Changes to Disruptive, Impulse Control and Conduct Disorders

- Oppositional Defiant Disorder (ODD) 313.81 F91.3
- Intermittent Explosive Disorder 312.14 F63.81
- Conduct Disorder
  - Childhood-onset type 312.81 F91.1
  - Adolescent-onset type 312.32 F91.2
  - Unspecified 312.89 F91.9
- Pyromania 312.31 F63.1
- Kleptomania 312.32 F63.3
- Antisocial Personality Disorder (dual listing – also in Personality Disorders chapter) 301.7 F60.2
- Other Specified DIC 312.89 F91.8
- Unspecified DIC 312.9 F91.9

Changes to Disruptive, Impulse Control and Conduct Disorders

- New Chapter in DSM 5 – brings together some of the Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence and Impulse Control Disorders
- Externalizing: all include problems in the self-regulation of emotional and behavioral control
- Anti-social Personality Disorder included here and in personality disorders (discussed here)
- ODD: 4 changes
  - Removed exclusionary criteria from DSM IV that said that Oppositional Defiant Disorder could only be diagnosed if criteria for Conduct Disorder not met.
  - Graduation from ODD to Conduct Disorder also eliminated
Changes to Disruptive, Impulse Control and Conduct Disorders

- ODD: 4 changes
  - Symptoms grouped into 3 types: at least 4 required with an individual who is not a sibling
  - Argumentative/defiant behavior
  - Vindictiveness
  - Frequency and intensity: occurring on most days for 6 months or less for children under 5 yrs; once/week for children >5 years.
    - Vindictiveness has its own criteria: "at least twice in past 6 months"
    - States also to consider beyond frequency if it is out of range for "normal" for gender, culture and developmental level
  - Severity rating added: mild, moderate, severe - related to the numbers of settings in which occurs

Changes to Disruptive, Impulse Control and Conduct Disorders

- ODD: 4 changes
  - Severity rating added: mild, moderate, severe - related to the numbers of settings in which occurs
    - Mild: only one
    - Moderate: some symptoms in at least 2
    - Severe: some symptoms in 3 or more settings

Changes to Disruptive, Impulse Control and Conduct Disorders

- Intermittent Explosive Disorder
  - 3 types of outbursts with 2 of them being new to DSM 5
    - Physical aggression required in DSM IV but not
    - Verbal aggression and non-destructive/non-injurious physical aggression also meet criteria in DSM 5
  - Minimum age of 6 years: there is no research to back up younger and it is difficult to distinguish between IED and normal temper tantrums in those younger
  - More specific criteria regarding frequency
    - Verbal or non-destructive physical: twice weekly on average for 6 months
    - Physical: 3 outbursts occurring within 12 months - must cause damage or destruction of property, physical assault with physical injury to others or animals
    - Must be impulsive or anger based - not committed to achieve a tangible objective
    - Must cause marked distress or impairment in occupational or interpersonal functioning or associated with financial or legal consequences
Changes to Disruptive, Impulse Control and Conduct Disorders

- Intermittent Explosive Disorder
  - Can be diagnosed with ADHD, Conduct Disorder, ODD, or autism spectrum when "recurrent, aggressive outbursts are in excess of those usually seen in these disorders". The IED requires independent clinical attention.

- Conduct Disorder
  - Not much change in criteria
  - New specifier: "with limited prosocial emotions"
    - In order to meet this specifier, at least 1 characteristic must be present in at least 2 settings, this specifier is independent of the number of characteristics over a 12-month period.
    - "Shallow or deficient affect: does not express emotions except in shallow, seemingly insincere, or superficial ways; turns on and off quickly; expresses only when can be used for gain".

Changes to Substance-Related and Addictive Disorders

See Handout for Coding
Changes to Substance-Related and Addictive Disorders

10 classes of drugs:
1. Alcohol
2. Caffeine – withdrawal added
3. Cannabis – withdrawal added
4. Hallucinogens (with separate category for phencyclidine (PCP, Angel Dust))
5. Inhalants
6. Opioids
7. Sedatives, Hypnotics, and Anxiolytics,
8. Stimulants (amphetamine-type, cocaine)
9. Tobacco
10. Other (or unknown) substances
Also includes gambling disorder

Changes to Substance-Related and Addictive Disorders

Two groupings:
• Substance use disorders
• Substance induced disorders (intoxication, withdrawal, and other substance/medication induced mental disorders – note some of these included in the chapter on the mental disorder but not discussed there)
• General discussion at beginning of chapter on substance use disorders and substance induced but then chapter breaks down into specific substances

Recording:
• Substance use: record code but in narrative use the specific substance, e.g. 304.40 = moderate cocaine use disorder not moderate stimulant use disorder
• Note ICD 10: different coding system – see additional codes in the list – note substance use can only be coded in absence of substance-induced

Changes to Substance-Related and Addictive Disorders

Recording:
• Substance induced:
  • Separate codes for the substance use disorder and the substance induced disorder
  • Use actual name of substance as above in substance use, not the title of the code
• DSM 5 does not distinguish between substance abuse and substance dependence
  • Distinction often confusing and arbitrary
  • Within substance use criteria:
    • Gone: recurrent substance-related legal problems
    • Added: craving or strong desire to use a substance
  • Other criteria are nearly identical to Substance Abuse and Substance Dependence
• Polysubstance dependence eliminated – not clinically useful – code each substance
  • Physiological subtype also eliminated as not clinically useful
Changes to Substance-Related and Addictive Disorders

Severity based on number of symptoms present:
- Threshold for SUD: 2 or more (DSM IV was 1 for SU and 1 for SD)
- Mild: 2-3 criteria
- Moderate: 4-5 criteria
- Severe: 6 or more

Specifiers for remission lumped into:
- In early remission: at least 3 months but less than 12 with exception of criteria for craving
- In sustained remission: no criteria met for a period of 12 months or longer with exception of craving

Specifiers also available for: in a controlled environment and on maintenance therapy

Changes to Substance-Related and Addictive Disorders

Caffeine Related: only substance that does not allow a substance use disorders:
- Caffeine intoxication and withdrawal and other and unspecified caffeine induced disorders only
- Caffeine use: located in Conditions for Further Study
- Other caffeine induced disorders are included in chapters related to the mental disorder:
  - Caffeine induced anxiety disorder
  - Caffeine induced sleep disorder

Cannabis Related: added cannabis withdrawal with specific symptoms listed – 50-95% of adults or adolescents enrolled in treatment of heavy cannabis users report

Changes to Substance-Related and Addictive Disorders

Gambling Disorder: replaces Pathological Gambling from the DSM IV Impulse Disorder section
- Reflecting similar activation of reward-systems and produce some similar behavioral symptoms
- Internet gaming included in “Further Study” section
- Other addictive behaviors not included - insufficient research at this time
Changes to Neurocognitive Disorders

Probable Major Neurocognitive Disorder Due to Alzheimer’s Disease
Code first 331.0 (G30.90) Alzheimer’s Disease
With behavioral disturbance 294.11 F02.81
Without behavioral disturbance 294.10 F02.80
Possible Major Neurocognitive Disorder Due to Alzheimer’s Disease
331.9 G31.9
Mild Neurocognitive Disorder Due to Alzheimer’s Disease
331.83 G31.84

Changes to Neurocognitive Disorders

Probable Major Neurocognitive Disorder Due to Frontotemporal Lobar Degeneration
Code first 331.19 (G31.09) Frontotemporal Disease
With behavioral disturbance 294.11 F02.81
Without behavioral disturbance 294.10 F02.80
Possible Major Neurocognitive Disorder Due to Frontotemporal Lobar Degeneration
331.9 G31.9
Mild Neurocognitive Disorder Due to Frontotemporal Lobar Degeneration
331.83 G31.84

Changes to Neurocognitive Disorders

Probable Major Neurocognitive Disorder with Lewy Bodies
Code first 331.82 (G31.83) Lewy Body Disease
With behavioral disturbance 294.11 F02.81
Without behavioral disturbance 294.10 F02.80
Possible Major Neurocognitive Disorder with Lewy Bodies
331.9 G31.9
Mild Neurocognitive Disorder with Lewy Bodies
331.83 G31.84
### Changes to Neurocognitive Disorders

**Probable Major Vascular Neurocognitive Disorder**
- No additional code for medical disorder
- With behavioral disturbance: 290.40 F01.51
- Without behavioral disturbance: 290.40 F01.50

**Possible Major Vascular Neurocognitive Disorder**
- 331.9 G31.9

**Mild Vascular Neurocognitive Disorder**
- 331.83 G31.84

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**Major Neurocognitive Disorder due to Traumatic Brain Injury**
- ICD-9-code 907.0 first late effect of intracranial injury without skull fracture
- ICD-10-code S06.2X9S-diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequel (Combined code)

- With behavioral disturbance: 294.11 F02.81
- Without behavioral disturbance: 294.10 F02.80

**Mild Neurocognitive Disorder Due to Traumatic Brain Injury**
- 331.83 G31.84

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**Substance/Medication-Induced Major or Mild Neurocognitive Disorder**
- No additional medical code
- Use substance-specific codes

**Major Neurocognitive Disorder due to HIV Infection**
- Code first 042 or B20- HIV infection

- With behavioral disturbance: 294.11 F02.81
- Without behavioral disturbance: 294.10 F02.80

**Mild Neurocognitive Disorder Due to HIV Infection**
- 331.83 G31.84
Changes to Neurocognitive Disorders

Major Neurocognitive Disorder due to Prion Disease
Code first 046.79 or A81.9 - Prion Disease
With behavioral disturbance  294.11  F02.81
Without behavioral disturbance  294.10  F02.80

• Mild Neurocognitive Disorder Due to Prion Disease
  331.83  G31.84

Changes to Neurocognitive Disorders

Major Neurocognitive Disorder Probably Due to Parkinson’s Disease
Code first 332.0 or G20 - Parkinson’s Disease
With behavioral disturbance  294.11  F02.81
Without behavioral disturbance  294.10  F02.80

• Major Neurocognitive Disorder Possibly Due to Parkinson’s Disease
  331.9  G31.9
• Mild Neurocognitive Disorder Due to Parkinson’s Disease
  331.83  G31.84

Changes to Neurocognitive Disorders

Major Neurocognitive Disorder due to Huntington’s Disease
Code first 333.4 or G10 - Huntington’s Disease
With behavioral disturbance  294.11  F02.81
Without behavioral disturbance  294.10  F02.80

• Mild Neurocognitive Disorder Due to Huntington’s Disease
  331.83  G31.84
Changes to Neurocognitive Disorders

Major Neurocognitive Disorder due to Another Medical Condition
Code first the other medical condition
With behavioral disturbance 294.11 F02.81
Without behavioral disturbance 294.10 F02.80

Mild Neurocognitive Disorder Due to Another Medical Condition
331.83 G31.84

Major Neurocognitive Disorder due to Multiple Etiologies
Code first all the etiological medical conditions with the exception of vascular disease
With behavioral disturbance 294.11 F02.81
Without behavioral disturbance 294.10 F02.80

Mild Neurocognitive Disorder Due to Multiple Etiologies 331.83 G31.84

Unspecified Neurocognitive Disorder 799.59 R41.9

Changes to Neurocognitive Disorders

Delirium updated – stand alones lumped and now specifiers

- Substance intoxication delirium: (291.0/Alcohol, 292.81 all others)
  - Use the Delirium code and the substance specifier instead of intoxication when Criteria A and C predominate and are severe enough to warrant clinical attention.
    - A = disturbance in attention and awareness
    - B = An additional disturbance in cognition
  - Same for substance withdrawal
  - Similar for medication-induced delirium
  - For Delirium due to another medical condition and delirium due to multiple etiologies – code first the underlying medical condition(s) – (for multiple it could be combo of substance and medication or medical)
  - Specifiers for : 1 – acute/persistent; 2 – hyperactive, hypoactive or mixed

Changes to Neurocognitive Disorders

- Major and Mild Neurocognitive Disorders
  - Moved into the body of the DSM 5
  - Mild is new with own diagnostic criteria
  - Dementia and amnestic disorders are now included together under major neurocognitive disorder
    - The word dementia may still be used in some of the subtypes where it is widespread and standard
  - Both mild and major based on 6 defined domains, severity levels and subtypes
    - The neurocognitive domains are listed and guidance on major vs mild is provided; also examples of types of assessments for each
Changes to Neurocognitive Disorders

- Both mild and major based on 6 defined domains, severity levels and subtypes
  - The neurocognitive domains continued:
    - Complex attention
    - Executive function
    - Learning and memory
    - Language
    - Perceptual-motor
    - Social cognition
  - E.g. Language includes both expressive and receptive language
  - Major: significant difficulties with one or both, use of general phrases instead of specific naming, severe - inability to recall names of friends and family, idiosyncratic word usage, grammatical errors, economy of output, stereotypy of speech, echolalia, and automatic speech.
    - Mild: noticeable word finding difficulty, may substitute general for specific, may avoid use of names, subtle grammatical errors.

Changes to Neurocognitive Disorders

- The line between mild and major is by necessity somewhat arbitrary it is important that the two levels are considered separately:
  - Major is in line with DSM IV and with the rest of medicine in considering the level of impairment. Mild is a less disabling syndrome but may be even so a focus of care and treatment.
    - Major:
      - Significant decline in at least one of 6 cognitive domains
      - Level of cognitive functioning interferes with independence of ADLs
      - Substantial impairment - preferably neurophysiological testing - or in its absence a qualified clinical assessment.

Changes to Neurocognitive Disorders

- The line between mild and major is by necessity somewhat arbitrary it is important that the two levels are considered separately:
  - Mild is increasingly important as research and care begins to extend to these individuals and where early identification is important to the outcomes of that care, in particular stardation of progression. Especially with Alzheimer's, cerebrovascular disorders, HIV, and traumatic brain injury.
    - Not used for normal aging
    - There must be a modest decline in at least one of the cognitive domains
    - Do not interfere with ADLs but compensatory strategies may be required
    - Symptoms from the individual, a knowledgeable informant, or the clinician
    - Prefer documentation via standard test cognitive testing - a qualified clinical assessment may substitute for absence of testing.
Changes to Neurocognitive Disorders

- Clinical sub-types:
  - Alzheimer’s disease: diagnosed by genetic mutation from family history or genetic testing
  - Frontotemporal lobar degeneration: degeneration of both frontal and temporal lobes - fourth common
  - Lewy Body disease: Lewys body build up in brain – very common
  - Vascular disease
  - Traumatic Brain Injury
  - Substance/medication induced
  - HIV infection
  - Prion Disease: infection causing spongiform encephalopathies
  - Parkinson’s disease
  - Huntington’s disease
  - Another Medical Condition
  - Multiple Etiologies
  - Unspecified

Changes to Neurocognitive Disorders

- Clinical sub-types:
  - In DSM IV there were specific sub-types only for Alzheimer’s, vascular dementia, and substance induced dementia – all other subsumed under dementia due to another medical condition with certain medical conditions specified. Now expanded clinical sub-types.
  - Clinical subtypes are same for mild and for major but for mild and possible you do not code the underlying etiology; for major/probable you code first the underlying etiology.
  - Each clinical sub-types has its own criteria and coding guidelines but there is a general discussion about diagnosing major vs mild prior to the sub-types guidance.
  - Clinical sub-types list criteria for major and mild and also for probable and possible within the sub-types.
  - Both major and minor have specifiers for with and without behavioral disturbance but only the major probabilities have separate codes. But you are told to include the specifier even if there is no specific code.

Changes to Neurocognitive Disorders

- Clinical sub-types:
  - E.G. for Major or Mild Neurocognitive Disorder Due to Alzheimer’s Disease
    - MAJOR:
      - Probable: criteria one or two: (and code first Alzheimer’s)
        1. Evidence of causative Alzheimer’s disease genetic mutation by family history or genetic testing
        2. OR, all of following are present:
          - Clear evidence of decline in memory and at least one other cognitive domain
          - Steady progressive decline in cognition without extended plateaus
          - No evidence of mixed etiology
      - Possible: if does not meet probable criteria – (do not code first Alzheimer’s)
        - No codes for with or without behavioral disturbance but should list
      - Mild: probable if 1 above is present; possible if 1 not present and all three of 2 are present. (No codes for behavioral disturbance but should list)
Changes to Personality Disorders

Cluster A Personality Disorders
- Paranoid Personality Disorder 301.0 F60.0
- Schizoid Personality Disorder 301.20 F60.1
- Schizotypal Personality Disorder 301.22 F21

Cluster B Personality Disorders
- Antisocial Personality Disorder 301.7 F60.2
- Borderline Personality Disorder 301.83 F60.3
- Histrionic Personality Disorder 301.50 F60.4
- Narcissistic Personality Disorder 301.81 F60.81

Cluster C Personality Disorders
- Avoidant Personality Disorder 301.82 F60.6
- Dependent Personality Disorder 301.6 F60.7
- Obsessive-Compulsive Personality Disorder 301.4 F60.5

Other Personality Disorders
- Personality Change Due to Another Medical Condition 310.1 F07.0
- Other Specified Personality Disorder 301.89 F60.89
- Unspecified Personality Disorder 301.9 F60.9

Changes to Personality Disorders

- No longer diagnosed on Axis II
- Criteria for personality disorders unchanged in section II of the DSM 5.

Changes:
- Cluster A: paranoid, schizoid, schizotypal - "individuals often appear odd or eccentric"
- Cluster B: antisocial, borderline, histrionic, and narcissistic - "individuals often appear dramatic, emotional or erratic"
- Cluster C: avoidant, dependent, and obsessive-compulsive - "individuals often appear anxious or fearful"

In section III an alternative approach to the diagnosing of personality disorders was developed and published for further study
- Dimensional model: personality disorders "represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another"
- Categorical model - retained in DSM 5: the disorders are qualitatively distinct syndromes
Changes to Personality Disorders

- Section II organized into:
  - General personality disorder
  - Then each specific sub-type
  - Note: personality change due to another medical condition moved into this chapter from Delirium, Dementia, Amnestic and Other Cognitive Disorders

Changes to Paraphilic Disorders

Voyeuristic Disorder 302.82 F65.3
Exhibitionistic Disorder 302.4 F65.2
Frotteuristic Disorder 302.89 F65.81
Sexual Masochism Disorder 302.83 F65.51
Sexual Sadism Disorder 302.84 F65.52
Pedophilic Disorder 302.2 F65.4
Fetishistic Disorder 302.81 F65.0
Transvestic Disorder 302.2 F66.1
Other Specified Paraphilic Disorder 302.89 F65.89
Unspecified Paraphilic Disorder 302.9 F65.9

Changes to Paraphilic Disorders

- Previously in DSM IV chapter “Sexual and Gender Identity Disorders”
- There are dozens of these and the specific ones listed are:
  - They are relatively common and/or
  - They involve criminal behaviors
- The disorders are grouped into:
  - Anomalous activity preferences further divided into
    - Courtship disorders: voyeuristic, exhibitionistic
    - Algologic disorders: sexual masochism (involving fear and pain)
  - Anomalous target preferences:
    - Directed at human: pedophilia
    - Directed elsewhere: fetishistic disorder
Changes to Paraphilic Disorders

- Paraphilic disorder:
  - Paraphilia that is causing distress or impairment or
  - A paraphilia which causes personal harm or risk of harm to others in order to be satisfied
  - Paraphilias are not by themselves a disorder. The paraphilia must cause distress or impairment or it must have through its satisfaction risk personal harm or harm to others.
  - You must have a paraphilia to have a paraphilic disorder but existence of a paraphilia does not necessarily require any clinical attention or intervention.
- The diagnoses in this section were all renamed in order to distinguish between atypical sexual interest and an actual disorder
  - Voyeurism vs Voyeuristic Disorder

Changes to Paraphilic Disorders

- For disorder must have both:
  - Criterion A = qualitative nature of the paraphilia
  - Criterion B = negative consequences
- DSM 5 has added specifiers to the course of the disorder:
  - In a controlled environment: applies to individuals living in institutional or other settings where the opportunity to engage in the behaviors specific to the disorder are restricted.
  - In full remission: individual has not "acted on the urges with a nonconsenting person" and there has been no distress or impairment of social, occupational or other areas of functioning for "at least" 5 years and in an environment that is uncontrolled.
  - Does not mean the specific disorder is gone but that behaviors and distress have "remitted"
  - Remission of behaviors and distress to "acceptable levels" supported by research.
  - Specifiers intended to convey very important changes in an individual’s status with regard to their disorder

Changes to Paraphilic Disorders

- Transvestic Disorder: sexual arousal by dressing as the opposite sex limited to heterosexual males in DSM IV, now no restriction
- Pedophilic Disorder: do not include an individual in late adolescence in an on-going relationship with a 12-13 year old.
Changes to Other Mental Disorders

Other Specified Mental Disorder Due to Another Medical Condition
294.8 F06.8

Unspecified Mental Disorder Due to Another Medical Condition
294.9 F09

Other Specified Mental Disorder
300.9 F99

Unspecified Mental Disorder
300.9 F99

In DSM IV used “general medical condition”
In DSM V uses “another medical condition”
In both cases before a diagnosis was made a medical condition had to be excluded as a cause of the symptoms.
New language intended to convey that psychiatric disorders are “medical”
This chapter is a residual category
Apply to presentations that do not meet full criteria for any other DSM 5 diagnosis
Always code first the other medical condition

Medication-Induced Movement Disorder and other adverse effects of Medication

- Neuroleptic-Induced Parkinsonism 332.1 G21.11
- Other Medication-Induced Parkinsonism 332.1 G21.19
- Neuroleptic Malignant Syndrome 333.92 G21.0
- Medication-Induced Acute Dystonia 333.72 G24.02
- Medication-Induced Acute Akathisia 333.99 G25.71
- Tardive Dyskinesia 333.85 G24.01
- Tardive Dystonia 333.72 G24.09
- Tardive Akathisia 333.99 G25.71
- Medication-induced Postural Tremor 333.1 G25.1
- Other Medication-Induced Movement Disorder 333.99 G25.79
Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Antidepressant Discontinuation Syndrome

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<th>Description</th>
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<td>Initial encounter</td>
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<td>995.29 T43.205D</td>
<td>Subsequent encounter</td>
</tr>
<tr>
<td>995.29 T43.205S</td>
<td>Sequelae</td>
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Other Adverse Effect of Medication

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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Initial encounter</td>
</tr>
<tr>
<td>995.20 T50.905D</td>
<td>Subsequent encounter</td>
</tr>
<tr>
<td>995.20 T50.905S</td>
<td>Sequelae</td>
</tr>
</tbody>
</table>

Medication-Induced Movement Disorders and Other Adverse Effects of Medication

- Included in Section II with other mental disorders because of their importance in both:
  - Medication management
  - Differential diagnosis of mental disorders
  - These are not mental disorders
  - Reminder that sometimes it is difficult to establish a causal relationship
  - Neuroleptic becoming outdated because of highlighting the propensity of anti-psychotics to cause abnormal movement—anti-psychotic used now more frequently—but DSM 5 states the term is appropriate here
  - Applies to typical, atypical anti-psychotics, certain dopamine-receptor-blocking drugs, and amoxapine (marketed as an anti-depressant)

Other Conditions

Other conditions and problems that may be a focus of treatment:

- May affect diagnosis, course, prognosis or treatment
- May provide context—e.g. Stages of Change
- ICD-9: usually V codes while ICD-10 will usually be Z Codes
- May also be used to help explain reason for a visit, test, procedure or treatment
- Provides a means for documenting what may be very useful information for pricing, outcomes, etc.
- These are not mental disorders but some may be reimbursable
Other Conditions

- Divided in DSM 5 into:
  - Relational Problems, e.g. Parent-Child Relational Problems
  - Abuse and neglect, e.g. child sexual abuse, child neglect
  - Educational and occupational problems, e.g. Academic or Educational Problem
  - Housing and economic problems, e.g. Homelessness
  - Other problems related to the social environment, e.g. Social Exclusion or Rejection
  - Problems related to crime or interaction with the legal system, e.g. Victim of Crime
  - Other Health Service Encounters for Counseling and Medical Advice, e.g. Sex Counseling
  - Problems related to other psychosocial, personal and environmental circumstances, e.g. Discord with Social Service Provider, Including Probation Officer, Case Manager, or Social Services Worker
  - Other circumstances of personal history, e.g. Personal History of Self-Harm

Section III

- Assessment Measures
  - Cross cutting Symptom measures for adults and children
  - Clinician-Rated Dimensions of Psychosis Symptom Severity
  - WHODAS
  - Cultural Formulation – interview and informant versions
  - Alternative DSM 5 Model for Personality Disorders
  - Conditions for Further Study

Conditions for Further Study

Proposed Conditions – Consensus of the DSM-5 Work Group indicated these conditions have merit but require further research before their inclusion as formal disorders. The proposed criteria sets have not been approved for clinical use.

1. Attenuated Psychosis Syndrome – Seen in a person who does not have a full-blown psychotic disorder but exhibits minor versions of relevant symptoms. May make more possible effective early intervention.
2. Depressive Episodes With Short-Duration Hypomania – Individuals exhibit bipolar behavior characterized by a hypomanic episode that lasts less than four days.
3. Persistent Complex Bereavement Disorder – A prolonged and excessively debilitating grief that keeps an individual from recovering from a loss. The condition likely requires a different treatment approach.
Conditions for Further Study

5. Internet Gaming Disorder - compulsive preoccupation to play online games, often to the exclusion of other needs and interests.

6. Neurobehavioral Disorder Due to Prenatal Alcohol Exposure (ND-PAE) – This is a new clarifying term intended to encompass the full range of development disabilities associated with exposure to alcohol in utero.

7. Suicidal Behavior Disorder - describes someone who has attempted suicide within the last 24 months. Help to identify the risk factors associated with suicide attempts including depression, substance abuse or lack of impulse control.

8. Nonsuicidal Self-Injury - This condition is a major public health problem and is used for those individuals who repeatedly inflict shallow, yet painful injuries to the surface of the body.

Intended Usage – These conditions are not intended for routine clinical use.Clinicians should select the appropriate “other specified” disorder and then indicate parenthetically that one of these proposed conditions is present.

Major Changes

• See handout

Controversy?

This listing comes from a training done on the DSM 5 by Doctors Gary Henschen and Varun Choudhary, both from Magellan Behavioral Health.

1. Disruptive Mood Dysregulation Disorder – may exacerbate the problem of overmedicating young children by turning temper tantrums into a mental disorder. New fall of overdiagnosis? For example: ADHD and childhood bipolar disorder which caused huge spikes in prescriptions.

2. Normal grief becomes a Major Depressive Disorder. Risk of medicalizing the normal grief reaction to loss of a loved one.

3. Mild Neurocognitive Disorder will result in everyone over the age of 50 being diagnosed. A very large false positive population that in fact is not at risk for dementia.

4. ADHD in adults may result in over-diagnosing with inappropriately prescribed stimulants and diversion of at least some of these for recreation, performance enhancement and illegal sales.

5. The criteria for Binge Eating (i.e., excessive eating 12 times in 3 months) may not be a psychiatric condition but a manifestation of gluttony or the easy availability of food.
Controversy?

- The changes in the definition of Autism could result in lower rates of the disorder (estimates range from 10-50%). Even though the new criteria are more accurate it will likely mean a reduction in school services where the IEP is tied to the diagnosis and not to the child’s educational status or needs.

- Combining substance abuse and substance dependence may result in substance abusers being combined with “hard-core addicts” despite differing treatment needs and prognosis.

- Introducing the concept of behavioral addictions, e.g. gambling disorder may create an easy opening for lots more, e.g. Internet and sex addiction. This may lead to lots of new programs of dubious efficacy, taking away monies from other high needs.

- Both Generalized Anxiety Disorder (GAD) and Posttraumatic Stress Disorder (PTSD) have “fuzzy” boundaries in their criteria. Will this cause an increase in prescriptions of anti-anxiety drugs. Forensic settings will be impacted by lack of diagnostic clarity.

Thank You

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