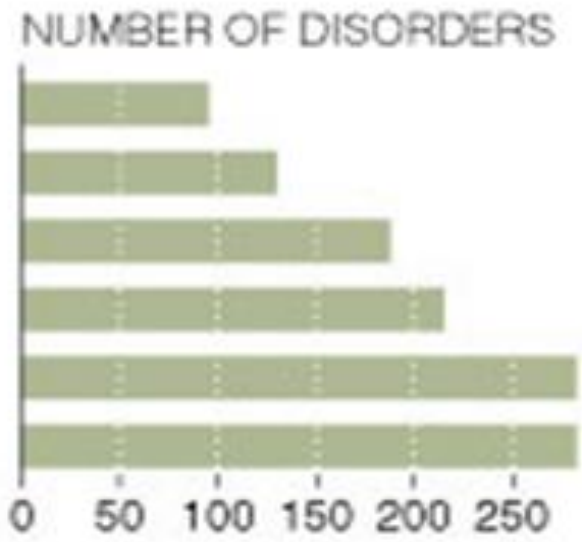
- La realidad es q cada vez el DSM es una herramienta más allá del área clínica, llegando incluso hasta el escenario comunitario debido a la comorbidez de Síntomas y dx)

- DSM 5 es como cualquier sistema de clasificación
  - MT TO, ICF, ICD,
  - Son documento vivos, en transformación continua

A Growing List Of Mental Ills

Work is progressing on a fifth edition of the Diagnostic and Statistical Manual of Mental Disorders. The current edition describes about three times the number of disorders as the first edition did in 1952.

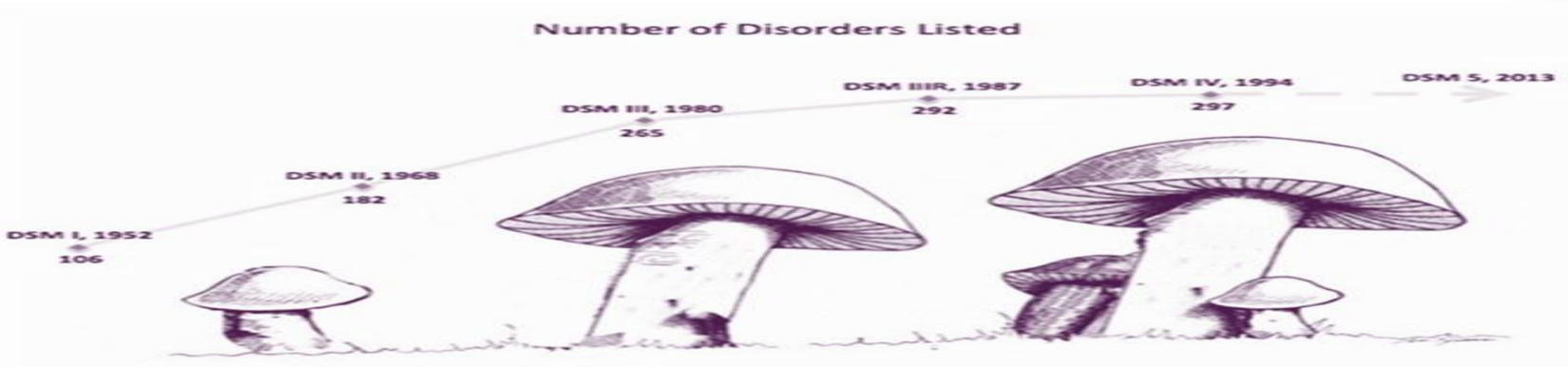
EDITION	YEAR
- I	1952
- II	1968
- III	1980
- III-R	1987
- IV	1994
- IV-TR	2000



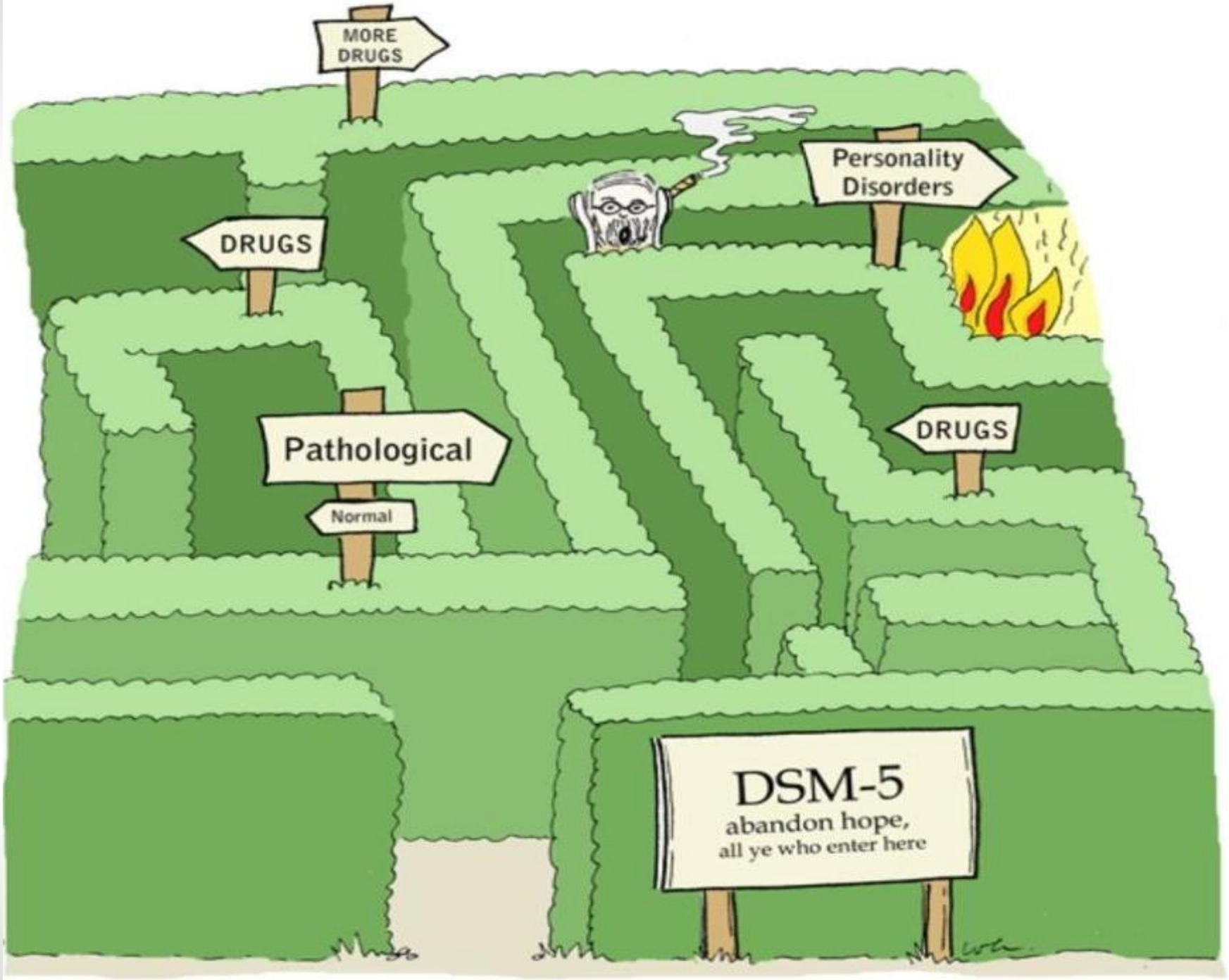
Source: American Psychiatric Association

Trayectoria histórica DSM's

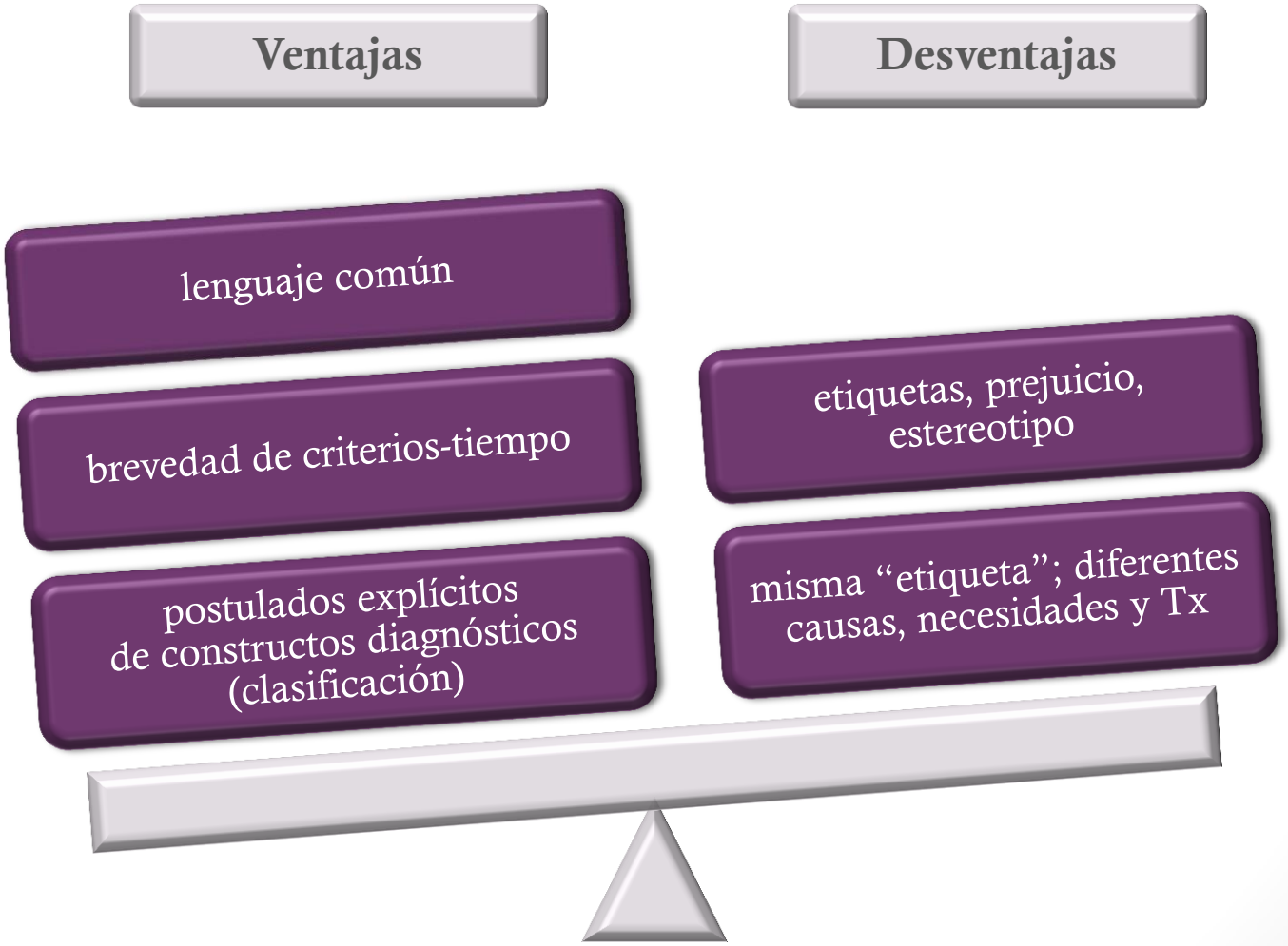
Edición	Años vigencia	# Dx	# pág.
1952 DSM	16 años	106	130
1968 DSM II	12 años	182	134
1974 DSM IIR	6 años	182	*
1980 DSM III	7 años	265	494
1987 DSM IIIR	7 años	292	567
1994 DSM IV	7 años	297	886
2000 DSM IV TR	13 años	297	947
2013 DSM 5	*	257	1023



Cuestionamiento de la naturaleza diagnóstica


MORE DRUGS
DRUGS
Personality Disorders
Pathological
Normal
DRUGS
DSM-5
abandon hope,
all ye who enter here

Ventajas y desventajas en un sistema de clasificación



Trasfondo histórico

1840-EEUU	✓ Primer intento en un Censo poblacional de clasificar estadísticamente los desórdenes mentales – "todo aquel que es diferente" ✓ Una categoría de clasificación: "idiosy"
1880	✓ Ocho categorías diagnósticas (ej. manía, melancolía, monomanía, paresis, demencia, epilepsia)
1948	✓ Se refina el sistema de clasificación y se formaliza su inclusión en un capítulo del *International Classification of Diseases* (ICD-6) - 26 categorías Dx (psicosis, psiconeurosis, desórdenes de conducta, inteligencia)
1952	✓ DSM I publicado por la APA ✓ Primer volumen comprensivo de desórdenes mentales (postulados biológicos de A. Meyer)

Trasfondo histórico

1968	✓ DSM II ✓ Descripciones generales y vagas; dificultad para llegar a un diagnóstico confiable (se ignoran recomendaciones del MD BRIT. Stengel)
Tomas Szasz 1974	✓ "La condición mental es un fenómeno social y no una enfermedad" ✓ Etiqueta para definir una conducta desviada, inaceptada por la sociedad ✓ Explica diferencias en diagnóstico
1970-1980	✓ Década de avances en psicofarmacología ✓ Instrumentos de diagnóstico: *- Research Diagnostic Criteria* *- Structured Clinical Interview*

Trasfondo histórico

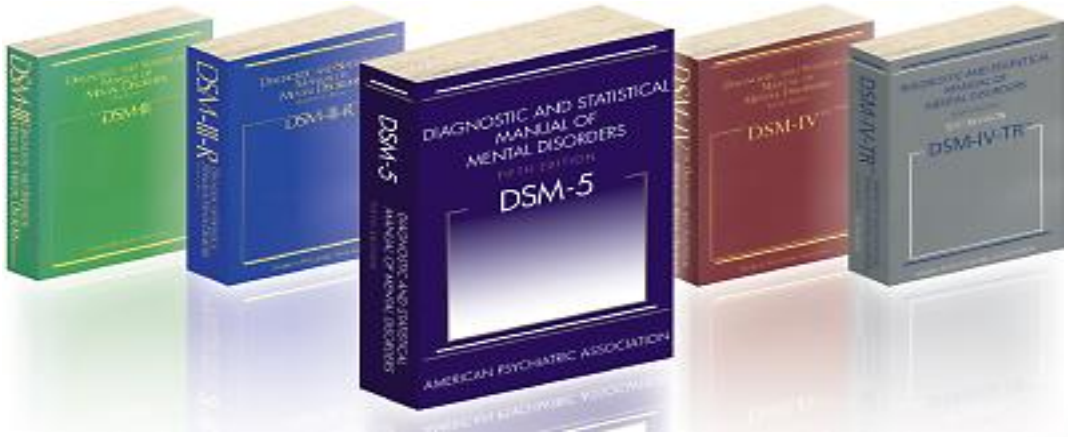
DSM IIR 1974	✓ Hasta aquí, procesos internos no observables; T. psicoanalítica
DSM III 1980	✓ 12,000 individuos evaluados ✓ Más de 150 diagnósticos ✓ Jerarquía de desórdenes ✓ Descripciones más específicas, síntomas, aparición (*onset*), duración, curso probable ✓ Clasificación operacional – descripción de psicopatología, no solo etiología ✓ Sistema de Clasificación Multiaxial ✓ Énfasis en describir problemas clínicos y no en interpretarlos ✓ Multiaxis – elimina la pobre confiabilidad de Dx anteriores que estaban basados en suposiciones

Trasfondo histórico

Continuación DSM III 1980	✓ "Homosexualidad egodistónica" - Angustia y sufrimiento que padece una persona con orientación gay o lesbiana por el hecho de serlo. - El término se retiró en 1986.
DSM IIIR 1987	✓ Se eliminan jerarquías de diagnósticos
DSM IV 1994	✓ Revisiones de literatura, meta-análisis, *field trials*, evidencia científica ✓ Diferencias culturales en los constructos psiquiátricos ✓ *Task force* de profesionales ✓ Se crean estándares internacionales para validar empíricamente los desórdenes ✓ Cubre mayor número de conductas maladaptativas ✓ Lenguaje más preciso

Trasfondo histórico

DSM IV-TR 2000	✓ No alteró criterios diagnósticos; incluyó últimos hallazgos investigativos
2013	✓ DSM 5 ✓ Kendall (2002), cinco criterios para mejorar taxonomía: - más comprensiva - fácil de usar - significancia clínica - mayor validez y confiabilidad



Trasfondo histórico – nuevas tendencias

Disforia de género*

Se elimina Dx. Trastorno de Identidad de Género

- angustia que sufre la persona que no está identificada con su sexo masculino o femenino

Síndrome de Diógenes = Trastorno de Acaparamiento*

- dificultades persistentes para deshacerse de sus posesiones, independientemente de su valor real
- tiene efectos dañinos (emocionales, físicos, sociales, económicos, e incluso, legales) para un acaparador y sus familiares

Síndrome de Asperger, Rett, Desintegrativo

- desaparece de los Trastornos del Espectro Autista

Trastorno de Estado de Ánimo Disruptivo y No Regulado*

- niños que muestran irritabilidad persistente y episodios frecuentes de arrebatos de conducta, tres o más veces a la semana, durante más de un año

Trasfondo histórico – nuevas tendencias

Desórdenes de Ansiedad

- Dx. Obsesivo Compulsivo
  - Excoriación* acto de arrancarse la piel de manera continuada

Schizotaxia* (Tsuang, et al. 2002)

- Susceptibilidad a esquizofrenia por un sutil desorden neurointegrativo + aprendizaje social = personalidad esquizotípica (Eje II)
  - desorden cognitivo – habla incoherente, tangencial
  - aversividad social, anhedonia, ambivalencia

Trastorno de Procesamiento Sensorial*

- Malinterpretación de información sensorial, abrumados por los estímulos, reacciones impulsivas o a evitar ciertas experiencias

Vigorexia*

- trastorno alimentario, preocupación excesiva por el físico y distorsión esquema corporal

Trasfondo histórico – nuevas tendencias

Pregorexia*

- "Pregnant anorexic"

Adicciones virtuales*

- internet, videojuegos, redes sociales, celulares

Trasfondo histórico

- Wakefield (2002) sugiere dos componentes en la enfermedad mental:
  - disfunción biológica
  - evidencia de participación o "involucramiento en situación de vida" (WHO)
- Aumento en la biomedicalización de la taxonomía
- Issue de la comorbidez – diagnóstico dual
  - Krueger estima que el 14% de la población de EEUU tiene Hx de dos o más Dx psiq
- Issue de variación cultural
  - Porter (1987)

    "lo mental y lo físico, la locura y lo malo, no son puntos fijos; sino culturalmente relativos"

Formato DSM IV-TR Clasificación Multiaxial

Eje	Descripción
Eje I	Diagnóstico principal
Eje II	Desórdenes de personalidad Retardación Mental
Eje III	Condiciones médicas asociadas
Eje IV	Problemas psicosociales y de contexto
Eje V	GAF Global Assessment of Functioning* Escala Global de Funcionamiento en Relaciones (GARF) • Solución de Problemas – Organización – Clima Emocional Escala de Funcionamiento Social y Ocupacional (SOFAS) • Ambas escalas del 1-100 como GAF- excelentes para el TO

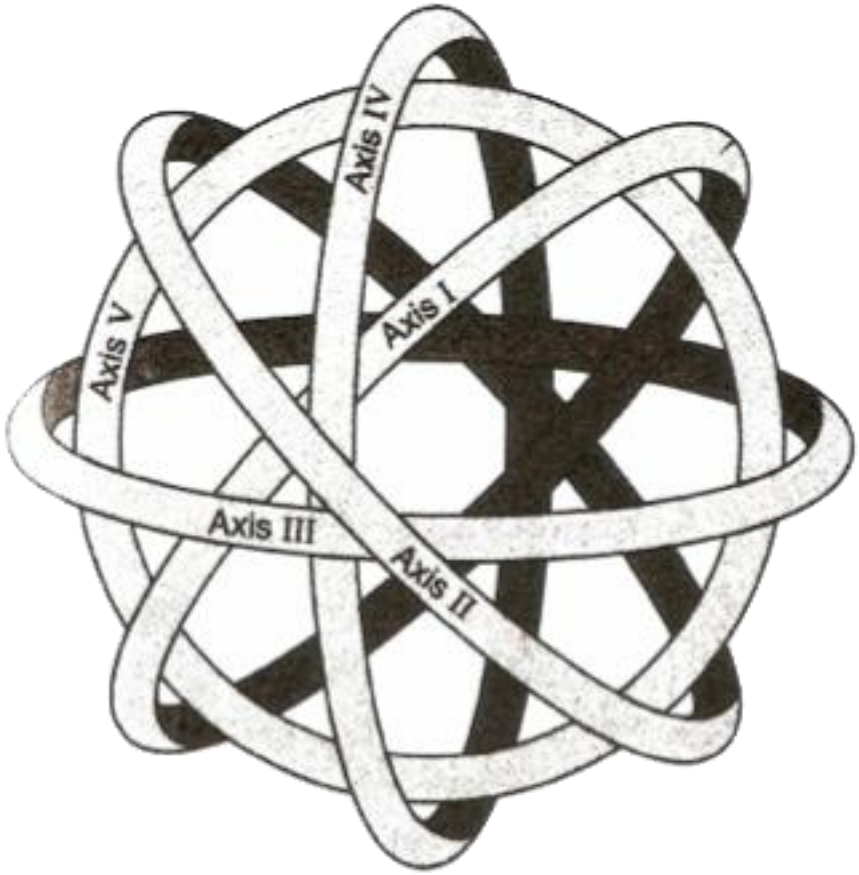


Figure 6-1. Multiaxial dimensions of psychiatric disorders.

Algunos mecanismos provistos en el DSM-IV TR para recopilar impresiones provisionales

R/O "RULE OUT" *	Descártese o confírmese este diagnóstico…
N.O.S. "NOT OTHERWISE SPECIFIED" *	Diagnóstico sin especificidad. No llena todos los criterios para un diagnóstico final, pero se detectan rasgos que lo sugieren.
DEFERRED*	Diferido. No hay información suficiente al momento de activar un juicio final o provisional.
NO Dx.	No diagnóstico. Se ha obtenido la información necesaria y se ha determinado que no existe patología.

Ejes en detalle

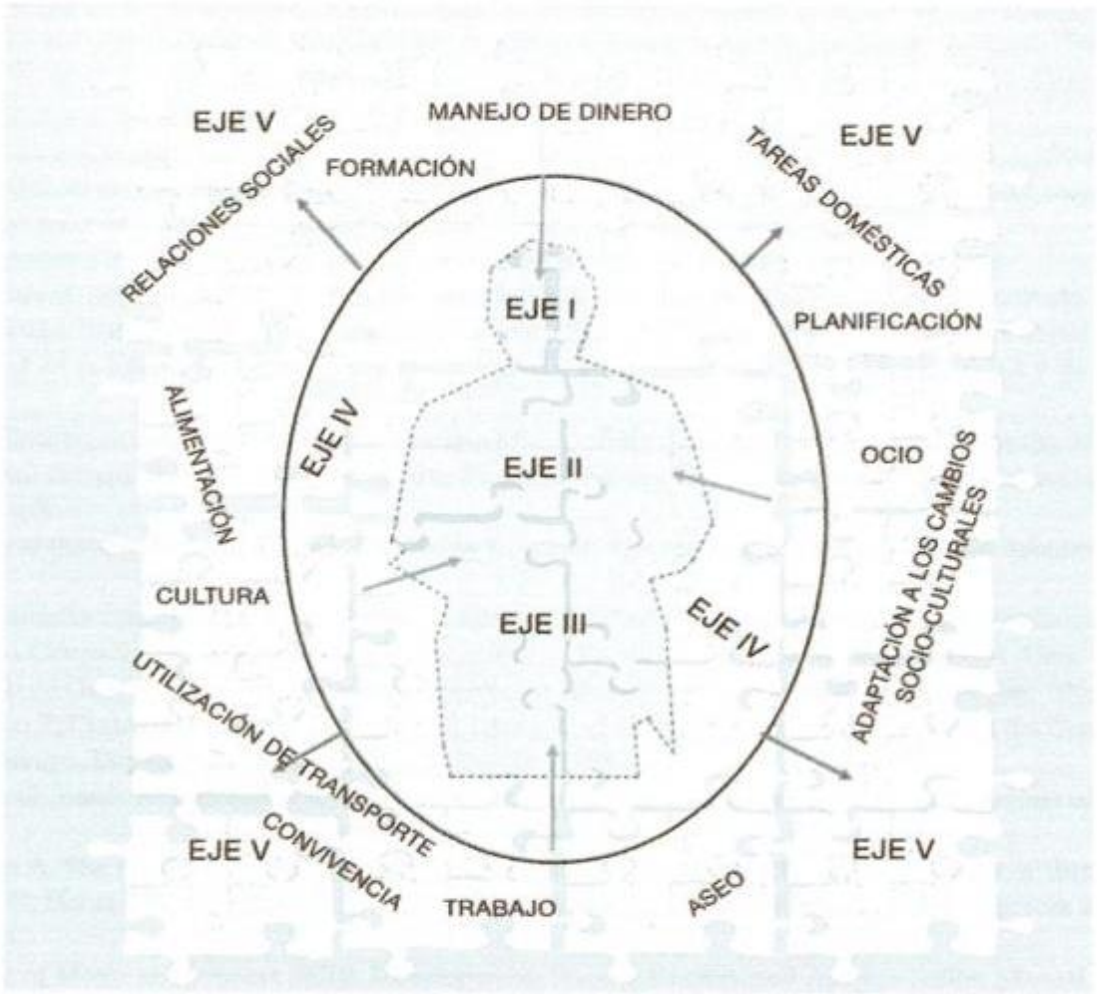


Figura 5. Modelo multiaxial integrador de la Terapia Ocupacional.

USO DE LOS "V-CODES"

Los llamados "V-Codes" son mecanismos mediante los cuales se indica que no existen criterios particulares y específicos para atribuir alguna disfunción conductual que indique patología psicológica. Más bien, lo que existe es algo situacional, genuino o fingido, que se convierte en el foco de atención clínica. Las aplicaciones de los "V-Codes" son documentadas primordialmente en el EJE I. A continuación se ofrece una lista de los "V-Codes" más utilizados.

CÓDIGO	APLICACIÓN
V61.20	Problemas de relaciones paterno-filiales, tales como: comunicación, sobreprotección o problemas de disciplina.
V61.1	Problemas de relaciones maritales, tales como: expectativas irreales, incompatibilidad sexual, infidelidad.
V61.8	Problemas de relaciones con pares, tales como: rivalidad entre hermanos, problemas con grupo primario.
V61.21	Maltrato físico, psicológico, sexual, negligencia en menores.
V61.10	Maltrato físico, psicológico o sexual en adultos.
V65.2	Fingimiento o "Malingering". La producción intencional y falsa de síntomas psicológicos y/o físicos con la expresa intención de evitar el cumplimento de alguna responsabilidad.
V62.3	Problemas académicos.
V62.2.	Problemas ocupacionales.
V62.4	Problemas de aculturación.

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health or illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code	*(Note: Use intermediate codes when appropriate, e.g., 45, 68, 2.)*
100 | 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
90 | | 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
80 | | 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
70 | | 61	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60 | 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

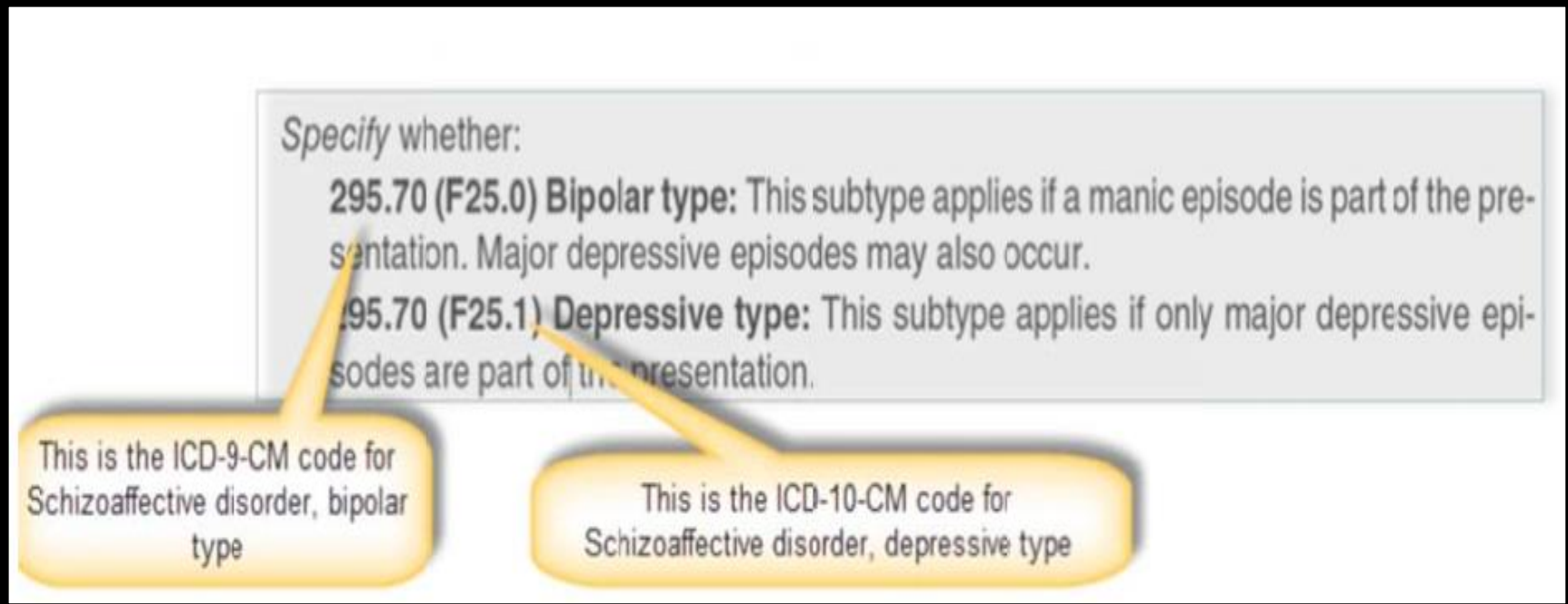
Figure 5-4. The Global Assessmment of Functioning (GAF) Scale

Global Assessment of Functioning (GAF) Scale

50 | 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
40 | | | 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 | | 21	Behavior is considerably influences by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home or friends).
20 | 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR gross impairment in communication (e.g., largely incoherent or mute).
10 | 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act clear expectation of death.
0	Inadequate information.

Figure 5-4. The Global Assessmment of Functioning (GAF) Scale


This is the ICD-9-CM code for Schizophrenia
This is the ICD-10-CM code for Schizophrenia
Schizophrenia
Diagnostic Criteria
295.90 (F20.9)


Specify whether:
295.70 (F25.0) Bipolar type: This subtype applies if a manic episode is part of the pre-
sentation. Major depressive episodes may also occur.
295.70 (F25.1) Depressive type: This subtype applies if only major depressive epi-
sodes are part of the presentation.
This is the ICD-9-CM code for Schizoaffective disorder, bipolar type
This is the ICD-10-CM code for Schizoaffective disorder, depressive type

DSM 5

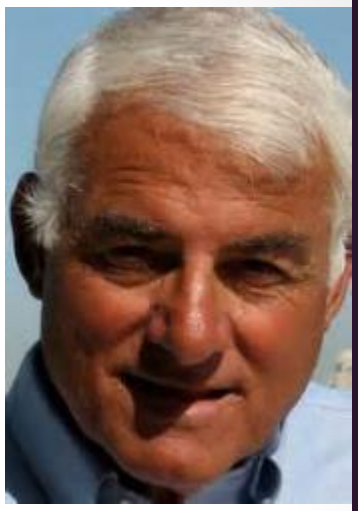

DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
DSM-5

David J. Kupfer (Task Force Chair) y Darrel Regier (Vice Chair)

- Junio 2012
  - "Por primera vez en la historia, el número total de diagnósticos en el DSM NO va a aumentar. De hecho el número actual de diagnósticos puede ir incluso por debajo de los que se presentó en el DSM III hace 30 años atrás."
- 50 organizaciones profesionales expresan oposición al DSM 5
  - División 32 (Sociedad de Psicología Humanista)
  - División 27 (Sociedad de Investigación y Acción Comunitaria)
  - División 49 (Sociedad de Psicología y Psicoterapia)
- Se utilice el ICD 9
  - En octubre 2014 ICD 10

DSM 5

- El **Dr. Allen Frances**, ex director y profesor emérito del Departamento de Psiquiatría de la Escuela de Medicina de la Universidad de Duke, y el **Dr. Thomas Insel**, director del Instituto de Salud Mental (NIMH):
  - ✓ participaron del proceso de revisión del DSM 5 y, previo a su conclusión, abandonaron el mismo, debido a que entendían que el nuevo manual abría la posibilidad a un aumento exponencial en diagnósticos y el estigma social.
  - ✓ sobre-medicación de miles de personas.
- Para otros profesionales de la salud el DSM 5 es considerado un documento vivo y en evolución constante que ha reconceptualizado el campo de la psiquiatría, acercándola más a la psicología y a la visión psicosocial de la enfermedad psiquiátrica.



Mayores críticas…

- Los marcadores biológicos y los neuro-circuitos genéticos específicos para proveer diagnósticos confiables y válidos, no se cumplieron.
- Conflictos de interés con casas farmacéuticas

Organización DSM 5

- En el DSM IV TR los Dxs mayormente se basaban en síntomas (Ej. Trastornos de Ansiedad)
- En el DSM 5/ICD se agrupan trastornos en factores subyacentes (Ej Trauma, Trastorno Obsesivo Compulsivo)
- No hay sección de niños
- No hay multiejes
- Cambios marcados en criterios diagnósticos
- Desaparecen más de 50 Dxs o subtipos (Ej. Esquizofrenia, Trastorno psicótico compartido)
- DSM 5 combina los primeros 3 ejes del DSM IV TR, condiciones de atención clínica codificadas en el ICD 9 como "V", y en el ICD 10 como códigos "Z"
  - DSM 5, pág 715-727

Fortalezas del DSM 5

- Importancia a factores culturales- se pretende internacionalizar el DSM 5

Trastorno Identidad Disociada (personalidad múltiple)

Experiencia de posesión

Oriente vs Occidente

No proliferación de diagnósticos

Eliminación de diagnósticos

No evidencia de incidencia y prevalencia- no evidencia o utilidad

13 grupos de trabajo

160 expertos de la salud mental

Fortalezas del DSM 5

- Pluralidad de expertos reconocidos en EEUU y multinacionales
  - Dra. Glorisa Canino
  - Dr. Roberto Lewis Fernández
- Revisiones extensas de literatura (2005-2012)
- Debates años antes de publicarse
- Colocar los criterios públicos y fomentar reacciones
- No proliferación desmedida de Dxs
- Manifestación medida por desarrollo
  - Justicia para los menores de edad

Debilidades del DSM 5

Índices Kappas bajos en varios diagnósticos

Índice de confiabilidad en evaluaciones luego de dos semanas no confirman el Dx inicial

- Kappas 0.6-0.8 excelentes
- 0.6-0.4 buenos
- 0.4-0.2 ¿aceptables?

Eliminación Multiaxial

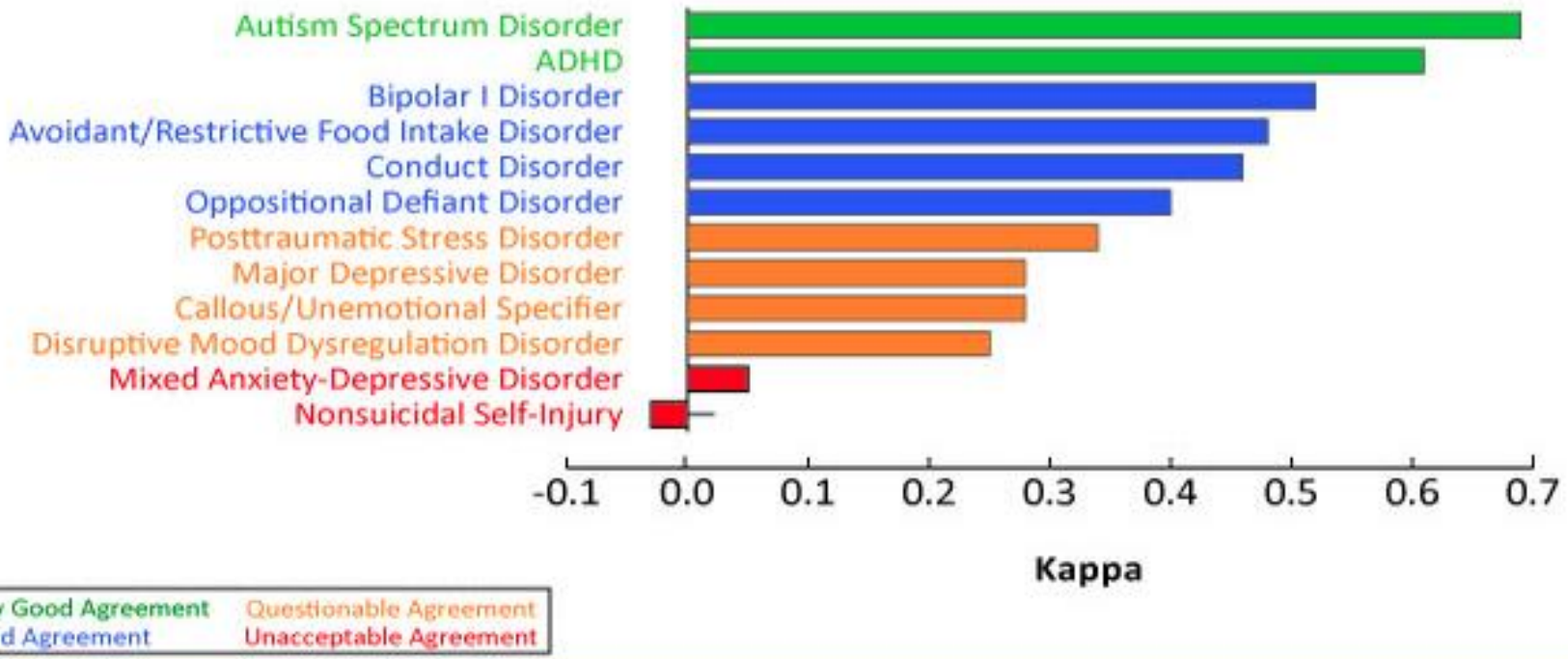
- Se pierde el contexto, es vital para el Dx y no GAF

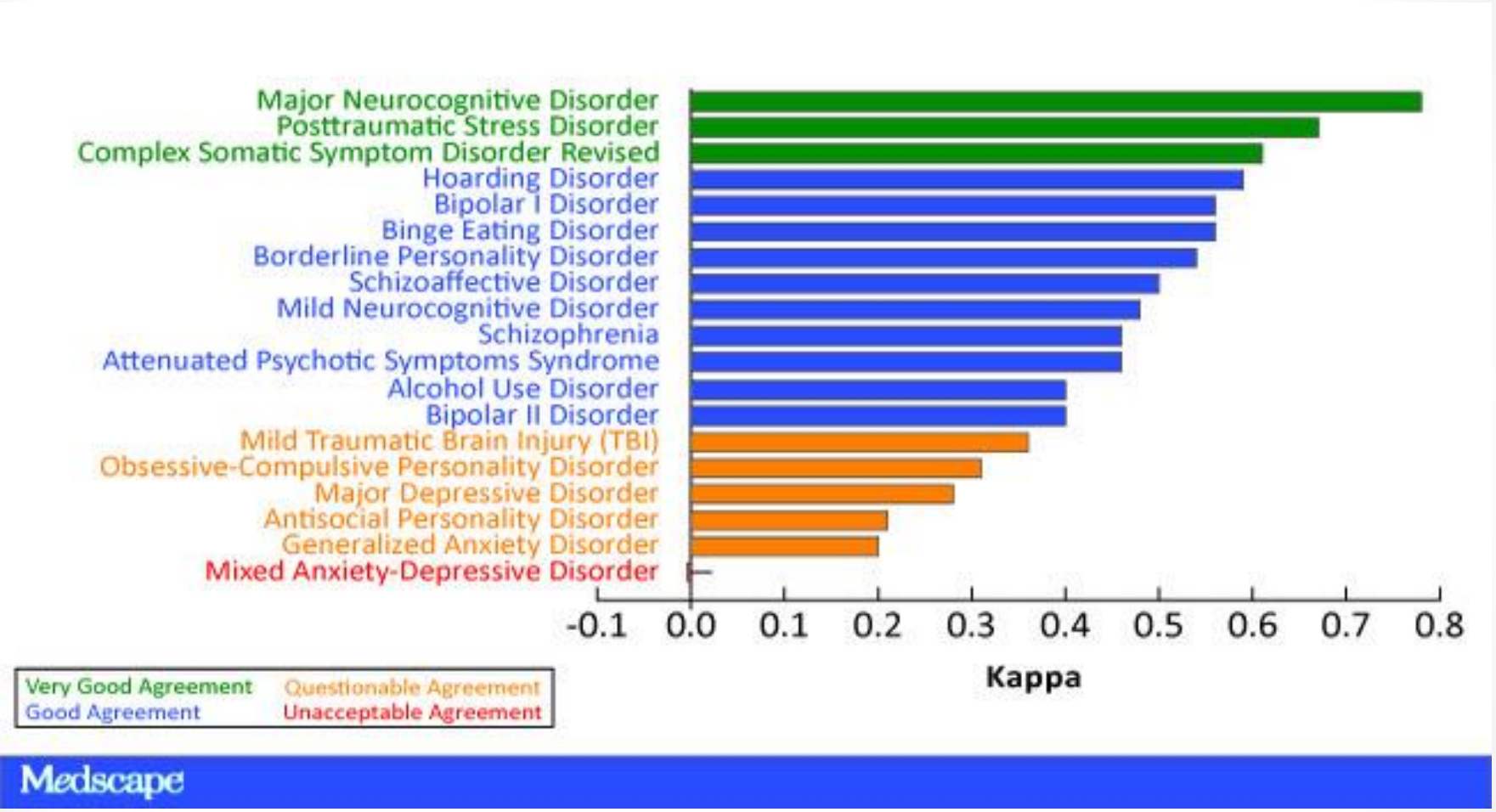
Patologización innecesaria

- Mild Neurocognitive Disorder
- Depresión Mayor por duelo
- Binge Eating Disorder
- Umbrales de edad Dx más bajos ej. ADHD, antes 12 años, ahora 7
- Retirada al café
- Restless leg sindrome

Indices kappa…

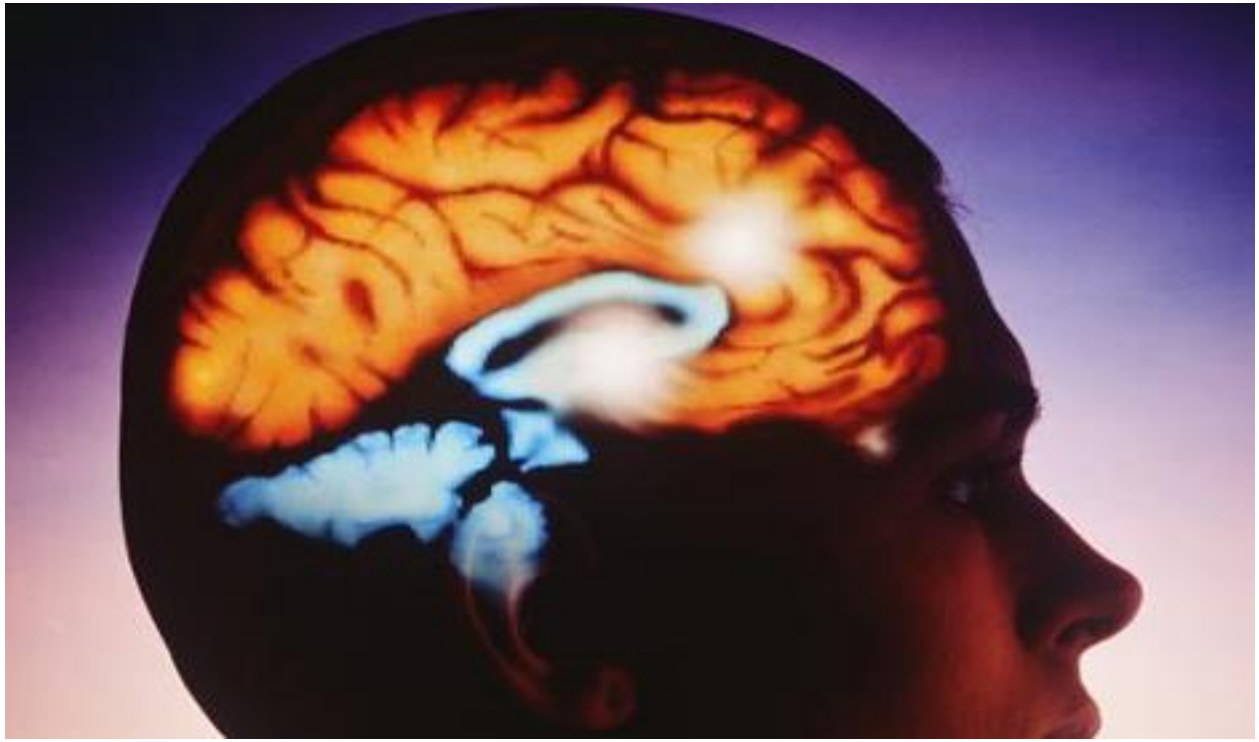
	DSM-5	DSM-IV	ICD-10	DSM-III
Generalized Anxiety Disorder	.20	.65	.30	.72
Post Traumatic Stress Disorder	.67	.59	.76	.55
Schizophrenia	.46	.76	.79	.81
Bipolar 1	.54	.69		
Major Depressive Disorder	.32	.59	.53	.80
Major Neurocognitive Disorder	.78		.60	.91
Mild Neurocognitive Disorder	.50			
Alcohol Use Disorder	.40		.71	.80
Obsessive Compulsive Personality/Hoarding	.59			
Binge Eating Disorder	.56			
Bipolar 2	.40			
Mixed Anxiety Depression Disorder	.06			
Attenuated Psychosis Syndrome	.46			
Obsessive Compulsive Personality Disorder	.31			
Antisocial Personality Disorder	.22			
Autistic Spectrum Disorder	.69	.85	.77	.01
Attention Deficit Disorder	.61	.59	.85	.50
Disruptive Mood Dysregulation Disorder	.50			
Oppositional Defiant Disorder	.41	.55		.66
Conduct Disorder	.48	.57	.78	.61


Autism Spectrum Disorder
ADHD
Bipolar I Disorder
Avoidant/Restrictive Food Intake Disorder
Conduct Disorder
Oppositional Defiant Disorder
Posttraumatic Stress Disorder
Major Depressive Disorder
Callous/Unemotional Specifier
Disruptive Mood Dysregulation Disorder
Mixed Anxiety-Depressive Disorder
Nonsuicidal Self-Injury
-0.1
0.0
0.1
0.2
0.3
0.4
0.5
0.6
0.7
Kappa
Very Good Agreement
Good Agreement
Questionable Agreement
Unacceptable Agreement


Major Neurocognitive Disorder
Posttraumatic Stress Disorder
Complex Somatic Symptom Disorder Revised
Hoarding Disorder
Bipolar I Disorder
Binge Eating Disorder
Borderline Personality Disorder
Schizoaffective Disorder
Mild Neurocognitive Disorder
Schizophrenia
Attenuated Psychotic Symptoms Syndrome
Alcohol Use Disorder
Bipolar II Disorder
Mild Traumatic Brain Injury (TBI)
Obsessive-Compulsive Personality Disorder
Major Depressive Disorder
Antisocial Personality Disorder
Generalized Anxiety Disorder
Mixed Anxiety-Depressive Disorder
-0.1 0.0 0.1 0.2 0.3 0.4 0.5 0.6 0.7 0.8
Kappa
Very Good Agreement
Good Agreement
Questionable Agreement
Unacceptable Agreement

Entonces…

¿Para qué le sirve el DSM 5 al terapeuta ocupacional?



Sirve para…

1. Establecer una impresión diagnóstica
   - ¿Qué es lo que creo que el paciente tiene?
2. Establecer prognosis
   - ¿Qué espero que suceda en el futuro del p/c , potencial de recuperación?
3. Juicio clínico

OJO:

Dx psiquiátrico compete al MD, Phd, Psy D, Trabajo Social Psiquiátrico, Consejero Profesional (según ley 408, 2008)

DSM 5 y Terapia Ocupacional

- ✓ El diagnóstico en Terapia Ocupacional difiere sustancialmente al Dx médico o psicológico.
- ✓ Contexto social y nivel de funcionalidad importantes para proceso de evaluación y tratamiento en Terapia Ocupacional.
- ✓ TO – Dx de ejecución ocupacional.

Conceptualización de Terapia Ocupacional del desorden mental

Medicina focaliza en enfermedad, Terapia Ocupacional focaliza en **FUNCIÓN**.

Catarro es una enfermedad, no necesariamente afecta función. Un individuo sin Dx puede tener problemas o déficits en ejecución (deprivación, aislamiento, otros).

Marco Conceptual-Trabajo en Terapia Ocupacional (3erd. Ed AOTA 2013)

Conceptualización de Terapia Ocupacional del desorden mental

Enfoques de intervención en psicosocial (AOTA, 2013):

- crear y promover (promoción salud)
- prevenir (discapacidad)
- establecer y restaurar (remediación)
- mantener función
- modificar (compensar, adaptar)
-

Estrategias de intervención:

- uso terapéutico de ocupaciones y actividades con propósito
- métodos preparatorios y tareas
- proceso de educación y adiestramiento
- Defensa y autogestión "advocacy"
- Intervención grupal


Diagnosis

Enfoque Canadiense de Diagnóstico Ocupacional

Factores de riesgo ocupacional:

- Desbalance ocupacional- (roles)
- Deprivación ocupacional- (no acceso)
- Enajenación ocupacional- (aislamiento)
- Interrupción ocupacional- (enfermedad temporal)
- Retraso ocupacional- (desarrollo/ cons. prmte.)
- Disparidad ocupacional- (no equivalencia exper.)
- Estrés ocupacional- (todo lo anterior)

Tendencias en el cuidado de salud mental y Terapia Ocupacional

Factores que impactan los servicios:

- tendencias hacia el servicio comunitario
- mayor conciencia de la interacción de condiciones físicas y mentales
- diversidad cultural y conceptualización de enfermedad
- tendencia a intervención interprofesional
- costo efectividad; EBP

DSM-5

Resumen de cambios más significativos

TABLE 1

CHAPTERS IN DSM-5

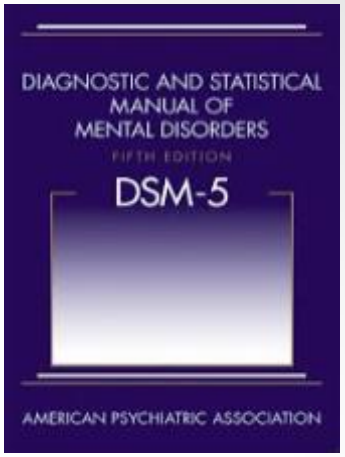
- Neurodevelopmental Disorders
- Schizophrenia Spectrum & Other Psychotic Disorders
- Bipolar & Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive & Related Disorders
- Trauma- & Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom Disorders
- Feeding & Eating Disorders
- Elimination Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse Control & Conduct Disorders
- Substance Use & Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorders
- Other Disorders

The number of total disorders in DSM-5 has not increased significantly, but some disorders have now had their importance recognized by being allocated separate chapter headings (e.g. Obsessive Compulsive Disorder). The chapter on Neurodevelopmental Disorders is a new heading containing autism spectrum disorders, intellectual development disorder, and attention/hyperactivity disorder (ADHD). The chapter on Substance Use & Addictive Behaviours will now includes gambling disorder. The importance of both Bipolar Disorder and Depressive Disorders is recognized by them being allocated to separate chapters.

TABLE 2

SUMMARY OF CHANGES IN DSM-5

- Axes I, II and II will be combined
  - Disorders no longer categorized as acute or life-long
- New chapters for OCD and Trauma & Stress-Related Disorders
  - Confirms the growing importance of these types of disorder as possibly independent of other anxiety-based problems
- Autism Spectrum Disorder will incorporate many previously separate labels (e.g. Asperger's disorder)
- New Disruptive Mood Dysregulation Disorder
  – Diagnoses children with persistent irritability
- Binge Eating Disorder, Hoarding Disorder & Skin-Picking Disorder included
  - All recognized as new independent disorder categories
- Personality Disorders retained with added dimensional scales
- PTSD included in new chapter on stress
  - Emphasizes the importance of trauma-related disorders
- Removal of bereavement exclusion in Major Depression
  - Allows bereavement to be included as a contributor to Major Depression
- Substance use disorder combines substance abuse and substance dependence



Trastornos de la salud mental más comunes en la práctica de Terapia Ocupacional- DSM 5

Definition of a Mental Disorder

- A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

- Is usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder.

- Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

Mental Disorder

Diagnosis of a mental disorder is not equivalent to a need for treatment.

Takes into consideration symptom severity, symptom salience (e.g., the presence of suicidal ideation), the patient' s distress (mental pain) associated with the symptom(s), disability related to the patient's symptoms, risks and benefits of available treatments, and other factors (e.g., psychiatric symptoms complicating other illness).

Clinicians may thus encounter individuals whose symptoms do not meet full criteria for a mental disorder but who demonstrate a clear need for treatment or care.

Additional information is usually required beyond that contained in the DSM-5 diagnostic criteria in order to make legal judgments on such issues as criminal responsibility, eligibility for disability compensation, and competency.

Criterion for Clinical Significance

DSM 5 and WHO separate the concepts of mental disorder and disability (impairment in social, occupational, or other important areas of functioning).

The WHO Disability Assessment Schedule (WHODAS) is based on the ICF and has proven useful as a standardized measure of disability for mental disorders.

Use of information from family members and other third parties (in addition to the individual's is recommended) regarding the individual's performance is recommended when necessary.

A DSM-5 diagnosis is usually applied to the individual's current presentation; previous diagnoses from which the individual has recovered should be clearly noted as such.

Diagnostic Criteria

- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Somatic Symptom Disorder and Related Disorder
- Feeding and Eating Disorders
- Disruptive, Impulse-Control, and Conduct Disorders
- Substance-Related and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders

Organization within Chapters

- Diagnostic criteria
  - Subtypes and specifiers
- Diagnostic features
- Associated features
- Prevalence
- Development and course
- Risks and prognosis factors
- Culture related issues
- Gender related issues
- Suicide risk
- Functional consequences
- Differential diagnosis
- Comorbility

Neurodevelopment Disorders

Neurodevelopment Disorders

Intellectual Disability

(Intellectual Development Disorder)

Global Development Delay

Autism Spectrum Disorder

Attention-Deficit/Hyperactivity Disorder

Specific Learning Disorder

Neurodevelopment Disorders

Intellectual Disability

(Intellectual Developmental Disorder)

Includes both intellectual and adaptive functioning deficits in conceptual, social, and practical Domains (pg 19).

Reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience confirmed by standardized intelligence testing.

Failure to meet developmental and sociocultural standards for personal independence and social responsibility.

Activities of daily living, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

Onset during developmental period.

A federal statute in the United States (Public Law 111-256, Rosa's Law) replaces the term mental retardation with intellectual disability, and research journals use the term intellectual disability.

Neurodevelopment Disorders

Intellectual Disability (Intellectual Developmental Disorder)

Intellectual disability	IQ	Severity level
• is the term in common use by medical, educational, and other professions and by the lay public and advocacy groups.	???	• Mild • Moderate • Severe • Profound

Neurodevelopment Disorders

Intellectual Disability (Intellectual Developmental Disorder)

- IQ- ya no es prioridad
- Nivel de funcionamiento- capacidad adaptativa
- Tres dominios
  - Conceptual: lenguaje, lectura, escritura, razonamiento, conocimiento, memoria, matemáticas
  - Social: empatía, juicio social, comunicación interpersonal, capacidad para hacer amistades
  - Práctico: auto gestión, cuidado personal, laboral, manejo de dinero, organización escolar

Neurodevelopment Disorders

Global Development Delay

Individuals under the age of 5 years.

Unable to undergo systematic assessments of intellectual functioning, including children who are too young to participate in standardized process.

Neurodevelopment Disorders

Autism Spectrum Disorder

Anteriormente en el DSM IV TR:

Ahora todos **integrados** en TEA en el DSM 5

Neurodevelopment Disorders
Autism Spectrum Disorder

- En el DSM IV TR, 3 dominios:
  - Interacción social
  - Comunicación
  - Conductas repetitivas
- En el DSM 5 se colapsan los primeros dos
  - Imp: Si está solo el componente social el diagnóstico es Trastorno de Comunicación Social
  - Ahora son 7 síntomas: antes eran 12 para el diagnóstico.
  - Se relaja la edad de comienzo
    - DSM IV TR- 3 años
    - DSM 5; Sxs presentes en el "Early Developmental period"

Neurodevelopment Disorders

Autism Spectrum Disorder

Persistent deficits in social communication and social interaction (3)

- Deficits in social-emotional reciprocity-failure to initiate or respond to social interactions
- Deficits in nonverbal communicative behaviors-eye contact and body language, gestures, expressions
- Difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers

Restricted, repetitive patterns of behavior, interests, or activities (4)

- Stereotyped or repetitive motor movements
- Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior
- Highly restricted, fixated interests
- Hyper or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment

Neurodevelopment Disorders

Autism Spectrum Disorder

Level 1- Requiring very substantial support : 2- Requiring substantial support: 3- Requiring support in the areas above (Pg 30)

Intellectual Disability and Autism Spectrum Disorder frequently co- occur

DSM-5 Criteria for Autism Spectrum Disorder

Currently, or by history, must meet criteria A, B, C, and D

A. Persistent deficits in social communication and social interaction across contexts, not accounted for by general developmental delays, and manifest by all 3 of the following:

1. **Deficits in social-emotional reciprocity**
2. **Deficits in nonverbal communicative behaviors used for social interaction**
3. **Deficits in developing and maintaining relationships**

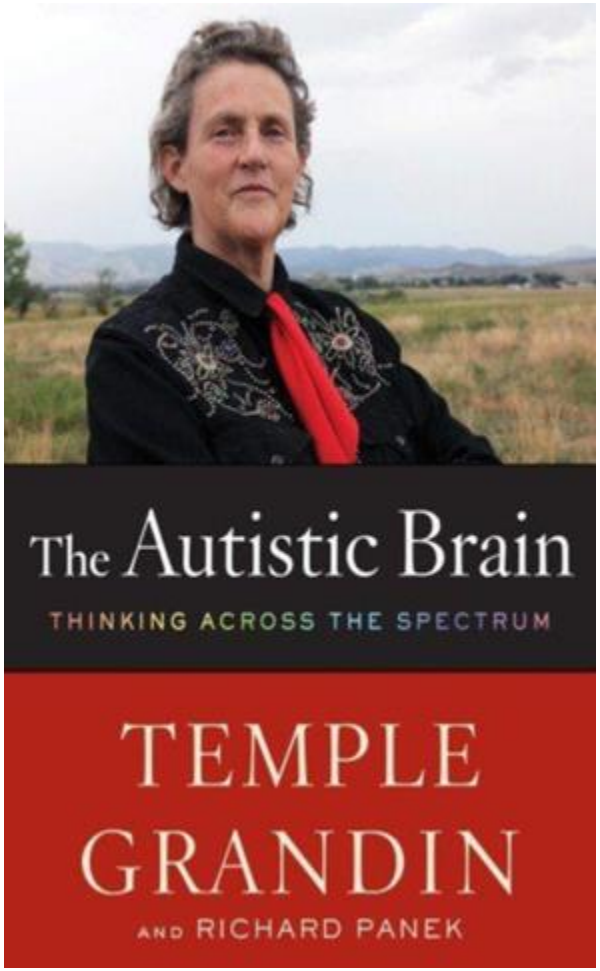
B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following:

1. **Stereotyped or repetitive speech, motor movements, or use of objects**
2. **Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change**
3. **Highly restricted, fixated interests that are abnormal in intensity or focus**
4. **Hyper-or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment;**

C. Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities

D. Symptoms together limit and impair everyday functioning.

Issue central TEA…



- De 12 síntomas en el DSM IV TR, a 7 en el DSM 5…..mi hijo antes tenía autismo, ahora no tiene… se curó??? Ayudas gubernamentales?
- En EU un 9% de los niños está mal diagnosticado (falsos positivos)- Estudio de Volkmar
- NIÑOS CON AUTISMO EN 20 AÑOS
- 1 EN 2,000
- 1 EN 150
- 1 EN 80
- 1 EN 38 (KOREA)

Neurodevelopment Disorders

Attention-Deficit/Hyperactivity Disorder

Persistent pattern of inattention and/or hyperactivity-impulsivity:

- Inattention: **six** (or more) of the following symptoms below 17 years old; **five** symptoms for people 17 years and older
  - fails to give close attention to details or makes careless mistakes
  - difficulty sustaining attention in tasks or play activities; no focus
  - does not seem to listen when spoken to directly
  - does not follow through on instructions
  - difficulty organizing tasks and activities
  - avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
  - loses things necessary for tasks or activities
  - easily distracted by extraneous stimuli
  - forgetful in daily activities

Neurodevelopment Disorders

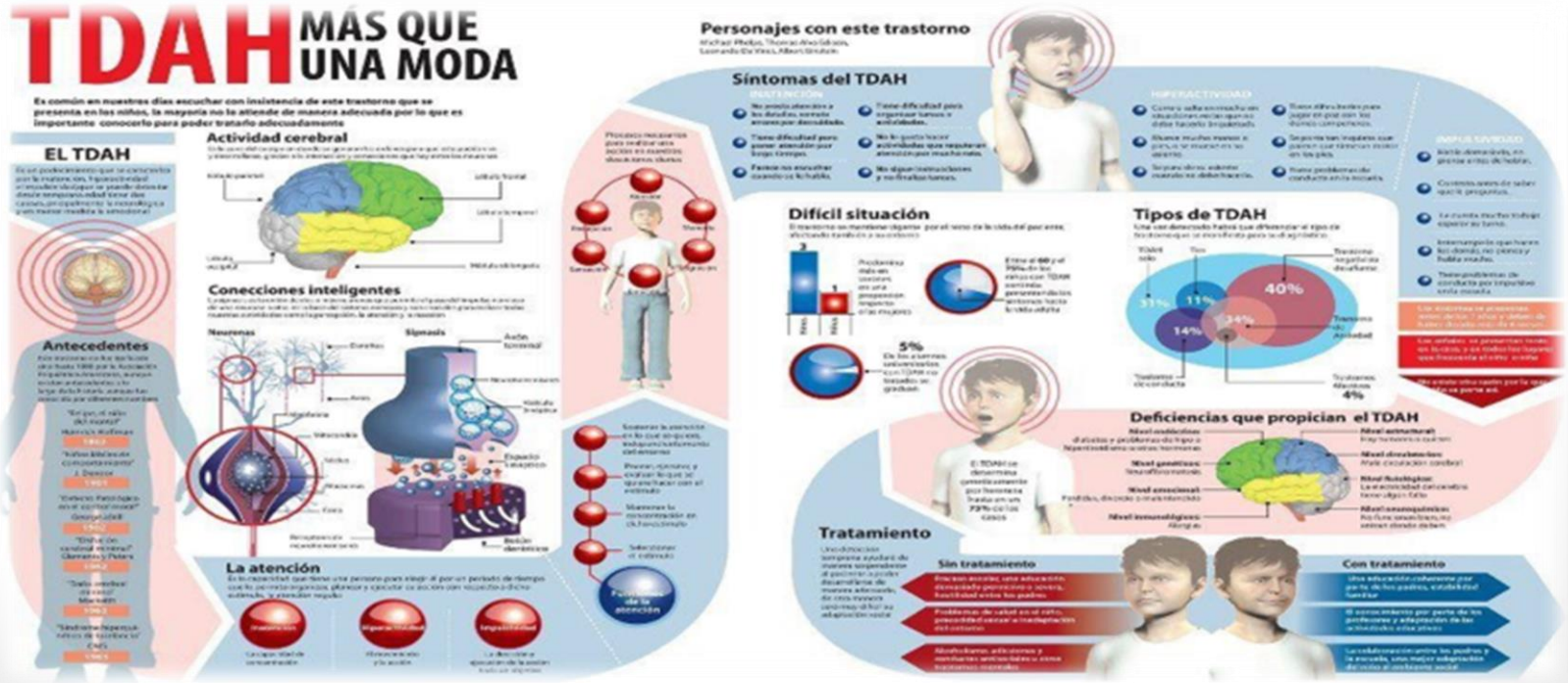
Attention-Deficit/Hyperactivity Disorder

- Hyperactivity and impulsivity: **six** (or more) of the following symptoms have persisted for at least 6 months, below 17 years old; **five** symptoms for people 17 years and older
  - fidgets with or taps hands or feet or squirms in seat
  - leaves seat in situations when remaining seated is expected
  - runs about or climbs in situations where it is inappropriate
  - unable to play or engage in leisure activities quietly
  - "on the go" acting as if "driven by a motor"
  - talks excessively
  - blurts out an answer before a question has been completed
  - difficulty waiting his or her turn
  - interrupts or intrudes on others

Neurodevelopment Disorders

Attention-Deficit/Hyperactivity Disorder

- Symptoms were present prior to age 12 years old
- Inattentive or hyperactive-impulsive symptoms in school, home, work, family, others.



Neurodevelopment Disorders

Specific Learning Disorder

- Presence of at least one of the following symptoms that have persisted for at least 6 months

Inaccurate or slow and effortful word reading
Difficulty understanding the meaning of what is read
Difficulties with spelling
Difficulties with written expression
Difficulties mastering number sense, number facts, or calculation
Difficulties with mathematical reasoning
Affected academic skills are substantially and quantifiably below those expected for the individual's chronological age

Neurodevelopment Disorders

Specific Learning Disorder

- More symptoms

Learning difficulties begin during school-age years
Are not better accounted for by intellectual disabilities
Dyslexia is an alternative term used to refer to a pattern of learning difficulties characterized by problems with accurate or fluent word recognition, poor decoding, and poor spelling abilities, reading comprehension or math reasoning.
Dyscalculia is an alternative term used to refer to a pattern of difficulties characterized by problems processing numerical information, learning arithmetic facts, and performing accurate or fluent calculations.

Predomina en niños

DISLEXIA: PROBLEMA DE COMUNICACIÓN

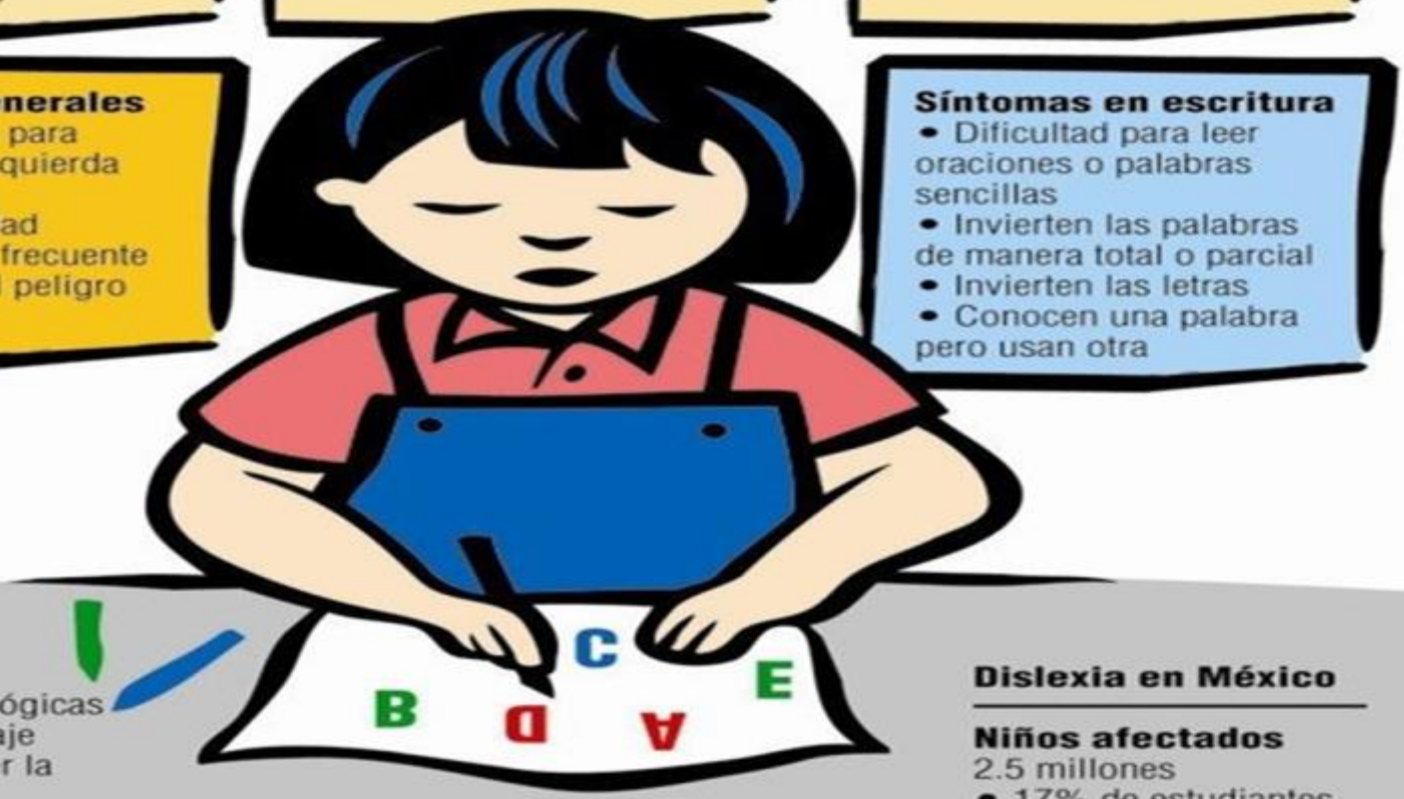
La dislexia es un padecimiento que se manifiesta, sobre todo, con la confusión de letras al leer o al escribir, y se presenta más en niños, quienes son tomados como distraídos o rebeldes, cuando lo que necesitan es ser tratados médicamente

¿Qué es la dislexia?
Una dificultad del sistema nervioso que afecta la captación, elaboración o comunicación de información (incapacidad de leer y escribir correctamente)

¿Quiénes la padecen?
Niños
- Pueden padecerla algunos adultos

Orígenes
- Causas genéticas
- Dificultades en el embarazo o en el parto
- Lesiones cerebrales
- Problemas adaptativos en la escuela

Síntomas generales
- Dificultades para distinguir la izquierda de la derecha
- Hiperactividad
- Distracción frecuente
- No miden el peligro



Síntomas en escritura
- Dificultad para leer oraciones o palabras sencillas
- Invierten las palabras de manera total o parcial
- Invierten las letras
- Conocen una palabra pero usan otra

Tratamiento
- Terapias psicológicas
- Sobreaprendizaje (Volver a aprender la lecto-escritura)

Dislexia en México

Niños afectados
2.5 millones
- 17% de estudiantes de primaria

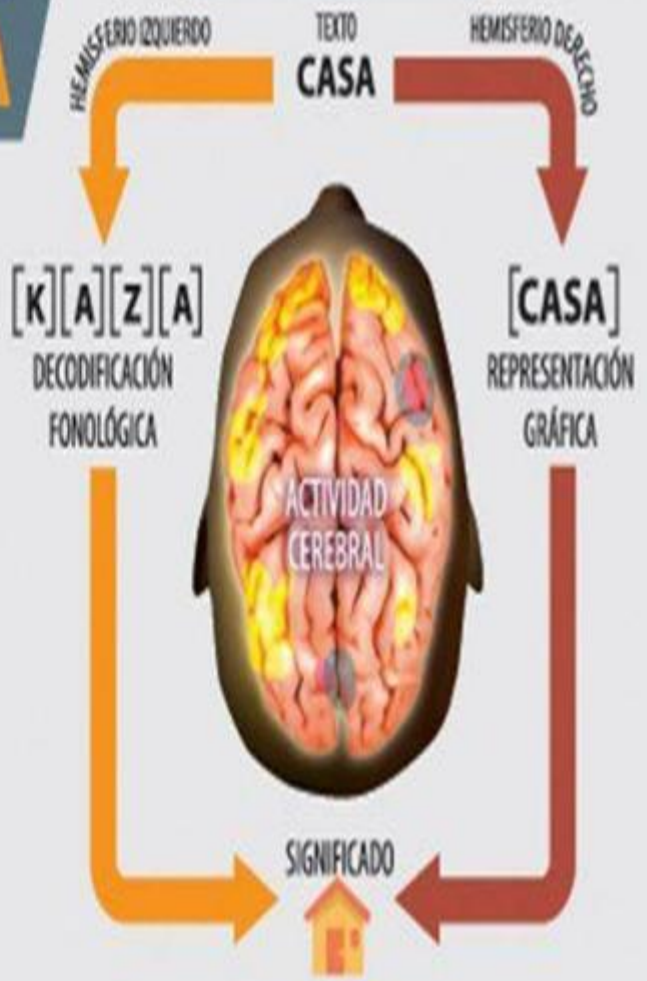
CÓMO SE PRODUCE LA DISLEXIA

La dislexia a diferencia de otros trastornos no tiene un área específica dentro del cerebro y se descubre casi siempre cuando inicia el proceso de aprendizaje de la lecto escritura.

El proceso de la lecto escritura es sumamente complejo, pues no es una función que venga programada neurológicamente como el habla. En este proceso se vinculan:

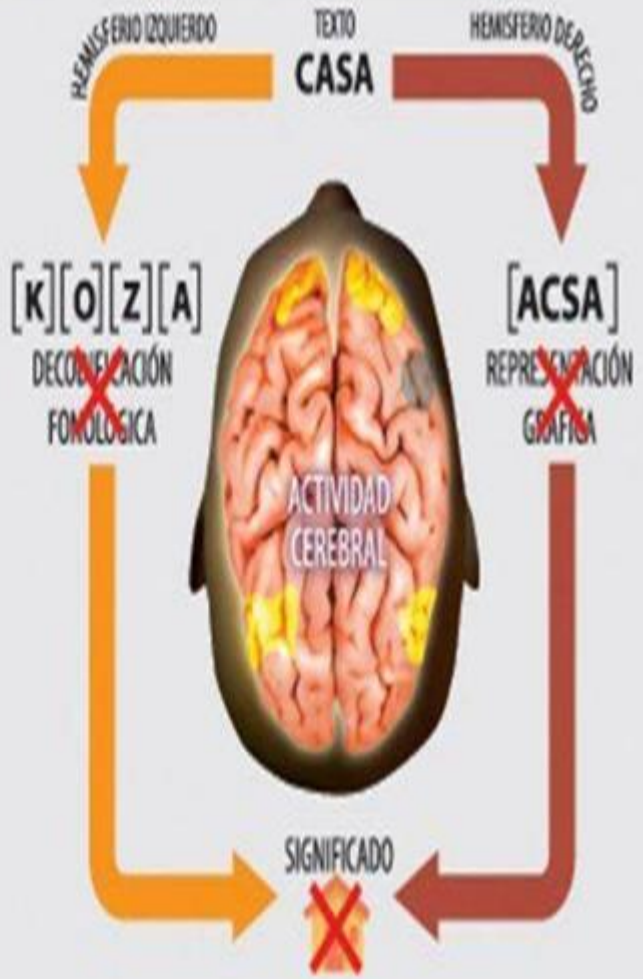
EL OÍDO FONEMÁTICO: La capacidad neurológica que ayuda a discriminar lo que se está escuchando. No se trata de que el niño no escuche bien, su audición puede ser perfecta pero a nivel neurológico no puede descifrar la información y relacionarla con un código visual. Es decir para él será igual la b, p, y q pues no le asigna un sonido a cada una.

LECTOR NORMAL



El cerebro humano trabaja en su totalidad durante la lectura pues ambos hemisferios, derecho e izquierdo, se comunican entre sí. Cada hemisferio está especializado en ciertas funciones. El hemisferio izquierdo se ocupa de los procesos del lenguaje, mientras que el derecho se especializa en la información visual y espacial.

LECTOR CON DISLEXIA



En los niños con dislexia se produce una disfunción -un fallo- en el hemisferio izquierdo y se ve afectada la velocidad de procesamiento de la información, lo que incapacita al niño para procesar cambios rápidos de estímulos o sucesiones, tanto en el área visual como auditiva.

Schizophrenia spectrum and other Psychotic Disorders

Schizophrenia spectrum and other Psychotic Disorders

Schizophrenia	Delusional Disorder
Brief Psychotic Disorder	Schizophreniform Disorder
Schizoaffective Disorder	Substance/Medication Induced Psychotic Disorder

Schizophrenia Spectrum and other Psychotic Disorders

Schizophrenia

Two (or more) of the following time during a **1-month** period

Positive symptoms

- *Delusions*
- *Hallucinations*
- *Disorganized speech* (e.g., frequent derailment or incoherence)
- *Grossly disorganized or catatonic behavior*

Negative symptoms (i.e., diminished emotional expression or avolition)

Continuous signs of the disturbance persist for at least 6 months

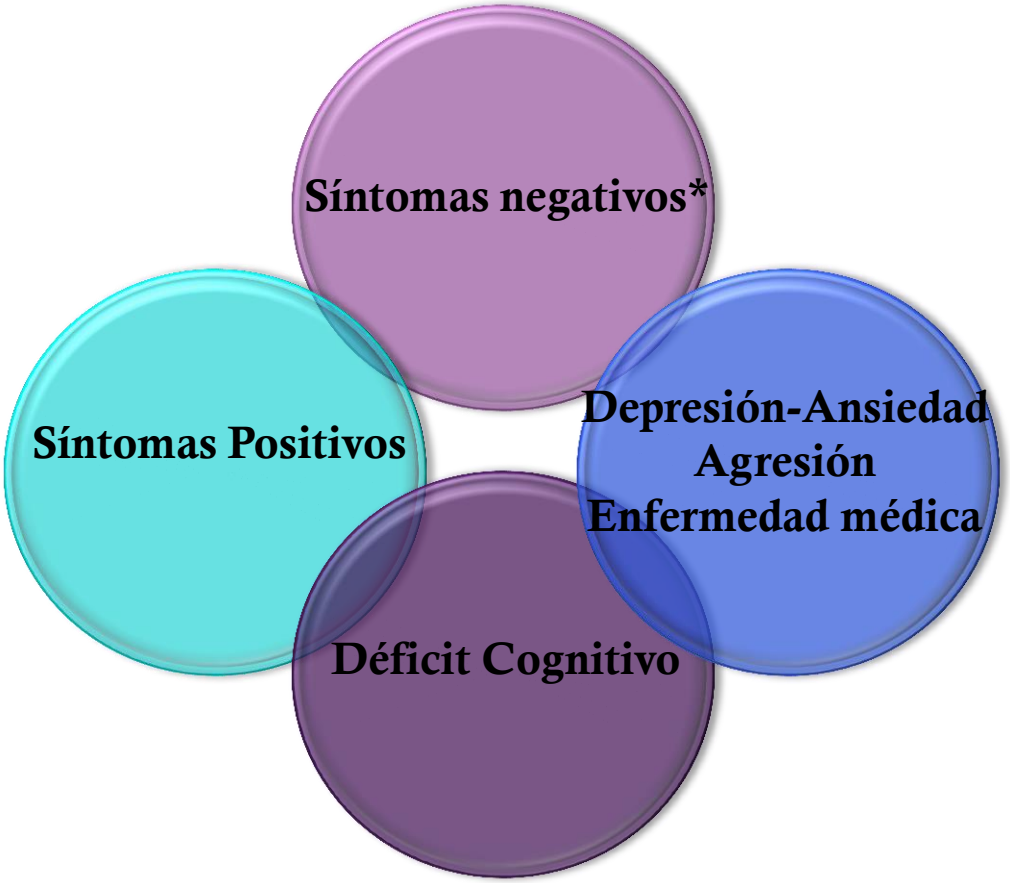


Figura 1. Manifestaciones clínicas de la esquizofrenia

Los síntomas negativos de dividen en:
Primarios: Alogia, afecto aplanado, abulia, anhedonia y deterioro de la atención.
Secundarios: A efectos secundarios de los antipsicóticos, desesperanza, depresión, aislamiento y apatía.

Los síntomas positivos incluyen las alucinaciones, delirios y trastornos del pensamiento.

Schizophrenia spectrum and other Psychotic Disorders

Schizophrenia: Positive symptoms

Delirios (pensamiento)

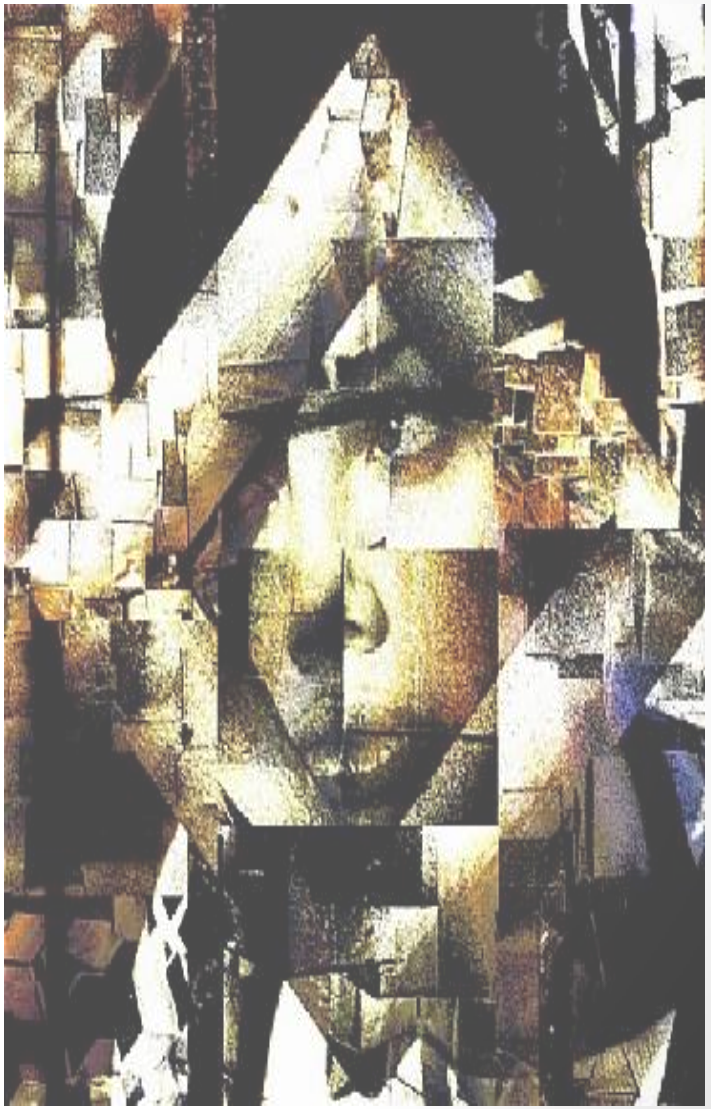
- creencias erróneas que envuelven malas interpretaciones de la realidad
- temas: persecución, religiosos, somáticos, de referencia(cree que gestos, comentarios, pasajes de libros, canciones son dirigidas a su persona)

Schizophrenia spectrum and other Psychotic Disorders

Schizophrenia: Positive symptoms

Tipos de delirios

- ✓ Pasividad somática
  - ser recipiente pasivo de sensaciones impuestas por un ente externo
- ✓ Inserción de ideas
  - "me ponen pensamientos"
- ✓ Difusión de pensamientos
  - "todo el mundo sabe lo que pienso"
- ✓ Robo de pensamientos
  - "alguien me los roba"
- ✓ Sentimientos artificiales
  - "lo que siento no me pertenece"
- ✓ Actos volitivos artificiales
  - "lo que hago no está en mi control"
- ✓ Impulsos artificiales
  - "mis impulsos no me pertenecen"



Schizophrenia spectrum and other Psychotic Disorders

Schizophrenia: Positive symptoms

Alucinaciones (percepción)

- auditivas, visuales, olfativa, gustativa, táctil

Habla desorganizada (comunicación)

- pobre organización de ideas
- asociaciones difusas o descarrilamiento
- respuestas a preguntas sin asociación (tangencial)
- lenguaje severamente desorganizado (incoherente, ensalada de palabras)

Schizophrenia spectrum and other Psychotic Disorders

Schizophrenia: Negative symptoms

Abulia

falta de energía, inhabilidad para iniciar y persistir en actividades

Afecto embotado

pobre contacto visual, inmovilidad, no lenguaje corporal

Alogia

vocabulario reducido, pobre contenido

Anhedonia

incapacidad para experimentar placer

Catatonia inmovilidad motora (catalepsia)

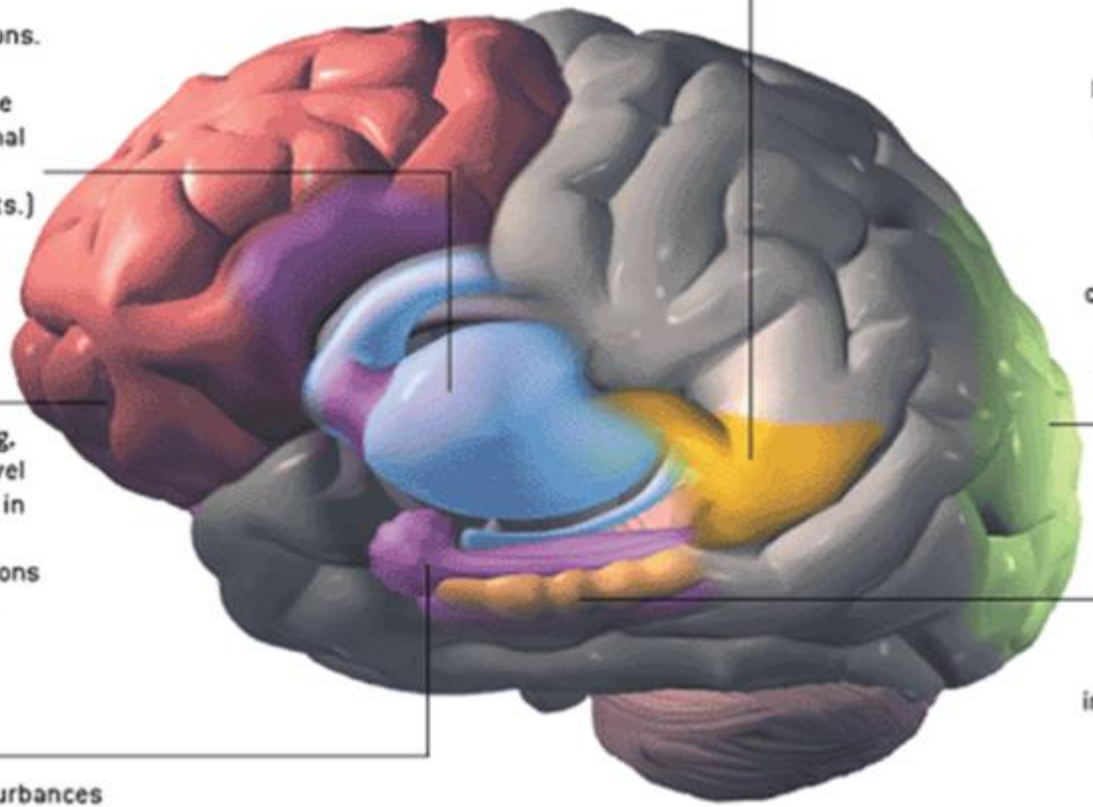
excesiva actividad motora, negativismo extremo o mutismo, movimientos voluntarios peculiares (posturas inapropiadas, bizarras, manerismos)

THE BRAIN IN SCHIZOPHRENIA

MANY BRAIN REGIONS and systems operate abnormally in schizophrenia, including those highlighted below. Imbalances in the neurotransmitter dopamine were once thought to be the prime cause of schizophrenia. But new findings suggest that impoverished signaling by the more pervasive neurotransmitter glutamate—or, more specifically, by one of glutamate's key targets on neurons (the NMDA receptor)—better explains the wide range of symptoms in this disorder.

BASAL GANGLIA
Involved in movement and emotions and in integrating sensory information. Abnormal functioning in schizophrenia is thought to contribute to paranoia and hallucinations. (Excessive blockade of dopamine receptors in the basal ganglia by traditional antipsychotic medicines leads to motor side effects.)

AUDITORY SYSTEM
Enables humans to hear and understand speech. In schizophrenia, overactivity of the speech area (called Wernicke's area) can create auditory hallucinations—the illusion that internally generated thoughts are real voices coming from the outside.



OCCIPITAL LOBE
Processes information about the visual world. People with schizophrenia rarely have full-blown visual hallucinations, but disturbances in this area contribute to such difficulties as interpreting complex images, recognizing motion, and reading emotions on others' faces.

FRONTAL LOBE
Critical to problem solving, insight and other high-level reasoning. Perturbations in schizophrenia lead to difficulty in planning actions and organizing thoughts.

HIPPOCAMPUS
Mediates learning and memory formation, intertwined functions that are impaired in schizophrenia.

LIMBIC SYSTEM
Involved in emotion. Disturbances are thought to contribute to the agitation frequently seen in schizophrenia.

ALFRED T. KAMAJIAN

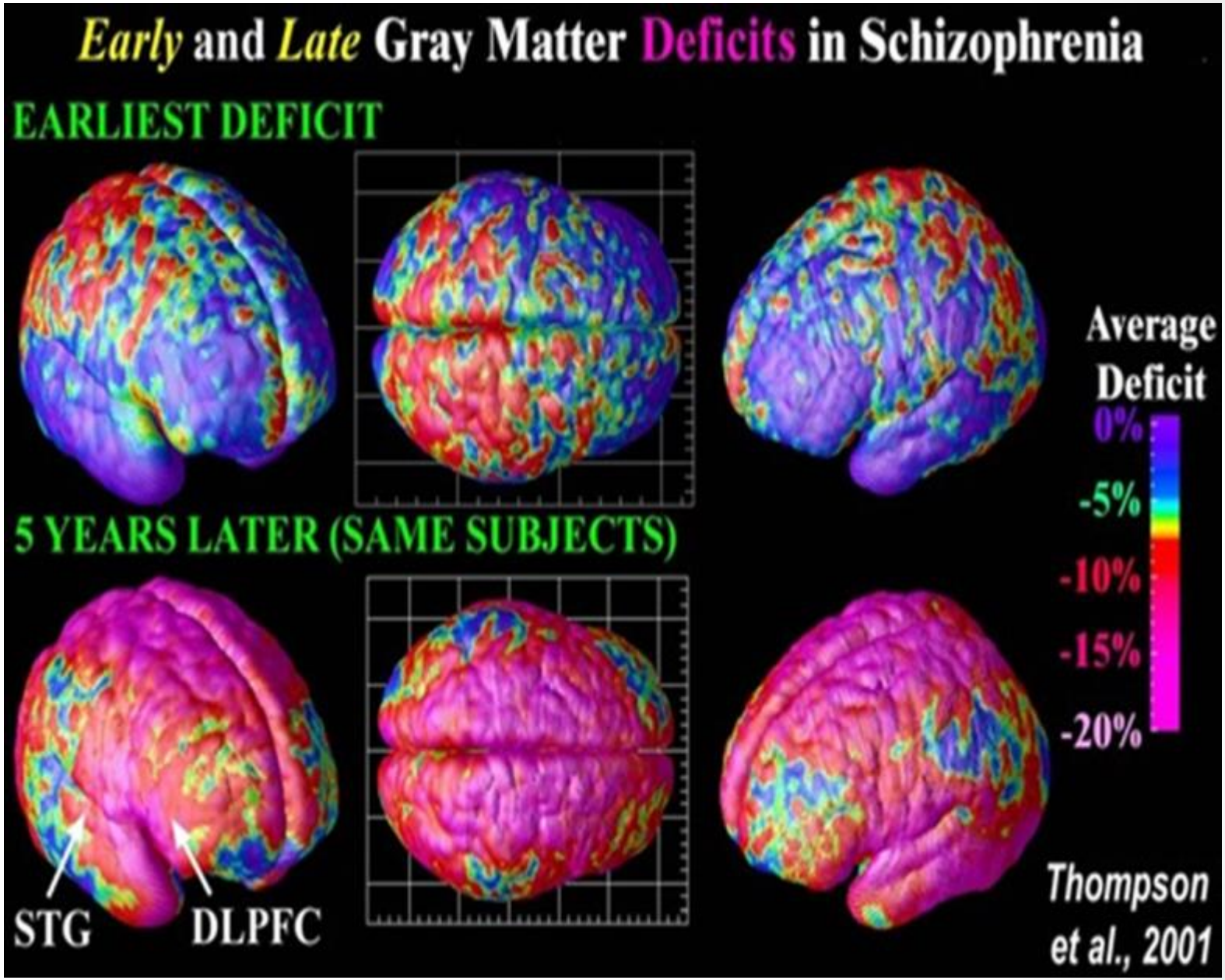

Early and Late Gray Matter Deficits in Schizophrenia
EARLIEST DEFICIT
5 YEARS LATER (SAME SUBJECTS)
Average Deficit
0%
-5%
-10%
-15%
-20%
STG
DLPFC
Thompson et al., 2001

Table 6-1. Syndromes of Schizophrenia: A comparison of Types 1 and 2

Type	*Symptomatology*	*Prognosis*	*Response to Treatment*
1	Predominance of positive symptoms with minimal or no cognitive deficits	Characterized by a fluctuating course of exacerbations and remissions. Usual onset involves a full-blown psychotic episode	Generally responds well to antipsychotic medication. May need little or no other therapeutic intervention between psychotic episodes providing there is a stable environment
2	Predominance of negative symptoms, typically with some degree of cognitive deficits	Usually a chronic course. Onset may be insidious but is generally identified by early adulthood	Responds poorly to typical antipsychotic medication but may experience a reduction of negative symptoms with an atypical agent. Usually needs ongoing supportive therapy for both rehabilitation and maintenance of living skills

Schizophrenia spectrum and other Psychotic Disorders

Delusional Disorder

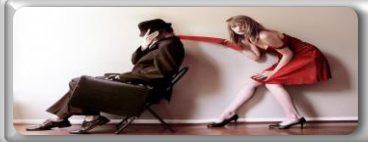
Delusions with a duration of 1 month or longer.

Criterion A for schizophrenia has never been met.

Functioning is not markedly impaired, and behavior is not obviously bizarre or odd.

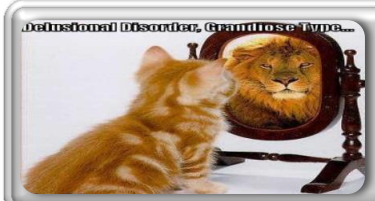
Schizophrenia spectrum and other Psychotic Disorders

Delusional Disorder Types



Erotomatic type

- another person is in love with the individual



Grandiose type

- conviction of having some great (but unrecognized) talent or insight

Jealous type

- his or her spouse or lover is unfaithful

Persecutory type

- belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals

Somatic type

- bodily functions or sensations

Schizophrenia spectrum and other Psychotic Disorders

Brief Psychotic Disorder

Presence of **one (or more)** of the following symptoms:

- Delusions
- Hallucinations
- Disorganized speech
  (e.g., frequent derailment or incoherence)
- Grossly disorganized or catatonic behavior

Do not include a symptom if it is a culturally sanctioned response

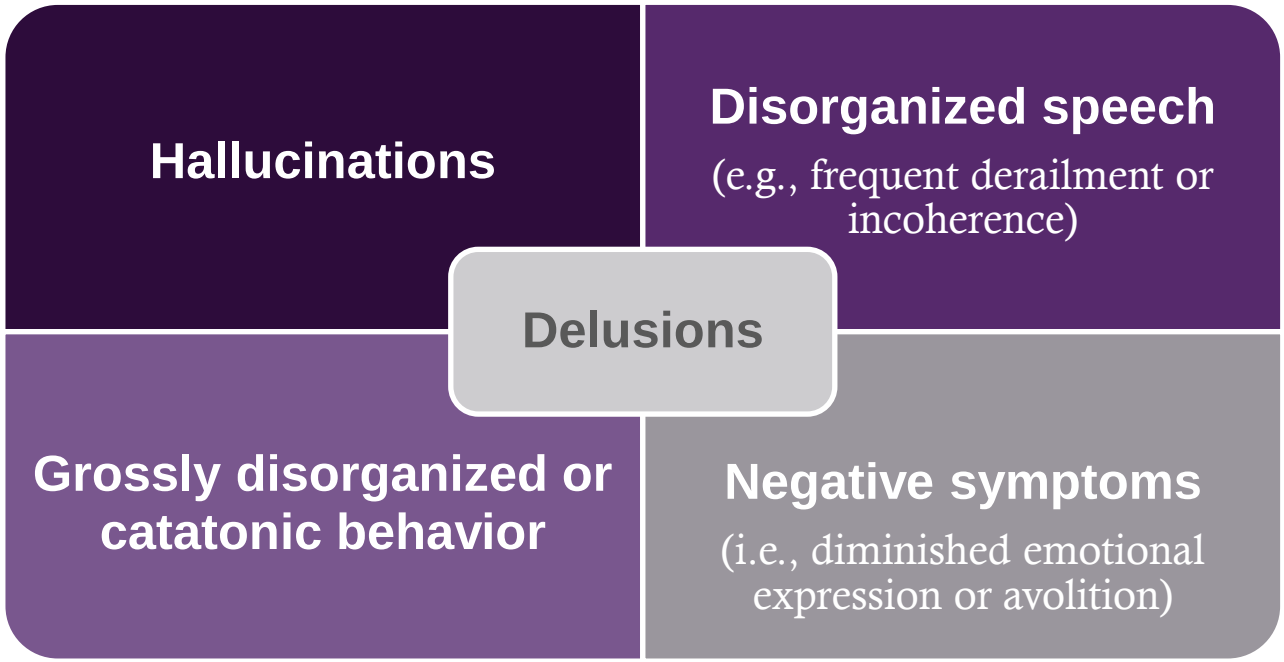
Duration of an episode of the disturbance is at least 1 day but less than 1 month

- Ex. postpartum onset

Schizophrenia spectrum and other Psychotic Disorders

Schizophreniform Disorder

- Two (or more) of the following during a 1 month period but less than 6 months



Schizophrenia spectrum and other Psychotic Disorders

Schizoaffective Disorder

Major mood episode concurrent with criterion A of Schizophrenia

Delusions or hallucinations for 2 or more weeks in the absence of a major mood disorder: most of time

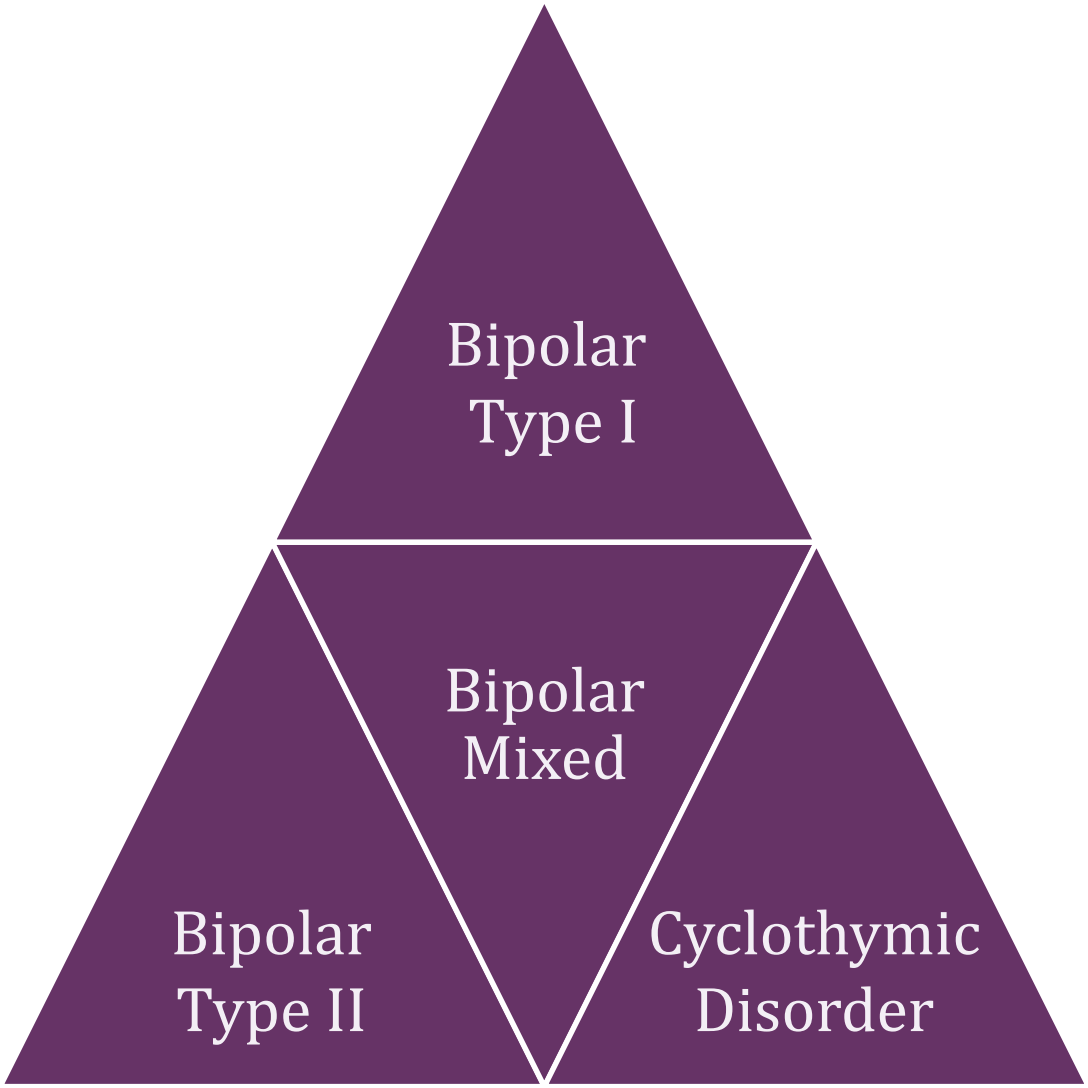
Schizophrenia spectrum and other Psychotic Disorders

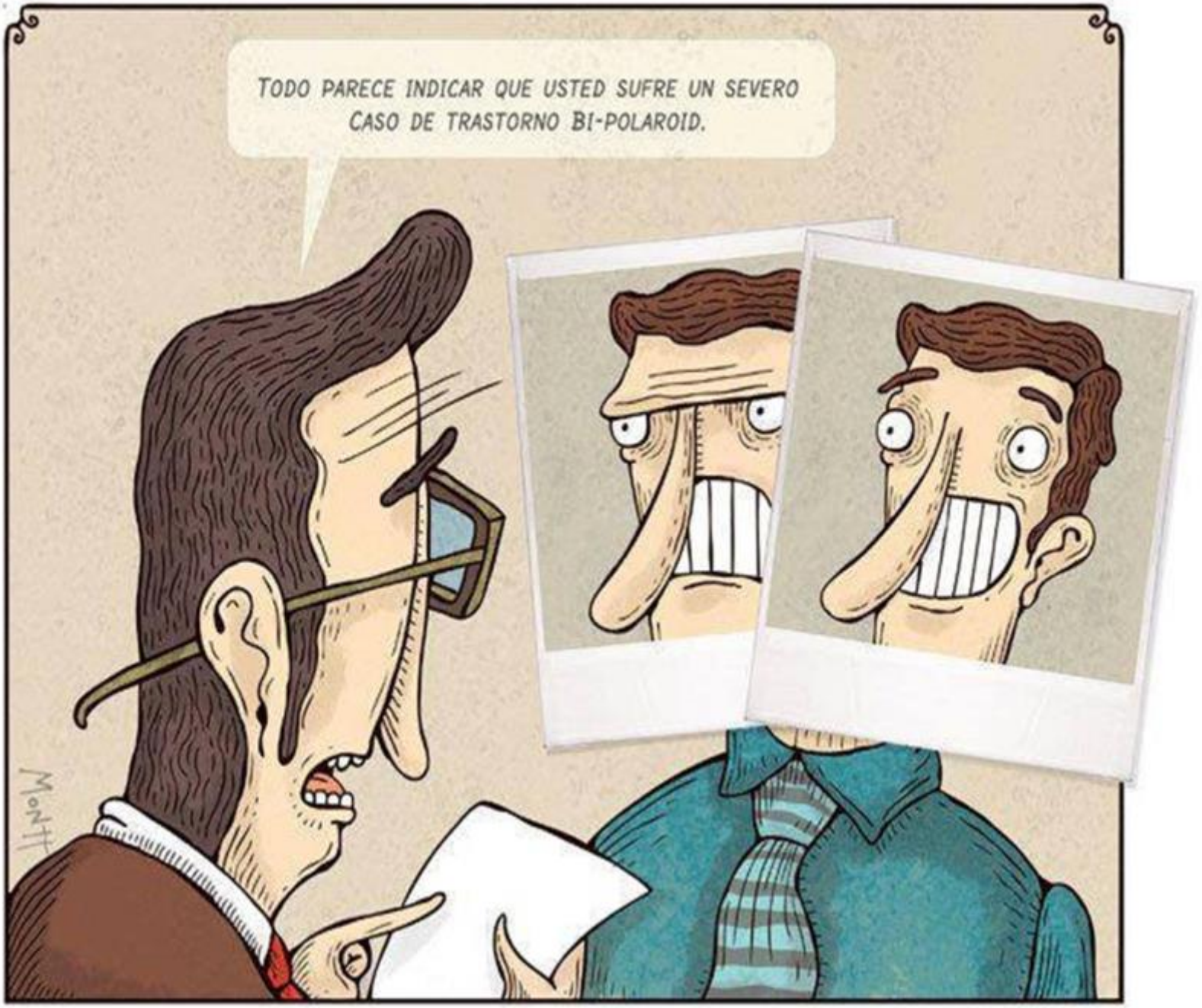
Substance/Medication-Induced Psychotic Disorder

- The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication. (Ex. Paranoia-cocaine)

Bipolar and Related Disorders

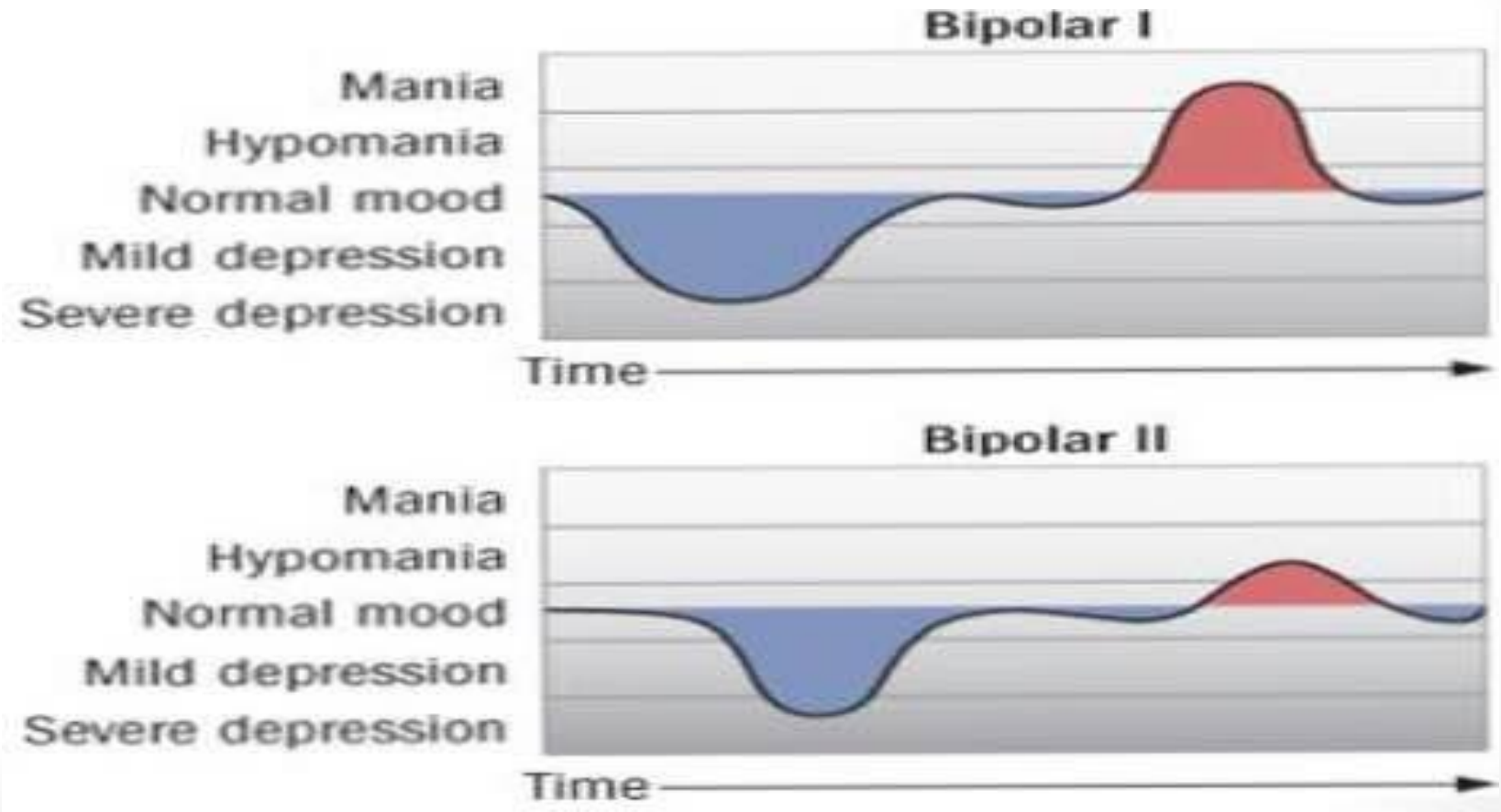
Bipolar and Related Disorders




TODO PARECE INDICAR QUE USTED SUFRE UN SEVERO CASO DE TRASTORNO BI-POLAROID.
MONTT
www.dosisdiarias.com

Bipolar and Related Disorders

Types of Bipolar Disorder



Bipolar and Related Disorders

Types of Bipolar Disorder

Type I, II

Mixed-highs and lows in a week

Cyclothymic Disorder

2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms

Table 7-1

Mood Disorders (More Severe and Less Severe Forms)

Manic episode	Bipolar disorder	Major depressive episode
↓	↓	↓
Hypomanic disorder	Cyclothymic disorder	Dysthymic disorder

Table 7-2. Clinical Picture: Major Symptoms of Depression and Mania

Symptoms	*Depression*	*Mania*
Emotional	Depleted mood Hopelessness Decreased sense of humor Lack of pleasure	Euphoric mood Grandiosity
Cognitive	Negative thinking Decreased concentration and attention Indecision	Grandiose, expansive thinking Decreased concentration and attention
Motivational	Decreased energy Paralysis of will and initiation Avoidance or escapist wishes	Increased energy Agitation Distraction Low frustration tolerance
Self-Concept	Worthlessness Guilt	Inflated sense of worth and power
Vegetative	Loss of appetite Sleep disturbance Loss of sexual desire	Loss of appetite Sleep disturbance Increased sexual preoccupation

Depressive Disorder

Depressive Disorder

Disruptive Mood Dysregulation Disorder

Major Depressive Disorder

Persistent Depressive Disorder (Dysthymia)

Premenstrual Dysphoric Disorder

Substance/Medication – Induced Depressive Disorder

Depressive Disorders

Disruptive Mood Dysregulation Disorder

Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) out of proportion in intensity or duration to the situation or provocation
Outbursts occur, on average, three or more times per week
Mood between temper outbursts is persistently irritable or angry most of the day
Present for 12 or more months
Present in at least two of three settings (i.e., at home, at school, with peers)
Diagnosis should not be made for the first time before age 6 years or after age 18 years
Diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder

Depressive Disorders

Major Depressive Disorder

- Five (or more) of the following symptoms have been present during the same 2-week period

Depressed mood (Note: In children and adolescents, can be irritable mood.)

Markedly diminished interest or pleasure

Significant weight loss when not dieting or weight gain

Insomnia or hypersomnia

Psychomotor agitation or retardation

Fatigue or loss of energy

Feelings of worthlessness or excessive or inappropriate guilt

Diminished ability to think or concentrate, or indecisiveness

Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation

Note: In responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability), clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss should be made.

Table 7-2
Mood Disorders

Disorder	Symptoms	Functional Deficits
Major depressive episode	1. Depressed mood 2. Anhedonia 3. Appetite/weight change 4. Insomnia/hypersomnia 5. Lack of energy 6. Feelings of worthlessness/ guilt 7. Possible suicidal ideation 8. Impaired function	Social, work, leisure Possibly ADLs and IADLs Habits, roles, routines deteriorate during episode Motor, process, and communication slowing All improve between episodes
Manic episode	1. Abnormally elevated or irritable mood 2. Grandiosity 3. Decreased sleep 4. Distractibility, flight of ideas 5. Poor judgment 6. Impaired function 7. May be delusions or hallucinations	Work, social, leisure habits, roles, and routines deteriorate during episodes Motor hyperactivity Process deficits Communication not severely affected Function tends to improve between episodes
Bipolar disorder	1. Recent alternating symptoms of both manic and major depressive episodes	As above
Dysthymia	1. Same as major depressive, but less severe 2. Duration at least 2 years (1 year for children)	Same as major depressive, but less severe More chronic
Hypomanic episode	1. Same as manic, but less severe	Same as manic, but less severe
Cyclothymia	1. Fluctuating hypomanic periods and periods of depressed mood 2. Duration at least 2 years (1 year for children) Symptom free for no more than 2 months	Same as bipolar but less severe

Depressive Disorders

Persistent Depressive Disorder (Dysthymia)

Chronic major depressive disorder

For at least 2 years

In children and adolescents, mood can be irritable and duration must be at least 1 year

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

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

Trastornos físicos que pueden causar depresión

Efectos secundarios de los fármacos
Anfetaminas (abstinencia de las mismas)
Fármacos antipsicóticos
Betabloqueadores
Cimetidina
Contraceptivos (orales)
Cicloserina
Indometacina
Mercurio
Metildopa
Reserpina
Talio
Vinblastina
Vincristina

Infecciones
SIDA
Gripe
Mononucleosis
Sífilis (estadio tardío)
Tuberculosis
Hepatitis vírica
Neumonía vírica

Trastornos hormonales
Enfermedad de Addison
Enfermedad de Cushing
Altos valores de hormona paratiroidea
Valores bajos y altos de hormona tiroidea
Valores bajos de hormonas hipofisarias (hipopituitarismo)

Enfermedades del tejido conectivo
Artritis reumatoide
Lupus eritematoso sistémico

Trastornos neurológicos
Tumores cerebrales
Lesiones craneales
Esclerosis múltiple
Enfermedad de Parkinson
Apnea del sueño
Accidentes vasculares cerebrales
Epilepsia del lóbulo temporal

Trastornos nutricionales
Pelagra (deficiencia de vitamina B_6)
Anemia perniciosa (deficiencia de vitamina B_{12})

Cánceres
Cánceres abdominales (de ovario y de colon)
Cánceres diseminados por todo el organismo

CAUSAS DE LA DEPRESIÓN

CLASE DE DEPRESIÓN	CAUSA FUNDAMENTAL
Depresión endógena	Herencia
Depresión neurótica	Ansiedad neurótica y/o inseguridad de sí mismo
Depresión situativa	Situación de vida
Depresión somatógena	Patología médica

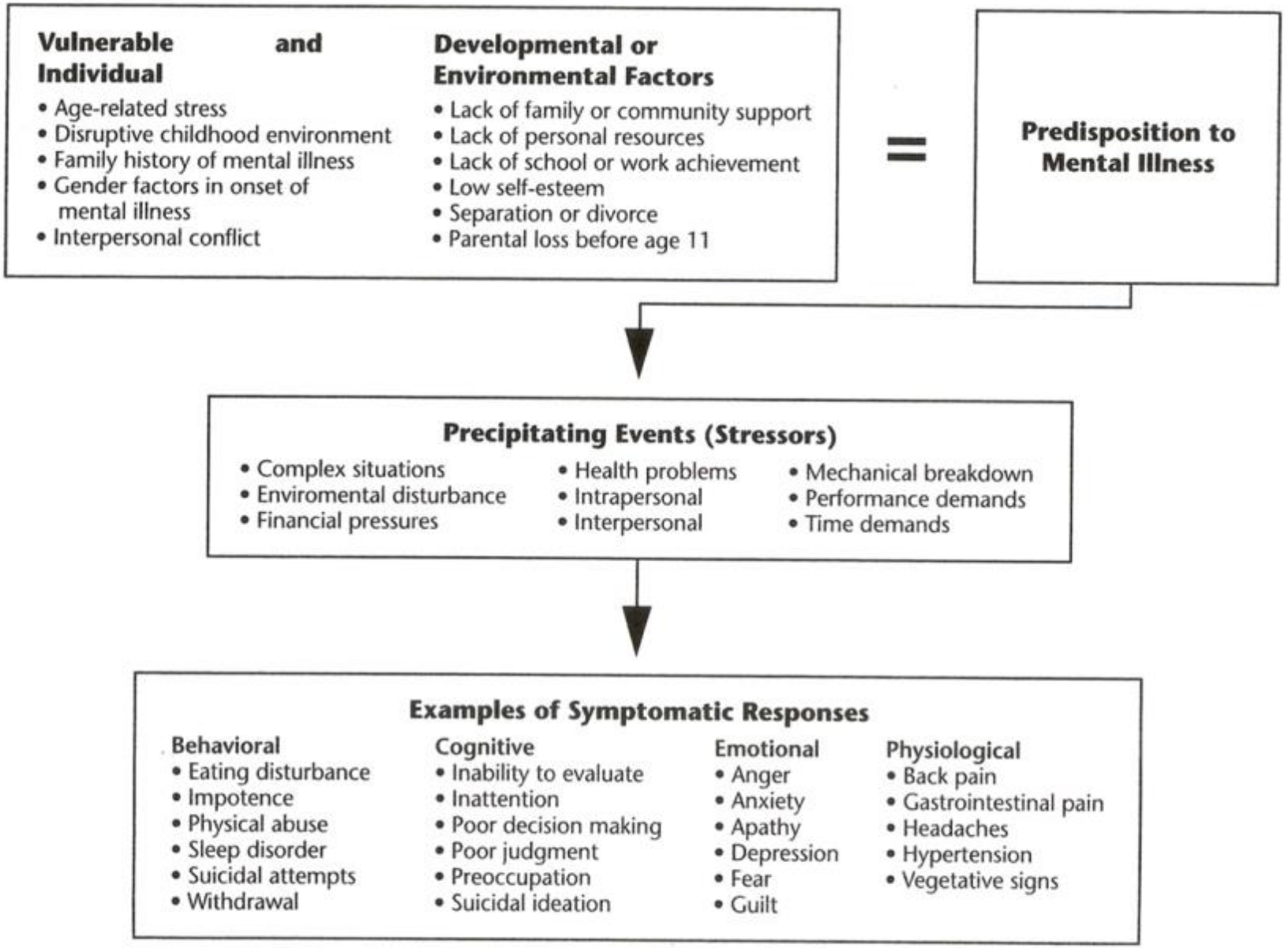


Figure 10–2. Diathesis-Stress Model. Precipitating factors leading to symptoms of mental illness.

Depressive Disorders

Premenstrual Dysphoric Disorder

In menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, one or more of the following symptoms:

Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection)

Marked irritability or anger or increased interpersonal conflicts

Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts

Marked anxiety, tension, and/or feelings of being keyed up or on edge

Decreased interest in usual activities (e.g., work, school, friends, hobbies)

Subjective difficulty in concentration

Depressive Disorders

Premenstrual Dysphoric Disorder

More symptoms:

Lethargy, easy fatigability, or marked lack of energy

Marked change in appetite; overeating; or specific food cravings

Hypersomnia or insomnia

A sense of being overwhelmed or out of control

Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating," or weight gain

Depressive Disorders

Substance/Medication-Induced Depressive Disorder

The symptoms developed during or soon after (one month) substance intoxication or withdrawal or after exposure to a medication (ex. Anxiolitics, alcohol, marijuana).

Anxiety Disorders

Anxiety Disorders

- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder
- (Social Phobia)
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder
- Substance/Medication-Induced Anxiety Disorder

Anxiety Disorders

Separation Anxiety Disorder

- Inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:
  a. Recurrent excessive distress when anticipating or experiencing separation
  b. Persistent and excessive worry about losing major attachment figures
  c. Persistent and excessive worry about experiencing an untoward event
  d. Persistent reluctance or refusal to go out, away from home
  e. Persistent and excessive fear of or reluctance about being alone
  f. Persistent reluctance or refusal to sleep away from home
  g. Repeated nightmares
  h. Repeated complaints of physical symptoms

Anxiety Disorders

Separation Anxiety Disorder

- The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.

Anxiety Disorders

Selective Mutism

Consistent failure to speak in specific social situations

Interferes with educational or occupational achievement or with social communication

At least 1 month (not limited to the first month of school)

The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation

Is not better explained by a communication disorder

Anxiety Disorders

Specific Phobia

Una evitación perturbadora y mediada por un miedo injustificado, que no es proporcional al peligro que representa determinado objeto o situación.

El temor objetivamente no constituye un peligro, pero interfiere con la vida de la persona.

Anxiety Disorders

Specific Phobia

Marked fear or anxiety about a specific object or situation

In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging

The phobic object or situation almost always provokes immediate fear or anxiety

The phobic object or situation is actively avoided

The fear or anxiety is out of proportion to the actual danger

Typically lasting for 6 months or more

Anxiety Disorders

Specific Phobia: Types

Animal

(e.g., spiders, insects, dogs, roaches, lizards)

Natural environment

(e.g., heights, storms, water)

Blood-injection-injury

(e.g., needles, invasive medical procedures)

Situational

(e.g. airplanes, elevators, closed spaces)

Other (e.g., situations that may lead to choking or vomiting in children, e.g., loud sounds or costumed characters)


SI NO PUEDES DESHACERTE DE TUS MIEDOS,
APRENDE A VIVIR CON ELLOS...
...UN CAFECITO?

La fobia moderna

Nomofobia

¿Qué es?

Se refiere al miedo irracional de no traer consigo el teléfono célular.

No te ha pasado que se te olvida el célular en tu casa y todo el día estas desesperada (o) o intranquila? Inclusive te has regresado porque según tu, *"no te hayas sin el cel"*.

Estos son sintomas de que tienes **Nomofobia**, la enfermedad de moda, de estos últimos años.

Estudios dictan que es más común entre los hombres con un 58% y en las mujeres con un 48% entre ellas.

Sintomas:

- *Ansiedad
- *Estrés
- *Nervios

Son síntomas semejantes al que se sienten un día antes de la boda o cuando se va al dentista. Explican los investigadores.

Anxiety Disorders

Social Anxiety Disorder (Social Phobia)

Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others

- Include:
  - ✓ social interactions (e.g., having a conversation, meeting unfamiliar people),
  - ✓ being observed (e.g., eating or drinking), and
  - ✓ performing in front of others (e.g., giving a speech)

Anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others)

Lasting for 6 months or more

Anxiety Disorders

Panic Disorder

A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within 10 minutes, and during which time four (or more) of the following symptoms:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, light-headed, or faint
- Chills or heat sensations
- Paresthesias (numbness or tingling sensations)
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control or "going crazy"
- Fear of dying

SÍNTOMAS DE UN ATAQUE DE PÁNICO

COGNITIVOS/EMOCIONALES

Preocupación constante.
Temor generalizado.
Pensamientos negativos.
Sensación de "irrealidad"
Dificultad para concentrarse.

FISIOLÓGICOS

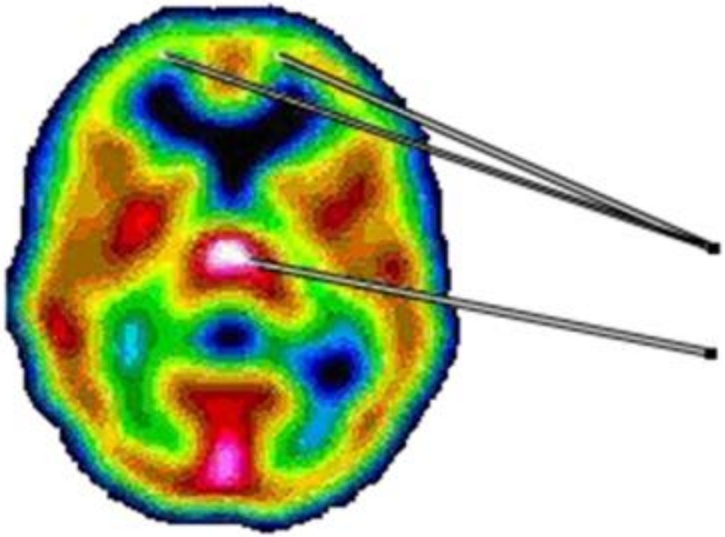
Palpitaciones, taquicardia.
Presión en el pecho.
Dificultad para respirar.
Molestias estomacales
Sudoración.
Tensión muscular.
Mareos.
Sensación de hormigueo.
Visión borrosa.

COMPORTAMIENTO

Inquietud.
Insomnio.
Evita las situaciones por miedo.

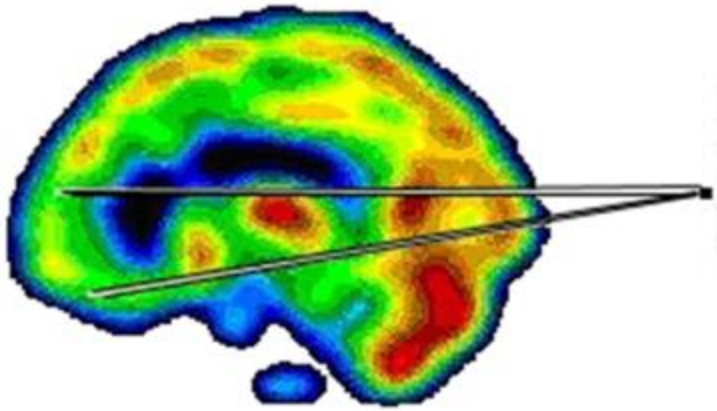
TRATAMIENTO PARA
TU ANSIEDAD.COM

Panic Attack



Decreased Frontal Lobe activity.

Increased brain activity in the Thalamus indicating sensory overload resulting in unusual perceptions.



Decreased brain activity in Frontal Lobes causing confusion, disorientation, and the potential for impulsive behavior.

DEVELOPMENT OF PANIC CYCLE

The Initial Circumstances (Internal or External).

Increase in unusual sensations, thoughts & feelings, adds to initial Anxiety.

Increased focus on physical sensations. Decreased focus on actual FACT. Anxiety increases more.

Catastrophic interpretation of sensations. Self reinforcement of perceived danger. 'What if thoughts about negative outcome. Physical response reaches a pinnacle.

PANIC

Figura del círculo vicioso de la ansiedad – Los pensamientos disparan mas síntomas del cuerpo que a su vez, provocan mas miedo

Anxiety Disorders

Agoraphobia

- Marked fear or anxiety about two (or more) of the following five situations:

using public transportation (e.g., automobiles, buses, trains, ships, planes)
being in open spaces (e.g., parking lots, marketplaces, bridges, seashore)
being in enclosed places (e.g., shops, theaters, cinemas)
standing in line or being in a crowd
being outside of the home alone

- Lasting for 6 months or more

¡Tengo miedo!

AGORAFOBIA

La agorafobia es un trastorno de ansiedad que consiste en el miedo a los lugares donde no se puede recibir ayuda, por temor a sufrir una crisis de pánico.

CAUSAS

Origen psicológico

Personas con predisposición a responder de forma excesiva ante las situaciones estresantes

ETIMOLOGÍA

"ágora" = "plaza"
"phobos" = "miedo"

MIEDOS

- Hacer el ridículo
- Vivir una crisis
- Miedo al miedo
- Desmayarse
- Sufrir un infarto
- Perder el control

EDADES PROMEDIO

De quienes lo padecen

De 20 a 40 años

FRECUENCIA

4% de la población

+ Mujeres

- Hombres

SENSACIONES

Taquicardia · Temblores · Falta de aire · Náuseas · Sensación de orinar o evacuar

CONSECUENCIAS

- Evita las situaciones temidas
- Las soporta con gran ansiedad o malestar
- Tiene la necesidad urgente de estar acompañado

TRATAMIENTO

Cognitivo-conductual

Se basa en someter al paciente a una exposición gradual a las situaciones que típicamente le provocan la ansiedad

Fuente: Enciclopedia libre, amadag.com, entornomedico.org Investigación y redacción: Susana H. Valles Arte y Diseño: Elizabeth Blanes

SUBMEDIKAL

Anxiety Disorders

General Anxiety Disorder

- Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months

- The individual finds it difficult to control the worry

- The anxiety and worry are associated with three (or more) of the following symptoms:
  - ✓ restlessness or feeling keyed up or on edge
  - ✓ being easily fatigued
  - ✓ difficulty concentrating or mind going blank
  - ✓ irritability
  - ✓ muscle tension
  - ✓ sleep disturbance (difficulty falling or staying asleep, or sleep)

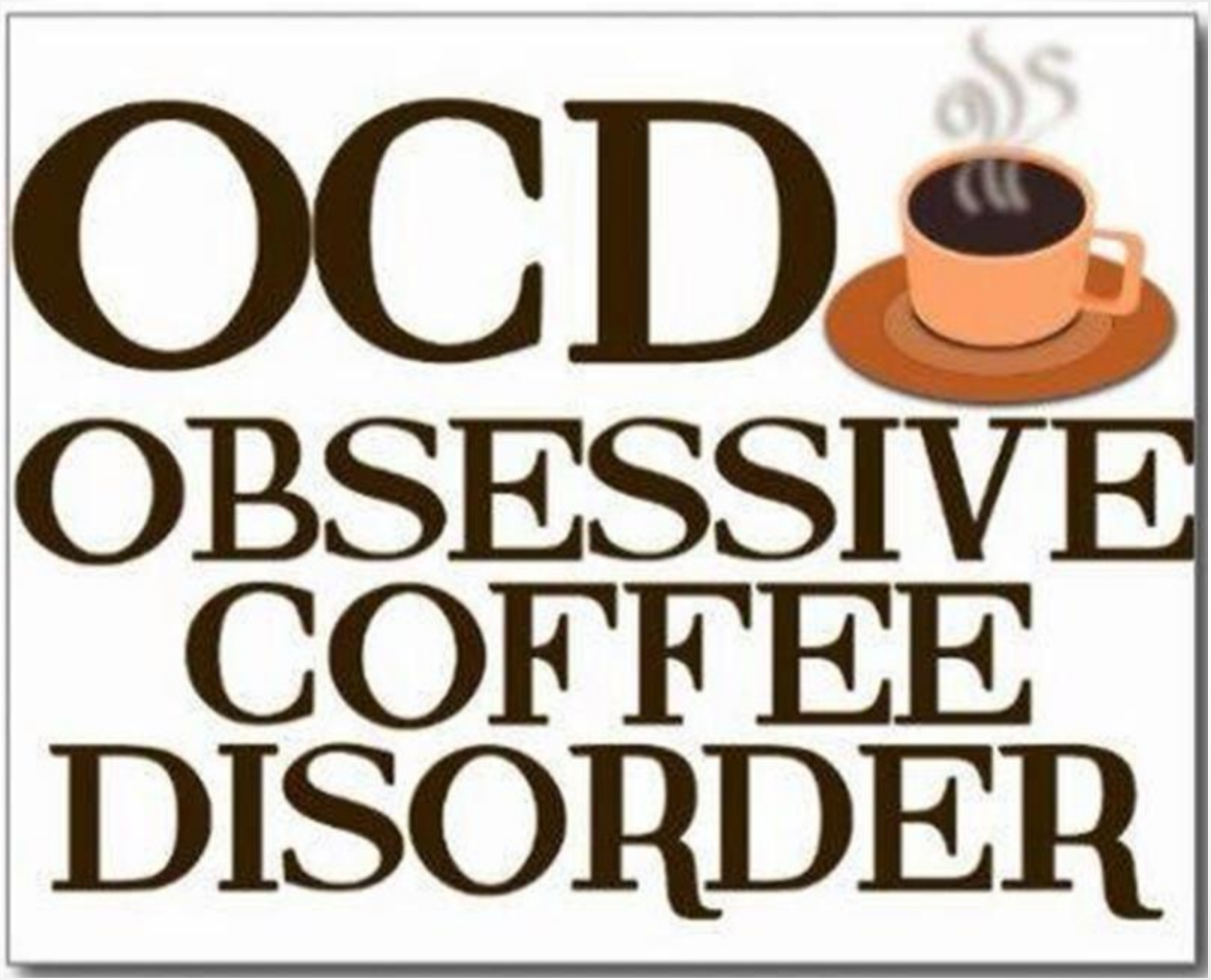
Note: Only **one** item is required in children.

Anxiety Disorders

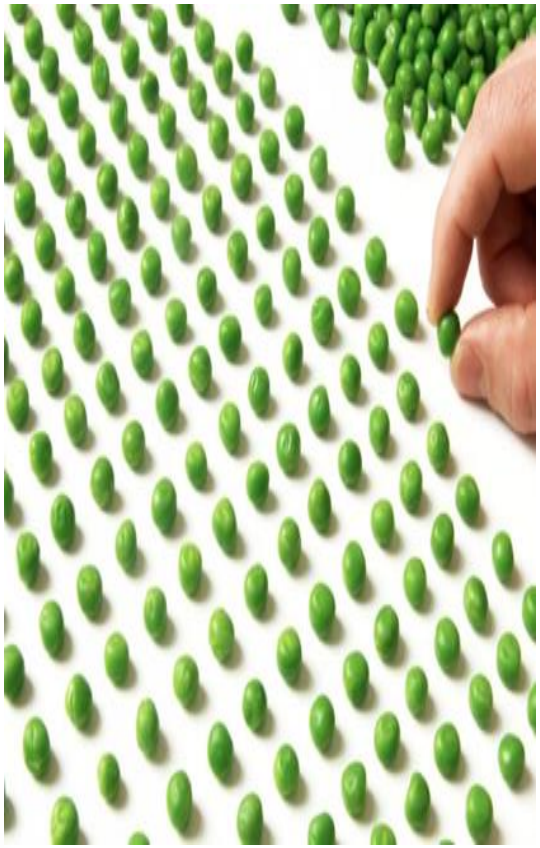
Substance/Medication-Induced Anxiety Disorder

The symptoms precede the onset of the substance/medication use; the persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication (Ex. Cocaine, heroine, coffee).

Obsessive-Compulsive and Related Disorders


OCD
OBSESSIVE
COFFEE
DISORDER

Obsessive-Compulsive and Related Disorders



- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania
- Excoriation (Skin-Picking) Disorder

Obsessive-Compulsive and Related Disorders

Obsessive-Compulsive Disorder

Obsessions	Compulsions
- Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress - The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion)	- Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly - The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive

Time-consuming (e.g., take more than 1 hour per day)

¿QUÉ ES EL TRASTORNO OBSESIVO COMPULSIVO O TOC?

El trastorno obsesivo compulsivo (TOC) estuvo considerado hasta hace algunos años como una enfermedad psiquiátrica rara que no respondía al tratamiento. Actualmente es reconocido como un problema común que afecta al 2% de la población.

SÍNTOMAS DEL TRASTORNO OBSESIVO COMPULSIVO

A- OBSESIONES

- Temor a contaminarse
- Temor a causar daños a otros o a que les pase algo a los seres queridos
- Ideas agresivas o de contenido sexual
- Escrupulosidad o/y religiosidad excesiva
- Pensamientos prohibidos
- Necesidad de simetría
- Necesidad de confesar

B- COMPULSIONES

- Lavarse
- Repetir una acción hasta hacerla 'bien'
- Asegurarse de haber cerrado la puerta, el agua...
- Tocar
- Contar objetos o hasta un determinado número
- Ordenar
- Acumular y no poder tirar nada
- Rezar

TIPOS DE TRASTORNO OBSESIVO COMPULSIVO

En función del tipo de obsesión, los expertos distinguen varios tipos de TOC:

- **Lavadores y limpiadores**
  Están obsesionados con la contaminación.
- **Verificadores**
  Se empeñan en evitar determinadas catástrofes.
- **Repetidores**
  Ejecutan acciones repetitivas.
- **Ordenadores**
  No paran de ordenar las cosas que les rodean.
- **Acumuladores**
  Coleccionan objetos insignificantes.
- **Ritualizadores mentales**
  Tienen ideas repetitivas.
- **Atormentados**
  Sus pensamientos negativos son incontrolables.
- **Sexuales**
  Con pensamientos sexuales recurrentes.

FUENTE: MedlinePlus.

3PLANOS | SINC


Obsessions
Anxiety
Compulsions
Relief
The OCD Cycle

Obsessive-Compulsive and Related Disorders

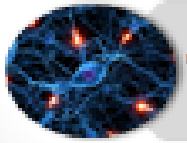
Etiología de TOC

Teoría psicoanalítica: provienen de fuerzas sexuales o agresivas (fijación etapa _____?_____)

Padres excesivamente dominantes

Teoría conductual: aprendido y reforzado

Teoría cognoscitiva: sobrestimación negativa



Teoría biológica: bajo nivel serotonina

Obsessive-Compulsive and Related Disorders

Body Dysmorphic Disorder

- Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others
- The individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns
- The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- Specify if…

  …with muscle dysmorphia: the individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular

  E.g. vigorexia

Obsessive-Compulsive and Related Disorders

Hoarding Disorder (Acaparamiento)

Persistent difficulty discarding or parting with possessions, regardless of their actual value

This difficulty is due to a perceived need to save the items and to distress associated with discarding them

The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use

If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities)

Obsessive-Compulsive and Related Disorders

Trichotillomania

- Recurrent pulling out of one's hair, resulting in hair loss
- Repeated attempts to decrease or stop hair pulling
- The hair pulling causes clinically significant distress or occupational stress

Obsessive-Compulsive and Related Disorders

Excoriation (Skin-Picking) Disorder

- Recurrent skin picking resulting in skin lesions
- Repeated attempts to decrease or stop skin picking
- The skin picking is not attributable to the physiological effects of a substance (cocaine) or another medical condition (e.g., scabies)

Trauma and Stressor Related Disorders

Trauma and Stressor Related Disorders

- Reactive Attachment Disorder
- Social Disinhibited Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorder

Trauma and Stressor Related Disorders

Reactive Attachment Disorder

A consistent pattern of inhibited, emotionally withdrawn behavior towards adult caregivers:

- the child rarely or minimally seeks comfort when distressed or
- responds to comfort when distressed

At least two of the following:

- Minimal social and emotional responsiveness to others
- Limited positive affect
- Episodes of irritability, sadness, fearfulness

Pattern of extremes of insufficient care:

- Social neglect or deprivation
- Repeated changes of primary caregivers
- Rearing in unusual settings that limit opportunities

Evident before age 5 years

Trauma and Stressor Related Disorders

Social Disinhibited Engagement Disorder

- Behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two:
  - Reduced or absent reticence in approaching and interacting with unfamiliar adults
  - Overly familiar verbal or physical behavior
  - Diminished or absent checking back with adult caregiver after venturing away
  - Willingness to go off with an unfamiliar adult with minimal or no hesitation

- Pattern of extremes of insufficient care:
  - Social neglect or deprivation
  - Repeated changes of primary caregivers
  - Rearing in unusual settings that limit opportunities

Trauma and Stressor Related Disorders

Posttraumatic Stress Disorder

Exposure to actual or threatened death, serious injury, or sexual violence **in one (or more)** of the following ways:

- Directly experiencing the traumatic event(s)
- Witnessing, in person, the event(s) as it occurred to others
- Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
    - Does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

Trauma and Stressor Related Disorders

Posttraumatic Stress Disorder

Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)
  - Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
- Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)
  - Note: In children, there may be frightening dreams without recognizable content.
- Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring
- Marked physiological and psychological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)

Trauma and Stressor Related Disorders

Posttraumatic Stress Disorder

Persistent avoidance of stimuli associated with the traumatic event(s)

- Avoidance of or efforts to avoid distressing memories, thoughts, or feelings
- Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations)

Negative alterations in cognitions and mood associated with the traumatic event(s) as evidenced by two (or more) of the following:

- inability to remember an important aspect of the traumatic event(s)
- persistent and exaggerated negative beliefs or expectations about oneself, others
- or the world (e.g., “I am bad," "No one can be trusted," "The world is completely
- dangerous ("My whole nervous system is permanently ruined.”) Persistent, distorted cognitions about the cause or consequences of the traumatic
- event(s) that lead the individual to blame himself/herself or others
- persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)
- markedly diminished interest or participation in significant activities
- feelings of detachment or estrangement from others
- persistent inability to experience positive emotions to happiness, satisfaction, or loving feelings)

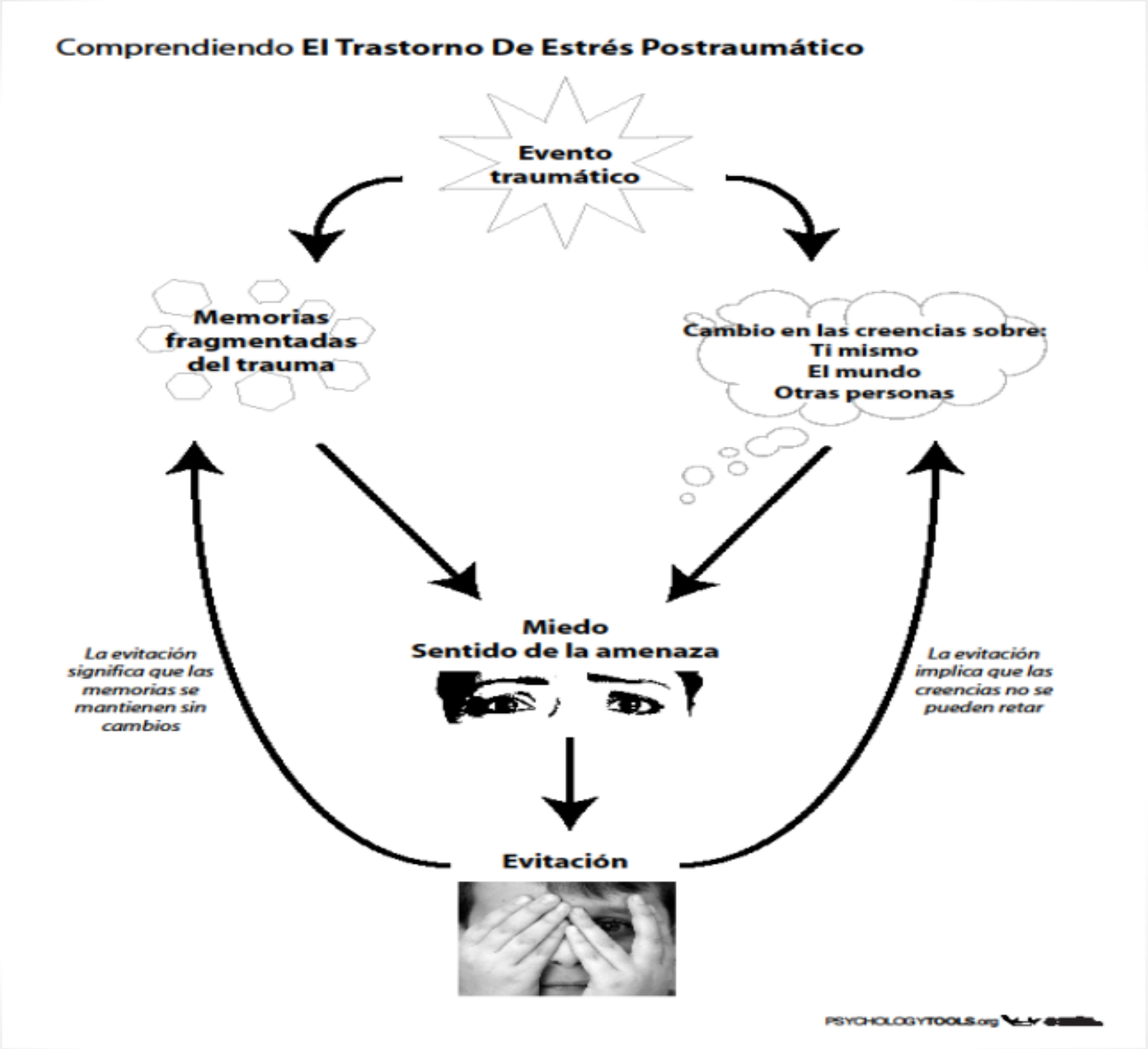
Trauma and Stressor Related Disorders

Posttraumatic Stress Disorder

Marked alterations in arousal and reactivity:

- irritable behavior and angry outbursts (with little or no provocation) expressed as verbal or physical aggression toward people or objects
- reckless or self-destructive behavior
- hypervigilance
- exaggerated startle response
- problems with concentration
- sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep)
- derealization and depersonalization

Duration of the disturbance is more than 1 month


Comprendiendo El Trastorno De Estrés Postraumático
Evento traumático
Memorias fragmentadas del trauma
Cambio en las creencias sobre:
Ti mismo
El mundo
Otras personas
Miedo
Sentido de la amenaza
La evitación significa que las memorias se mantienen sin cambios
La evitación implica que las creencias no se pueden retar
Evitación
PSYCHOLOGYTOOLS.org

Trauma and Stressor Related Disorders

Acute Stress Disorder

Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
- directly experiencing the traumatic event(s)
- witnessing, in person, the event(s) as it occurred to others
- learning that the event(s) occurred to a close family member or close friend
- experiencing repeated or extreme exposure to aversive details of the traumatic
- event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse)

Trauma and Stressor Related Disorders

Acute Stress Disorder

Presence of ***nine (or more)*** of the following symptoms from any of the ***five categories*** of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms
- recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)
- distressing dreams
- dissociative reactions (e.g., flashbacks)
- intense or prolonged psychological distress or marked physiological reactions

Negative Mood
- persistent inability to experience positive emotions

Dissociative Symptoms
- an altered sense of the reality of one's surroundings or oneself, inability to remember

Avoidance Symptoms
- efforts to avoid distressing memories, thoughts, or feelings
- efforts to avoid external reminders (people, places, conversations, activities, objects, situations)

Arousal Symptoms
- sleep disturbance
- irritable behavior and angry outbursts
- hypervigilance
- problems with concentration
- exaggerated startle response

3 days to 1 month after trauma exposure

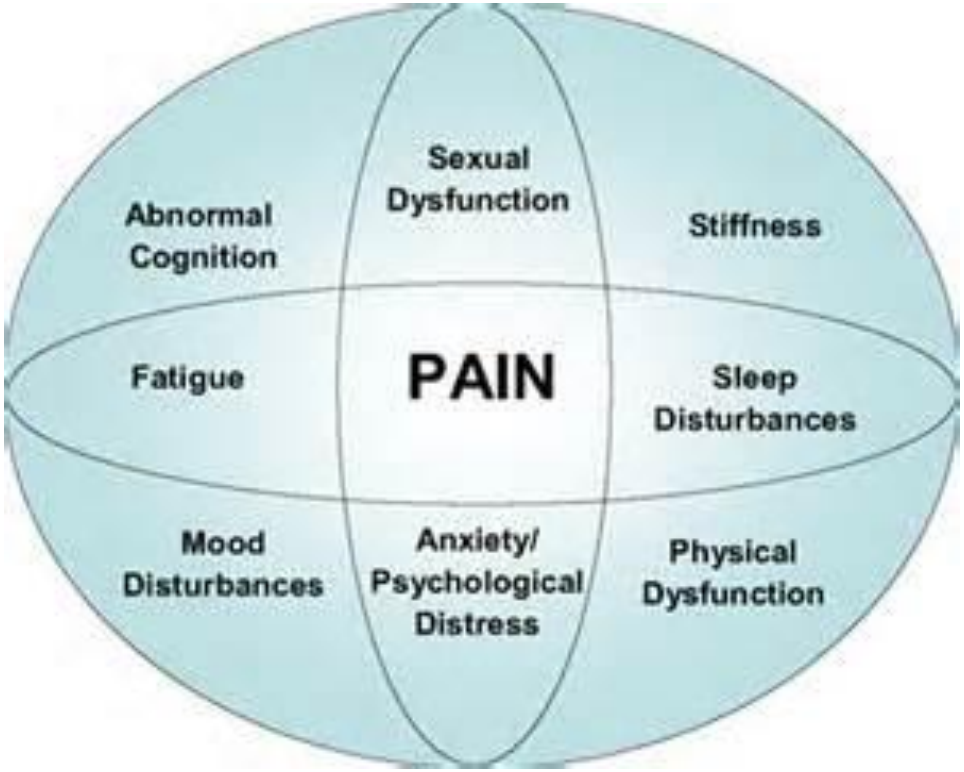
Trauma and Stressor Related Disorders

Adjustment Disorder

Development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s)

- marked distress that is out of proportion to the severity or intensity of the stressor
- significant impairment in social, occupational, or other important areas of functioning
- symptoms do not represent normal bereavement
- symptoms do not persist for more than an additional 6 months

Somatic Symptom Disorder and Related Disorders



Somatic Symptom Disorder and Related Disorders

Somatic Symptom Disorder

Factitious Disorder

Conversion Disorder

Illness Anxiety Disorder

Somatic Symptom Disorder and Related Disorders

Somatic Symptom Disorder

- Symptoms that disrupt every day life
- Excessive thoughts, feelings or behavior associated with health:
  - disproportioned and persistent thoughts about the seriousness of symptoms
  - high level of anxiety about health
  - excessive time and energy devoted to health concerns
- Predominate pain

Somatic Symptom Disorder and Related Disorders

Illness Anxiety Disorder (Hypochondriasis)

- Preoccupation with having or acquiring a serious illness
- Somatic symptoms are not present
- The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals)
- Present for at least 6 months

Somatic Symptom Disorder and Related Disorders

Conversion Disorder

One or more symptoms of altered voluntary motor or sensory function
Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions - Paralysis, seizures, sensory loss

Somatic Symptom Disorder and Related Disorders

Factitious Disorder

Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception

The individual presents himself or herself to others as ill, impaired, or injured

Feeding and Eating Disorders

Feeding and Eating Disorders

Pica	Rumination Disorder	Avoidant Restrictive Food Intake Disorder
Anorexia Nervosa	Bulimia Nervosa	Binge Eating

Feeding and Eating Disorders

Pica

- Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month Ex. Dirt, paint, glue, chalk

Rumination Disorder

- Repeated regurgitation of food over a period of at least 1 month
- Regurgitated food may be re-chewed, re-swallowed, or spit out

Avoidant Restrictive Food Intake Disorder

- An eating or feeding disturbance

  (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating)

  - Significant weight loss
  - Significant nutritional deficiency
  - Dependence on enteral feeding or oral nutritional supplements
  - Marked interference with psychosocial functioning

Feeding and Eating Disorders

Anorexia Nervosa

Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health

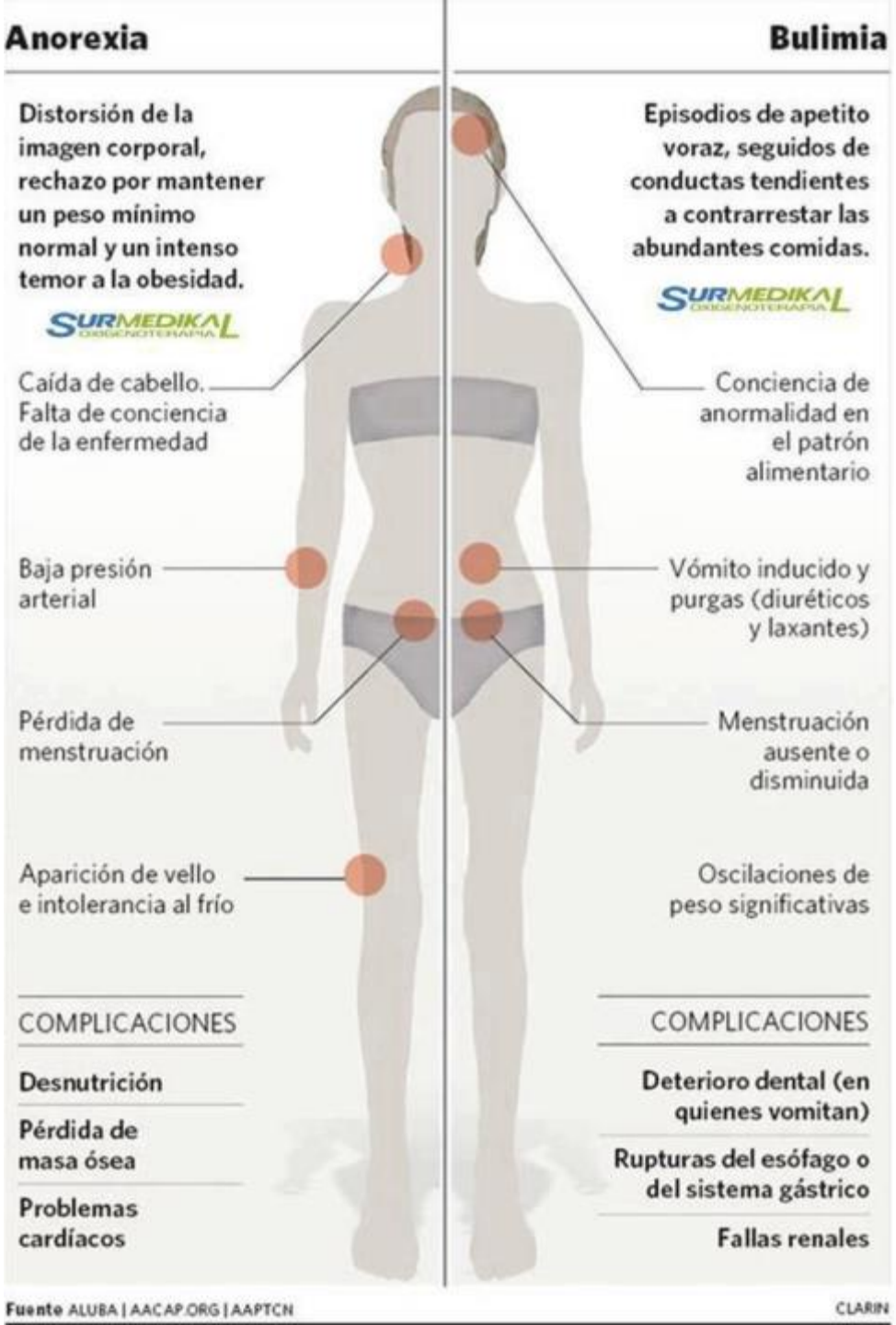
Intense fear of gaining weight or of becoming fat

Persistent behavior that interferes with weight gain, even though at a significantly low weight

Feeding and Eating Disorders

Bulimia Nervosa

- Recurrent episodes of binge eating:
  - Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances
  - A sense of lack of control over eating during the episode
- Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise
- At least once a week for 3 months


Anorexia
Bulimia
Distorsión de la imagen corporal, rechazo por mantener un peso mínimo normal y un intenso temor a la obesidad.
SURMEDIKAL
Episodios de apetito voraz, seguidos de conductas tendientes a contrarrestar las abundantes comidas.
SURMEDIKAL
Caída de cabello. Falta de conciencia de la enfermedad
Conciencia de anormalidad en el patrón alimentario
Baja presión arterial
Vómito inducido y purgas (diuréticos y laxantes)
Pérdida de menstruación
Menstruación ausente o disminuida
Aparición de vello e intolerancia al frío
Oscilaciones de peso significativas
COMPLICACIONES
Desnutrición
Pérdida de masa ósea
Problemas cardíacos
COMPLICACIONES
Deterioro dental (en quienes vomitan)
Rupturas del esófago o del sistema gástrico
Fallas renales
Fuente ALUBA | AACAP.ORG | AAPTCN
CLARIN

Feeding and Eating Disorders

Binge Eating

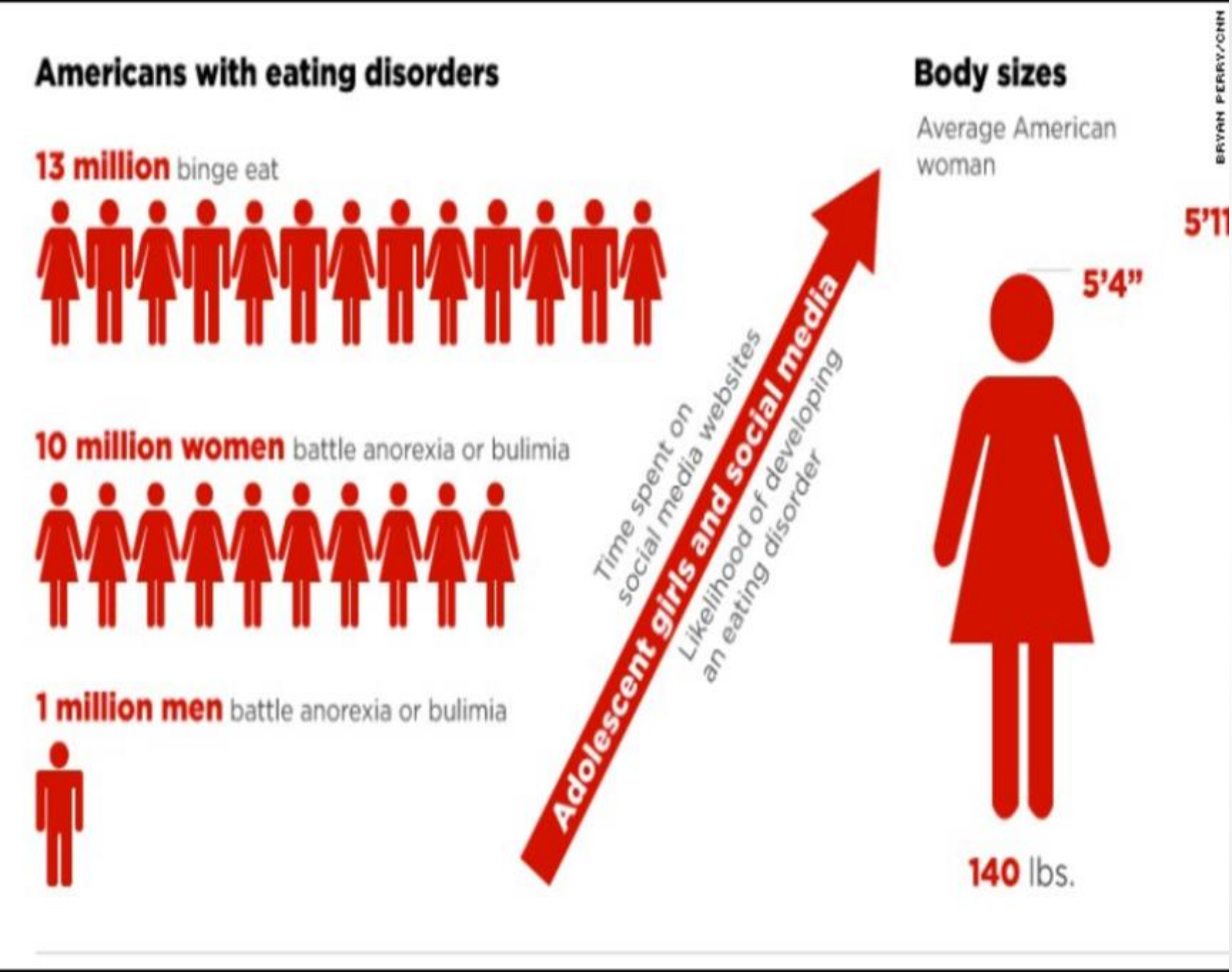
An episode of binge eating is characterized by both of the following:

- Eating, in a discrete period of time (e.g., within any 2-hour period), an amount food that is definitely larger than what most people would eat in a similar time under similar circumstances
- A sense of lack of control over eating during the episode

Three (or more) of the following:

- Eating much more rapidly than normal
- Eating until feeling uncomfortably full
- Eating large amounts of food when not feeling physically hungry
- Eating alone because of feeling embarrassed by how much one is eating
- Feeling disgusted with oneself, depressed, or very guilty afterward

At least once a week for 3 months


Americans with eating disorders
13 million binge eat
10 million women battle anorexia or bulimia
1 million men battle anorexia or bulimia
Adolescent girls and social media
Time spent on social media websites
Likelihood of developing an eating disorder
Body sizes
Average American woman
5'11
5'4"
140 lbs.
BRYAN PERRY/CNN

Other interesting but not on DSM 5…

Interesantes, pero no en DSM-5:

Pregorexia

- Excessive preoccupation with diet in pregnant women

Ortorexia

- Obsesión por siempre comer "saludable"
  - desnutrición
  - anemia
  - pérdida de masa ósea
  - falta de vitaminas y minerales debilidad general
  - alto riesgo a infecciones

Selfitis

Nomofobia

Disruptive, Impulse-Control and Conduct Disorder

Disruptive, Impulse-Control and Conduct Disorder

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Pyromania
- Kleptomania

Disruptive, Impulse-Control and Conduct Disorder

Oppositional Defiant Disorder

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:

Angry/Irritable Mood
- Often loses temper
- Is often touchy or easily annoyed
- Is often angry and resentful

Argumentative/Defiant Behavior
- Often argues with authority figures
- Often actively defies or refuses to comply with requests from authority figures or with rules
- Often deliberately annoys others
- Often blames others for his or her mistakes or misbehavior

Vindictiveness
- Has been spiteful or vindictive at least twice within the past 6 months

Disruptive, Impulse-Control and Conduct Disorder

Intermittent Explosive Disorder

- Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by either of the following:
  - Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) 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.
  - 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.
- The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors
- The recurrent aggressive outbursts are not premeditated (i.e., they are impulsive and/or anger-based) and are not committed to achieve some tangible objective (e.g., money, power, intimidation)
- The recurrent aggressive outbursts cause either marked distress in the individual or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences
- Chronological age is at least 6 years

TANTRUM VS AUTISM MELTDOWN

Tantrum

--"Want" directed
--Goal/Control Driven
--Audience to perform
--Checks engagement
--Protective mechanisms
--Resolves if goal is accomplished

AGE: 1 to 5 years

www.autism-daddy.blogspot.com
www.facebook.com/autismdaddy

Autism Meltdown

--Overstressed/ Overwhelmed
--Reactive mechanism
--Continues without attention
--Safety may be compromised
--Fatigue
--Not goal dependent
--May require assistance to gain control

AGE: Through Adulthood

Disruptive, Impulse-Control and Conduct Disorder

Conduct Disorder

A repetitive and persistent pattern of behavior in which the basic rights of others or major age appropriate societal norms or rules are violated, at least three or more of the following criteria in the past 12 months:

Aggression to people and animals

- bullies, threatens, or intimated others
- initiates physical fights
- has used a weapon (bat, brick, broken bottle, knife, gun) to cause harm
- has been physically cruel to people
- has been physically cruel to animals
- has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- has forced someone into sexual activity

Destruction of property

- has deliberately engaged in fire setting with the intention of causing serious damage
- has deliberately destroyed others' property (other than by tire setting)

Disruptive, Impulse-Control and Conduct Disorder

Conduct Disorder

Deceitfulness or theft

- has broken into someone else's house, building, or car
- often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
- has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

- often stays out at night despite parental prohibitions, beginning before age 13 years
- 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
- is often truant from school, beginning before age 13 years

Disruptive, Impulse-Control and Conduct Disorder

Pyromania

Deliberate and purposeful fire setting on more than one occasion

Tension or affective arousal before the act

Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, consequences)

Pleasure, gratification, or relief when setting fires or when witnessing or participating in their aftermath

Disruptive, Impulse-Control and Conduct Disorder

Kleptomania

- Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value
- Increasing sense of tension immediately before committing the theft
- Pleasure, gratification, or relief at the time of committing the theft
- The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination

Substance Related and Addictive Disorder

DSM–IV		DSM–5		
Any 1 = ALCOHOL ABUSE	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household.	1	Alcohol is often taken in larger amounts or over a longer period than was intended. (See DSM–IV, criterion 7.)	The presence of at least 2 of these symptoms indicates an **Alcohol Use Disorder (AUD).** The severity of the AUD is defined as: **Mild:** The presence of 2 to 3 symptoms **Moderate:** The presence of 4 to 5 symptoms **Severe:** The presence of 6 or more symptoms
	Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol abuse).	2	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. (See DSM–IV, criterion 8.)	
	Recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct). ****This is not included in DSM–5****	3	A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. (See DSM–IV, criterion 9.)	
	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about the consequences of intoxication, physical fights).	4	Craving, or a strong desire or urge to use alcohol. ****This is new to DSM–5****	
Any 3 = ALCOHOL DEPENDENCE	Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect b) Markedly diminished effect with continued use of the same amount of alcohol	5	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. (See DSM–IV, criterion 1.)	
	Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol b) Alcohol is taken to relieve or avoid withdrawal symptoms	6	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. (See DSM–IV, criterion 4.)	
	Alcohol is often taken in larger amounts or over a longer period than was intended.	7	Important social, occupational, or recreational activities are given up or reduced because of alcohol use. (See DSM–IV, criterion 10.)	
	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.	8	Recurrent alcohol use in situations in which it is physically hazardous. (See DSM–IV, criterion 2.)	
	A great deal of time is spent in activities necessary to obtain alcohol (e.g., driving long distances), use alcohol, or recover from its effects.	9	Alcohol 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 alcohol. (See DSM–IV, criterion 11.)	
	Important social, occupational, or recreational activities are given up or reduced because of alcohol use.	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 (See DSM–IV, criterion 5.)	
	Alcohol 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 the substance (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).	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. (See DSM–IV, criterion 6.)	

Substance Related and Addictive Disorder

Substance Use Disorder

Intoxication

- problematic behavior, slurred speech, incoordination, unsteady gait, nystagmus, low attention and memory, stupor or coma

Withdrawal

- cessation of alcohol use that causes autonomic hyperactivity, hand tremor, insomnia, nausea/vomiting, transient hallucinations, psychomotor agitation, anxiety, tonic/clonic seizures

Tolerance

- markedly increased amounts of alcohol to achieve intoxication; markedly diminished effect when use the same amount

Craving

- strong desire o urge to use

Substance Related and Addictive Disorder

Types

- Alcohol
- Cannabis
- Inhalants
- Sedatives
- Anxiolytics
- Tobacco
- Caffeine
- Hallucinogens
- Opioids
- Hypnotics
- Stimulants

Gambling Disorder

Substance Related and Addictive Disorder

Alcohol Related Use Disorder

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

- Alcohol is often taken in larger amounts or over a longer period than was intended
- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
- Deal of time spent
- Craving
- Failure in obligations
- Continued alcohol use despite problems
- Diminish occupational, social, recreational activities
- Recurrent use in hazardous situations
- Tolerance

Magnetic Resonance Imaging of the Brain

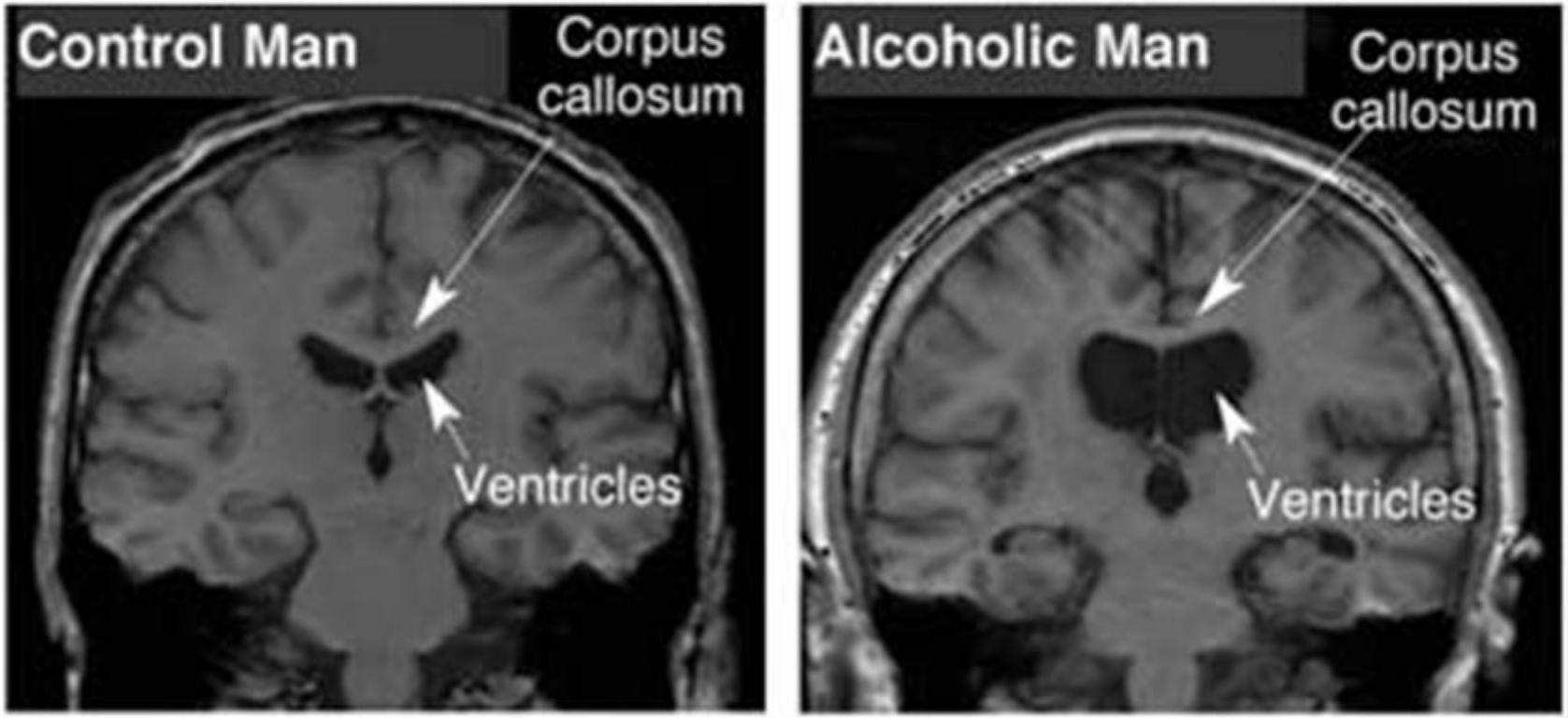
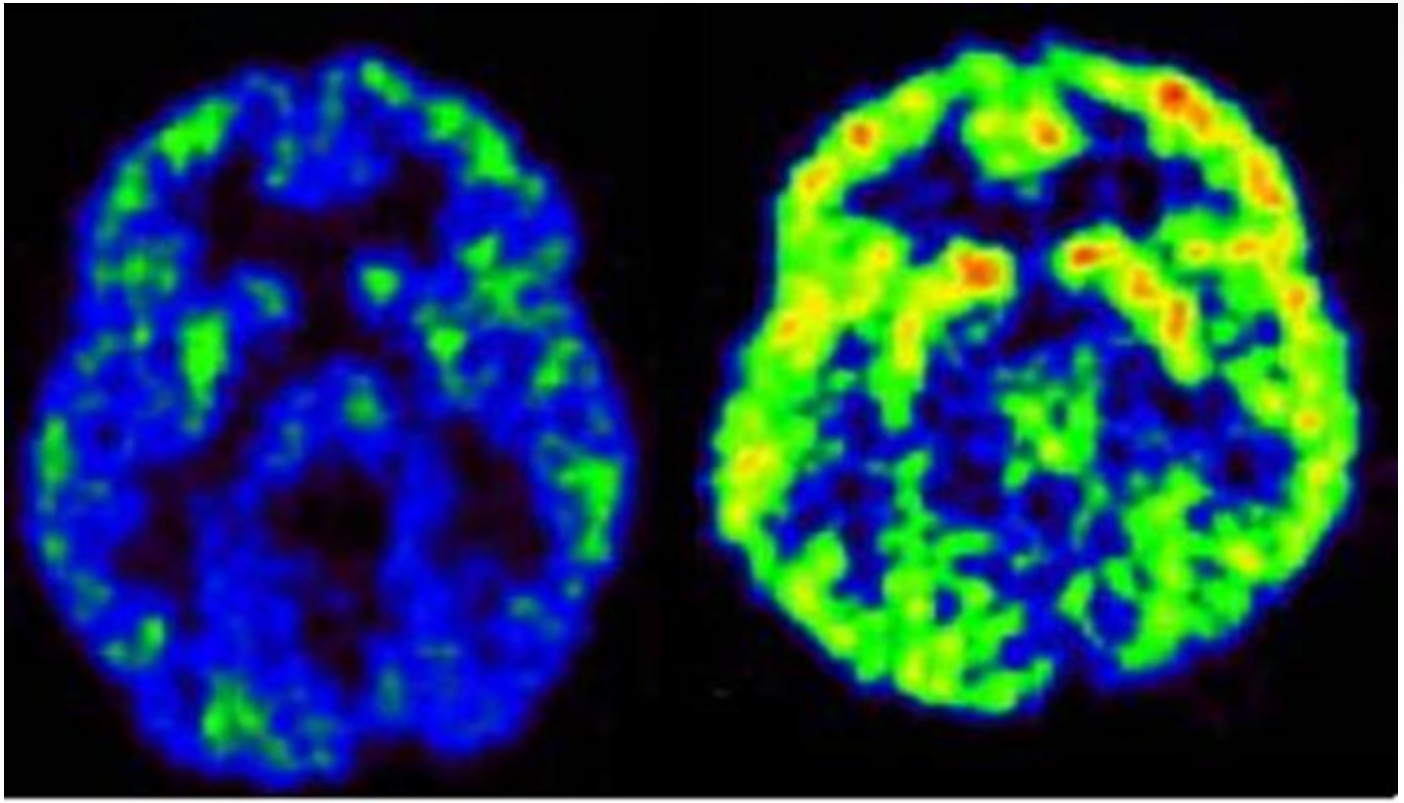


Image courtesy of the National Institute on Drug Abuse



Alcoholic

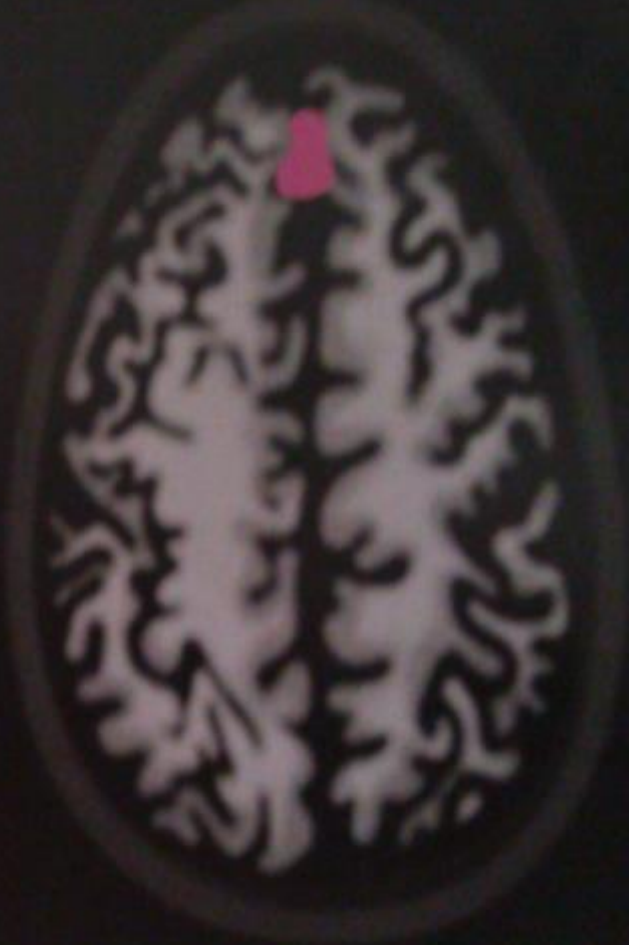
Darker Colouring indicates depressed brain activity

Normal

Healthy levels of brain activity

The Effects of Heavy Drinking on the Teen Brain

15 Year-old Non-Drinker



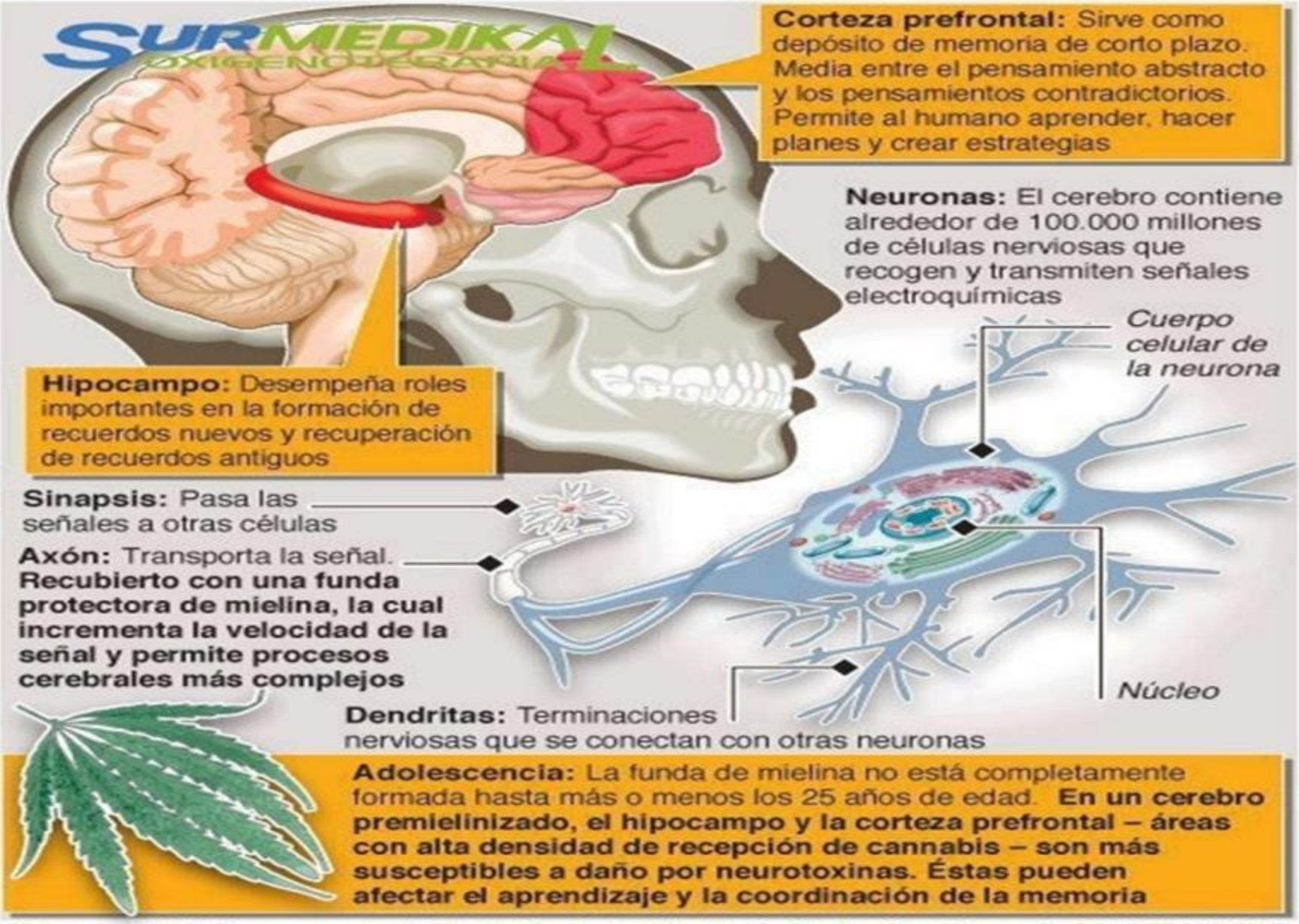
15 Year-old Heavy Drinker

Functional MRI scans of two teens while they took a working memory test. The images show that the heavy drinker isn't using those brain areas normally used to complete a memory test, while the non-drinker is. Researchers suggest that in school, heavy drinkers may not be activating those regions of the brain required to remember a lesson.


1
¿BEBES PARA RELAJARTE CUANDO TIENES PROBLEMAS?
2
¿BEBES CUANDO TE SIENTES IRRITADO, FRUSTRADO, INFELIZ O AIRADO?
3
¿PREFIERES BEBER A SOLAS?
4
¿ESTÁN BAJANDO TUS CALIFICACIONES? ¿TIENES PROBLEMAS EN EL TRABAJO?
5
¿HAS TRATADO ALGUNA VEZ DE DEJAR DE BEBER O BEBER MENOS Y FRACASASTE?
6
¿BEBES POR LA MAÑANA?
7
¿TE TRAGAS LAS BEBIDAS DE UN GOLPE?
8
¿HAS OLVIDADO ALGUNA VEZ LO QUE PASÓ CUANDO ESTABAS BEBIENDO?
9
¿MIENTES ACERCA DE TU FORMA DE BEBER?
10
¿TE METES EN PROBLEMAS CUANDO BEBES?
11
¿TE EMBORRACHAS CUANDO BEBES AUN CUANDO NO QUIERAS?
12
¿TE PARECE UNA GRAN HAZAÑA AGUANTAR MUCHO BEBIENDO?

Marihuana afecta desarrollo cerebral de adolescentes

El uso habitual de marihuana en adolescentes puede afectar su CI en la edad adulta según un estudio de 25 años realizado en 1.037 jóvenes. Una causa posible es que los adolescentes son vulnerables a los efectos de la marihuana en la química cerebral

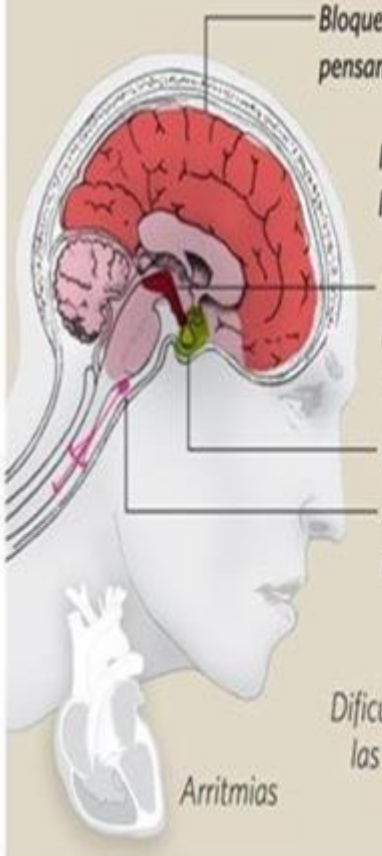


Fuentes: PNAS; Departamento de Psiquiatría, Universidad de California, San Diego © GRAPHIC NEWS

JÓVENES DESCONOCEN LOS EFECTOS ADVERSOS DEL ÉXTASIS

EFECTOS ADVERSOS DEL CONSUMO DE ÉXTASIS

Fuerza al cerebro a elevar los niveles de neurotransmisión (serotonina)



EFECTOS ATRIBUIDOS AL CONSUMO DE ÉXTASIS

Sondeo a escolares de 1° a 5° de secundaria en el Perú (2009)

Consumo por año de estudios:

CON QUE ACOMPAÑAN LA DROGA

PREVALENCIA

Según sexo

POR TIPO DE COLEGIO:

Fuente: DEVIDA.

LA REPÚBLICA

Table 16-2	The Transtheorical Model of Behavior Change Stages
Stage	*Change*
Precontemplation	The individual is unaware of having problems with substance use; however, he or she may be able to recount some negative consequences related to a using incident.
Contemplation	The person is aware of pros and cons for using, but is ambivalent about change.
Preparation	The person has decided change is necessary and is considering and planning several alternatives for facilitating the change process.
Action	The person is learning new behaviors in place of substance use, though the new behaviors are somewhat fragile at this point.
Maintenance	The newly learned behaviors are incorporated into one's habits and routines on a long-term basis.

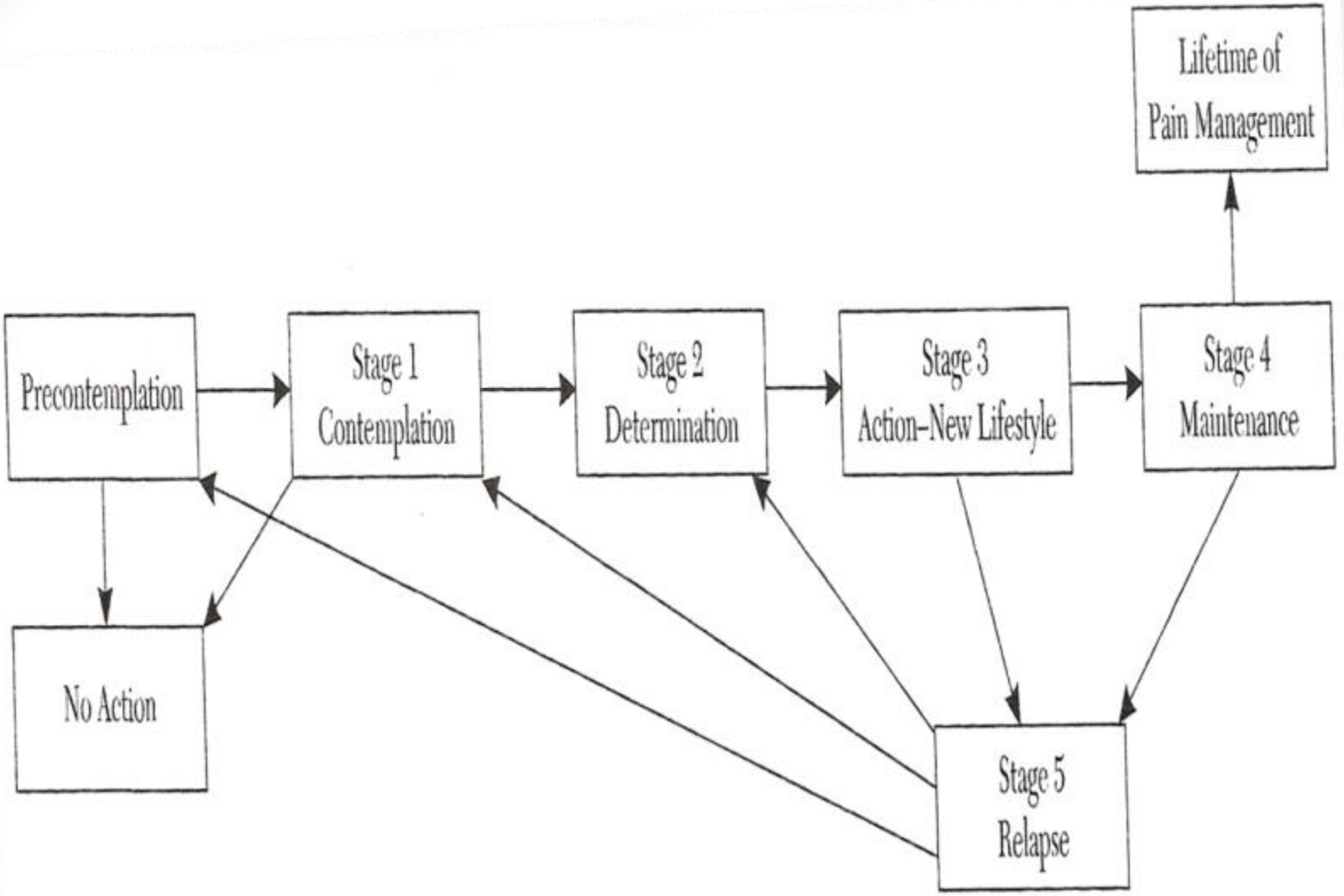
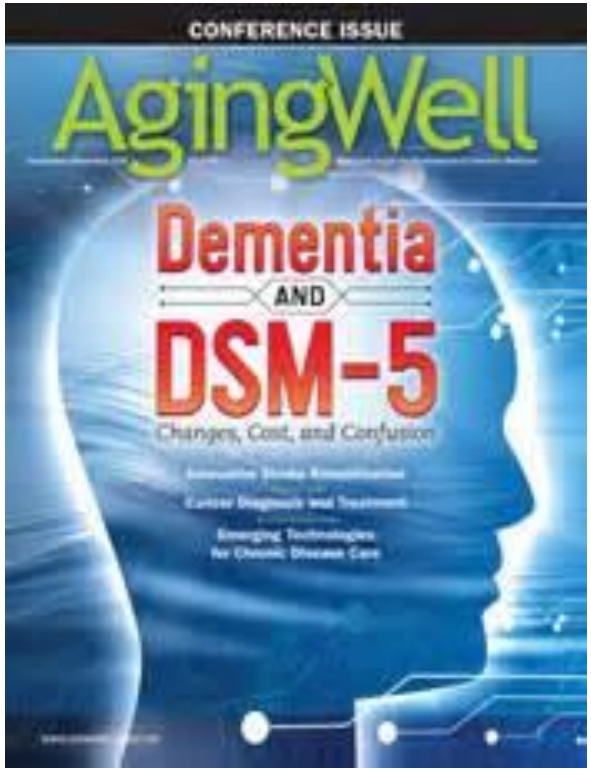


Figure 15-2. States of Health Behavior Changes (Transtheoretical Therapy Model)

Drogas mas destructivas:

- Marihuana 33%
- Cocaína 50%
- Éxtasis 79%
- Heroína 85%
- Candy Crush 1530%
- Facebook 96237%.!!!

Major and Mild Neurocognitive Disorder



Major and Mild Neurocognitive Disorder

Cognitive Domains (pg. 288)

- Complex attention
- Executive function
- Learning and memory
- Language
- Perceptual motor
- Social cognition

Delirium

Alzheimer's Disease

Frontotemporal

Vascular

TBI

HIV

Neurocognitive Disorder

Delirium

A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment)

The disturbance develops over a short period of time (usually hours lo a few days), represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day

An additional disturbance in cognition (e.g., memory deficit, language, visuospatial ability, or perception)

Substance Intoxication Delirium

Neurocognitive Disorder

Alzheimer's Disease

- The criteria are met for major or mild neurocognitive disorder
- There is insidious onset and gradual progression of impairment in one or more cognitive domains (for major neurocognitive disorder, at least two domains must be impaired)
  - Evidence of a causative Alzheimer's disease genetic mutation from family history or genetic testing
- All three of the following are present:
  - Evidence of decline in memory and learning and at least one other cognitive domain (based on detailed history or serial neuropsychological testing)
  - Steadily progressive, gradual decline in cognition, without extended plateaus
  - No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline)

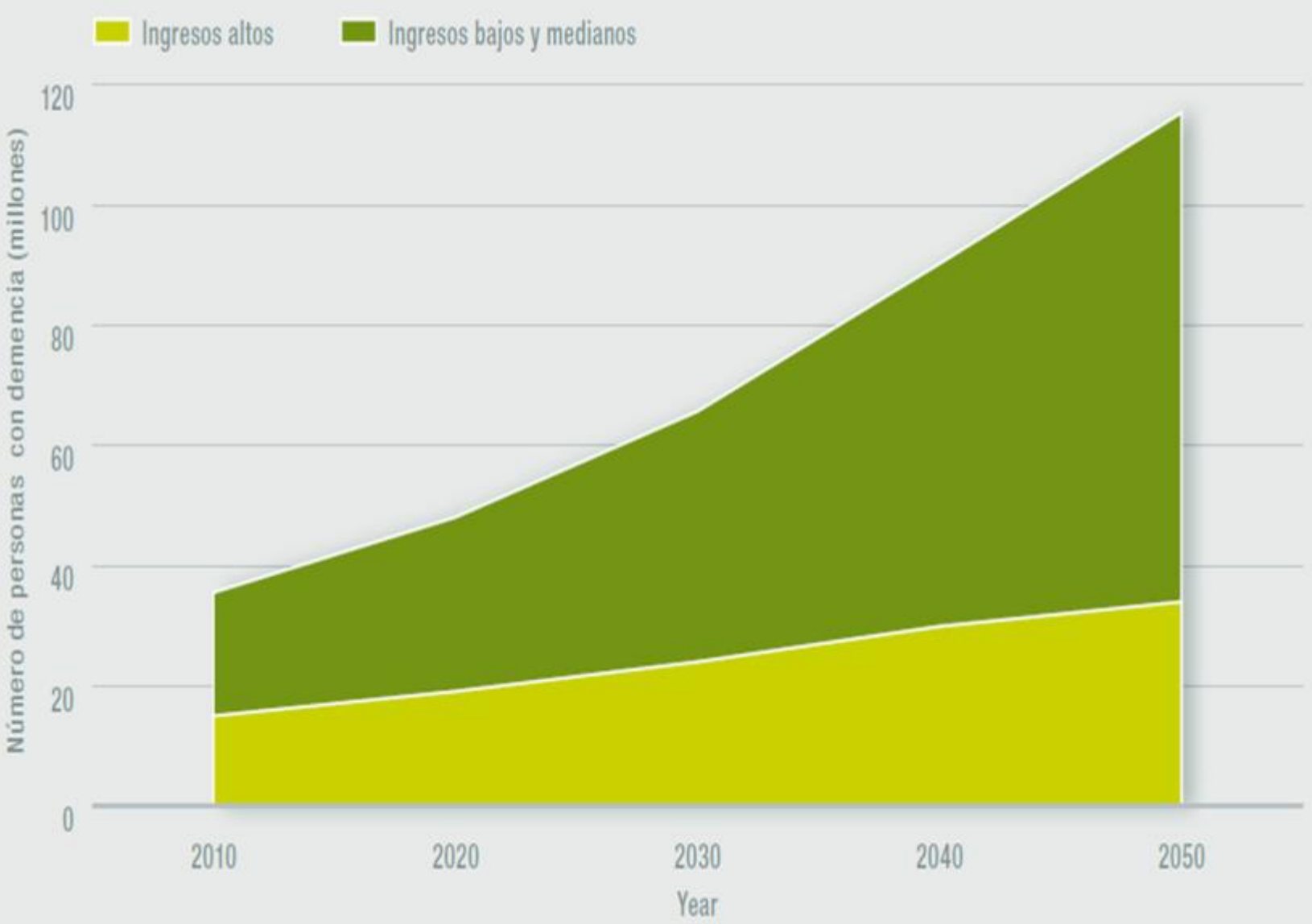


FIGURA 2.3 Crecimiento del número de personas con demencia en los países de ingresos altos e ingresos bajos y medianos.

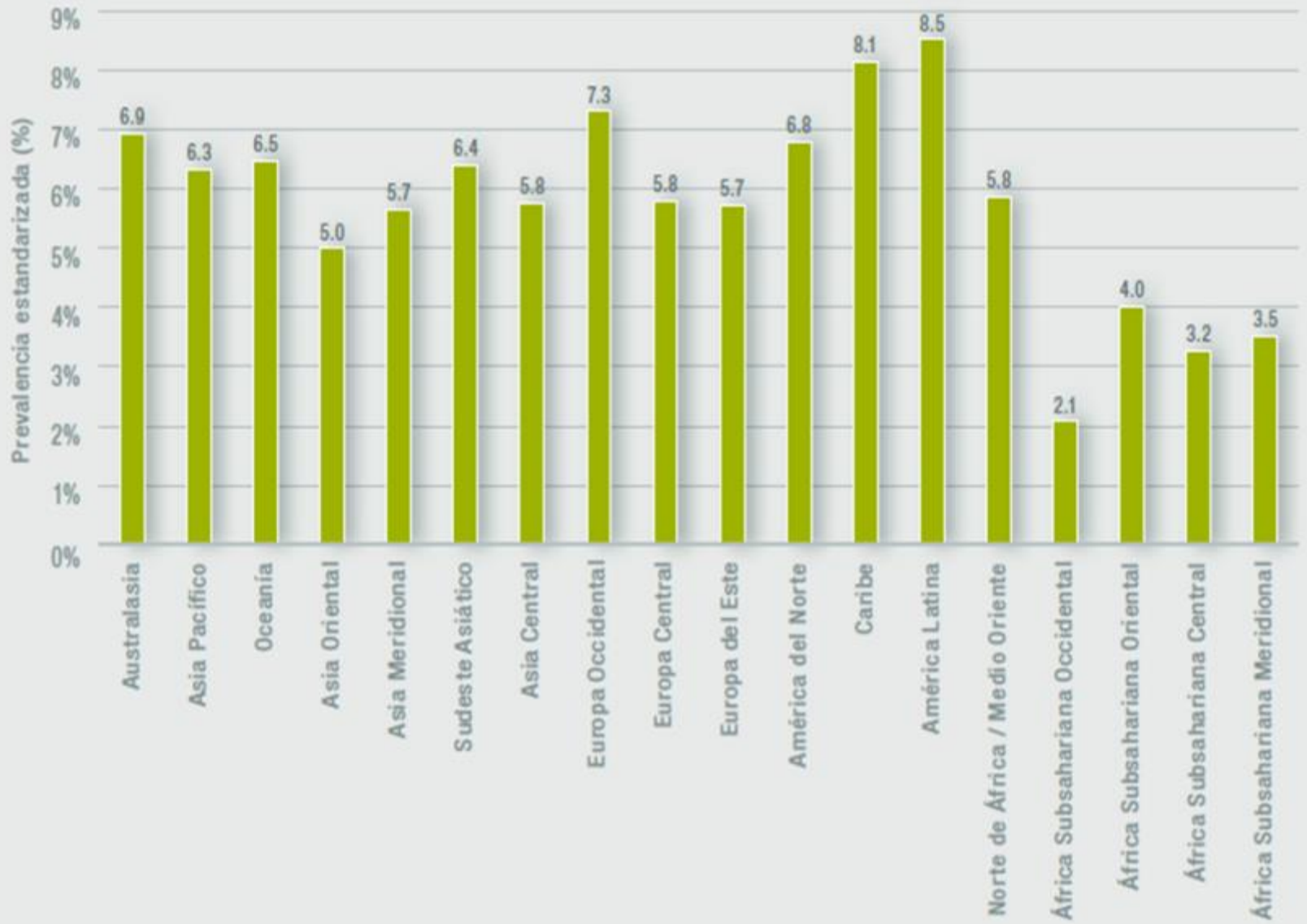


FIGURA 2.2 Prevalencia estimada de la demencia en personas de 60 años y más, estandarizada según la población de Europa Occidental, por región de la Carga Mundial de Morbilidad.

1996

1997

1998

1999

1. ESTOS SEIS AUTORRETRATOS del artista William Utermohlen, un ciudadano estadounidense que vive en Londres, son una demoledora crónica de su experiencia con la enfermedad de Alzheimer. Desde que se le diagnosticara la enfermedad cuando tenía sesenta años, sus poderosas, emocionalmente complejas representaciones de la enfermedad han cosechado un notable éxito. La primera de esta serie (*arriba a la izquierda*) se pintó en 1996, justo antes del diagnóstico. La mujer del artista, crítica de arte, ha especulado que la conciencia progresiva del deterioro cognitivo puede haber contribuido a que el artista se pintara detrás del cristal y de lo que parecen los barrotes de una celda. Las otras cinco pinturas, que Utermohlen creó a lo largo de los cuatro años siguientes, muestran una pérdida progresiva de la habilidad de representar relaciones espaciales complejas y proporcionan algunos indicios de sus crecientes dificultades perceptuales. Poco después de completar el último de los trabajos, el artista dejó de trabajar. La enfermedad de Alzheimer daña la capacidad de realizar tareas espaciales y secuenciales, como las necesarias para pintar o vestirse. El artículo describe las actuales perspectivas sobre los mecanismos moleculares de la enfermedad e indica algunos tratamientos novedosos, entre los que se encuentra una propuesta del propio autor.

2000


Todavìa me enamoro de ella cada dia.

Neurocognitive Disorder

Alzheimer's Disease

Deterioro de memoria, de aprender información nueva o de recordar información aprendida previamente

Afasia:

alteración del lenguaje

Apraxia:

incapacidad de llevar a cabo actividades motoras; la función está intacta

Agnosia:

fallo en reconocer e identificar objetos; función sensorial intacta

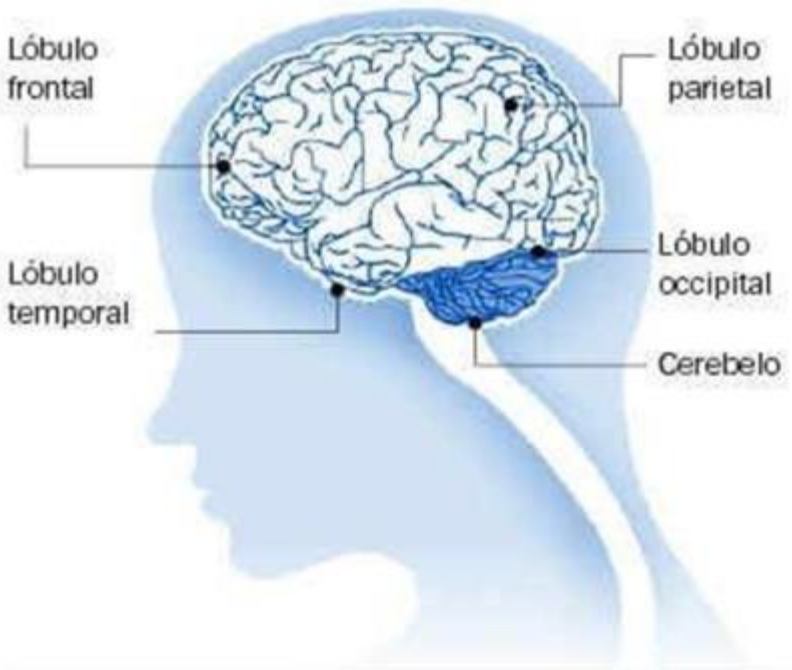
Alteración en ejecución:

planificación, organización, secuencia, abstracción

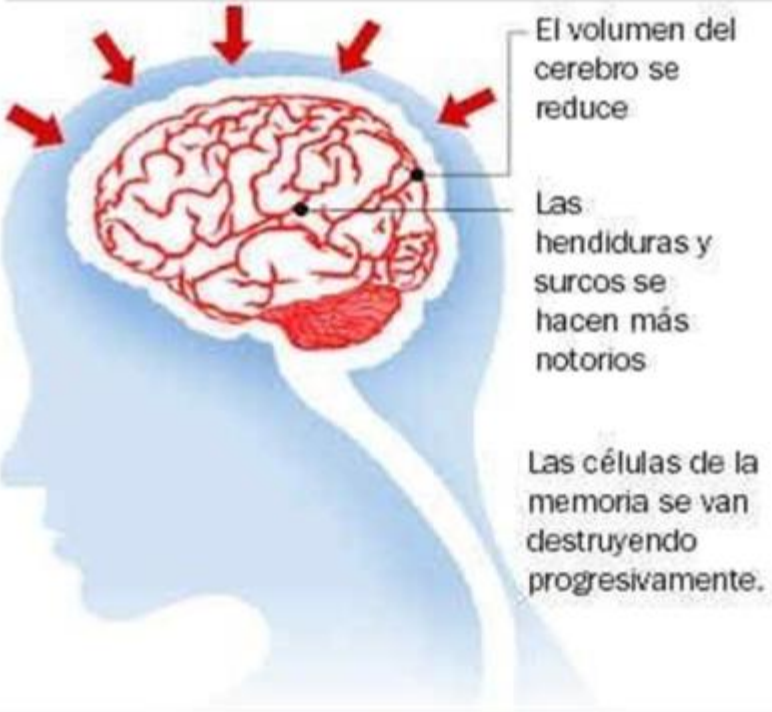
Cómo evoluciona la enfermedad

El Alzheimer provoca un gradual deterioro del sistema nervioso.

CEREBRO NORMAL



CEREBRO ENFERMO CON ALZHEIMER



PRIMERAS ETAPAS

- Pérdida de la memoria durante un corto plazo.
- Ligeros cambios de personalidad (apatía, poco interés en actividades de tipo social).
- Problemas para el pensamiento abstracto y el funcionamiento intelectual.
- Irritabilidad, carácter agresivo, dificultad para vestirse.

ETAPAS POSTERIORES

- Confusión, desorientación sobre el tiempo.
- Divagación, incapacidad para entablar una conversación.
- Erráticos cambios de humor.
- Pérdida del control de la vejiga y los intestinos.
- Incapacidad para cuidarse solo.
- Muerte, como resultado de un serio deterioro de la salud.

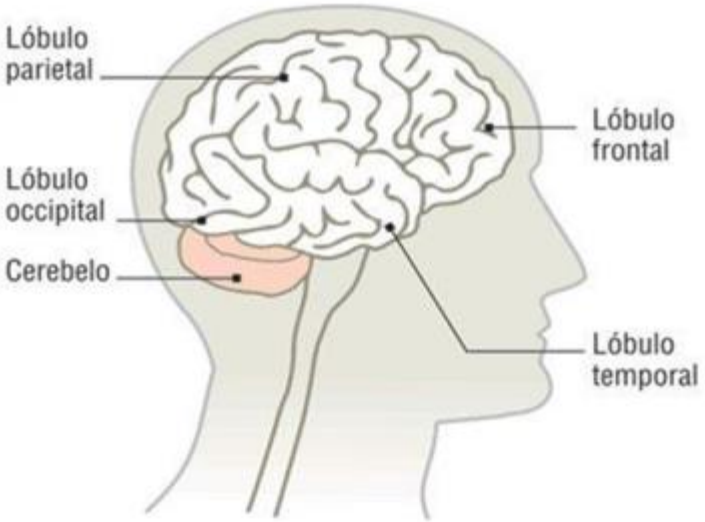
Otros datos de la enfermedad

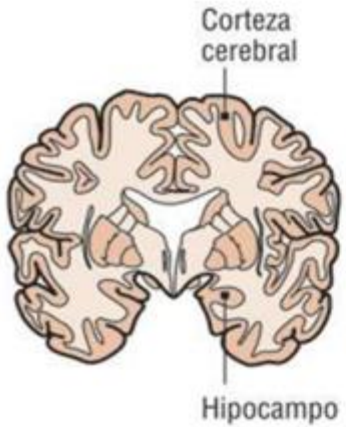
- 20% de los mayores de 70 años padecen la enfermedad.
- La enfermedad, rara vez aparece antes de los 40 años.

Fuente KRT

CLARIN

CEREBRO SANO

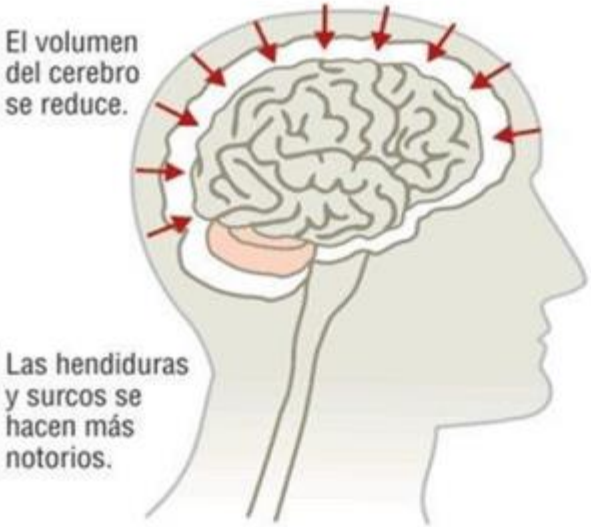




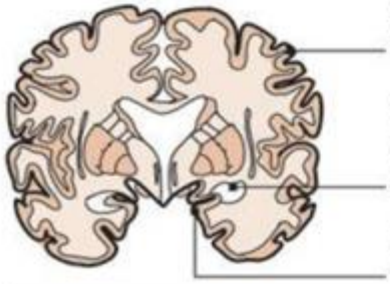
PRIMEROS SINTOMAS

- Pérdida de la memoria durante corto plazo.
- Dificultad para desempeñar tareas habituales.
- Problemas con el habla (como no encontrar palabras).
- Desorientación de tiempo y lugar.
- Incapacidad para juzgar situaciones cotidianas.
- Dificultad para realizar tareas mentales (sumar o restar).
- Colocación de objetos en lugares equivocados.
- Cambios repentinos en el humor.

CEREBRO CON MAL DE ALZHEIRMER

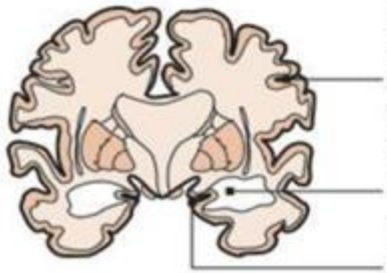


ENFERMEDAD MODERADA



- Breves pérdidas de memoria.
- Cambios de personalidad
- Menor capacidad intelectual
- Irritabilidad y dificultades motrices.

ENFERMEDAD AVANZADA



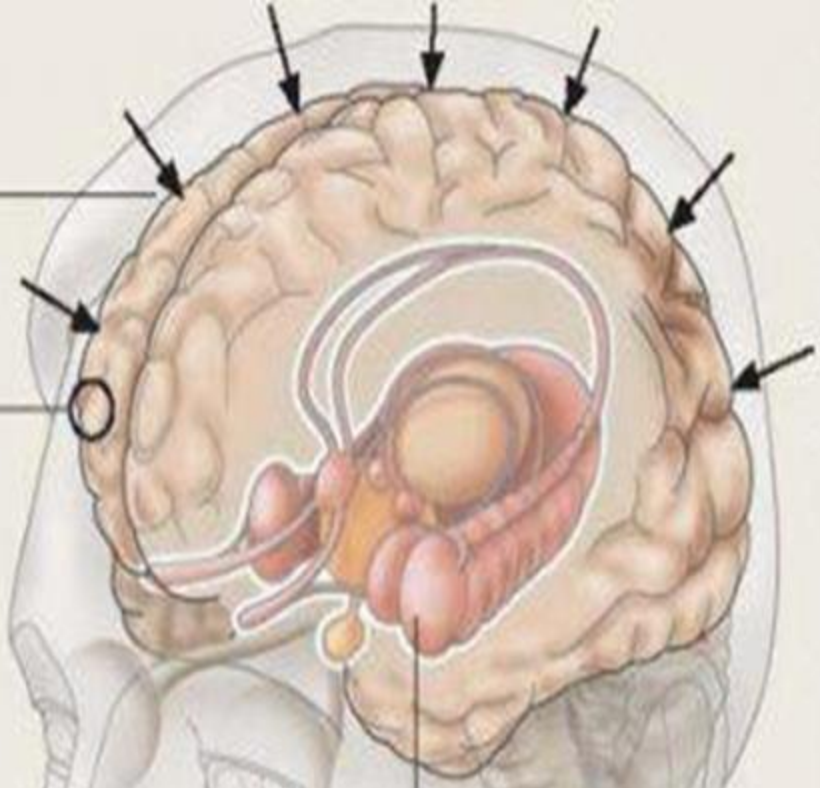
- Confusión, desorientación temporal.
- Divagación, dificultad para conversar.
- Incapacidad para cuidarse solo.

EL ALZHEIMER

El volumen del cerebro se reduce por la muerte de las células nerviosas.

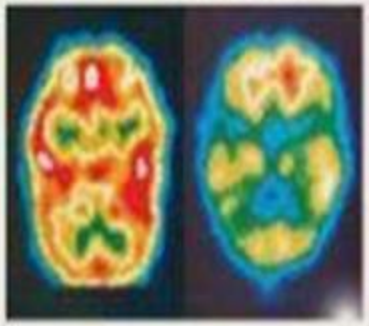
Las hendiduras y surcos se hacen más notorios.

Las células que subsisten pierden capacidad de reaccionar a los estímulos nerviosos.



CEREBRO NORMAL

CEREBRO CON ALZHEIMER



Fuente WWW.ALZ.ORG CLARIN

LOS SINTOMAS

Primeras etapas

- Breves pérdidas de la memoria.
- Cambios de personalidad (apatía, desinterés en la actividad social).
- Menor capacidad intelectual.
- Irritabilidad y dificultades motrices.

Etapas posteriores

- Confusión, desorientación temporal.
- Divagación, dificultad para conversar.
- Erráticos cambios de humor.
- Incapacidad para cuidarse solo.
- Serio deterioro de la salud y muerte.

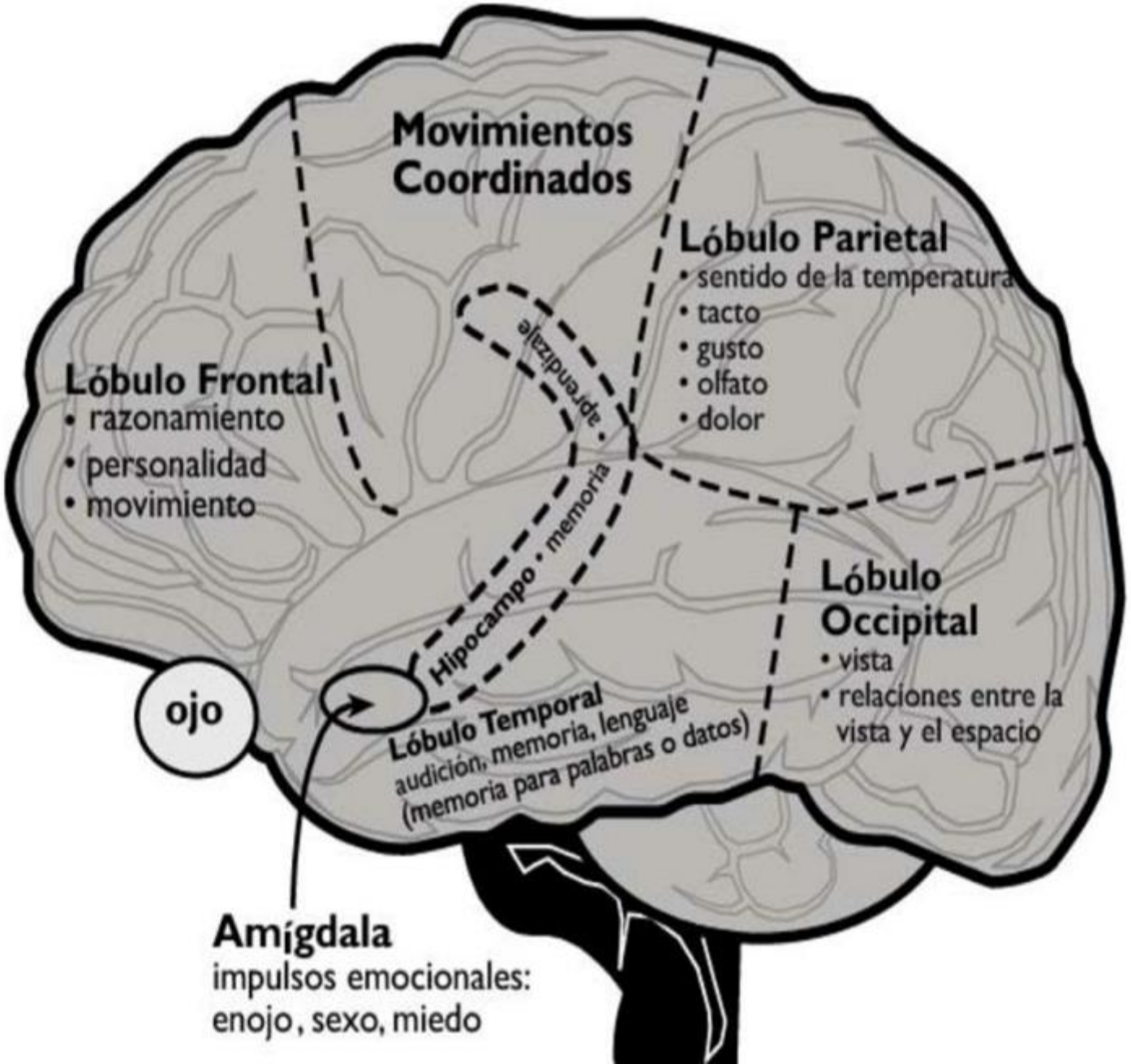
A QUIENES AFECTA

20%

De los mayores de 70 años

Rara vez aparece antes de los 40 años.

Lóbulos del cerebro afectados por la Enfermedad de Alzheimer



Alzheimer:

10 señales de advertencia

Por Santiago E. Medina Mangual, MD

Especial para Suplementos

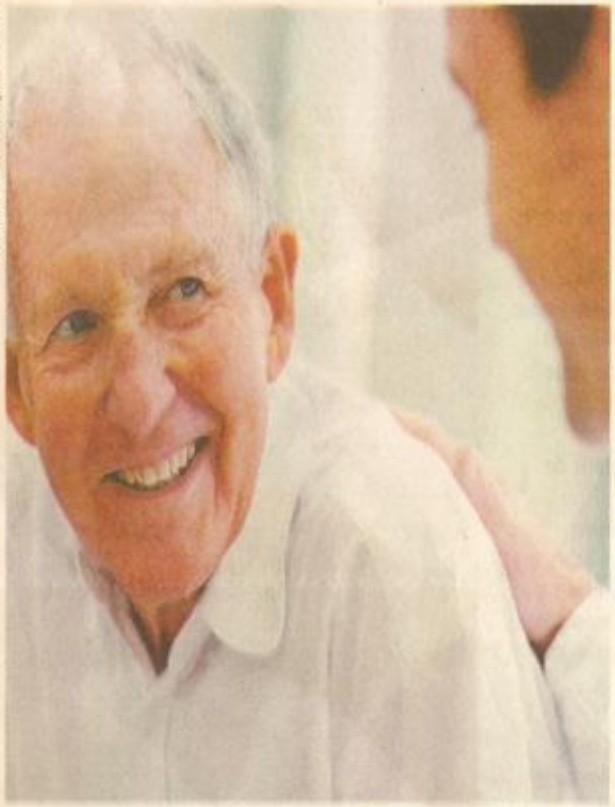


Foto: Archivo de Suplementos

Las personas con pérdida de memoria severa u otros síntomas de Alzheimer no se dan cuenta o no quieren aceptarlo. Muchas veces, es más obvio para los cuidadores, familiares y amigos.

La enfermedad de Alzheimer es la forma más común de demencia (pérdida de memoria y pérdida de habilidades intelectuales que afectan las actividades del diario vivir). Se estima que en Estados Unidos, 5.3 millones de personas tienen la enfermedad y, que para el año 2050, sean unos 11 a 16 millones. Según la Alzheimer's Association, el riesgo de desarrollar Alzheimer en los hispanos es 1.5 veces mayor que en los norteamericanos blancos.

No se sabe con certeza qué lo causa, pero se han podido identificar factores de riesgo que aumentan las posibilidades de desarrollar Alzheimer como son: edad mayor de 65 años, herencia, factores genéticos, diabetes mellitus tipo 2, alta presión, obesidad, colesterol alto, vida sedentaria y falta de actividad social.

La enfermedad va dañando y matando células del cerebro. Con el tiempo, el cerebro se encoge, afectando todas sus funciones. El paciente no podrá pensar, planificar, recordar bien, mantener conversaciones o tomar decisiones sabias sobre su cuidado. Los familiares, amigos y cuidadores tienen un rol importante en el diagnóstico temprano. La Alzheimer's Association creó una lista de señales de advertencia de la enfermedad:

1- **Cambios de memoria que dificultan la vida cotidiana.** Olvidar información recién aprendida, olvidar fechas, eventos importantes y repetir la misma pregunta.

2- **Dificultad para planificar o resolver problemas.** El paciente es incapaz de crear y seguir un plan, una receta, trabajar con números o cuadrar la chequera.

3- **Dificultad para desempeñar tareas habituales en la casa, el trabajo o en su tiempo libre.** A veces, el paciente podría tener dificultad para llegar a un lugar conocido o administrar un presupuesto en el trabajo.

4- **Desorientación de tiempo o lugar.** Los pacientes pueden perder la noción del tiempo, olvidar la fecha, estaciones del año, lugar donde están y cómo llegaron allí.

5- **Dificultad para entender imágenes visuales y relación en espacio.** Dificultad para leer, determinar colores, contrastes o distancias.

6- **Nuevos problemas con el uso de palabras en el habla o lo escrito.** Dificultad en seguir o participar en una conversación.

7- **Colocación de objetos fuera de lugar.** Con frecuencia al paciente se le pierden las cosas y es posible que acuse a los demás de robarles.

8- **Disminución o falta de buen juicio.** Pueden experimentar cambios en la toma de decisiones.

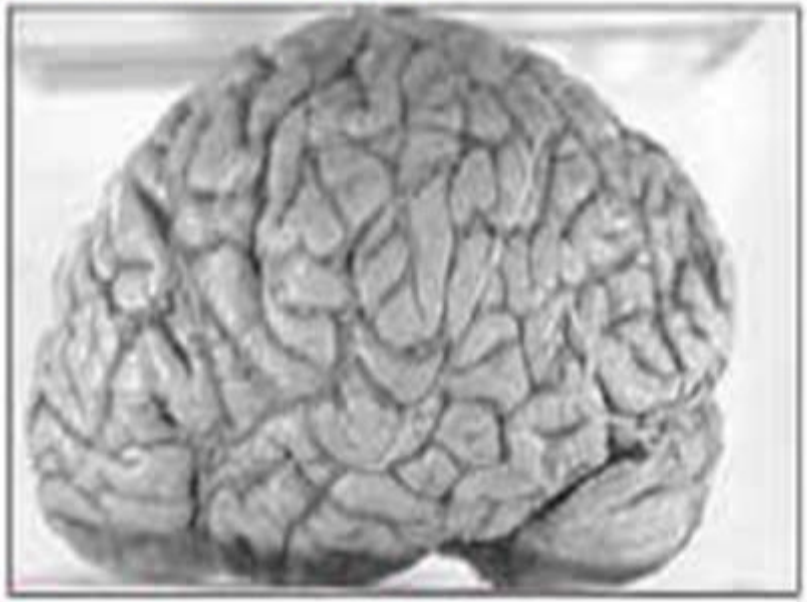
9- **Pérdida de iniciativa en el trabajo, pasatiempos y actividades sociales.** Pueden perder interés en nuevos proyectos de trabajo.

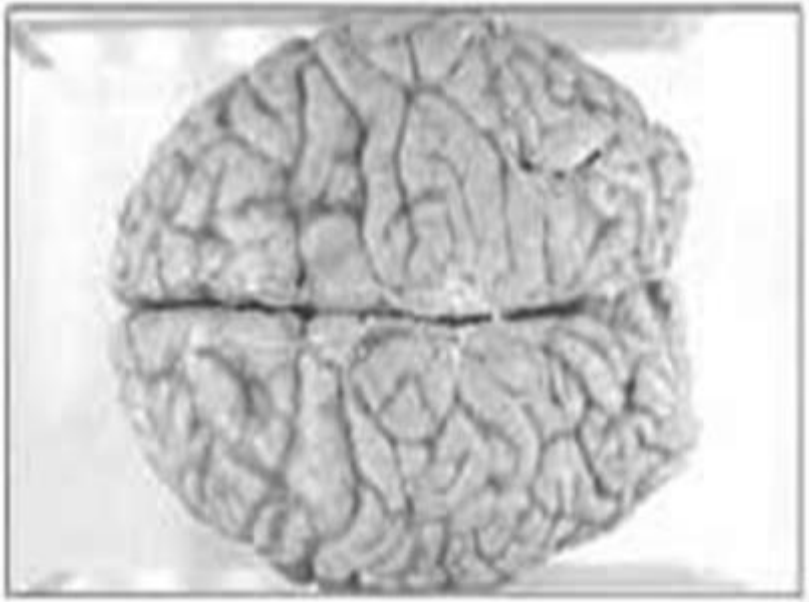
10- **Cambios en humor o personalidad.** Pueden presentar ansiedad, confusión, depresión, enojo y nuevos miedos.

Las personas con pérdida de memoria severa u otros síntomas de Alzheimer no se dan cuenta o no quieren aceptarlo. Es importante que si se nota alguna de las 10 señales de advertencia de la enfermedad, visite su médico de cabecera. El le hará preguntas y pruebas de imágenes (MRI y CT) para descartar otras condiciones y obtener un buen diagnóstico. Este referirá al paciente a especialistas en psicología, psiquiatría y neurología, estableciendo un equipo de cuidado multidisciplinario. El Alzheimer no tiene cura pero con un diagnóstico temprano y nuevos tratamientos farmacológicos disponibles se puede atrasar el progreso de la enfermedad y alargar la vida productiva del paciente.

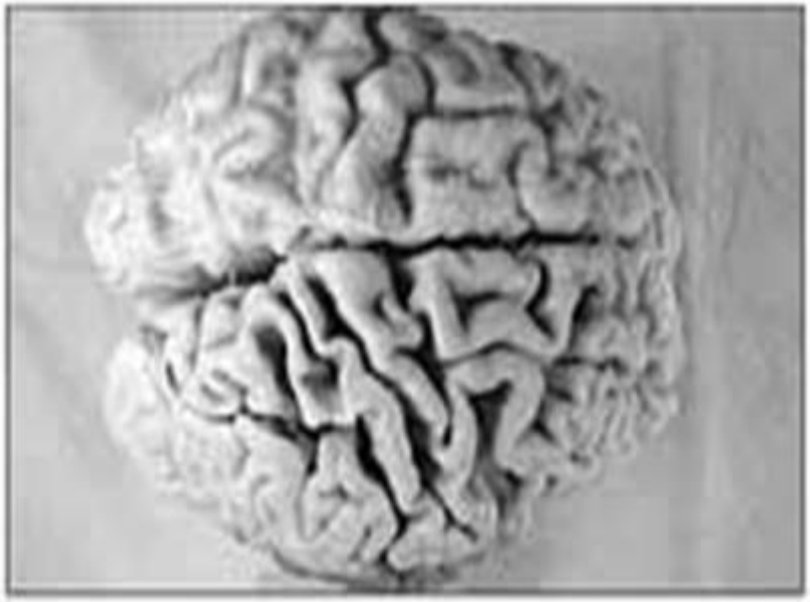
El autor es tesorero de la Academia de Medicina General de Puerto Rico. Para información, acceda a: www.alz.org o llame al 787-760-0770.

Cerebro normal

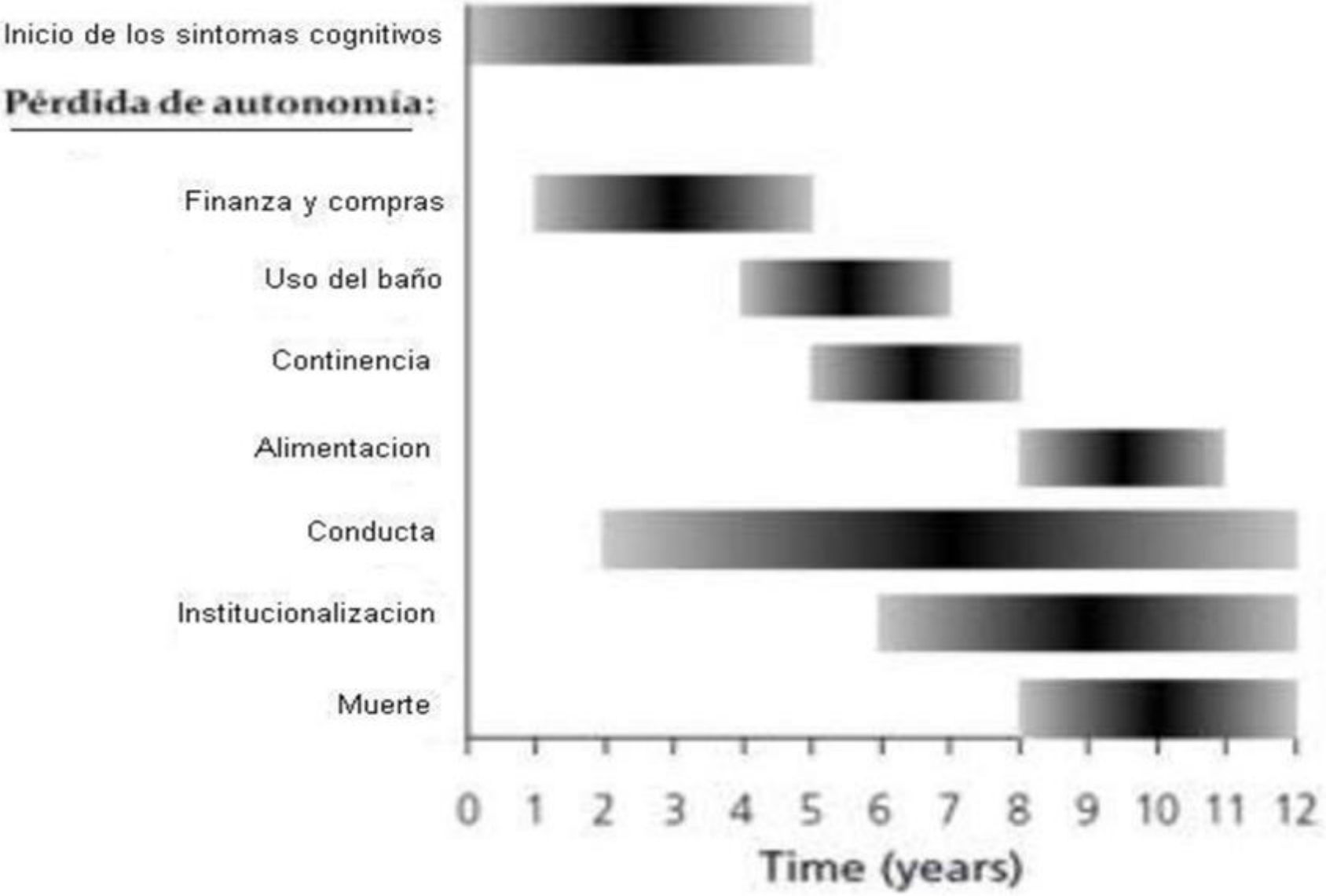




Cerebro con Alzheimer



Progresión de la Enfermedad de Alzhimer



Fuente: Sloane PD. Advances in the treatment of Alzheimer's disease. Am Fam Physician 1998; 58(7) 15771588

Personality Disorders

Personality Disorders

General Personality Disorder

Cluster A (raros, extravagantes y/o excéntricos)

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder

Cluster B (exagerados, emotivos, erráticos)

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder

Cluster C (ansiedad y miedo)

- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive Compulsive Disorder

Personality Disorders

Definición (comportamientos atípicos a la mayoría)

- grupo heterogéneo de alteraciones persistentes, inflexibles y maladaptativas que deterioran el funcionamiento social y ocupacional, sin perder el contacto con la realidad
- pueden ocasionar malestar emocional
- todo ser humano los posee en cierto grado
- representan tendencias o rasgos humanos estrictos o rígidos
- patrones persistentes e inflexibles
- provocan malestar social/laboral
- son estables y de larga duración
- no responden a situaciones o eventos (la persona siempre es así)
- no es el resultado de otro trastorno

Personality Disorders

- An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
  - Cognition
    (i.e., ways of perceiving and interpreting self, other people, and events)
  - Affectivity
    (i.e., the range, intensity, lability, and appropriateness of emotional response)
  - Interpersonal functioning
  - Impulse control
- The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

Personality Disorders

Paranoid Personality Disorder

A pervasive distrust or suspiciousness of others such as their motives are interpret as malevolent; four of the following:

- ✓ Suspects that others are exploiting, harming or deceiving him or her
- ✓ Unjustified doubts about loyalty or trust (e.g. friends, spouse)
- ✓ Reluctant to confide
- ✓ Reads hidden demeaning or threatening
- ✓ Bears grudges
- ✓ Perceives attacks to his reputation

Personality Disorders

Schizoid Personality Disorder

A pervasive pattern of detachment from social 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:

- Neither desires nor enjoys close relationships, including being part of a family
- Almost always chooses solitary activities
- Has little, if any, interest in having sexual experiences with another person
- Takes pleasure in few, if any, activities
- Lacks close friends or confidants other than first-degree relatives
- Appears indifferent to the praise or criticism of others
- Shows emotional coldness, detachment, or flattened affectivity

Personality Disorders

Schizotypal Personality Disorder

A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

Ideas of reference (excluding delusions of reference)
Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
Unusual perceptual experiences, including bodily illusions
Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
Suspiciousness or paranoid ideation

Personality Disorders

Antisocial Personality Disorder

- A pervasive pattern of disregard tor and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
  - Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest
  - Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  - Impulsivity or failure to plan ahead
  - Irritability and aggressiveness, as indicated by repeated physical fights or assaults
  - Reckless disregard for safety of self or others
  - Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
  - Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
- The individual is at least age 18 years

Personality Disorders

Borderline Personality Disorder

- A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts

- As indicated by five (or more) of the following:
  - Frantic efforts to avoid real or imagined abandonment
  - A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
  - Identity disturbance: markedly and persistently unstable self-image or sense of self
  - Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
  - Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

Personality Disorders

Borderline Personality Disorder

- 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).
- Chronic feelings of emptiness.
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- Transient, stress-related paranoid ideation or severe dissociative symptoms

10 Signs of Borderline Personality Disorder

http://www.rightdiagnosis.com/b/borderline_personality_disorder/stats-country.htm#extrapwarning

Country/Region	Extrapolated Prevalence	Population Estimated Used
Borderline Personality Disorder in North America (Extrapolated Statistics)		
USA	5,873,108	293,655,405[1]
Canada	650,157 WARNING! (Details)	32,507,874[2]
Mexico	2,099,191 WARNING! (Details)	104,959,594[2]
Borderline Personality Disorder in Central America (Extrapolated Statistics)		
Belize	5,458 WARNING! (Details)	272,945[2]
Guatemala	285,611 WARNING! (Details)	14,280,596[2]
Nicaragua	107,195 WARNING! (Details)	5,359,759[2]
Borderline Personality Disorder in Caribbean (Extrapolated Statistics)		
Puerto Rico	77,959 WARNING! (Details)	3,897,960[2]
Borderline Personality Disorder in South America (Extrapolated Statistics)		
Brazil	3,682,022 WARNING! (Details)	184,101,109[2]
Chile	316,479 WARNING! (Details)	15,823,957[2]
Colombia	846,215 WARNING! (Details)	42,310,775[2]
Paraguay	123,827 WARNING! (Details)	6,191,368[2]
Peru	550,886 WARNING! (Details)	27,544,305[2]
Venezuela	500,347 WARNING! (Details)	25,017,387[2]

Normal thinking

Borderline thinking

Borderline Personality Disorder is characterized by polarized thinking...all or nothing, good or bad etc.

Antisocial Personality Disorder (APD)	• Those with BPD may perform antisocial acts, but are more likely to feel personal shame or remorse than those with APD. • People with APD usually regret their actions only because of the consequences to themselves, not others. • Antisocial acts committed by people with BPD are usually viewed as survival issues, and the individual experiences uncomfortable anxiety as a result. Those with APD usually feel no anxiety about their antisocial behavior.
Histrionic Personality Disorder (HPD)	• Those with HPD have a higher overall functional level, display greater employment and relationship stability, and maintain a more stable self- image than those with BPD. • Those with HPD do not commit the repeated self-destructive acts characteristic of those with BPD.[6]
Narcissistic Personality Disorder (NPD)	• Those with BPD openly express their need for support in interpersonal relationships while narcissistics are more subtle. • Those with NPD typically deny their many dependency needs. They are better able to have consistent and sustained relationships. People with BPD have more extreme affective displays and less stable relationships. • NPD clients demonstrate grandiosity in contrast to the devalued sense of self that is evident in people with BPD.[2]
Schizotypal Personality Disorder (SPD)	• The flat affect that often accompanies BPD with depression is usually temporary or state-like (it lifts as the depression lifts). Flat affect is stable or trait-like for those with SPD. • Clinicians view the psychotic symptoms present in those with SPD to be more trait-like while those with BPD demonstrate similar symptoms that are more transient, stress-related, or state-like.[35] • Those with BPD have significantly higher rates of depression as well as drug and alcohol abuse compared to those with SPD.[35]
Affective Disturbance (Depression, Dysthymia, Bipolar Disorder)	• Some researchers argue that BPD is a part of the affective disturbance spectrum. Others highlight the overlap between BPD and affective disturbance.[6] • People who have affective instability, but who function well with minimal support and intervention, likely suffer from an affective disorder and would not meet the BPD criteria.

Borderline Personality Disorder

1 in 10 commit suicide

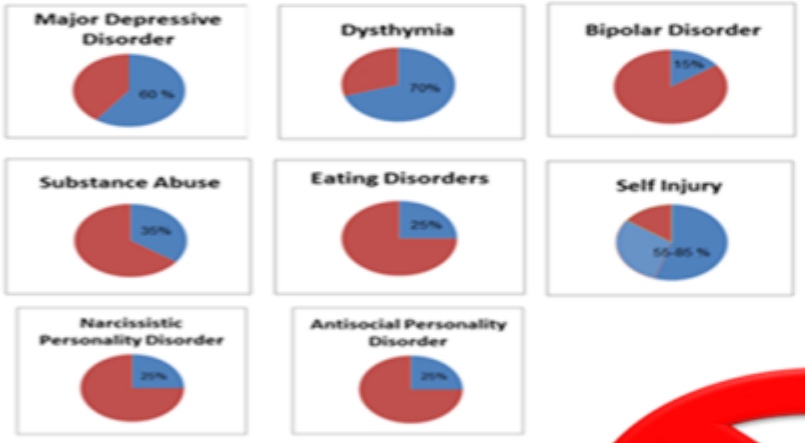
BPD is characterized by IMPULSIVITY and INSTABILITY in mood, self-image, and personal relationships.

People with BPD may self-harm to help regulate their emotions, to punish themselves, or to express their pain. They do not always see these behaviors as harmful.

PREVALENCE

2% to 6%

Common Co-occurring Disorders



Risk factors:

- **Hereditary predisposition.** You may be at a higher risk if a close family member — your mother, father, brother or sister — has the same or a similar disorder, particularly a mood or anxiety disorder.
- **Childhood abuse.** Many people with the disorder report being sexually or physically abused during childhood.
- **Neglect.** Some people with the disorder describe severe deprivation, neglect and abandonment during childhood.

Not all people who self injure have Borderline Personality Disorder. And not all those with Borderline Personality Disorder self injure.

Self-injurious behavior includes suicide and suicide attempts, as well as self-harming behaviors.

Like most personality disorders, borderline personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml
http://www.mayoclinic.org/diseases-conditions/borderline-personality-disorder/basics/risk-factors/con-20023204
http://www.nami.org/
http://psychcentral.com/lib/symptoms-of-borderline-personality-disorder/0001063
http://www.bpdresourcecenter.org/factsStatistics.html
http://www.bpdresourcecenter.org/co-occuringDisorders.html

Personality Disorders

Histrionic Personality Disorder

A pervasive 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:

- Is uncomfortable in situations in which he or she is not the center of attention
- Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
- Displays rapidly shifting and shallow expression of emotions
- Consistently uses physical appearance to draw attention to self
- Has a style of speech that is excessively impressionistic and lacking in detail
- Shows self-dramatization, theatricality, and exaggerated expression of emotion
- Is suggestible (i.e., easily influenced by others or circumstances)
- Considers relationships to be more intimate than they actually are

Personality Disorders

Narcissistic Personality Disorder

A pervasive 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:

Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
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)
Requires excessive admiration
Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations)
Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends)
Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
Is often envious of others or believes that others are envious of him or her
Shows arrogant, haughty behaviors or attitudes

Personality Disorders

Avoidant Personality Disorder

A pervasive 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:

- Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection
- Is unwilling to get involved with people unless certain of being liked
- Shows restraint within intimate relationships because of the fear of being shamed or ridiculed
- Is preoccupied with being criticized or rejected in social situations
- Is inhibited in new interpersonal situations because of feelings of inadequacy
- Views self as socially inept, personally unappealing, or inferior to others
- Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Personality Disorders

Dependent Personality Disorder

A pervasive and 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:

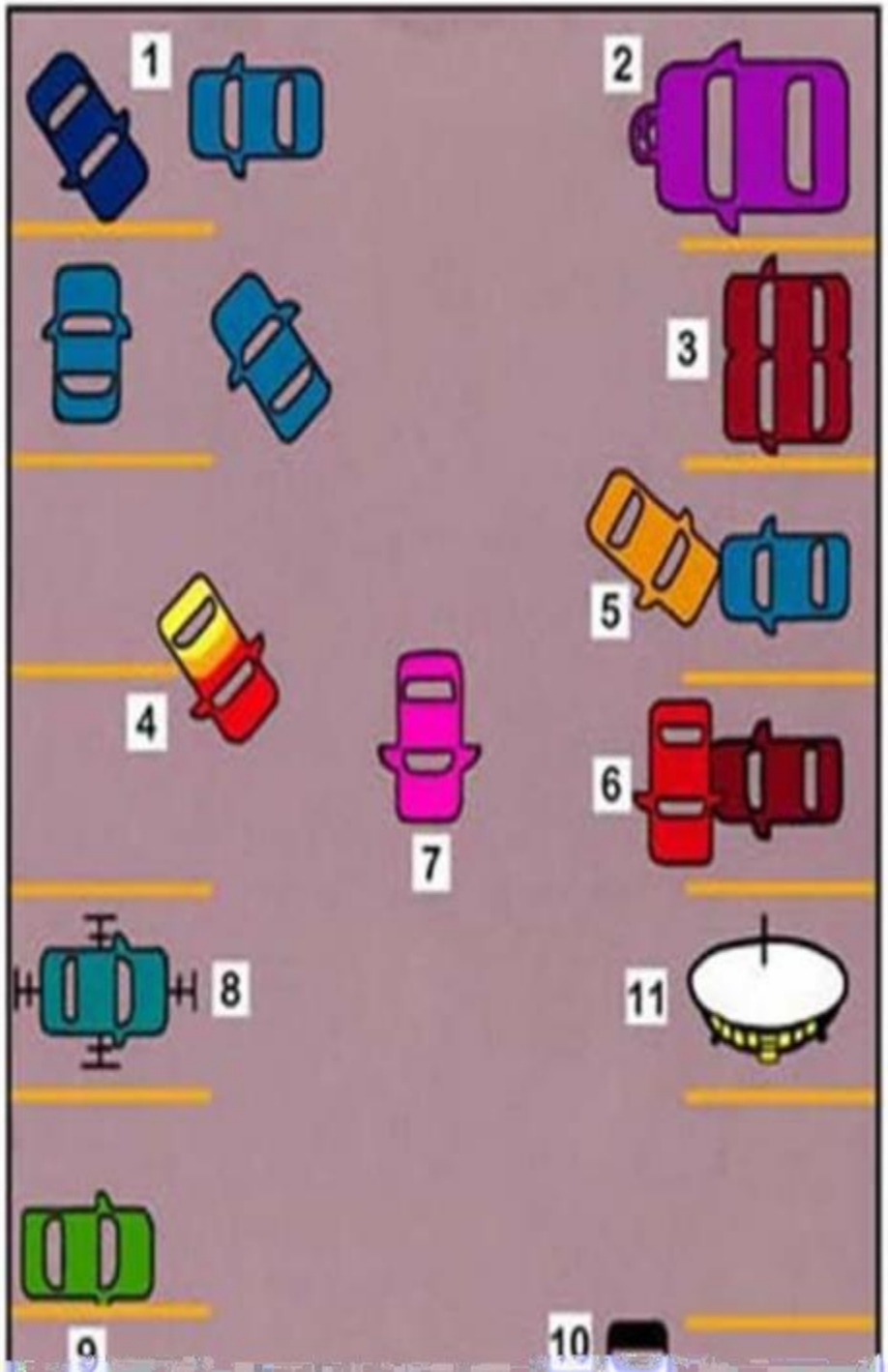
- Difficulty making everyday decisions without an excessive amount of advice and reassurance from others
- Needs others to assume responsibility for most major areas of his or her lite
- Has difficulty expressing disagreement with others because of fear of loss of support or approval
- Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
- Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
- Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
- Urgently seeks another relationship as a source of care and support when a close relationship ends
- Is unrealistically preoccupied with fears of being left to take care of himself or herself

Personality Disorders

Obsessive Compulsive Disorder

A pervasive 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:

- Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
- Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
- Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
- Is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values
- Is unable to discard worn-out or worthless objects even when they have no sentimental value
- Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
- Adopts a miserly spending style toward both self and others; money is viewed as something to be hoard for future catastrophes

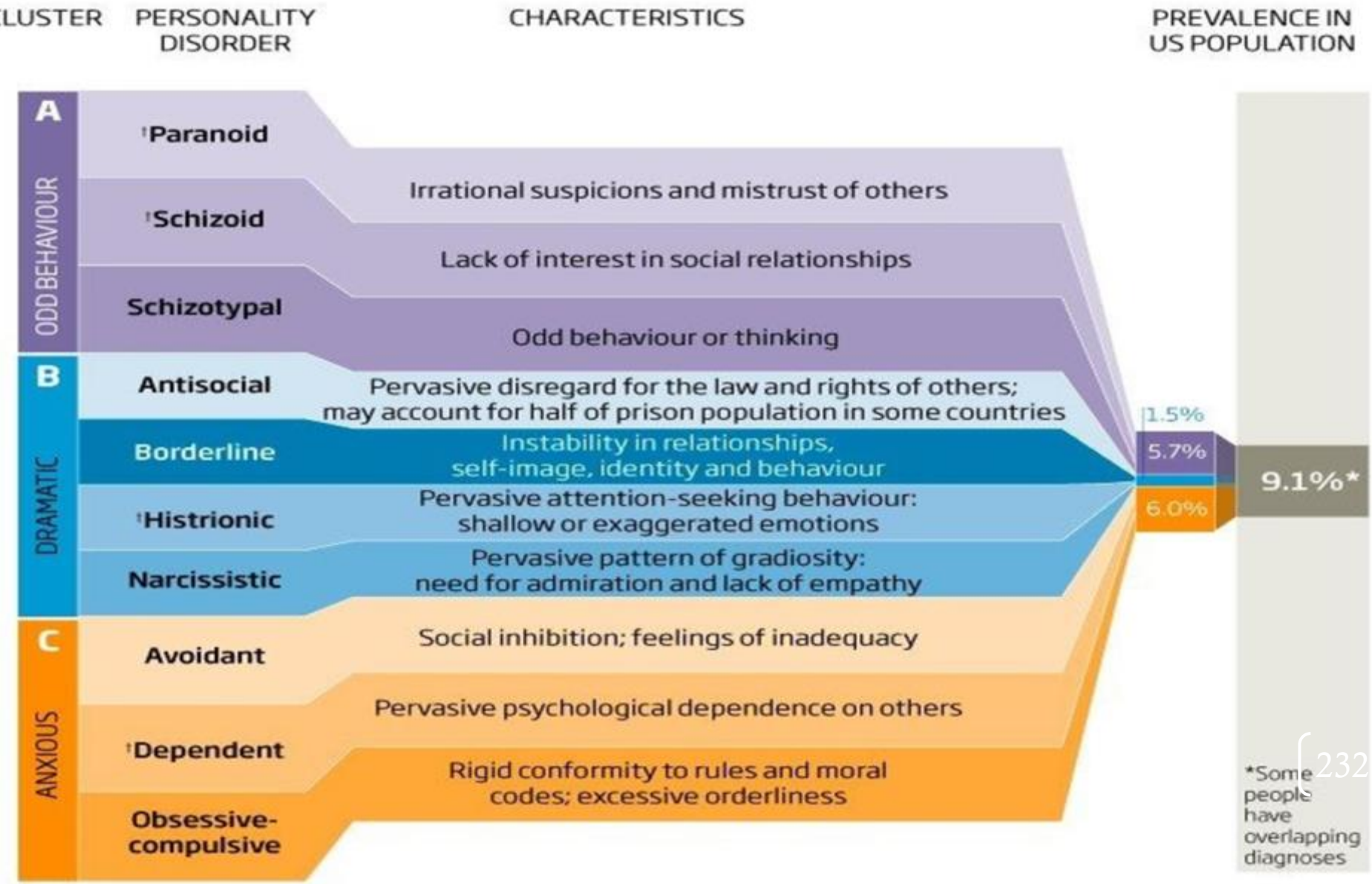


Párking de los trastornos de la personalidad

1) PARANOIDE: ¡Estoy arrinconado de nuevo!
2) NARCISISTA: ¿Os gusta mi nuevo coche?, es más grande y potente.
3) DEPENDIENTE: Necesita otros coches cerca.
4) PASIVO AGRESIVO: Tuerce el coche para ocupar dos plazas...
5) LÍMITE: De morros contra el coche del ex amante.
6) ANTISOCIAL: Bloquea al resto de coches.
7) HISTRIÓNICO: ¿Nadie a visto mi coche? Es terrible dónde he tenido que aparcar.
8) OBSESIVO: Perfectamente alineado con la plaza.
9) EVITATIVO: Se oculta en la esquina.
10) ESQUIZOIDE: No puede tolerar otros coches cerca.
11) ESQUIZOTÍPICO: Plaza intergaláctica, he venido con Dark Vader.

Spectrum of personality disorders

There are currently 10 personality disorders but psychiatrists think this diagnostic framework is in need of an overhaul



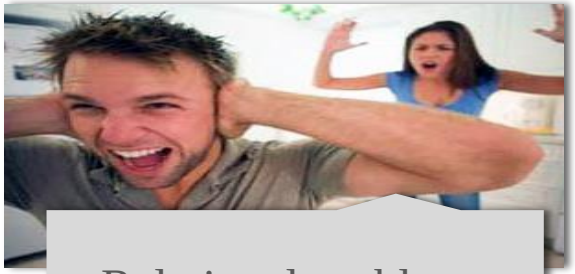
†Terms proposed for removal in next edition of the *Diagnostic and Statistical Manual of Mental Disorders*

Personality Disorders- lo nuevo…

- 5 dominios
  - Afectividad negativa
  - Desapego
  - Antagonismo
  - Deshinbición/compulsividad
  - Psicoticismo

Other Conditions Focus of Clinical Attention

(page 355)



Relational problems

Abuse and neglect

Educational and occupational problems

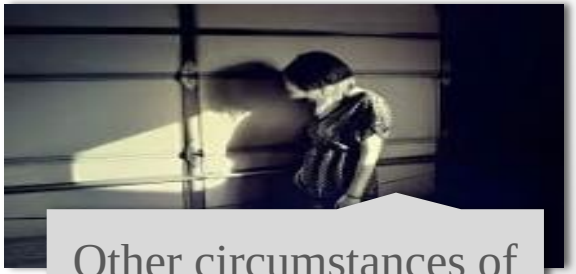
Housing and economic problems

Other problems related to the social environment

Problems related to crime or interaction with legal system

Other health service encounters for Counseling and Medical Advise

Problems related to other psychosocial, personal, and environmental circumstances



Other circumstances of personal history

Other interesting but not on DSM 5…

- Síndrome de psicosis atenuada
- Trastorno neuroconductual asociado a exposición prenatal de alcohol
- Trastorno de conducta suicida
- Esquizotaxia
- Síndrome de Procesamiento Sensorial

Conceptulización de casos DSM 5

- ¿Qué cuadro de síntomas están presentes para establecer un criterio diagnóstico?
- ¿Existe algún cuadro de síntomas diagnóstico desorden de personalidad?
- ¿Hay alguna condición de salud que afecte o sea afectada por los diagnósticos establecidos?
- Mencione otras condiciones de atención clínico presentes que estén relacionadas al(os) diagnóstico(s) establecido(s).

Estudio de caso #1

Federico, joven de 29 años, "bartender" de una concurrida discoteca del área metropolitana. Fue recomendado a participar de un programa de terapia donde se ofrecen los servicios de terapia ocupacional. Del Hx se desprende que Federico lleva alrededor de un año y medio con una conducta inapropiada.

Sebastián, compañero de trabajo, reporta que Federico lleva bastante tiempo tomando más alcohol del que sirve. Indica que Federico comenzó tomando casualmente mientras trabajaba, pero al pasar el tiempo tomaba tanto que no podía trabajar.

Al entrevistar a Federico éste reporta que al principio todo era por diversión y que no tomaba en horas de trabajo. Indica que su ingesta de alcohol fue aumentando gradualmente y que si no tomaba mientras trabajaba sentía que no podía trabajar. Ha intentado dejar de beber en varias ocasiones. "Es como un impulso que si no lo hago no me deja en paz".

Federico reporta que su pareja lo abandonó hace un mes reprochándole que él ya no es el mismo. Recientemente Federico ha dejado de jugar baloncesto, siempre está tomado y se la pasa hablando incoherencias y con un patrón de caminar errático.

Preguntas para establecer un diagnóstico de salud mental

1. ¿Qué cuadro de síntomas están presentes para establecer un criterio diagnóstico?
2. ¿Existe algún cuadro de síntomas diagnóstico desorden de personalidad?
3. ¿Hay alguna condición de salud que afecte o sea afectada por los diagnósticos establecidos?
4. Mencione otras condiciones de atención clínico presentes que estén relacionadas al(os) diagnóstico(s) establecido(s).

Diagnóstico: Caso #1

Federico presenta un diagnóstico de Trastorno de Uso de Sustancias: Alcohol, con episodios de intoxicación.

No hay historial o presencia de alguna condición de salud física que exacerbe los síntomas relacionados al uso de alcohol.

Problemas de atención clínica que afectan su situación actual se encuentran: problemas relativos a grupo apoyo primario donde existe una ruptura reciente relación sentimental, y problemas ocupacionales relacionados a uso de alcohol en horas laborales.

Estudio de caso #2

Vanessa es una joven estudiante de 23 años. Es admitida a una clínica de salud mental para recibir Tx. Al entrevistarla observamos que está orientada en tiempo, lugar y persona, y no presenta ideativa suicida. Es una joven saludable; reporta ser asmática, aunque no ha tenido ningún episodio en los últimos seis meses.

Vanessa narra haber sufrido un accidente de auto con su novio hace mes y medio. En el accidente, el novio de Vanessa muere en el acto. Desde entonces Vanessa no puede dormir en las noches. Si intenta dormir durante el día, cada vez que cierra los ojos ve el accidente y se desespera. Refiere "ya no puedo montarme en un carro, las manos me empiezan a sudar y el corazón se me quiere salir del pecho… es como si viviera el accidente cada día".

Por el lado positivo, Vanessa cuenta con el apoyo de su madre quién desde hace una semana la lleva a la universidad y la acompaña en las gestiones que realiza.

Preguntas para establecer un diagnóstico de salud mental

1. ¿Qué cuadro de síntomas están presentes para establecer un criterio diagnóstico?
2. ¿Existe algún cuadro de síntomas diagnóstico desorden de personalidad?
3. ¿Hay alguna condición de salud que afecte o sea afectada por los diagnósticos establecidos?
4. Mencione otras condiciones de atención clínico presentes que estén relacionadas al(os) diagnóstico(s) establecido(s).

Diagnóstico: Caso #2

Vanessa presenta un diagnóstico de Trastorno de Estrés Postraumático.

No hay historial o presencia de alguna condición de salud física que exacerbe los síntomas relacionados a su diagnóstico principal.

Entre los problemas de atención clínica que afectan su situación actual se encuentra la muerte reciente de un ser querido.

Estudio de caso #3

Andy es un hombre soltero de 31 años de edad, vive con su madre y hermano. Trabaja clasificando correspondencia en una oficina de correo, tras abandonar la universidad abruptamente hace 1 año atrás. Menciona que solicitó este tipo de trabajo ya que el contacto con la gente es mínimo. Dice que le daban "ataques de nervios"; se volvió hipersensible cuando hablaba con extraños e incluso sus amigos. Dejó la universidad porque oía zumbidos en su cabeza, tenía sofocones, sudaba continuamente y, en ocasiones, sentía que estaba como fuera de su cuerpo. "Creo que me da miedo decir o hacer algo estúpido", por lo que no aceptaba invitaciones a actividades, como jugar bolos, bailes e ir al cine. Verbaliza que lo ponen nervioso los baños públicos y que tiende a no usarlos. Aunque tiene dos amigos íntimos, indica que no ha salido con chicas desde que abandonó la universidad. Como producto de síntomas de ansiedad su condición de úlcera péptica de ha agudizado recientemente.

Preguntas para establecer un diagnóstico de salud mental

1. ¿Qué cuadro de síntomas están presentes para establecer un criterio diagnóstico?
2. ¿Existe algún cuadro de síntomas diagnóstico desorden de personalidad?
3. ¿Hay alguna condición de salud que afecte o sea afectada por los diagnósticos establecidos?
4. Mencione otras condiciones de atención clínico presentes que estén relacionadas al(os) diagnóstico(s) establecido(s).

Diagnóstico: Caso #3

Andy presenta un diagnóstico de Fobia Social.

Episodios de Úlcera péptica se agudiza con ansiedad.

Posee diagnóstico de Desorden de Personalidad tipo evitación.

Entre los problemas de atención clínica que afectan su situación actual se encuentra el abandono de sus estudios universitarios.

Estudio de caso #4

Sofía presenta persistente infelicidad y angustia continua desde que era adolescente. Actualmente tiene 32 años de edad, vive sola y trabaja como asistente de investigación. No ha logrado mantenerse en un mismo empleo por más de año y medio de duración. Lleva 3 años de completar estudios como doctora en sociología, pero no ha comenzado su tesis.

Su aspecto es triste y apático, y señala que en su niñez y adolescencia fue maltratada emocionalmente por su padre. Actualmente tiene muchos cambios en su peso corporal; su sueño no es conciliador, por lo que se siente pesada, cansada y soñolienta. Señala que hace unos meses rompió una relación sentimental con un hombre, el cual luego de cinco años no demostró un compromiso formal. Actualmente toma el medicamento Synthroid para la condición de hipotiroidismo.

Preguntas para establecer un diagnóstico de salud mental

1. ¿Qué cuadro de síntomas están presentes para establecer un criterio diagnóstico?
2. ¿Existe algún cuadro de síntomas diagnóstico desorden de personalidad?
3. ¿Hay alguna condición de salud que afecte o sea afectada por los diagnósticos establecidos?
4. Mencione otras condiciones de atención clínico presentes que estén relacionadas al(os) diagnóstico(s) establecido(s).

Diagnóstico: Caso #4

Sofía presenta un diagnóstico de Distimia.

La condición de hipotiroidismo podría exacerbar los síntomas relacionados a su diagnóstico principal.

Entre los problemas de atención clínica que afectan su situación actual se encuentra el abandono de sus estudios universitarios y dificultad para mantener su empleo.

Enfoque Canadiense de Diagnóstico Ocupacional

Factores de riesgo ocupacional:

- Desbalance ocupacional- (roles)
- Deprivación ocupacional- (no acceso)
- Enajenación ocupacional- (aislamiento)
- Interrupción ocupacional- (enfermedad temporal)
- Retraso ocupacional- (desarrollo/ consec. prmte.)
- Disparidad ocupacional- (no equivalencia exper.)
- Estrés ocupacional- (todo lo anterior)

DUDAS…

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