DSM Part 3

Disruptive, Impulse Control and Conduct Disorders through Other Conditions and Summary

Changes to Disruptive, Impulse Control and Conduct Disorders

Oppositional Defiant Disorder (ODD)	313.81	F91.3
Intermittent Explosive Disorder	312.34	F63.81
Conduct Disorder		
– Childhood-onset type	312.81	F91.1
– Adolescent-onset type	312.82	F91.2
– Unspecified	312.89	F91.9
Pyromania	312.33	F63.1
Kleptomania	312.32	F63.2
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 – poorly controlled behaviors and/or poorly controlled emotions – DSM 5 uses a sort of developmental hierarchy going from ODD to Conduct Disorder to Anti-social Personality Disorder
  - Anti-social Personality Disorder included here and in personality disorders (discussed in personality disorder chapter)
- ADHD is often comorbid with these but it is in Chapter with neurodevelopmental disorders in recognition of its biological connection

Changes to Disruptive, Impulse Control and Conduct Disorders

- Oppositional Defiant Disorder: 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 as a concept. ODD to anxiety and depressive disorders considered.
  - Symptoms grouped into 3 types: at least 4 required symptoms expressed with an individual who is not a sibling – recognition that there are usually both emotional and behavioral symptoms straddling CD and Intermittent explosive disorder
    - Angry irritable mood
    - Argumentative/defiant behavior
    - Vindictiveness

Changes to Disruptive, Impulse Control and Conduct Disorders

- ODD: 4 changes
  - Frequency and intensity: occurring on most days for 6 months or less for children < 5 yrs; Once/week for children >5 years.
    - Vindictiveness has its own criteria – " at least twice in past 6 months"
    - States also to consider in addition to frequency if it is out of range for "normal" for gender, culture and developmental level - guidance provided
  - Severity rating added: mild, moderate, severe - related to the numbers of settings in which occurs – severity = pervasiveness
    - Mild: only one
    - Moderate: some symptoms in at least 2 settings
    - Severe: some symptoms in 3 or more settings

Changes to Disruptive, Impulse Control and Conduct Disorders

- Intermittent Explosive Disorder (page 467)
  - 3 types of outbursts with 2 of them being new to DSM 5
    - Criterion A:
      - Verbal or physical aggression towards occurring twice weekly for 3 months. Physical aggression does not result in destruction to property or or physical injury to person or animal OR
      - Three outbursts resulting in damage or destruction of property or injury to person or animal within a 12 month period.
  - 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

Changes to Disruptive, Impulse Control and Conduct Disorders

- Intermittent Explosive Disorder (page 467)
  - Magnitude of aggressiveness grossly out of proportion to the provocation
  - 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
  - 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 in these cases requires independent clinical attention.

Changes to Disruptive, Impulse Control and Conduct Disorders

- Conduct Disorder
  - Not much change in criteria BUT
  - New specifier: "with limited prosocial emotions"
    - To qualify must have met at least 2 characteristics over a 12 month period AND in multiple relationships and settings. Should reflect a typical pattern. Consider both self and "other" reporters
      - Lack of remorse or guilt: cannot count remorse if expressed only when caught or facing consequences
      - Callous – lack of empathy: "described as cold and uncaring"; more concern for self and impact
      - Unconcerned about performance: poor performance school,work; despite clear expectations; blames others
      - 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 Disruptive, Impulse Control and Conduct Disorders

- Conduct Disorder
  - New specifier: “with limited prosocial emotions”
    - Research supports that this specifier indicates more severe form with likely different response to treatment
    - Should be minority of individuals with this diagnosis
      - More likely to have child-onset type with higher severity rating at start

Changes to Substance-Related and Addictive Disorders

See Handout for Coding to ICD 9

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- DSM 5

Two groupings:

- Substance use disorders: no differentiation tween use, abuse, dependence
- 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
- Term addiction is eliminated

Recording in DSM 5:

- Substance use: record code but in narrative use the specific substance, e.g. 304.40 = moderate cocaine use disorder not moderate stimulant use disorder

Changes to Substance- Related and Addictive Disorders DSM 5

Recording:

- Substance induced for DSM 5
  - 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 which is generic for the group of substances in the class
- DSM 5 does not distinguish between substance abuse and substance dependence (Note that ICD 10 currently does distinguish until reconciliation)
  - 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 together – impaired control, social impairment, risky use, pharmalogical (tolerance, and/or w/drawal)
  - Polysubstance dependence eliminated – not clinically useful –code each substance
  - Physiological subtype also eliminated as not clinically useful, i.e. is the individual physiologically dependent or not

Changes to Substance- Related and Addictive Disorders DSM 5

Recording:

- Severity based on number of symptoms present
  - Threshold for SUD: 2 or more (DSM IV was 1 for SU and 3 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

Coding in ICD 10

- Substances F10-F19
  - Unlike with ICD 9 where two codes are used for e.g. use disorder and for use disorder induced psychosis, ICD 10 uses one code.
    - Substance use, abuse or dependence alone can only be coded in absence of any induced disorder
  - Greater specificity in the codes in ICD 10 allow for this:
    - 4th character: qualify specific aspects of the effects (e.g. abuse and dependence) F10.1 = ETOH abuse; F10.2 =ETOH dependence
    - 5th character: to identify aspects of the use (e.g. withdrawal state, in remission, intoxication or other induced disorders) e.g. F11.25: Opioid dependence with opioid induce psychotic disorder
    - 6th character: some of the manifestations (e.g. hallucinations, delusions, perceptual disturbances, etc. E.g. F11.122: Opioid abuse with intoxication with perceptual disturbance.

Documentation Guidance (partial) for DSM and ICD 10

- Mental and Behavioral Disorders Due to Psychoactive Substances – document:
  - Type of substance: alcohol, opioid, cannabis, sedatives/hypnotics, cocaine, other stimulants, hallucinogens, nicotine, inhalants, other (list specific), unknown. If poly requires documenting and coding each)
  - Use, abuse or dependence (there are 45 ETOH codes alone)
  - Status: uncomplicated, delirium, with or without hallucinations, dementia, etc.
  - With other drug or alcohol induced disorders – e.g. combo with anxiety, sleep, sexual dysfunction, psychotic disorder
  - Severity: specifier from DSM 5 and not embedded in code yet
  - Stage: remission (early or sustained); maintenance therapy; controlled environment – NOTE stage is a specifier from DSM 5 and not embedded in code yet.
- For polysubstance use or dependence record each separately

Changes to Substance- Related and Addictive Disorders DSM 5

Substance Induced Disorders

- Criterion for each class of substance for withdrawal and intoxication
- Criterion for other Substance Induced disorders in the Chapters of the mental disorder with just a brief description in this chapter
- Criteria A: disorder is a clinically symptomatic presentation of a relevant mental disorder
- Criterion B: evidence from history, physical exam, or lab findings that:
  - Developed within one month of substance intoxication, withdrawal or taking a med
  - Involved substance is capable of producing the mental disorder

Changes to Substance- Related and Addictive Disorders DSM 5

Substance Induced Disorders

- Criterion C: Disorder not better explained by an independent mental disorder. Evidence might include:
  - Mental disorder preceded the substance/medication use
  - Mental disorder persisted after substance/medication withdrawn (1 month); doesn't apply to persisting
- Criterion D: Doesn't occur exclusively during a delirium
- Criterion E: Clinically significant distress or impairment

Changes to Substance- Related and Addictive Disorders DSM 5

- Caffeine Related: only substance that does not allow a substance use disorder
  - Caffeine intoxication and withdrawal and other and unspecified caffeine induced disorders only (Caffeine withdrawal is new)
  - 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 symptoms of withdrawal
  - Cannabis withdrawal not in ICD 10

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 – NOTE: Code same as possible – this is not in the DSM. This was in a coding update. Concern about insurance reimbursement

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 ***Code same as probable***
- 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 ***Code same as probable.***
- 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

Code same as probable

Mild Vascular Neurocognitive Disorder

331.83 G31.84

Changes to Neurocognitive Disorders

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 consicousness of unspecified duration, sequela (**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

Changes to Neurocognitive Disorders

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 – ***code same as probable***

- 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 alone diagnoses lumped and now added as specifiers

- Substance Intoxication delirium: (291.0/Alcohol, 292.81 all others)
  - Use the Delirium code and the substance intoxication specifier instead of Substance Intoxication (from SA codes) when Criteria A and C predominate and are severe enough to warrant clinical attention.
    - A= disturbance in attention and awareness
    - C=An additional disturbance in cognition (memory, disorientation)
  - Same for substance withdrawal delirium
  - 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 :
    - Acute/persistent;
    - Hyperactive, hypoactive or mixed level of activity

Changes to Neurocognitive Disorders

- Major and Mild Neurocognitive Disorders
  - Mild moved into the body of the DSM 5
    - Mild is new with own diagnostic criteria – very scary
  - 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 (substantial guidance in DSM 5)
  - The neurocognitive domains are listed and guidance on major vs mild is provided; also examples of types of assessments for each domain.

Changes to Neurocognitive Disorders

- Both mild and major based on 6 defined domains, severity levels (major and mild) and subtypes
  - The neurocognitive domains: (page 593)
    - 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 more; 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 but it was decided that it was 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 through neurophysiological testing – or in its absence a qualified clinical assessment.

Changes to Neurocognitive Disorders

- 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 retardation 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 standardized neurophysiological 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 probable and possible but for mild you **do not** code the underlying etiology; for major/probable you code first the underlying etiology. NOTE this is a change that is in the Coding Update and not in the DSM 5 books. The Coding Update was done out of concern that a major but only possible would not be reimbursed by insurance with original codes.
  - Each clinical sub-type has its own criteria and coding guidelines but there is a general discussion about diagnosing major vs mild prior to the sub-types guidance. See Coding update rather than chart in DSM page 603.
  - Clinical sub-types list criteria for major and mild and also for probable and possible within the sub-types.
  - Both major and mild have specifiers for with and without behavioral disturbance have separate codes. But for mild you are told to include the behavioral disturbance specifier in the narrative description

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 3 of following are present:
           - Clear evidence of decline in memory and at least one other cognitive domain
           - Steadily progressive decline in cognition without extended plateaus
           - No evidence of mixed etiology
      - **Possible:** if does not meet probable criteria because of no clear evidence of disease but other criteria are met.
        - Coding Update has codes for with or without behavioral disturbance that are not in DSM book
        - 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

Changes to Personality Disorders

- 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 – so listed in order of clinical priority OR on claim listed in order of attention at a particular session/admission
- Criteria for personality disorders unchanged in section II of the DSM 5.
  - Clusters: kept but warned not consistently validated and have serious limitations – note individuals frequently present with co-occurring personality disorders
    - A = paranoid, schizoid, schizotypal – "individuals often appear odd or eccentric"
    - B = antisocial, borderline, histrionic and narcissitic – " individuals often appear dramatic, emotional or erratic"
    - 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"
    - DSM 5 -Categorical model –retained in DSM 5: the disorders are qualitatively distinct syndromes
    - Some criticism of operational use of Dimensional model – too difficult/diffuse

Changes to Personality Disorders

- Section II on Personality Disorders organized into:
  - General personality disorder description
  - 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 - this may impact reimbursement. Medicare, in particular, is writing both national and local coverage policy about the use of and reimbursement for this diagnosis.

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	302.3	F65.1
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:
  - relatively common and/or
  - they involve criminal behaviors
- The disorders are grouped into:
  - Anomalous activity preferences further divided into
    - courtship type disorders: voyeuristic, exhibitionistic
    - Algolagnic disorders: sexual masochism (involving fear and pain)
  - Anomalous target preferences:
    - Directed at other humans: 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 – make sure they are used

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

Changes to Other Mental Disorders

- 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 ---------- ---------

Initial encounter	995.29	T43.205A
Subsequent encounter	995.29	T43.205D
Sequelae	995.29	T43.205S

• Other Adverse Effect of Medication --------- ----------

Initial encounter	995.20	T50.905A
Subsequent encounter	995.20	T50.905D
Sequelae	995.20	T50.905S

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
- DSM 5 reminds that sometimes it is difficult to establish a causal relationship
- Neuroleptic medication term 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
  - Neuroleptic: 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.
4. Caffeine Use Disorder – The potential addictive behavior caused by excessive, sustained consumption of caffeine.

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 fad 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. CDC disagrees and suggests underdiagnosing is the bigger problem.
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, eg. Internet and sex addiction. This may lead to lots of new programs of untested 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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