The DSM-5: Integrating Ethical and Adherence Issues into Using DSM-5 in Medi-Cal Specialty Mental Health Services

Rachel B. Michaelsen, MSW, LCSW
445 Bellevue Ave. Suite 202
Oakland, CA 94610
510-869-7121
rbmlcsw@sbcglobal.net
www.psyte-online.com

• DSM® and DSM-5® are registered trademarks of the American Psychiatric Association. This seminar is neither affiliated with nor endorsed by the American Psychiatric Association.

• This presentation is for educational purposes only, and is not intended as a replacement for the Diagnostic and Statistical Manual of Mental Disorders, 5th edition.
Learning Objectives

This course is designed to help participants:

• Use the new structure and organization of the DSM-5 to determine diagnoses
• Analyze and Identify which DSM-5 diagnoses are covered by Medi-Cal specialty mental health services
• Adhere to the regulations of the Department of Health Care Services when utilizing the DSM-5 criteria for diagnoses that are covered by Medi-Cal specialty mental health services
• Apply ethical, adherence and cultural considerations when using the DSM5 for Medi-Cal specialty mental health services

Course Outline

• History of the DSM and diagnosing
• Ethics of Diagnosing
• Cultural Consideration when Diagnosing
• Changes to structure of the manual
• Cross Walk from DSM-IV to MediCal SMHS approved diagnoses
• Changes to Chapters
• Criteria for Disorders Covered by Medi-Cal SMHS
History of the DSM

<table>
<thead>
<tr>
<th>Year</th>
<th>Edition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1945-1952</td>
<td>4 diagnoses</td>
</tr>
<tr>
<td>1952</td>
<td>DSM</td>
</tr>
<tr>
<td>1968</td>
<td>DSM-II</td>
</tr>
<tr>
<td>1980</td>
<td>DSM-III</td>
</tr>
<tr>
<td>1987</td>
<td>DSM-III-R</td>
</tr>
<tr>
<td>1994</td>
<td>DSM-IV</td>
</tr>
<tr>
<td>2000</td>
<td>DSM-IV-R</td>
</tr>
<tr>
<td>2013</td>
<td>DSM-5</td>
</tr>
</tbody>
</table>

History of DSM 5

<table>
<thead>
<tr>
<th>TIME LINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999 Planning started</td>
</tr>
<tr>
<td>2002 A Research Agenda for DSM-5 published</td>
</tr>
<tr>
<td>2004-2008 13 conferences</td>
</tr>
<tr>
<td>2007-2008 Nominations for DSM-5 Task Force and 13 Associated Work Groups</td>
</tr>
<tr>
<td>2008-2012 Review and Revision of Diagnostic Criteria</td>
</tr>
<tr>
<td>2010 DSM5.org launched Field Trials started in Academic Medical Centers</td>
</tr>
<tr>
<td>2011 Field Trials in community based clinics and individual practitioners offices</td>
</tr>
<tr>
<td>2012 Draft Diagnostic Criteria Published online APA Board of Trustees approved final draft criteria</td>
</tr>
</tbody>
</table>
Case of Michele B.

Born: 1882
Admitted to Willard: 1928
Died at Willard: 1960

- Michele was an Italian Immigrant, a laborer, he saved his money and bought his own home. He was hospitalized after the police were called to his home because he was screaming. He said that he had guns to protect himself. He understood little English, so it was very difficult for others to talk with him. He did not believe he was insane, but admitted he sang a lot.

- In his suitcase, among other things, there was a photo of him in an American military uniform of the WWI era and a prayer card.

Diagnosing
Origins of word

Diagnosis – late 17th century – modern latin
Greek Origins
Dia – apart
Gignoskein – recognize, know
Diagignoskein – distinguish, discern

Definition of Diagnosis

1.
• the identification of the nature of an illness or other problem by examination of the symptoms - "early diagnosis and treatment are essential"
• synonyms: identification, detection, recognitions, determination, discovery, pinpointing

2.
• the distinctive characterization in precise terms of a genus, species, or phenomenon.
Who Uses the DSM and Why?

Why do we Diagnose

- Communication
- Billing
- Documentation
- Develop a treatment plan
Potential Benefits of Diagnosis to Client

- Understanding of condition
- Understanding of treatment

Potential Harm of Diagnosis to Client

- Stigma
- Loss of personal freedom
- Exposure to toxic environments and treatments
- Life long labeling
- Legal and social disadvantages
  - Declaration of non-responsibility
    - Family
    - Finances
Professional Ethics and Diagnosis

-- Code of Ethics

Standard 2. Clinical social workers shall have and continue to develop specialized knowledge and understanding of individuals, families, and groups and of therapeutic and preventive interventions.

#3. Specific practice skills, including the ability to:
1. establish a relationship of mutual acceptance and trust,
2. obtain, analyze, classify, and interpret social and personal data, including assessment and diagnosis,
3. establish compatible goals of service with the client,
4. bring about changes in behavior (thinking, feeling, or doing) or in the situation in accordance with the goals of service.
CAMFT – Code of Ethics

3. Professional Competence and Integrity Marriage and family therapists maintain high standards of professional competence and integrity.

- SCOPE OF COMPETENCE: Marriage and family therapists take care to provide proper diagnoses of mental and emotional disorders or conditions and do not assess, test, diagnose, treat, or advise on problems beyond the level of their competence as determined by their education, training, and experience. While developing new areas of practice, marriage and family therapists take steps to ensure the competence of their work through education, training, consultation, and/or supervision.

APA – Code of Ethics

9.01 Bases for Assessments

(a) Psychologists base the opinions contained in their recommendations, reports and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)
APA – Code of Ethics

9.01 Bases for Assessments

(a) 9.01c. Psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(b) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.
Definition of a Mental Health Disorder

• A syndrome
• Significant dysfunction in an individual
  – cognition
  – emotion regulation
  – behavior
• Reflect dysfunction
  – psychological
  – biological
  – developmental process
Definition of a Mental Disorder

• Significant distress or disability
  – social
  – occupation
  – other important activities
• Not an expectable or culturally sanctioned response to stressor or loss
• Not a culturally deviant behavior
• Not conflict between individual and society

Cultural Consideration when Diagnosing
1.1. Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation.

1.1 NON-DISCRIMINATION: Marriage and family therapists do not condone or engage in discrimination, or refuse professional service to anyone on the basis of race, gender, gender identity, gender expression, religion, national origin, age, sexual orientation, disability, socioeconomic, or marital status. Marriage and family therapists make reasonable efforts to accommodate patients who have physical disabilities.

3.6 CULTURAL SENSITIVITY: Marriage and family therapists actively strive to identify and understand the diverse cultural backgrounds of their clients by gaining knowledge, personal awareness, and developing sensitivity and skills pertinent to working with a diverse client population.

3.7 THERAPIST CULTURAL VALUES: Marriage and family therapists make continuous efforts to be aware of how their cultural/racial/ethnic identity, values, and beliefs affect the process of therapy.
1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

2.01 Boundaries of Competence

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.
Culture and Diagnosis

- Goal of DSM-5 to improve diagnosis and care of people from all backgrounds through:
  A. List of cultural bound syndromes
  B. Criteria that reflect cross-cultural variations in presentations
  C. Interview tool to facilitate comprehensive, person-centered assessments

Common Cultural Concepts of Distress

- Cultural Syndromes
- Cultural Idioms of Distress
- Cultural Explanations or Perceived Causes
Cultural Syndromes

“clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts . . . that are recognized locally as coherent patterns of experience” [p. 758]

Cultural Idioms of Distress

• “ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns” [p. 758]

• Glossary of cultural concepts of distress [Pg. 833] — lists nine of “the best-studied concepts of distress around the world”
### Culture and Diagnosis - A

List of cultural bound syndromes – 9 most studied:

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ataque de nervios</td>
<td>Latina/os Caribbean and much of Latin America</td>
</tr>
<tr>
<td>Dhat syndrome</td>
<td>South Asia</td>
</tr>
<tr>
<td>Khyal cap</td>
<td>Cambodian</td>
</tr>
<tr>
<td>Kufungisisa</td>
<td>Shona of Zimbabwe</td>
</tr>
<tr>
<td>Maladi moun</td>
<td>Haitian</td>
</tr>
<tr>
<td>Nervious</td>
<td>Latina/os in US &amp; Latin America</td>
</tr>
<tr>
<td>Shenjing shuairuo</td>
<td>Chinese</td>
</tr>
<tr>
<td>Susto</td>
<td>Latina/os in US, Mexico, Central &amp; S. America</td>
</tr>
<tr>
<td>Taijin kyofusho</td>
<td>Japanese</td>
</tr>
</tbody>
</table>

Pages 833-837

### Cultural Explanations of Distress or Perceived Causes

“labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress.” [p. 758]
4 Key Features of Cultural Concepts

1. Seldom 1-to-1 correspondence
2. May apply to a wide range of severity
3. Same cultural term frequently denotes more than one type of cultural concept
4. Cultural concepts may change over time

Culture and Diagnosis - B

Criteria that reflect cross-cultural variations in presentations.

Examples: Panic Disorder
Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen.
Culture and Diagnosis - B

Criteria that reflect cross-cultural variations in presentations.

Examples: Social Anxiety Disorder
B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejections or offend others)

Culture and Diagnosis - C

Interview tool to facilitate comprehensive, person-centered assessments –

Cultural Formulation Interview
• Used in research and clinical settings
• Potentially useful tools to enhance clinical understanding and decision-making
• Not the sole basis for making a clinical diagnosis.
Cultural Formulation Interview

2 versions in the manual
• CFI – pages 752-754
• CFI - Informant Version – pages 755-757
Also available online along with
• Supplementary Modules to the Core
  Cultural Formulation Interview

https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

Cultural Formulation Interview

• 16 questions
• Part of psychosocial assessment
• Effect of culture on diagnosis and treatment
• Recommended for all diagnostic interviews
• Explores
  – client’s view
  – influence of others
  – influence of culture
  – experience of pursuing help
  – expectations for help
Cultural Formulation Interview

4 Domains
- Cultural definition of the problem
- Cultural perceptions of the cause context and support
- Cultural factors affecting self-coping and past help-seeking
- Cultural factors affecting current help seeking

Cultural Formulation Interview

- Assessment outcome
  - Improve accuracy of diagnosis
  - Improve rapport
  - Obtain useful information for treatment planning
Structural Changes to Manual

Manual’s New Structure

- DSM-5 Classification and Preface
- Section I: DSM-5 Basics
- Section II: Essential Elements: Diagnostic Criteria and Codes
- Section III: Emerging Measures and Models
- Appendix
- Index
Manual’s New Structure

DSM-5 Classification and Preface

—Classification
  • Codes
  • Subtypes
  • Specifiers

—Preface

Manual’s New Structure

Section I: DSM-5 Basics

—Introduction
—Use of the Manual
—Forensic Use Cautionary Statement
Manual’s New Structure
Section II: Essential Elements: Diagnostic Criteria and Codes

- overview of the chapter
- diagnostic criteria for each diagnosis
- diagnostic features
- associated features supporting diagnosis
- prevalence
- development and course of disorder
- risk and prognostic factors
- culture related diagnostic issues
- gender related diagnostic issues
- suicide risk
- functional consequences of disorder
- differential diagnosis
- comorbidity

Manual’s New Structure
Section III: Emerging Measures and Models

- Assessment Measures
  - www.psychiatry.org
- Alternative DSM-5 Model for Personality Disorders
- Conditions for Further Study
Manual’s New Structure

Section III: Emerging Measures and Models

• Assessment Measures [www.psychiatry.org]
  – Cross Cutting Symptom Measure for Adults
  – Cross Cutting Symptom Measure for Children
  – Clinician-rated Dimensions of Psychosis Symptom Severity
  – WHODAS 2.0
  – Cultural Formulation Interview

Manual’s New Structure

Section III: Emerging Measures and Models

• Alternative DSM-5 Model for Personality Disorder
• Conditions for Further Study
Manual’s New Structure

Appendix
- Highlights of Changes from IV to 5
- Glossary of Terms
- Glossary of Cultural Concepts of Distress
- Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9)
- Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9)
- Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10)
- DSM-5 Advisors and Other Contributors

Coding
- Even if criteria is new or different
- Diagnosis codes the same
- Bold
  - ICD-9
- Parenthesis
  - ICD-10
Capturing the Complexity of the Human Experience in a Mental Health Evaluation

- Categorical versus Dimensional Approach
- Subtypes and Specifiers
  - Severity Ratings

Subtypes and Specifiers

Specifiers

- More than one specifier may be given at a time
- Allow for defining more homogeneous subgroupings
- Individuals with the same disorder share features
- Convey information relevant to management of the disorder
- Specify or Specify if
Specifiers Examples

Depressive Disorders
- With anxious distress
- With mixed feature
- With melancholic features
- With atypical features
- With mood congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With season pattern

Insomnia Disorder
- With non-sleep disorder mental comorbidity
- With other medical comorbidity
- With other sleep disorder

Transvestic Disorder
- With festishism
- With autogynephelia

Enuresis
- Nocturnal Only
- Diurnal Only
- Nocturnal and Diurnal

Severity Measures

Based on:
- Number of symptoms
- Biological markers
- Frequency of behaviors
- Number of settings where behavior occurs
Subtypes and Specifiers

Subtypes

- Diagnostic subgroups
- Can fall into only one subgroup at a time
- All the possible subgroups are listed
- Specify Whether

Subtype Examples

Delusional Disorder
- Erotomanic type
- Grandiose type
- Jealous type
- Persecutory type
- Somatic type
- Mixed type
- Unspecified type

Attention-Deficit/Hyperactivity Disorder
- Combined Presentation
- Predominantly inattentive presentation
- Predominantly hyperactive/impulsive presentation
### Subtypes and Specifiers

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Subtypes</th>
<th>Specifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia Nervosa</td>
<td>Specify whether:</td>
<td>• Specify if: In partial remission</td>
</tr>
<tr>
<td></td>
<td>Restricting type</td>
<td>• Specify if: In full remission</td>
</tr>
<tr>
<td></td>
<td>Binge-eating/purgin g type</td>
<td>• Specify current severity: mild, moderate, severe, extreme</td>
</tr>
</tbody>
</table>

### Developmental Approach

- Chapters arranged by developmental level
- Order of Chapters
- Diagnoses within Chapters
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

- Neurodevelopmental Disorders
- Anxiety Disorders
- Trauma- and Stressor-Related Disorders
- Feeding & Eating Disorders
- Elimination Disorders
- Disruptive, Impulse Control, and Conduct Disorders

NOS Category Eliminated

- **NOS** has been replaced by Other Specified Disorder and Unspecified Disorder.
- **Other Specified**: When symptoms don’t meet full criteria for a disorder but the clinician chooses to specify the reasons why the symptoms don’t meet the full criteria.
- **Unspecified**: When the clinician chooses not to specify the reasons why the presentation does not meet the full criteria, or in cases where this is a lack of information in order to make a full diagnosis.
Removal of Axes

• Axial System
  – I clinical disorder
  – II personality d/o, mental retardation
  – III general medical condition
  – IV psychosocial and environmental problems
  – V GAF
• Axes are eliminated

Diagnosing

Mental Disorders
  – Principal Diagnosis
    • Inpatient
      – reason for admission
    • Outpatient
      – reason for visit
      – focus of care
  • Other diagnoses
  • Disorders due to medical conditions
Diagnosing

Psychosocial Stressors

- V-codes: ICD 9
- Z-codes: ICD 10

Indicate conditions and problems that impact:

- Diagnosis
- Course of illness
- Prognosis
- Treatment of a mental illness

Examples:
- Spouse or partner violence
- Child neglect
- Homelessness
- Problem related to unwanted pregnancy
- Social exclusion or rejection
- Low income
Stanly

Stanly is a 7-year-old boy in second grade who has been having school difficulties since he started attending preschool due to having trouble staying in his seat, focusing on his schoolwork, and keeping his belongings organized. He also talks out of turn and fidgets. His academic performance has been declining over time. Stanly is currently recovering from an ear infection.

Stanly’s Diagnoses

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trouble staying in his seat</td>
<td>Leaves seat in situations when remaining seated is expected</td>
</tr>
<tr>
<td>Trouble focusing on his school work</td>
<td>Often has difficulty sustaining attention in tasks or play activities</td>
</tr>
<tr>
<td>Trouble keeping belongings organized</td>
<td>Often has difficulty organizing task and activities</td>
</tr>
<tr>
<td>Talking out of turn</td>
<td>Often interrupts or intrudes on others</td>
</tr>
<tr>
<td>Fidgeting</td>
<td>Often fidgets or taps hands &amp; feet squirms</td>
</tr>
</tbody>
</table>
Stanly’s Diagnoses

DSM-IV-R
I. 314.9 Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified
II. V71.09 None
III. Otitis Media, per Pediatrician
IV. Educational problems
V. Between 50 -70 (more info needed)

DSM-5
• 314.01 (F90.8) Other Specified Attention-Deficit/Hyperactivity Disorder
• V62.3 (Z55.9) Academic or Educational Problem

The Crosswalk
Diagnostic Determination for Medical Specialty Mental Health Services

Per MHSUDS Info Notice No. 16-051

- Effective no later than April 1, 2017, MHPs are required to use the DSM-5 to diagnose mental disorders for the purpose of determining medical necessity for SMHS and related clinical documentation. DSM-5 is needed to guide diagnosis, as the ICD-10 classification provides a listing of disease names and their corresponding codes, but does not contain information needed to determine diagnosis.

Diagnostic Determination for Medical Specialty Mental Health Services

In using the DSM-5 to determine the correct diagnosis, MHPs must also ensure that their diagnoses and clinical documentation (i.e., beneficiary symptoms, behaviors and relevant psychiatric and developmental history) align with the ICD-10 codes reported to claim the SMHS provided. Both the ICD-10 and the corresponding DSM-5 diagnosis codes should be indicated in the beneficiary’s clinical record. MHPs should follow the steps outlined below in establishing mental health diagnoses for SMHS and claiming.
Diagnostic Determination for Medical Specialty Mental Health Services

The shift from DSM-IV to DSM-5 does not change the diagnoses required to meet medical necessity criteria for inpatient or outpatient SMHS. The crosswalks provided with Information Notice 15-030 are intended to crosswalk providers from included ICD-9 diagnoses for outpatient and inpatient SMHS to included ICD-10 diagnoses. No diagnoses which are entirely new to DSM-5 are included in the tables of included diagnoses.

How to Use the Crosswalk

• Using the crosswalk provided (for outpatient services MHSUDS INFORMATION NOTICE 15-030) find the ICD-9 code (listed numerically).
• Note the corresponding ICD-10 code
• Determine if the ICD-10 code is in the DSM-5
Crosswalk has 180 ICD-10 codes; 73 are not in the DSM-5 and therefore cannot be used

How to Use the Crosswalk

• Determine if the ICD-10 code is in the DSM-5
  – **If yes**, review the criteria to determine if the clients symptoms meet the criteria. If they do, use this ICD-10 code and ensure clinical documentation aligns with DSM-5 diagnostic criteria.
  – **If no**, identify an alternative ICD-10 diagnosis which is in the DSM-5 and for which the symptoms align with the DSM-5 criteria.
To simplify this...

**Clinician’s Gateway EHR**

Selecting Diagnosis:
DSM-IV cross-walk to DSM-5
DSM-5 cross-walk to DSM-IV
Final Phase of DSM-5 Diagnosis Implementation

- *InSyst* Data Entry:
  - MH Clients
  - SUD Clients
- *Medical Records* Documentation:
  - MH Clients
  - SUD Clients
  - Clinicians Gateway EHR Screen Shots

Implementation Deadline: 4/1/17

- Effective April 1st, 2017 all new and updated behavioral health care documentation and claiming requires utilization of only ICD-10 diagnosis (Dx) codes.
  - *Existing Clients will be phased in at their next face-to-face visit.*
- That is, DSM-IV-TR codes will not be utilized in new or updated Medical Records, nor entered into InSyst.)
Implementation Deadline:
4/1/17

- Announcements will be forthcoming for any changes made to InSyst forms such as the Client Registration, Episode Opening and Episode Closing forms.
- For those providers who wish to begin utilizing the new protocol now, they may begin doing so immediately.

InSyst Data Entry for MH Clients:

- Enter on InSyst lines labeled: ICD10Dx 1 to 5:
  1.) Required ICD-10 Primary Included Medi-Cal MH Diagnosis (see attached Included Lists)
  2.) Optional ICD-10 Secondary Included Medi-Cal MH Diagnosis
  3.– 5.) Optional ICD-10 Included or Excluded MediCal MH Diagnosis OR physical health Diagnosis
InSyst Data Entry for MH Clients Cont.

- Required Axis IV: Principal Psychological and/or Environmental A-J code
  
  A. Problems with primary support group
  B. Problems related to the social environment
  C. Educational Problems
  D. Occupational Problems
  E. Housing Problems
  F. Economic Problems
  G. Problems with access to health care services
  H. Problems related to interaction with legal system/crime
  I. Other psychological and environmental problems
  J. Unknown/Unavailable

v.1.18.2016

InSyst Data Entry for MH Clients Cont.

- No longer required: Axis V: GAF rating score

- Required General Medical Codes (GMC); up to 3 codes may be added

01 = Arterial Sclerotic Disease
02 = Heart Disease
03 = Hypercholesterolemia
04 = Hyperlipidemia
05 = Hypertension
06 = Birth Defects
07 = Cystic Fibrosis
08 = Psoriasis
09 = Digestive Disorder
10 = Ulcers
11 = Cirrhosis
12 = Diabetes

v.1.18.2016
InSyst Data Entry for MH Clients Cont.

- Required General Medical Codes Continued (GMC); up to 3 codes may be added

13 = Infertility
14 = Hyperthyroid
15 = Obesity
16 = Anemia
17 = Allergies
18 = Hepatitis
19 = Arthritis
20 = Carpal Tunnel Syndrome
21 = Osteoporosis
22 = Cancer
23 = Blind / Visually Impaired
24 = Chronic Pain
25 = Deaf / Hearing Impaired

v.1.18.2016

InSyst Data Entry for MH Clients Cont.

- Required General Medical Codes Continued (GMC); up to 3 codes may be added

26 = Epilepsy / Seizures
27 = Migraines
28 = Multiple Sclerosis
29 = Muscular Dystrophy
30 = Parkinson's Disease
31 = Physical Disability
32 = Stroke
33 = Tinnitus
34 = Ear Infections
35 = Asthma
36 = Sexually Transmitted Disease (STD)
37 = Other
39 = Unknown/Not Reported General Medical Cond
00 = No General Medical Condition

v.1.18.2016
**InSyst Data Entry for SUD Clients.**

- **For SUD Services enter in InSyst:**
  
  1.) Required ICD-10 Primary Included Medi-Cal SUD Dx (see attached)
  2.) Optional ICD-10 Secondary SUD Diagnoses (may be Included or Excluded)

---

**Medical Records Documentation for MH Clients**

- For MH Clients, the Dx is maintained in the MH Assessment.
- See attached Medi-Cal Included Dx Lists for:
  - *Outpatient MH Services M/C Included Dx List (by ICD-10 Code and DSM Name)*
  - *Inpatient MH Services M/C Included Dx List (by ICD-10 Code and DSM Name)*
- Do not use the M/C Included Lists posted by DHCS on their website as they include more Dx’s than may actually be utilized.
- Also, as DHCS continues to update their Included Dx Lists—we will update ours and keep you posted.
Medical Records Documentation for MH Clients Cont.

• **Crosswalk for Outpatient MH Services: DSM-IV-TR to DSM-5/ICD-10**
  
  – This crosswalk offers alternatives for Included Dx’s when the client’s Dx was on the prior Included M/C List (DSM-IV-TR) but has dropped off the current Included M/C List (ICD-10).
  
  – It only has possibilities, and the clinician must ensure than the ICD-10 Included Dx’s DSM Criteria is consistent with the client’s current signs and symptoms.

Medical Records Documentation for MH Clients Cont.

• Medical Record Documentation will follow DSM-5 guidelines (utilizing DSM-5/ICD-10 codes). DSM-IV-TR codes and conventions will no longer be followed.

• Medi-Cal will require that documentation for each Dx within the Assessment clearly documents the diagnostic criteria established in the DSM-5.

• The only exception is if an additional Dx is listed as “by history” (such as for an excluded or physical health Dx). In that case, indicate “by history” and the source of the data.
The only exceptions to utilizing the DSM-5 criteria are for those diagnoses listed below in Table 1, where the DSM-IV-TR descriptions (names) and criteria will continue to be utilized (with the ICD-10 code indicated):

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>DSM-IV-TR Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>F84.5</td>
<td>Asperger’s Disorder</td>
</tr>
<tr>
<td>F84.9</td>
<td>Pervasive Developmental Disorder, NOS</td>
</tr>
<tr>
<td>F84.2</td>
<td>Rett’s Disorder</td>
</tr>
<tr>
<td>F84.3</td>
<td>Childhood Disintegrative Disorder</td>
</tr>
<tr>
<td>F84.0</td>
<td>Autism (excluded) Dx for Outpatient MH Svs</td>
</tr>
</tbody>
</table>

When listing the ICD-10 Diagnoses in the Medical Record, the fields on the next slide are required.

Note, than when entering the **Dx Code**—the full DSM Description (Dx name) with **Specifiers** ALSO must be noted.

DHCS also recommends additionally including the ICD-10 Description (Dx name).
Medical Records Documentation for MH Clients Cont.

• For MH Services:
  – Required ICD-10 Primary Included Medi-Cal MH Diagnosis (see attached)
  – Required ICD-10 Additional MH Diagnoses (start with any additional Included, followed by any additional Excluded Dx's)
  – Required ICD-10 SUD Diagnoses (all Excluded Dx)
  – Required ICD-10 Medical Diagnoses (or General Medical Codes—see earlier slide. If GMC Codes are utilized in the Medical Record they must also be described by name.)
  – Required ICD-10 Psycho-Social Conditions—principal listed first (see attached)
  – Optional Disability Score: WHODAS or other.

Medical Records Documentation for SUD Clients

• In the SUD Record, Dx are maintained in the Client Plan.
• See attached Medi-Cal Included Dx Lists for:
  – SUD Services M/C Included Dx List (by ICD-10 Code and by DSM Name)
• Do not use the M/C Included Lists posted by DHCS on their website as they include more Dx's than may actually be utilized.
• Also, as DHCS continues to update their Included Dx Lists—we will update ours and keep you posted.
Medical Records Documentation for SUD Clients Cont.

• Medical Record Documentation will follow DSM-5 guidelines (utilizing DSM-5/ICD-10 codes). DSM-IV-TR codes and conventions will no longer be followed.

• Medi-Cal will require that documentation for each Dx clearly documents the diagnostic criteria established in the DSM-5.
  – The only exception is if an additional Dx is listed as “by history” (such as for an excluded or physical health Dx). In that case, indicate “by history” and the source of the data.

Medical Records Documentation for SUD Clients Cont.

• When listing the ICD-10 Diagnoses in the Medical Record, the fields on the next slide are required.

• Note, than when entering the Dx Code—the full DSM Description (Dx name) with Specifiers ALSO must be noted.

• DHCS also recommends additionally including the ICD-10 Description (Dx name).
Medical Records Documentation for SUD Clients Cont.

• For SUD Services:
  – ICD-10 Primary Included Medi-Cal SUD Dx (see attached)
  – ICD-10 Additional SUD Diagnoses (may be Included or Excluded Dx)
  – ICD-10 MH Diagnoses (Excluded Dx)

Medical Records Documentation for SUD Clients Cont.

• For SUD Services:
  – ICD-10 Medical Diagnoses (or General Medical Codes—see attached. If GMC Codes are utilized in the Medical Record they must also be described by name)
    • See slides above slides for GMC Codes
  – ICD-10 Psycho-Social Diagnoses-principal listed first (see attached)
Medical Records Documentation for SUD Clients Cont.

• For SUD Services:
  – ICD-10 Medical Diagnoses (or General Medical Codes—see attached. If GMC Codes are utilized in the Medical Record they must also be described by name)
  – See slides above slides for GMC Codes

Clinician’s Gateway MH Dx Fields

<table>
<thead>
<tr>
<th>DSM-5: Mental Health</th>
<th>ICD-10</th>
<th>ICD-10 Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Select)</td>
<td>(Select)</td>
<td>(Select)</td>
</tr>
</tbody>
</table>

Signs & Symptoms that Support Diagnosis or Per History:

Add Additional Diagnosis

IF DX HAS CHANGED, YOU MUST CORRECT IN EHR FOR CORRECT CLAIMING.
Coordinate Diagnoses with other clinicians
Clinician’s Gateway MH Dx Fields Cont.

### DSM-5: Substance Use

<table>
<thead>
<tr>
<th>DSM-5 Descriptor</th>
<th>ICD-10</th>
<th>ICD-10 Descriptor</th>
<th>Rule Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Select)</td>
<td>(Select)</td>
<td>(Select)</td>
<td></td>
</tr>
</tbody>
</table>

**Sigs & Symptoms that Support Diagnosis or Per History:**

*Add Additional Diagnosis*

**IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING. Coordinate Diagnoses with other clinicians***

---

Clinician’s Gateway MH Dx Fields Cont.

### Physical Health: General Medical Codes

<table>
<thead>
<tr>
<th>General Medical Codes</th>
<th>(Select code)</th>
<th>(Select diagnosis description)</th>
<th>Rule Out</th>
</tr>
</thead>
</table>

**Sigs & Symptoms that Support Diagnosis or Per History:**

*Add Additional Diagnosis*

**IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING. Coordinate Diagnoses with other clinicians***

---
Clinician’s Gateway MH Dx Fields Cont.

<table>
<thead>
<tr>
<th>DSM-5 Descriptor</th>
<th>ICD-10</th>
<th>ICD-10 Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Select)</td>
<td>(Select)</td>
<td>(Select)</td>
</tr>
<tr>
<td>Signs &amp; Symptoms that Support Diagnosis or Past History:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Add Additional Diagnosis:

IF DX HAS CHANGED, YOU MUST CORRECT IN SYST TO CORRECT CLAIMING.

Coordinate Diagnoses with other clinicians.

Clinician’s Gateway MH Dx Fields Cont.

v.1.8.2016
Contacts

• For assistance with Medical Record Documentation requirements effective 4/1/17 please contact your ACBHCS Quality Assurance Technical Assistance Contact.
  – See Contact List.

ACBHCS QA Contacts

Mental Health: Master Contract Providers (aka CBOs), County Clinics/Programs & Network Providers

<table>
<thead>
<tr>
<th>CBO’s by Parent Agency Name, or County Clinic by Program Name</th>
<th>QA Technical Support Staff Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>All CBO’s &amp; Network Providers: A-I</td>
<td>Jeff Sammis, PsyD</td>
</tr>
<tr>
<td>All Children’s County Clinics and Programs</td>
<td><a href="mailto:jsmmis@acbhc.org">jsmmis@acbhc.org</a></td>
</tr>
<tr>
<td>All CBO’s &amp; Network Providers: I-Z</td>
<td>Michael DeVito, LMFT</td>
</tr>
<tr>
<td>All Adult County Clinics and Programs</td>
<td><a href="mailto:MDeVito@acbhc.org">MDeVito@acbhc.org</a></td>
</tr>
</tbody>
</table>

Substance Use Disorder Treatment & Prevention Providers

<table>
<thead>
<tr>
<th>Provider Agency Name</th>
<th>QA Technical Support Staff Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-Z</td>
<td>Sharon Loveseth, CADCII, LAADC*</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:SLoveseth@acbhc.org">SLoveseth@acbhc.org</a></td>
</tr>
<tr>
<td></td>
<td>*a non-governmental license LNR4020332</td>
</tr>
</tbody>
</table>
Contacts Cont.

- For assistance with entering ICD-10 codes into InSyst effective 4/1/17 please contact the Information Systems Help Desk @ 510.567.8181.

Changes to Chapters
Changes to Chapters

22 chapters…

One chapter kept the same name ~ Personality Disorders

6 chapters with new names but identical or similar diagnoses

<table>
<thead>
<tr>
<th>DSM IV</th>
<th>DSM 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia and Other Psychotic Disorders</td>
<td>Schizophrenia Spectrum and Other Psychotic Disorders</td>
</tr>
<tr>
<td>Somatoform Disorders</td>
<td>Somatic Symptom and Related Disorders</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>Feeding and Eating Disorders</td>
</tr>
<tr>
<td>Sleep Disorders</td>
<td>Sleep-Wake Disorders</td>
</tr>
<tr>
<td>Substance-Related Disorders</td>
<td>Substance-Related and Addictive Disorders</td>
</tr>
<tr>
<td>Delirium, Dementia, and Amnestic and Other Cognitive Disorders</td>
<td>Neurocognitive Disorders</td>
</tr>
</tbody>
</table>
Changes to Chapters
15 chapters with significant changes

- Neurodevelopmental Disorders
- Bipolar and Related Disorders
- Depressive Chapters
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Elimination Disorders
- Sexual Dysfunctions
- Gender Dysphoria

- Disruptive, Impulse-Control and Conduct Disorders
- Paraphilic Disorders
- Other Mental Disorders
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication
- Other Conditions that may be a Focus of Clinical Attention

Chapters in which Medi-Cal SMHS covers diagnoses

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescences (Pervasive Developmental Disorder, Tic Disorders, ADHD)</td>
<td>Neurodevelopmental Disorders</td>
</tr>
<tr>
<td>Schizophrenia and Other Psychotic Disorders</td>
<td>Schizophrenia Spectrum and Other Psychotic Disorders</td>
</tr>
</tbody>
</table>
### Chapters in which Medi-Cal SMHS covers diagnoses

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorders</td>
<td>Bipolar and Related Disorders</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>Depressive Disorders</td>
</tr>
<tr>
<td>Anxiety Disorders, Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence</td>
<td>Anxiety Disorders</td>
</tr>
<tr>
<td>Anxiety Disorders, Somatoform Disorders, Impulse-Control Disorder Not Elsewhere Classified</td>
<td>Obsessive-Compulsive and Related Disorders</td>
</tr>
</tbody>
</table>

### Chapters in which Medi-Cal SMHS covers diagnoses

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders, Adjustment Disorder, Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence</td>
<td>Trauma- and Stressor-Related Disorders</td>
</tr>
<tr>
<td>Anxiety Disorders, Adjustment Disorder, Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence</td>
<td>Dissociative Disorders</td>
</tr>
<tr>
<td>Somatoform Disorders</td>
<td>Somatic Symptom and Related Disorders</td>
</tr>
</tbody>
</table>
### Chapters in which Medi-Cal SMHS covers diagnoses

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence &amp; Eating Disorders</td>
<td>Feeding and Eating Disorders</td>
</tr>
<tr>
<td>Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence</td>
<td>Elimination Disorders</td>
</tr>
<tr>
<td>Sexual and Gender Identity Disorders</td>
<td>Gender Dysphoria</td>
</tr>
</tbody>
</table>

### Chapters in which Medi-Cal SMHS covers diagnoses

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence &amp; Impulse Control Disorders Not Elsewhere Classified</td>
<td>Disruptive, Impulse Control, and Conduct Disorders</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>Personality Disorders</td>
</tr>
<tr>
<td>Sexual and Gender Identity Disorders</td>
<td>Paraphilic Disorder</td>
</tr>
</tbody>
</table>
Chapters in which Medi-Cal SMHS covers diagnoses

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Conditions That May Be A Focus of Clinical Attentions</td>
<td>Medication-Induced Movement Disorders and Other Adverse Effects of Medication</td>
</tr>
<tr>
<td>Substance-Related Disorders, and Impulse-Control Disorders Not Elsewhere Classified</td>
<td>Substance Related and Addictive Disorders*</td>
</tr>
</tbody>
</table>

* Gambling Disorder is the only one covers by Medi-Cal SMHS

Neurodevelopmental Disorders

- Intellectual Disabilities
- Communication Disorders
- Autism Spectrum Disorder
- ADHD
- Specific Learning Disorder
- Motor Disorders
- Other Neurodevelopmental Disorders
Schizophrenia Spectrum & Psychotic Disorders

- Schizotypal (Personality) Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Substance/Medication-Induced Psychotic Disorder
- Psychotic Disorder Due to Another Medical Condition
- Catatonia Associated With Another Mental Disorder (Catatonia Specifiers)
- Catatonic Disorder Due to Another Medical Condition
- Unspecified Catatonia

Mood Disorders

Divided into 2 chapters
- Bipolar and Related Disorders
- Depressive Disorders
Bipolar & Related Disorders

- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder
- Substance/Medication-Induced Bipolar and Related Disorder
- Bipolar and Related Disorder Due to Another Medical Condition
- Other Specified Bipolar and Related Disorder
- Unspecified Bipolar and Related Disorder

Depressive Disorders

- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Substance/Medication-Induced Depressive Disorder
- Depressive Disorder Due to Another Medical Condition
- Other Specified Depressive Disorder
- Unspecified Depressive Disorder
Anxiety Disorders

Divided into 3 chapters
• Anxiety Disorders
• Obsessive-Compulsive and Related Disorders
• Trauma- and Stressor-Related Disorders

Anxiety Disorders

• Separation Anxiety Disorder
• Selective Mutism
• Specific Phobia
• Social Anxiety Disorder
• Panic Disorder
• Panic Attack
• Agoraphobia
• Generalized Anxiety Disorder
Obsessive-Compulsive and Related Disorders

- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania (Hair-Pulling Disorder)
- Excoriation (Skin-Picking) Disorder
- Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
- Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
- Other Specified Obsessive-Compulsive and Related Disorder
- Unspecified Obsessive-Compulsive and Related Disorder

Trauma- and Stressor-Related Disorders

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- PTSD
- Acute Stress Disorder
- Adjustment Disorders
- Other Specified Trauma- and Stressor-Related Disorder
- Unspecified Trauma- and Stressor-Related Disorder
Dissociative Disorders

- Dissociative Identity Disorder
- Dissociative Amnesia
- Depersonalization/Depersonalization Disorder
- Other Specified Dissociative Disorder
- Unspecified Dissociative Disorder

Somatic Symptom and Related Disorders

- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder (Functional Neurological Symptom Disorder)
- Psychological Factors Affecting Other Medical Conditions
- Factitious Disorder
- Other Specified Somatic Symptom and Related Disorder
- Unspecified Somatic Symptom and Related Disorder
Feeding & Eating Disorders

- Pica
- Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder
- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Other Specified Feeding and Eating Disorder
- Unspecified Feeding and Eating Disorder

Photo courtesy of Wikipedia

Elimination Disorders

- Enuresis
- Encopresis
- Other Specified Elimination Disorder
- Unspecified Elimination Disorder

Photo courtesy of Wikipedia
Sleep-Wake Disorders

- Replaces Sleep Disorders
- Three Categories:
  - Sleep
  - Breathing related
  - Parasomnias

Sexual & Gender Identity Disorders

Divided into 3 chapters:
- Sexual Dysfunctions
- Gender Dysphoria
- Paraphilic Disorders
Sexual Dysfunctions*

- Delayed Ejaculation
- Erectile Disorder
- Female Orgasmic Disorder
- Female Sexual interest/Arousal Disorder
- Genito-Pelvic Pain/Penetration Disorder
- Male Hypoactive Sexual Desire Disorder
- Premature (Early) Ejaculation
- Substance/Medication-Induced Sexual Dysfunction

Gender Dysphoria

- Gender Dysphoria in Children
- Gender Dysphoria in Adolescents and Adults
Paraphilic Disorder

- Voyeuristic Disorder
- Exhibitionistic Disorder
- Frotteuristic Disorder
- Sexual Masochism Disorder
- Sexual Sadism Disorder
- Pedophilic Disorder
- Fetishistic Disorder
- Transvestic Disorder

Disruptive, Impulse-Control & Conduct Disorders

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorder
- Pyromania
- Kleptomania
- Other Specified Disruptive, Impulse-Control, and Conduct Disorder
- Unspecified Disruptive, Impulse-Control, and Conduct Disorder

Photo courtesy of Wikipedia
Substance-Related & Addictive Disorders

- Substance Use Disorders
- Substance Induced Disorders
- Other Substance/Medication-Induced Mental Disorders
- Behavioral Addictions

Neurocognitive Disorders*

- Replaces Delirium, Dementia, Amnestic and Other Cognitive Disorders
- No Dementia
- Major or Mild Neurocognitive Disorder Due to ....
  - HIV
  - Parkinson’s
  - Substance/Medication Induced
  - Traumatic Brain Injury
Personality Disorders

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Personality Change Due to Another Medical Condition
- Other Specified Personality Disorder
- Unspecified Personality Disorder

Medication Induced Movement Disorders and Other Adverse Effects of Medication

- Neuroleptic-induced parkinsonism
- Other Medication-Induced Parkinsonism
- Neuroleptic Malignant Syndrome
- Medication-induced Acute Dystonia
- Medication-induced Acute Akathisia
- Tardive Dyskinesia
- Tardive Dystonia
- Medication-induced Postural Tremor
Diagnoses

Neurodevelopmental Disorders

– Intellectual Disability
– Communication Disorders
– *Pervasive Developmental Disorders*
– ADHD
– Specific Learning Disorder
– Motor Disorders
Neurodevelopmental Disorders

Characteristics

Developmental Period
• Negatively affected development trajectory
• Specifiers:
  – Factors that influence etiology
  – Factors that influence clinical course
  – Age of onset
  – Severity rating

Communication Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressive Language Disorder and Mixed Receptive-Expressive Language Disorder</td>
<td>Language Disorder</td>
</tr>
<tr>
<td>Phonological Disorder</td>
<td>Speech Sound Disorder</td>
</tr>
<tr>
<td>Stuttering</td>
<td>Childhood Onset Fluency Disorder (Stuttering)</td>
</tr>
<tr>
<td>Social (Pragmatic) Communication Disorder</td>
<td></td>
</tr>
</tbody>
</table>
new –

Social (Pragmatic) Communication Disorder

Symptoms
• Deficits in using communication for social purposes in a manner that is appropriate for the social context
• Impairment of the ability to change communication to match context or the needs of the listener
• Difficulties following rules for conversation and storytelling
• Difficulty understanding what is not explicitly stated and nonliteral or ambiguous meanings of language

new –

Social (Pragmatic) Communication Disorder

Symptoms
• Results in functional limitations in
  – Effective communication
  – Social participations
  – Social relationship
  – Academic achievement
  – Occupational performance
• Onset in early developmental period
new –
Social (Pragmatic) Communication Disorder

Development & Course
– Usually identified by age 4 or 5
– Milder form identified in adolescents

Risk and Prognostic Factors
– Genetic and physiological

Autism Spectrum Disorders

<table>
<thead>
<tr>
<th>DSM IV</th>
<th>DSM 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autistic Disorder</td>
<td>Autism Spectrum Disorder (ASD) with specifiers</td>
</tr>
<tr>
<td>Asperger's Disorder</td>
<td></td>
</tr>
<tr>
<td>Childhood Disintegrative Disorder</td>
<td>Not being used by Medi-Cal for Specialty Mental Health Services</td>
</tr>
<tr>
<td>Pervasive developmental disorder not otherwise specified</td>
<td></td>
</tr>
<tr>
<td>Rett's Disorder</td>
<td></td>
</tr>
</tbody>
</table>
Pervasive Developmental Disorders

Use the DSM-IV criteria

- Autistic Disorder (F84.0)
- Rett’s Disorder (F84.2)
- Childhood Disintegrative Disorder (F84.3)
- Asperger’s Disorder (F84.5)
- Other Pervasive Developmental Disorder (F84.8)
- Pervasive Developmental Disorder Unspecified (F84.9)

Attention-Deficit/Hyperactivity Disorder

<table>
<thead>
<tr>
<th>DSM IV</th>
<th>DSM 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder</td>
<td><strong>Attention-Deficit/Hyperactivity Disorder</strong></td>
</tr>
<tr>
<td></td>
<td>• Predominantly inattentive</td>
</tr>
<tr>
<td></td>
<td>• Predominantly hyperactive/impulsive</td>
</tr>
<tr>
<td></td>
<td>• Combined</td>
</tr>
<tr>
<td>Other Specified Attention-Deficit/Hyperactivity Disorder</td>
<td><strong>Other Specified Attention-Deficit/Hyperactivity Disorder</strong></td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified</td>
<td><strong>Unspecified Attention-Deficit/Hyperactivity Disorder</strong></td>
</tr>
</tbody>
</table>
Attention-Deficit/Hyperactivity Disorder

- Similar criteria
- Some significant changes:
  - Children and adults
  - Symptoms required in each setting
  - Symptoms by age 12
  - Co-occurring with ASD
  - Fewer symptoms for adults

ADHD

A persistent pattern of **inattention** and /or **hyperactivity-impulsivity** symptoms that interferes with functioning or development

- Six + symptoms (children & youth) five (17+ years of age)
- At least 6 months
- Inconsistent with developmental levels
- Directly negatively impact social and academic/occupational activities
- Several symptoms were present prior to age 12
- Several symptoms present in two or more settings
- Clear evidence that symptoms interfere with or reduce the quality of social, academic or occupational functioning
ADHD

Subtypes
- Combined presentation
- Predominantly inattentive presentation
- Predominantly hyperactive/impulsive presentation

Specifiers
- In partial remission
- Severity:
  - Mild: Few, if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning
  - Moderate: Symptoms or functional impairments between “mild” and “severe” are present.
  - Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning

Motor Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Coordination Disorder</td>
<td>Developmental Coordination Disorder</td>
</tr>
<tr>
<td>Stereotypic Movement Disorder</td>
<td>Stereotypic Movement Disorder</td>
</tr>
<tr>
<td>Tourette’s Disorder</td>
<td>Tourette’s Disorder</td>
</tr>
<tr>
<td>Chronic Motor or Vocal Tic Disorder</td>
<td>Persistent (Chronic) Motor or Vocal Tic Disorder</td>
</tr>
<tr>
<td>Transient Tic Disorder</td>
<td>Provisional Tic Disorder</td>
</tr>
<tr>
<td>Tic Disorder Not Otherwise Specified</td>
<td>Other Specified Tic Disorder</td>
</tr>
<tr>
<td>Tic Disorder Not Otherwise Specified</td>
<td>Unspecified Tic Disorder</td>
</tr>
</tbody>
</table>
Stereotypic Movement Disorder

- Repetitive, seemingly driven, and apparently purposeless motor behavior (e.g. hand shaking or waving, body rocking, head banging, self-biting, hitting own body)
- The behavior interferes with social, academic, or other activities and may result in self-injury
- Onset – early developmental period
- Specifiers:
  - With or without self-injurious behaviors
  - Assoc. with known medical, genetic condition, neurodev. disorder or environmental factor
  - mild, moderate or severe

Schizophrenia Spectrum and Psychotic Disorders
Spectrum of Psychotic Disorders

Least severe

to

Most Severe

Schizophrenia Spectrum and Psychotic Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizotypal Personality Disorder</td>
<td>Schizotypal (Personality) Disorder</td>
</tr>
<tr>
<td>Delusional Disorder</td>
<td>Delusional Disorder</td>
</tr>
<tr>
<td>Brief Psychotic Disorder</td>
<td>Brief Psychotic Disorder</td>
</tr>
<tr>
<td>Schizophreniform Disorder</td>
<td>Schizophreniform Disorder</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>Schizoaffective Disorder</td>
</tr>
<tr>
<td>Substance –Induced Psychotic Disorder</td>
<td>Substance/Medication-Induced Psychotic Disorder</td>
</tr>
<tr>
<td>Psychotic Disorder Due to a General Medical Condition with Delusions</td>
<td>Psychotic Disorder Due to Another Medical Condition</td>
</tr>
<tr>
<td>Psychosis NOS</td>
<td>Other specified schizophrenia spectrum and other psychotic disorder</td>
</tr>
<tr>
<td>Psychosis NOS</td>
<td>Unspecified schizophrenia spectrum and other psychotic disorder</td>
</tr>
<tr>
<td>None</td>
<td>Unspecified Catatonia</td>
</tr>
</tbody>
</table>
Delusional Disorder

- One or more delusion present for 1 month or longer
- Does not meet criteria for
  - Hallucination, disorganized speech, grossly disorganized or catatonic behavior
- Behavior not markedly impaired, behavior not obviously bizarre or odd – except impact of delusion and its ramifications
- Sx of mania or major depression, if occurred, brief in comparison to period of delusions

Schizophrenia Spectrum

All disorders defined by abnormalities in 5 symptom domains
- Delusions
- Hallucinations
- Disorganized Thinking/Speech
- Grossly Disorganized/Abnormal Motor Behavior
  - includes catatonia
- Negative symptoms
Brief Psychotic Disorder

1 of 5 symptoms
1 day to less than 1 month

Schizophreniform Disorder

2 or more of 5 symptoms
At least 1 is a delusion, hallucination or disorganized speech
Significant portion of time during a 1 month period (or less if successfully treated) to 6 months

Schizophrenia

2 or more of 5 symptoms
At least 1 is a delusion, hallucination or disorganized speech
Significant portion of time during a 1 month period (or less if successfully treated) for at least 6 months

Clinician-Rated Dimensions of Psychosis Symptom Severity

• Assesses variations in the severity of symptoms
• Information useful for
  – Treatment planning
  – Prognostic decision-making
  – Research on pathophysiological mechanisms
• Rates primary symptoms on a 5 point scale:
  – 0 - not present
  – 1 - equivocal
  – 2 - present but mild
  – 3 - present and moderate
  – 4 - present and severe

Page 743
Specifiers

- With catatonia
- Current severity
  - Last 7 days
  - 5 point scale
    - Use Clinician Rated Dimensions of Psychosis Symptoms Severity measurement tool
      - 0 = not present
      - 4 = present and severe

In order to conform with ICD-9/10 in some instances these can be coded in the 4th or 5th digit...however in other instances it is documented after the name of the disorder

Specifiers – for Brief Psychotic Disorder

Specify if:
- With marked stressors
- Without marked stressors
- With postpartum onset
Specifiers – for Schizoaffective
Specify if:

• Good prognostic features
  – At least two of the following
    • Onset of first psychotic symptoms within 4 weeks of the first noticeable change in functioning or behavior
    • Confusion or perplexity
    • Good premorbid social or occupational functioning
    • Absence of blunted/flat affect

• Poor prognostic features
  – Two or more of the above features have NOT been present

Specifiers – for Schizophrenia
Specify if:

• after 1-year duration of the disorder
• not in contradiction to the diagnostic course
  – First episode, currently in acute episode
  – First episode, currently in partial remission
  – First episode, currently in full remission
  – Multiple episodes, current in acute episode
  – Multiple episodes, currently in partial remission
  – Multiple episodes, currently in full remission
  – unspecified
Schizoaffective Disorder

- Uninterrupted period that includes
  - Major mood episode (major depression, with depressed mood, or manic)
    - Major mood episode symptoms present majority of the total during of the active and residual portions of the illness
  - 2 or more of 5 symptoms (at least one is a delusion, hallucination or disorganized speech) for 2 or more weeks

- Subtypes
  - Bipolar Type, Depressive Type

- Specifiers
  - with Catatonia, first or multiple episodes, severity rating

Ryan

A 18 year old senior, Ryan, transfers to a new high school in January. He is referred to the school counselor due to “unusual behaviors” including hiding in the bathroom between classes. He tells the counselor that the classrooms and bathroom are the only place where the FBI cannot find him. He also hears voices telling him he has behaved poorly and deserves to be punished. He says he wishes the voices would go away and sometimes he is able to ignore them. It is hard to follow what Ryan is saying as he jumps from topic to topic. He reports that he moved in with his grandmother last month, as his mother “couldn’t deal with me anymore. Sometimes, she says, I am normal, and other times I am too weird for her.” After 6 months she got tired of his odd behaviors and kicked him out of the house. He denies any hospitalizations, using substances, or taking prescription medications.
Ryan’s Diagnoses

1. What primary diagnosis would you give Ryan?

2. Which Z-codes might you use in Ryan’s diagnosis?

3. What if, Ryan’s mother had kicked him out of the house after 12 months of the odds behaviors instead of 6 months?

4. How would you rate Ryan using the Clinician-Rated Dimensions of Psychosis Symptom Severity?

Bipolar and Related Disorders
# Bipolar and Related Disorders

<table>
<thead>
<tr>
<th>DSM IV</th>
<th>DSM 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar I Disorder</td>
<td>Bipolar I Disorder</td>
</tr>
<tr>
<td>Bipolar II Disorder</td>
<td>Bipolar II Disorder</td>
</tr>
<tr>
<td>Cyclothymic Disorder</td>
<td>Cyclothymic Disorder</td>
</tr>
<tr>
<td>Substance-Induced Mood Disorder</td>
<td>Substance/Medication-Induced Bipolar and Related Disorder</td>
</tr>
<tr>
<td>Mood Disorder Due to ...</td>
<td>Bipolar and Related Disorder Due to Another Medical Condition</td>
</tr>
<tr>
<td>[Indicate the General Medical Condition]</td>
<td>Other Specified Bipolar and Related Disorder</td>
</tr>
<tr>
<td>Bipolar Disorder Not Otherwise Specified</td>
<td>Unspecified Bipolar and Related Disorder</td>
</tr>
</tbody>
</table>

# Manic Episode

<table>
<thead>
<tr>
<th>DSM IV</th>
<th>DSM 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>A distinct period of abnormally and persistently elevated,</td>
<td>A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased activity or energy</td>
</tr>
<tr>
<td>persistently elevated, expansive or irritable mood</td>
<td></td>
</tr>
</tbody>
</table>
**Bipolar I**

Must meet the criteria for a manic episode and preceding or following manic episode there may be either a hypomanic episode or major depressive episode

- **Manic Episode**
  - Abnormally elevated mood state (euphoric or irritable)
  - Increased energy or activity

- **Hypomanic Episode**

- **Major Depressive Episode**

**Bipolar I Specifiers**

Current or most recent episode:

- Manic, hypomanic, depressed, unspecified

Severity Rating

- Mild, Moderate, Severe

Other

- With psychotic features, in partial remission, in full remission, unspecified
Bipolar I Specifiers

- With anxious distress
- With mixed features*
- With rapid cycling
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

With mixed features specifier

Replaces Bipolar I most recent episode mixed
- For Manic or Hypomanic, with mixed features:
  - Full criteria are met for manic or hypomaniac episode
  - At least 3 of the listed symptoms of depression are present during the majority of days of the current or most recent episode of mania or hypomania
- For Depressive, with mixed features:
  - Full criteria are met for major depressive episode
  - At least 3 of the listed symptoms of mania/hypomania are present during the majority of days of the current or most recent episode of depression
Bipolar II

Current or past:
• Hypomanic Episode
  – Abnormally elevated mood state (euphoric or irritable)
  – Increased energy or activity
• Major Depressive Episode
• Only one code
• Specify current or most recent episode
  – Hypomanic
  – Depressed

Cyclothymic Disorder

• For at least 2 years (1 for children)
  – numerous periods with hypomanic sx – do not meet full criteria for a hypomanic episode &
  – numerous periods with depressive sx – do not meet full criteria for MDE
• For at least 2 years (1 for children)
  – Sx have been present for at least half the time and no sx free period for more than 2 months at a time
• Criteria never met for major depressive, manic or hypomanic episode
Carmen

Carmen is a 15 year old girl who lives with her mother, Ms. Gonzales, and her 7 year old half-sister, Eloisa, in a 2 bedroom apartment. Ms. Gonzales works as a medical receptionist. When Carmen was 2 her father, Antonio, left. Carmen has not seen him since and has little contact with his family, who live in Mexico. According to Ms. Gonzales, Antonio inconsistently took lithium and would sometimes act very “odd.” Eloisa has contact with her father and grandparents. Ms. Gonzales’s parents and two older siblings live 6 hours away by car.

According to Ms. Gonzales, in the last year and a half Carmen’s GPA has dropped from a 3.0 to 1.5. She has lost most of her long-term friends and has been having conflicts with her mother and sister. Ms. Gonzales reports that Carmen has become “nasty and mean” at times. She reports that this moody behavior started when Carmen was 14. She will spend several days by herself, sleeps much of the time and seems so sad. During these times, Carmen tells her mother that none of her friends like her anymore and she looses interest in her favorite activities including video games and writing in her journal.
Carmen

Ms. Gonzales reports that at other times Carmen is “a holy terror” full of energy and yelling at her sister and her mom. She will become giddy and laugh at everything. During these periods, which last for several days, Carmen is enthusiastic about getting housework done and not only helps out, but initiates cleaning projects. She also seems to write in her journal a lot during these times. Ms. Gonzales reports that Carmen has not been on any medication other than antibiotics, when she was young for ear infections and 2 episodes of strep throat.

Carmen

In a meeting with a clinician Carmen states that she does not like how she has been feeling. “I will feel so depressed for 4 or 5 days, I can hardly get out of bed or do anything and then I will feel murderous, like someone was churning up my insides. This will last for five days or so.” She says, “I don’t know why I have these feelings but I hate them. Then I will feel great, full of energy and ready to conquer the world. I never know how I will feel from day to day.” Carmen denies using alcohol or other drugs, hearing voices outside her head, seeing things that are not really there and has not felt suicidal or homicidal.
Carmen

What diagnoses would you consider for Carmen and why?

Carmen’s Symptoms

Decreased GPA
Loss of friends
Withdrawn socially
Conflicts with family
Moody
Hypersomnia
Beliefs friends don’t like her
Stops favorite activities
(video games, journaling)

“Holy Terror”
Yelling
Fighting with mother and sister
Increased energy
Giddy
Laughing
Helping with chores
Initiating clean up projects
Feeling murderous, Internal churning
Carmen

Manic Episode
• A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased activity or energy, lasting at least 1 week and present most of the day, nearly every day

Hypomania
• A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

Carmen

Symptoms of Manic or Hypomaniac Episode:
3 or more of the following
1. Inflated self-esteem
2. Decreased need for sleep
3. More talkative than usual
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility
6. Increased goal directed activity
7. Excessive involved in activities that have a high potential for painful consequences
Carmen

At the end of Carmen’s Sophomore year, the family moves back to Ms. Gonzales’s parent’s home after she is laid off from her job. When Carmen is almost 18, Ms. Gonzales calls 911 after Carmen swallows an unknown number of her grandmother’s pain medication. Ms. Gonzales tells the ER doctor that Carmen has stopped taking her medication and has been having serious problems including very “dark periods” that include not going to school, not doing any school work and sleeping for hours. She will hardly eat at these time and has lost up to five pounds. She also is tearful and at times can be very irritable with a hair trigger temper. These episodes are lasting 2 to 3 weeks.

Carmen’s mood will switch over to periods of giddiness and laughing at everything for a week to ten days. She will then stay up to all hours and hardly sleeping at all, trying to get caught up on her school work and working on a novel based on her journal writings. She wants to get it published before she graduates from high school. Ms. Gonzales also thinks that Carmen is having sex with various boys during these times of high energy. She has come home from work to find different boys in Carmen’s bed. Ms. Gonzales has tried to get Carmen to go see a new counselor but Carmen has refused.
Carmen

What diagnoses would you consider for Carmen and why?

Carmen

Bipolar I
Manic Episode
A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased **goal-directed** activity or energy, lasting at least **1 week** and present most of the day, nearly every day.

1. Decreased need for sleep
2. Increased goal directed activity
3. Excessive involved in activities that have a high potential for painful consequences
Carmen

Bipolar I
Major Depressive Episode
• Five or more symptoms present during the same 2-week period and represent a change from previous functioning.
• At least one of the symptoms is depressed mood or loss of interest or pleasure
  1. Depressed mood
  2. Markedly diminished interest or pleasure in all or almost all activities
  3. Hypersomnia nearly every day
  4. Suicide Attempt

What diagnoses would you consider for Carmen if:
Ms. Gonzales told the ER doctor that Carmen has stopped taking her medication and has been having serious problems including very “dark periods” that include not going to school, not doing any school work and sleeping for hours. She will hardly eat at these time and has lost up to five pounds. She also is tearful and at times can be very irritable with a hair trigger temper. These episodes are lasting 2 to 3 weeks.
Carmen

And during those dark times, when Ms. Gonzales got up in the middle of the night, she would find Carmen either sitting in bed with her lap top working on her novel which she plans to complete before graduation or she would be asleep with different boys in hers bed. When Ms. Gonzales found the time to sit down to talk to her daughter, Carmen would be very talkative.

Carmen

What diagnoses would you consider for Carmen now?
## Depressive Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td><strong>Disruptive Mood Dysregulation Disorder</strong></td>
</tr>
<tr>
<td>Major Depression</td>
<td><strong>Major Depressive Disorder</strong></td>
</tr>
<tr>
<td>Dysthymia</td>
<td><strong>Persistent Depressive Disorder (Dysthymia)</strong></td>
</tr>
<tr>
<td>none</td>
<td>Premenstrual Dysphoric Disorder</td>
</tr>
<tr>
<td>Substance-Induced Mood Disorder</td>
<td>Substance/Medication-Induced Depressive Disorder</td>
</tr>
<tr>
<td>Mood Disorder Due to . . . [Indicate the General Medical Condition]</td>
<td>Depressive Disorder Due to Another Medical Condition</td>
</tr>
<tr>
<td>Depressive Disorder Not Otherwise Specified</td>
<td><strong>Other Specified Depressive Disorder</strong></td>
</tr>
<tr>
<td>Depressive Disorder Not Otherwise Specified</td>
<td><strong>Unspecified Depressive Disorder</strong></td>
</tr>
</tbody>
</table>
Bereavement

- No longer excluded as symptom of depression
- The first two months after a death
- Scientific reasons for change: symptoms and treatment similar
- Other types of losses accepted
- Concerns: unwarranted diagnoses, unnecessary medication

Grief Versus Depression

<table>
<thead>
<tr>
<th>Grief</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Painful feelings mixed with positive memories</td>
<td>Negative mood</td>
</tr>
<tr>
<td>Self-esteem preserved</td>
<td>Poor self-esteem</td>
</tr>
<tr>
<td>Positive emotions and humor</td>
<td>Not much in the way of positive emotions or humor</td>
</tr>
<tr>
<td>Wanting to die in order to join the deceased</td>
<td>Wanting to die due to feeling worthless, undeserving, unable to cope</td>
</tr>
</tbody>
</table>
**new - Disruptive Mood Dysregulation Disorder**

**Symptoms**
- bad temper & rage outbursts
- outburst inconsistent with developmental level
- 3+ times a week – average
- irritable or angry between outbursts
  – most of day, most days
- symptoms present x 12 months
  – can have up to 3 months without all symptoms
- symptoms present in 2 of three settings
- diagnosed made between 6 and 18 years old
- age of onset if before 10 years old
- no subtypes or specifiers

**Differential Diagnosis**
- Bipolar Disorders
- Oppositional Defiant Disorder
- ADHD, major depressive disorder, anxiety disorders and Autism Spectrum Disorder
- Intermittent Explosive Disorder

**Comorbidity**
- Disruptive behavior, mood, anxiety
- ASD
- Either DMDD or Bipolar
- If DMDD + ODD &/or IED
  – Only use DMDD
Major Depression

- Five or more symptoms present during the same 2-week period and represent a change from previous functioning.
  - Fatigue or loss of energy almost every day
  - Insomnia or hypersomnia nearly every day
  - Psychomotor agitation or retardation nearly every day
  - Feelings of worthlessness or excessive or inappropriate guilt almost every day
  - Impaired concentration, indecisiveness
  - Markedly diminished interest or pleasure in almost all activities nearly every day
  - Restlessness or feeling slowed down
  - Recurring thoughts of death or suicide
  - Significant weight loss or gain
- At least one of the symptoms is depressed mood or loss of interest or pleasure
- The symptoms cause clinically significant distress or impairment in social, occupations or other important areas of functioning

new – Persistent Depressive Disorder

Consolidates
  - Dysthymic Disorder
  - Chronic Major Depression

- Symptoms (2 or more)
  - At least 2 years in adults
  - At least 1 year in children and adolescents (counting irritability)
    - Appetite Disturbance
    - Sleep Disturbance
    - Low Energy/Fatigue
    - Low Self-Esteem
    - Poor Concentration/Decision-Making
    - Hopelessness
### Persistent Depressive Disorder

#### Specifiers

<table>
<thead>
<tr>
<th>Specifiers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>With pure dysthymic syndrome</td>
<td>Full criteria for major depressive episodes not met in preceding 2 years</td>
</tr>
<tr>
<td>With persistent major depressive episode</td>
<td>Full criteria for major depression met throughout preceding 2 years</td>
</tr>
<tr>
<td>With intermittent major depressive episodes, with current episode</td>
<td>Full criteria for major depressive episode currently met but at least 8 weeks in the preceding 2 years without all symptoms needed to meet criteria</td>
</tr>
<tr>
<td>With intermittent major depressive episodes, without current episode</td>
<td>Full criteria not currently met, has been one or more major depressive episode in at least the preceding 2 years</td>
</tr>
</tbody>
</table>

### Persistent Depressive Disorder

#### Specifiers

<table>
<thead>
<tr>
<th>Specifiers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious distress</td>
<td></td>
</tr>
<tr>
<td>Mixed features</td>
<td></td>
</tr>
<tr>
<td>Melancholic features</td>
<td></td>
</tr>
<tr>
<td>Atypical features</td>
<td></td>
</tr>
<tr>
<td>Mood-congruent psychotic features</td>
<td></td>
</tr>
<tr>
<td>Mood-incongruent psychotic features</td>
<td>Peripartum onset – during pregnancy or 4 weeks after delivery</td>
</tr>
<tr>
<td>In partial remission</td>
<td>Sx of previous MDE present but not full criteria or period &lt; 2 months without MDE sx after last episode</td>
</tr>
<tr>
<td>In full remission</td>
<td>Last 2 months, no significant signs or sx</td>
</tr>
<tr>
<td>Early onset</td>
<td>Before age 21</td>
</tr>
<tr>
<td>Late onset</td>
<td>After age 21</td>
</tr>
</tbody>
</table>
Persistent Depressive Disorder

- Note: Because the criteria for a major depressive episode included four sx that are absent from the symptoms list of PDD (dysthymia), a very limited number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for PDD. If full criteria for a major depressive episode have been met at some point during the current episode of illness, they should be given a diagnosis of major depressive disorder. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

- Individuals whose sx meet MDD criteria for 2 years should be given a dx of PDD and MDD
Marie

Marie is a 17 year old junior at a public high school. She is having trouble keeping her grades up and meets with her academic counselor. She tells the counselor that her parents have arguments and yell frequently when they are both home. Her parents have never physically hurt each other or the kids and very infrequently yell at the children. They both work and are gone 12 to 15 hours 6 days a week. Her older sister had been the one to raise her and her younger brother until she left for college two years ago. Marie and her younger brother have been fending for themselves since then. Since her sister moved out two years ago, Marie has found it harder to stay focused on her school work.

Marie

She usually skips breakfast and dinner as she does not want to cook for herself and does not feel hungry but she does eat lunch at school. All of her clothes are now too big on her. She is also not sure the purpose of living and states that she cries herself to sleep most nights and feels pretty hopeless about life getting any better. Marie stated that she is generally tired but she tends to wake up several hours before her alarm goes off almost every day. Marie is unable to think of activities that she enjoys. She mentions that after her sister visits, Marie has trouble getting out of bed and misses school for several days. At those times she has thought about how to kill herself. The only plan she has considered was taking pills but she does not know how to get any that are lethal.
What Primary Diagnoses Might You Consider for Marie?

Including ICD-10 code

George

A 35-year-old man, George, attends marital therapy with his wife, Janet. Janet shares that George became “a different person” after his mother died 3 years ago. She reports that he used to enjoy working in the yard, initiating and planning outings, and going to movies. However, nowadays he is “too lazy” to do anything around the house, and prefers to sit on the couch watching television or listening to music. George agrees that he has been feeling “down in the dumps” most of the time since his mother died. He has trouble sleeping through the night, and usually wakes up an hour or two before he needs to.
George
George is always tired, and isn’t interested in eating. He has lost twenty pounds in the last year. Janet pushed him to get a physical exam, but the results were normal. The therapist asks George whether he has ever wanted to die or kill himself. George replies, “Since my mother died, during the holiday season I feel like dying.” Janet adds that George has never actually hurt himself, “but I’ve been scared he might.” George also reports that he is in danger of losing his job: He is frequently late, and when he is there, he often has a hard time focusing, and his numbers are down. The couple has come to therapy because Janet is threatening to leave him if things don’t change.

What Primary Diagnoses Might You Consider for George?

Including ICD-10 code
## Anxiety Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separation Anxiety Disorder</td>
<td>Separation Anxiety Disorder</td>
</tr>
<tr>
<td>Selective Mutism</td>
<td>Selective Mutism</td>
</tr>
<tr>
<td>Simple Phobia</td>
<td>Specific Phobia</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>Social Anxiety Disorder (Social Phobia)</td>
</tr>
<tr>
<td>Panic D/O with &amp; without Agoraphobia</td>
<td>Panic Disorder</td>
</tr>
<tr>
<td>— none —</td>
<td>panic attack (a specifier, not a diagnosis)</td>
</tr>
<tr>
<td>Panic Disorder with Agoraphobia</td>
<td>Agoraphobia</td>
</tr>
<tr>
<td>&amp; Agoraphobia w/o History of Panic Disorder</td>
<td></td>
</tr>
<tr>
<td>Generalized Anxiety Disorder (includes</td>
<td>Generalized Anxiety Disorder</td>
</tr>
<tr>
<td>Overanxious Disorder of Childhood)</td>
<td></td>
</tr>
<tr>
<td>Substance-Induced Anxiety Disorder</td>
<td>Substance/Medication-Induced Anxiety Disorder</td>
</tr>
<tr>
<td>Anxiety Disorder Due to . . . [Indicate the</td>
<td>Anxiety Disorder Due to Another</td>
</tr>
<tr>
<td>General Medical Condition]</td>
<td>Medical Condition</td>
</tr>
<tr>
<td>Anxiety Disorder NOS</td>
<td>Other Specified Anxiety Disorder</td>
</tr>
<tr>
<td>Anxiety Disorder NOS</td>
<td>Unspecified Anxiety Disorder</td>
</tr>
</tbody>
</table>
Separation Anxiety

- Moved from *Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence* to include adults.
- Criteria is mostly unchanged with language changes to include symptoms in adults.
- Medi-Cal SMHS only covers this disorder in children.

Selective Mutism

- Moved from *Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence* due to the fact the most children with the disorder are anxious.
- Criteria mostly unchanged
  - Consistent failure to speak in specific social situations in which there is an expectation for speaking despite speaking in other situations.
Specific Phobia

- Was Simple Phobia
- Core features the same
- Over 18 years old, not required to recognize fear or anxiety are excessive or unreasonable
- All ages – typically lasting for 6 months or more
- Specifiers indicated different types
- Each type has its own ICD-10 code

Social Anxiety

- Mostly the same criteria
- Individual over 18 does not need to recognize that their fear or anxiety is excessive or unreasonable
- Duration of “typically lasting for 6 months or more” required of all ages
- Specifier:
  - Removed: Generalized
  - Added: Performance only (if the fear is restricted to speaking or performing in public)
Panic Disorder

Recurrent unexpected panic attacks.

- An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes with 4 (or more) symptoms occurring:
  - Heart palpitation, pounding, racing
  - 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)
  - Derealization (feeling of unreality) or depersonalization (being detached from oneself)
  - Fear of losing control or “going crazy”
  - Fear of dying

Panic Attack Specifier

- 11.2% of adults
- Agoraphobia is a separate disorder
- An abrupt surge of intense fear of intense discomfort
- Can occur with
  - Anxiety disorder
    - including Panic Disorder
  - Depressive disorder
  - PTSD
  - Substance use disorder
  - Some medical conditions
- Is a specifier
- Is not a mental disorder
Agoraphobia

- Marked fear or anxiety about two (or more) of the following:
  - Using public transportation
  - Being in open spaces
  - Being in enclosed places
  - Standing in line or being in a crowd
  - Being outside of the home alone
- The fear or avoidance is due to thought that escape might be difficult or help might not be available if panic-like symptoms occur

Nadine

Nadine is a 15-year-old girl who was living with her stepfather for about two years after her mother died of cancer. She was removed from her stepfather’s home after he was arrested for drug and gun trafficking in a late-night raid on the home while Nadine was present. After several months in foster care, her foster mother, Stephanie, decided Nadine needed someone to talk with, as she was not willing to share much with Stephanie.
Nadine

Stephanie also noted that Nadine seemed to be struggling with her homework, had a GPA of 2.4, and often looked tired; also, Nadine’s hands would shake uncontrollably from time to time. Nadine also did not seem to have any friends, and was unwilling to go out of the house by herself except to attend school. When Nadine met alone with the counselor, she was reluctant to say much about herself. She did tell her counselor that she was constantly tense.

She admitted that her anxiety had been “really bad” for several years and often included episodes of dizziness, sweaty palms, upset stomach, and crying. She said she was generally unable to speak in any situation outside of her home or classes. She refused to leave her house alone for fear of being forced to interact with someone. She was especially anxious around other teenagers, but she also has become “too nervous” to speak to adult neighbors she had known for years before she moved to the foster home.
Nadine

She said it felt impossible to walk into a restaurant and order from “a stranger” at the counter for fear of being humiliated. She hates going to the mall, as she can’t stand being around crowds or waiting in lines, and tries to buy her clothes online. Once, when her foster mother insisted they get clothing for her at a store, she reported feeling fearful and tense the whole time they were out of the house.

Nadine

What diagnoses would you consider for Nadine and why?
# Obsessive-Compulsive & Related Disorders

## Obsessive-Compulsive and Related Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>Obsessive-Compulsive Disorder</td>
</tr>
<tr>
<td>Body Dysmorphic Disorder</td>
<td>Body Dysmorphic Disorder</td>
</tr>
<tr>
<td>none</td>
<td>Hoarding Disorder</td>
</tr>
<tr>
<td>Trichotillomania</td>
<td>Trichotillomania (Hair-Pulling Disorder)</td>
</tr>
<tr>
<td>none</td>
<td>Excoriation (Skin-Picking) Disorder</td>
</tr>
<tr>
<td>Substance-Induced Anxiety Disorder with Obsessive-Compulsive Symptoms</td>
<td>Substance/Medication-Induced Obsessive-Compulsive and Related Disorder</td>
</tr>
<tr>
<td>Anxiety Disorder Due to General Medical Condition with Obsessive-Compulsive Sx</td>
<td>Obsessive-Compulsive and Related Disorder Due to Another Medical Condition</td>
</tr>
<tr>
<td>Anxiety Disorder Not Otherwise Specified</td>
<td>Other Specified Obsessive-Compulsive and Related Disorder</td>
</tr>
<tr>
<td></td>
<td>Unspecified Obsessive-Compulsive and Related Disorder</td>
</tr>
</tbody>
</table>

227

228
Obsessive-Compulsive Disorder

Presence of obsessions, compulsions or both

Obsessions:
• 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 attempt to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or actions

Compulsions:
• Repetitive behaviors 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 behavior or mental acts are not connected to a realistic way with what they are designed to neutralize or prevent, or are clearly excessive
Obsessive-Compulsive Disorder

The obsessions or compulsions are
- Time consuming or
- Cause clinically significant distress or impairment

Specify if
- With good or fair insight
- With poor insight
- With absent insight/delusional beliefs
- Tic Related

Body Dysmorphic Disorder

- Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others
- At some point during the course of the disorder, individual has performed repetitive behaviors (mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (comparing appearance with others) in response to appearance concerns.
Body Dysmorphic Disorder

• Specifiers
  – With muscle dysmorphia
  – With good or fair insight
  – With poor insight
  – With absent insight/delusional beliefs

new - Hoarding Disorder

Symptoms
• Persistent difficulty discarding and 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 only because of the interventions of third parties
• The hoarding causes clinically significant distress or impairment in social, occupation, or other important areas of functioning (including maintaining a safe environment)
• The hoarding is not attributable to another medical condition
• The hoarding is not better explained by symptoms of another mental disorders
**new - Hoarding Disorder**

No Subtypes

Specifiers-
Specify if:
- With excessive acquisition

Specify if:
- With good or fair insight
- With poor insight
- With absent insight/delusional beliefs

---

**new - Hoarding Disorder**

Prevalence
- 2-5%

Development/Course
- Starts 11-15 years old
- Severity increases with age

Risk and Prognostic Factors
- Temperamental
- Environmental
- Genetic & Physiological

Photo courtesy of Wikipedia
**new - Hoarding Disorder**

Differential Diagnosis
- Other Medical Conditions
- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Major Depressive Episode
- OCD
- Neurocognitive Disorders

Comorbidity
- Anxiety Disorder
- Major Depressive Disorder
- Social Anxiety
- Generalize anxiety Disorder
- OCD

---

**Trichotillomania**

Symptoms
- Recurrent pulling out of one’s hair, resulting in hair loss
- Repeated attempts to decrease or stop hair pulling
- Causes significant distress or impairment
new – Excoriation Disorder

Symptoms
• Recurrent skin picking resulting in skin lesions
• Repeated attempts to decrease or stop skin picking
• Causes clinically significant distress or impairment in Functioning
• Skin picking is not attributable to physiologic effects of a substance (e.g., cocaine) or another medical condition (e.g. scabs)
• Not better explained by symptoms of another mental disorder
• No Subtypes or Specifiers

Prevalence
• 1.4% in adult population
• ¾ are women

Development/Course
• Any age
  – Adolescence most common
• Generally Chronic
• Can come and go
## Trauma & Stressor-Related Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive Attachment Disorder of Infancy or Early Childhood</td>
<td>Reactive Attachment Disorder</td>
</tr>
<tr>
<td>Reactive Attachment Disorder of Infancy or Early Childhood</td>
<td>Disinhibited Social Engagement Disorder</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder</td>
<td>Posttraumatic Stress Disorder</td>
</tr>
<tr>
<td>Acute Stress Disorder</td>
<td>Acute Stress Disorder</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>Adjustment Disorders</td>
</tr>
<tr>
<td>Anxiety Disorder Not Otherwise Specified</td>
<td>Other Specified Trauma- and Stressor-Related Disorder</td>
</tr>
<tr>
<td></td>
<td>Unspecified Trauma- and Stressor-Related Disorder</td>
</tr>
</tbody>
</table>
new
Disinhibited Social Engagement Disorder
&
Reactive Attachment Disorder

Etiology is the same:
• Exposure to extremes of insufficient care
  – social neglect/deprivation
  – repeated changes in caregivers
  – rearing in unusual settings

Comparison - Symptoms

<table>
<thead>
<tr>
<th>RAD</th>
<th>DSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both</td>
<td>A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults</td>
</tr>
<tr>
<td>A persistent social and emotional disturbance</td>
<td>The above behaviors are not limited to impulsivity (as in ADHD) but include socially disinhibited behavior</td>
</tr>
<tr>
<td>The child has experienced a pattern of extremes of insufficient care</td>
<td>The child has experienced a pattern of extremes of insufficient care</td>
</tr>
</tbody>
</table>
## Comparison – Development & Course

<table>
<thead>
<tr>
<th>RAD</th>
<th>DSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Neglect first months of life</td>
<td>- Neglect in first months of life</td>
</tr>
<tr>
<td>- Between 5 &amp; 9 months old manifestation is similar</td>
<td>- Neglect starting after age 2 – not associated with symptoms of disorder</td>
</tr>
<tr>
<td>- Unclear if and how occurs in children over 5.</td>
<td>- Toddlers: indiscriminate social behaviors and lack of reticence</td>
</tr>
<tr>
<td></td>
<td>- Preschoolers: attention-seeking behavior</td>
</tr>
<tr>
<td></td>
<td>- Middle childhood: verbal and physical overfamiliarity &amp; inauthentic expression of emotions</td>
</tr>
<tr>
<td></td>
<td>- Adolescence: indiscriminate behavior, conflicts</td>
</tr>
</tbody>
</table>

### Frank

Frank, 3, is the younger of two brothers. They were removed from their parents' home when Frank was 1 and his older brother Robert was found looking for food in the street wearing only his underwear. Both Frank’s mother and father were involved in drug use and drug sales and had spent time in jail. During these times the children lived with shifting sets of relatives and friends. Frank either cried inconsolably or withdrew into a corner and rocked back and forth. When the brothers were adopted together, Frank made slow but steady progress. Although at three he is still cautious and hesitant in his relationships, he is gradually learning to trust his adoptive parents.

RAD or DSED? Why?
Brittany

Brittany, 4, was adopted when she was 1 1/2 through an agency placement. Little was known about her biological parents or early life other than that she was removed due to neglect related to substance abuse. Since leaving her parents at age 7 months she lived with three sets of foster parents. At the time of her adoption she was physically underdeveloped, showed only momentary interest in toys or people, and evidenced symptoms similar to those manifested by a child with Attention-Deficit/Hyperactivity Disorder. She also was unable to differentiate among people she knew and strangers. Brittany was willing to climb on to the lap of any adult. She did not show signs of missing her principal caregivers.

RAD or DSED? Why?

Post Traumatic Stress Disorder

Criterion A

<table>
<thead>
<tr>
<th>DSM – IV</th>
<th>DSM - 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person has been exposed to a traumatic event in which both of the following are present:</td>
<td>Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:</td>
</tr>
<tr>
<td>1. Experienced, witnessed or was confronted with an event (s) that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. 2. The person’s response involved intense fear, helplessness or horror</td>
<td>1. Direct Experience traumatic event 2. Witnessed event (s) in person as they occurred 3. Close family member or friend (If actual or threatened death, violent or accidental) 4. Repeated or extreme exposure</td>
</tr>
</tbody>
</table>

247
### Post Traumatic Stress Disorder

<table>
<thead>
<tr>
<th>DSM – IV</th>
<th>Criteria</th>
<th>DSM – 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>re-experiencing</td>
<td>B Intrusion</td>
<td></td>
</tr>
<tr>
<td>avoidance</td>
<td>C Avoidance</td>
<td></td>
</tr>
<tr>
<td>Increased arousal</td>
<td>D Negative alteration in cognitions and mood</td>
<td></td>
</tr>
<tr>
<td>Duration &gt; 1 month</td>
<td>E Marked alterations in arousal and reactivity associated with trauma</td>
<td></td>
</tr>
<tr>
<td>Distress or impairment in social, occupational, other important areas of functioning</td>
<td>F Duration &gt; 1 month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G Distress or impairment in social, occupational, other important areas of functioning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H Not caused by substances or other medical condition</td>
<td></td>
</tr>
</tbody>
</table>

### Intrusions

One or more:
- Recurrent, involuntary and intrusive distressing memories of the traumatic event(s)
  - Children: repetitive play with themes or aspects of traumatic event(s)
- Recurrent distressing dreams in which the the content and/or affect of the dream are related to the traumatic event(s)
  - Children: frightening dreams, no recognizable content
- Dissociative reactions in which the individual feels or acts as if the traumatic event(s) were recurring
  - Children: trauma-specific reenactment may occur in play
- Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
- Marked physiological reaction to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
Avoidance

One or both:

- Avoids or effort to avoid distressing memories, thought, feelings about or closely associated with the traumatic events
- Avoidance of or efforts to avoid external reminders that arouse distressing memories, thought or feelings about or closely associated with the traumatic event(s)

Negative alterations in cognitions & mood

Two or more:

- Inability to remember an important aspect of the traumatic event(s)
- Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world
- Persistent, distorted cognitions about the cause or consequences of the traumatic events that lead the individual to blame self or others
- Persistent, negative emotional state
- Markedly diminished interest or participation in significant activities
- Feelings of detachment or estrangement from other
- Persistent inability to experience positive emotions
Marked alterations in arousal and reactivity associated with trauma

Two or more:
- Irritable behavior and angry outburst typically expresses as verbal or physical aggression towards people or objects
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

Post Traumatic Stress Disorder
Children 6 and under
Criterion A

<table>
<thead>
<tr>
<th>Older than 6 years</th>
<th>Under 6 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person has been exposed to a traumatic event in which both of the following are present:</td>
<td>Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:</td>
</tr>
<tr>
<td>1. Direct Experience traumatic event</td>
<td>1. Direct Experience traumatic event</td>
</tr>
<tr>
<td>2. Witnessed event (s) in person as they occurred</td>
<td>2. Witnessed event (s) in person as they occurred to others, especially primary caregivers (not through electronic media, TV, movies, pictures)</td>
</tr>
<tr>
<td>3. Close family member or friend (If actual or threatened death, violent or accidental)</td>
<td>3. Learning that trauma event(s) occurred to a parent or caregiver</td>
</tr>
<tr>
<td>4. Repeated or extreme exposure</td>
<td></td>
</tr>
</tbody>
</table>

253
PTSD - children 6 and under

<table>
<thead>
<tr>
<th>DSM – IV</th>
<th>Criteria</th>
<th>DSM - 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrusion</td>
<td>B Intrusions (one or more)</td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>C Avoidance &amp; Negative Alterations in Cognitions (one or more)</td>
<td></td>
</tr>
<tr>
<td>Negative alteration in cognitions and mood</td>
<td>D Alterations in arousal and reactivity associated with traumatic (event(s) (two or more)</td>
<td></td>
</tr>
<tr>
<td>Marked alterations in arousal and reactivity associated with trauma</td>
<td>E Duration &gt; 1 month</td>
<td></td>
</tr>
<tr>
<td>Duration &gt; 1 month</td>
<td>F Distress or impairment in relationship with parents, sibling, peers, or other caregivers or with school behavior</td>
<td></td>
</tr>
<tr>
<td>Distress or impairment in social, occupational, other important areas of functioning</td>
<td>G The disturbance is not attributable to the physiological effects of a substance (e.g., medications or alcohol or another medical condition</td>
<td></td>
</tr>
<tr>
<td>Not caused by substances or other medical condition</td>
<td>H</td>
<td>255</td>
</tr>
</tbody>
</table>

Post Traumatic Stress Disorder

- Specify if
  - delayed expression
- Subtypes:
  - Dissociative
    - depersonalization
    - derealization

Photo courtesy of Wikipedia

Copywrite 2017 • Rachel Michaelsen, LCSW
• www.psyte-online.com
Acute Stress Disorder

- Same Criteria B, C, D, E as PTSD
- Durations 3 days to 1 month after trauma exposure
- Sx typically begin immediately after the trauma, but last for at least 3 days to 1 month

Adjustment Disorder

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).</td>
<td>The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).</td>
</tr>
<tr>
<td>These symptoms or behaviors are clinically significant as evidence by either of the following: • Marked distress that is in excess of what would be expected from exposure to the stressor • Significant impairment in social or occupational (academic) functioning</td>
<td>These symptoms or behaviors are clinically significant, as evidence by one or both of the following: • Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation • Significant impairment in social, occupation, or other important areas of functioning.</td>
</tr>
</tbody>
</table>
Adjustment Disorder

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify if:</td>
<td>Specify If:</td>
</tr>
<tr>
<td><strong>Acute</strong>: if the disturbance lasts less than 6 months</td>
<td><strong>Acute</strong>: If the disturbance lasts less than 6 months</td>
</tr>
<tr>
<td><strong>Chronic</strong>: if the disturbance lasts for 6 months or longer. By definition, symptoms cannot persist for more than 6 months after the termination of the stressor or its consequences. The Chronic specifier therefore applies when the duration of the disturbance is longer than 6 months in response to a chronic stressor or to a stressor that has enduring consequences.</td>
<td><strong>Persistent (chronic)</strong>: if the disturbance lasts for 6 months or longer</td>
</tr>
</tbody>
</table>

*This is found only in the Update.

Justin

Justin, the youngest of three children, is a 4½-year-old boy referred by his pre-school teacher. The teacher reports problems including hitting children, destroying furniture and other children’s belongings in the classroom, saying mean things, and having verbal outbursts when he is frustrated. According to his mother, Justine, the pregnancy went to term, the delivery was uneventful, and Justin has been healthy, with no ear infections or other major childhood illnesses.
Justin

Currently Justin has tantrums, is easily frustrated and picks fight with his older brother. When he was about 2, his father, Jerry, lost his job, and Justine began working full-time as a home health aid. Due to heavy drinking and verbal abuse, Justin’s father was in and out of the home over the next two years. When Justin was 3, he fell off of the bike he was on with his older brother and cut open his chin. In the ER, he was given stitches with no medication.

Justin

Justin reported that he had nightmares for some time after the incident. Jerry’s brother offered Jerry a job in his construction business last spring and he moved to the Bay Area last spring. The rest of the family joined him in the Bay Area last summer after living in a rural community in Northern California near Justine’s family.
Justin

What diagnoses might you consider for Justin?

Dissociative Disorders
## Dissociative Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociative Identity Disorder</td>
<td>Dissociative Identity Disorder</td>
</tr>
<tr>
<td>Dissociative Amnesia</td>
<td>Dissociative Amnesia</td>
</tr>
<tr>
<td>Depersonalization Disorder</td>
<td>Depersonalization/De Realization Disorder</td>
</tr>
<tr>
<td>Dissociative Disorder Not Otherwise Specified</td>
<td>Other Specified Dissociative Disorder</td>
</tr>
<tr>
<td>Dissociative Disorder NOS</td>
<td>Unspecified Dissociative Disorder</td>
</tr>
</tbody>
</table>

## Somatic Symptom and Related Disorders
Somatic Symptom and Related Disorders

<table>
<thead>
<tr>
<th>DSM IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatization Disorder</td>
<td>Somatic Symptom Disorder</td>
</tr>
<tr>
<td>Undifferentiated Somatoform Disorder</td>
<td></td>
</tr>
<tr>
<td>Pain Disorder Associated with Both Psychological Factors and a General Medical Condition</td>
<td></td>
</tr>
<tr>
<td>Pain Disorder Associated with Psychological Factors</td>
<td></td>
</tr>
<tr>
<td>Hypochondriasis (with somatic symptoms)</td>
<td></td>
</tr>
<tr>
<td>Hypochondriasis (with predominantly anxiety symptoms)</td>
<td>Illness Anxiety Disorder</td>
</tr>
<tr>
<td>Conversion Disorder</td>
<td>Conversion Disorder (Functional Neurological Symptom Disorder)</td>
</tr>
<tr>
<td>[Specified Psychological Factor] Affecting …</td>
<td>Psychological Factors Affecting Other Medical Conditions</td>
</tr>
<tr>
<td>[Indicate the General Medical Condition]</td>
<td></td>
</tr>
<tr>
<td>Factitious Disorder</td>
<td>Factitious Disorder</td>
</tr>
<tr>
<td>Somatoform Disorder Not Otherwise Specified</td>
<td>Other Specified Somatic Symptom and Related Disorder</td>
</tr>
</tbody>
</table>

Somatic Symptom Disorder

Symptoms

- One or more somatic symptoms that are distressing or result in significant disruption of daily life
- Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
  - Disproportionate and persistent thoughts about the seriousness of one's symptoms
  - Persistently high level or anxiety about health or symptoms
  - Excessive time and energy devoted to these symptoms or health concerns
- Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)
Conversion Disorder
(Functional Neurological Symptom Disorder)

- Criteria are modified to
  - Emphasize the essential importance of the neurological exam
  - Recognize relevant psychological factors may not be demonstrated at the time of diagnosis

Factitious Disorder

- Moved to Somatic Symptoms and Related Disorders chapter from its own chapter.
- Criteria slightly changed
Ms. Adams

Geraldine Adams, a 66-year-old woman, was referred to an outpatient clinic by her primary-care physician. She continues to complain about serious pain, but her physician says x-rays and a physical exam indicate that her injury is almost completely healed. Ms. Adams told the counselor she has been suffering from horrible back pain after being assaulted while entering her apartment building a little over a year ago. The mugger had thrown her to the ground, taken her purse and bag of groceries, and kicked her in the back, leaving her with a fractured rib, several large bruises that took months to clear up, and a cut to her left hand that required stitches.

Ms. Adams

Prior to the attack, Ms. Adams had been enjoying her life after retiring from a 30-year career at the Social Security office. She had, had many friends that she visited, and spent time with her niece and grand-nephew. After the attack, she has been afraid to go out if she would not be home before dark, and always tries to do her grocery shopping with a neighbor or her niece. She reports feeling tired all the time since the attack.
Ms. Adams

When asked about how she is sleeping, Ms. Adams reports difficulty falling asleep, as she is thinking about whether she will ever recover from her broken rib. She states that she has had nightmares a couple of times a week since the attack. Ms. Adams stated several times that she thinks she will never recover from her back pain. She reports that she has lost most of her friends since the attack, as they are not patient with her, leading her to become angry and shout at them.

Ms. Adams

What diagnoses might you consider?
Ms. Adams

What diagnosis would you give Ms. Adams if 8 months after the attack she met the full criteria for PTSD but had not met the full criteria until that point?

Feeding and Eating Disorders
## Feeding & Eating Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pica</td>
<td><em>Pica</em></td>
</tr>
<tr>
<td>Rumination Disorder</td>
<td><em>Rumination Disorder</em></td>
</tr>
<tr>
<td>Feeding Disorder of Infancy or Early Childhood</td>
<td><em>Avoidant/Restrictive Food Intake Disorder</em></td>
</tr>
<tr>
<td>Anorexia Nervosa</td>
<td><em>Anorexia Nervosa</em></td>
</tr>
<tr>
<td>Bulimia Nervosa</td>
<td><em>Bulimia Nervosa</em></td>
</tr>
<tr>
<td>none</td>
<td><em>Binge Eating Disorder</em></td>
</tr>
<tr>
<td>Eating Disorder Not Otherwise Specified</td>
<td><em>Unspecified Feeding and Eating Disorder</em></td>
</tr>
</tbody>
</table>

### Avoidant/Restricted Food Intake Disorder

**Symptoms**

- An eating or feeding disturbance
  - Apparent lack of interest in eating or food
  - Avoidance based on sensory characteristics of food
  - Concern about aversive consequences of eating
- As manifested by persistent failure to meet appropriate nutritional and or energy needs associated with one (or more) of the following:
  - Significant weight loss (or failure to achieve expected weight gain or faltering growth in children
  - Significant nutritional deficiency
  - Dependence on enteral feeding or oral nutritional supplements
  - Marked interference with psychosocial functioning
Anorexia

- Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory, and physical health
- Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight
- Disturbance in the way in which one’s body or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Bulimia

- Recurrent episodes of binge eating characterized by both:
  - Eating, in a discrete period of time an amount of food that is definitely larger than what most individual 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 behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, other des, fasting, or excessive exercise
- Binging and purging occur on average 1x/wk x 3 mos
- Self-evaluation is unduly influenced by body shape and weight
- Does not occur exclusively during episode of anorexia nervosa
new - Binge Eating Disorder

Symptoms
• Recurrent episodes of binge eating characterized by:
  – Eating an amount of food that is definitely larger than what most people would eat in a discrete period of time
  – A sense of lack of control over eating during the episode
• The binge-eating episodes are associated with three or more of the following:
  – Eating much more rapidly than normal
  – Eating until uncomfortably full
  – Eating large amount 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 afterwards
• Presence of marked distress over eating
• Average 1x a week for 3 months
• Not associated with compensation measures, or exclusively with bulimia or anorexia

new - Binge Eating Disorder

Subtypes
– None
Specifiers
• In partial remission
• In full remission
• Severity Measures
  episodes of binge eating per week
  • Mild 1-3
  • Moderate 4-7
  • Severe 8-13
  • Extreme 14+

Photo courtesy of Wikipedia
## Elimination Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enuresis (Not Due to a General Medical Condition)</td>
<td><strong>Enuresis</strong></td>
</tr>
<tr>
<td>Encopresis with or without constipation and overflow incontinence</td>
<td><strong>Encopresis</strong></td>
</tr>
<tr>
<td>— none</td>
<td><strong>Other Specified Elimination Disorder</strong></td>
</tr>
<tr>
<td>— none</td>
<td><strong>Unspecified Elimination Disorder</strong></td>
</tr>
</tbody>
</table>

283

284

**Elimination Disorders**
Gender Dysphoria

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Identity Disorder</td>
<td>Gender Dysphoria in children</td>
</tr>
<tr>
<td>Gender Identity Disorder NOS</td>
<td>Other Specified Gender Dysphoria</td>
</tr>
<tr>
<td>Gender Identity Disorder NOS</td>
<td>Unspecified Gender Dysphoria</td>
</tr>
</tbody>
</table>
Gender Dysphoria

- A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration.

- In Children (manifest by 6 of 8 criteria)
- In Adolescents and Adults* (manifest by 2 of 6 criteria)

*Adults not covered by Medi-Cal SMHS

Disruptive, Impulse Control and Conduct Disorders
Disruptive, Impulse Control and Conduct Disorder

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>Oppositional Defiant Disorder</td>
</tr>
<tr>
<td>Intermittent Explosive Disorder</td>
<td>Intermittent Explosive Disorder</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>Conduct Disorder</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>Antisocial Personality Disorder</td>
</tr>
<tr>
<td>Pyromania</td>
<td>Pyromania</td>
</tr>
<tr>
<td>Kleptomania</td>
<td>Kleptomania</td>
</tr>
<tr>
<td>Other Specified Disruptive, Impulse-Control, and Conduct Disorder</td>
<td>Other Specified Disruptive, Impulse-Control, and Conduct Disorder</td>
</tr>
<tr>
<td>Unspecified Disruptive, Impulse-Control, and Conduct Disorder</td>
<td>Unspecified Disruptive, Impulse-Control, and Conduct Disorder</td>
</tr>
</tbody>
</table>

Oppositional Defiant Disorder

- **angry/irritable mood**
  - Often loses temper
  - Is often touchy or easily annoyed
  - Is often angry and resentful

- **argumentative/defiant behavior**
  - Often argues with authority figure or, for children and adolescent, with adults
  - 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 he past 6 months
Oppositional Defiant Disorder

• Removed Conduct Disorder Exclusion
• Frequency
• Added Sibling Exclusion
• Severity Rating
  – Mild: one setting
  – Moderate: at least 2 settings
  – Severe: 3 or more

Intermittent Explosive Disorder

Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by either:

• Verbal aggression, physical aggression toward property, animals or individuals (2x wkly, 3 mos)
  No destruction of property or injury to humans or animals
• 3 behavioral outbursts resulting in damage or destruction of property and/or physical assault = physical injury (animals or humans) within 12 mos.
• Age 6+ (chronologically or developmentally
Conduct Disorder

- Criteria are mostly the same.
- Can have ODD and CD
- Specifiers
  - Childhood or Adolescent Onset (different ICD-10 codes)
  - Severity Ratings: mild, moderate or severe
  - New specifier
    - With limited prosocial emotions

Isaiah

Isaiah is an 8-year-old boy who has been having significant outbursts at school, and has been sent home for punching peers and teachers as well as destroying property. His teacher says he appears angry and resentful much of the time. He lives with his material grandmother, Mrs. Woodrow, and his 17-year-old uncle, Frank. Currently, the school psychologist is planning to test Isaiah in preparation for an IEP. When she meets with Mrs. Woodrow, she learns that Isaiah was placed in her care two years ago due to abuse and neglect by his mother, Juanita. Juanita is currently in drug rehab. Isaiah’s father has been in and out of prison and is currently on the streets, whereabouts unknown.
Isaiah

Mrs. Woodrow reports that Isaiah never seems happy no matter what she tries, and “seems irritated by just about everything.” He gets upset when he does poorly at video games, and has broken his uncle’s Wii. He also gets upset and starts screaming when Mrs. Woodrow requires him to do homework. He says he can’t do the work, and has thrown his books at her on several occasions. Isaiah also bothers his uncle when Frank is studying, and won’t do anything his uncle asks him to do. Isaiah falls asleep easily and tends to sleep through the night. When the school psychologist goes to Isaiah’s classroom to fetch him for testing, she learns he has been sent to the principal’s office for starting a fight before school. Isaiah tells the school psychologist that the fight was not his fault because some kid stole his hat and wouldn’t give it back, so he “had to punch him.”

Match the Symptom with the Diagnosis

<table>
<thead>
<tr>
<th>Symptom</th>
<th>DMDD</th>
<th>ODD</th>
<th>CD</th>
<th>IED</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often argues with authority figures or adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blaming others for his mistakes or behaviors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irritability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe, recurrent tantrums</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refusal to comply with requests</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defiance of rules</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often being angry and resentful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Destroying property</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Isaiah

What diagnoses would you consider for Isaiah?

Include ICD-10 code

Substance-Related and Addictive Disorders
Two Groups of Substance-related Disorders

1. Substance Use Disorders (SUDs)

2. Substance-Induced Disorders
   - Intoxication
   - Withdrawal
   - Other substance/medication-induced mental disorders

Substance Use Disorders

- 9 classes of substances
- Other (or unknown) Substance-Related Disorders
Criteria for Substance Use Disorder

2 or more of the 11 diagnostic criteria in the past 12-months

Impaired Control
1. Using more or using for a longer period than was intended
2. Persistent desire or unsuccessful effort to cut down or control substance use
3. A great deal of time is spend in activities necessary to obtain use or recover for the effects of substance
4. Cravings, or a strong desire or urge to use substance

Social Impairment
5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of substance
7. Important social, occupational or recreational activities are given up or reduced because of substance use
Criteria for Substance Use Disorder

Risky Use

8. Recurrent substance use in situations in which it is physically hazardous.

9. Substance 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 substance.

Criteria for Substance Use Disorder

Pharmacological Criteria

10. Tolerance
    - A need for increased amounts to achieve intoxication or desired effects
    - Diminished effect with continued use of the same amount of substance

11. Withdrawal
    - The characteristic withdraw syndrome for substance
    - A substance or a closely related substance is taken to relieve or avoid withdrawal symptoms
Severity Measures

0 - 1 criteria: No Diagnosis
2 - 3 criteria: Mild Substance Use Disorder
4 - 5 criteria: Moderate Substance Use Disorder
6 or more: Severe Substance Use Disorder

Substance-Induced Disorders

<table>
<thead>
<tr>
<th>Intoxication</th>
<th>Withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Caffeine</td>
<td>Caffeine</td>
</tr>
<tr>
<td>Cannabis</td>
<td>Cannabis</td>
</tr>
<tr>
<td>Hallucinogen</td>
<td>none</td>
</tr>
<tr>
<td>Phencyclidine (PCP)</td>
<td>none</td>
</tr>
<tr>
<td>Inhalant</td>
<td>none</td>
</tr>
<tr>
<td>Opioid</td>
<td>Opioid</td>
</tr>
<tr>
<td>Sedative, Hypnotic or Anxiolytic</td>
<td>Sedative, Hypnotic or Anxiolytic</td>
</tr>
<tr>
<td>Stimulant</td>
<td>Stimulant</td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
</tr>
<tr>
<td>Other (or Unknown) Substance</td>
<td>Other (or Unknown) Substance</td>
</tr>
</tbody>
</table>
**Intoxication Criteria**

A. Recent ingestion of substance  
B. Clinically significant problematic behavior or psychological changes (specific to the substance) that developed during or shortly after ingestion  
C. Two (or more) signs or symptoms (specific to the substance) developing within a time frame which is specific to substance (differs for each substance).  
D. Not attributable to another medical condition, mental disorder or intoxication with another substance.

---

**Intoxication Specifiers**

<table>
<thead>
<tr>
<th>Specify if</th>
<th>Perceptual disturbances (Cannabis, Opioid, Amphetamine-type substance, Cocaine, other or unspecified stimulant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify</td>
<td>Specific intoxicant (Amphetamine-type substance, Cocaine, other or unspecified stimulant)</td>
</tr>
</tbody>
</table>
Withdrawal Criteria

A. Due to cessation of or reduction in, heavy and prolonged use of substance-specific problematic behavioral changes
B. Symptoms that develop within a time frame specific to the substance, after cessation or reduction of use the substance
C. The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
D. Symptoms not due to another medical condition or mental disorder

Withdrawal Specifiers

<table>
<thead>
<tr>
<th>Specify if</th>
<th>With perceptual disturbances (Alcohol; Sedative, Hypnotic, or Anxiolytic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify</td>
<td>The specific substance that causes the withdrawal syndrome (Hallucinogen, PCD; Amphetamine-type substance, Cocaine or other or unspecified stimulant)</td>
</tr>
</tbody>
</table>
new Cannabis Withdrawal

- irritability, anger, or aggression
- nervousness or anxiety
- sleep difficulty (e.g., insomnia, disturbing dreams)
- decreased appetite or weight loss
- Restlessness
- depressed mood
- at least one of the following physical symptoms:
  - stomach pain
  - shakiness/chills
  - sweating
  - fever
  - chills
  - headache

new Caffeine Withdrawal

- Daily Use of Caffeine
- 3 or more
  - headache
  - marked fatigue or drowsiness
  - dysphoric or depressed mood, or irritability
  - difficulty concentrating
  - flu like symptoms
- clinically significant distress or impairment in social, occupational or other important areas of functioning.
- not due to the direct physiological effects of a general medical condition
Anton

Anton is a 16-year-old boy who lives with his mother and 5-year-old sister. He has been smoking marijuana almost daily for the past 6 months, and drinks on the weekends. His mother has asked him why his grades have gone down this school year and he seems less interested in drawing cartoons, something he did for years. Anton finds that he often wants to smoke marijuana, especially before bed, as he find it helps him to sleep. He also likes to smoke before he plays Internet games.

Match the behaviors with the criteria

<table>
<thead>
<tr>
<th>Behaviors</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Grades going down</td>
<td>A. Cravings, or a strong desire or urge to use substance</td>
</tr>
<tr>
<td>2. Less interest in</td>
<td>B. Continued substance use despite having persistent or recurrent social</td>
</tr>
<tr>
<td>drawing cartoons</td>
<td>or interpersonal problems caused or exacerbated by the effects of substance</td>
</tr>
<tr>
<td>3. Smoking before</td>
<td>C. Important social, occupational, or recreational activities are given</td>
</tr>
<tr>
<td>sleeping</td>
<td>up or reduced because of substance use</td>
</tr>
<tr>
<td>4. Smoking before</td>
<td>D. A need for increased amounts to achieve intoxication or desired effects</td>
</tr>
<tr>
<td>Internet gaming</td>
<td></td>
</tr>
</tbody>
</table>
Anton

Anton tells his school counselor that he never meant to smoke marijuana daily; he used to just smoke on the weekends, but over time his smoking has crept into his daily life. He reports that he has tried to cut down, but he finds himself unable to decrease or stop his use. He also tells his counselor that he has driven while drinking several times. Additionally, he reports that he needs more marijuana to get high than he did in the past.

Match the behaviors with the criteria

<table>
<thead>
<tr>
<th>Behaviors</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Never meant to smoke daily</td>
<td>A. Persistent desire or unsuccessful effort to cut down or control substance use</td>
</tr>
<tr>
<td>2. Unable to cut down use</td>
<td>B. Using more or using for a longer period than was intended</td>
</tr>
<tr>
<td>3. Drinking and driving</td>
<td>C. Tolerance A need for increased amounts to achieve intoxication or desired effects</td>
</tr>
<tr>
<td>4. Needs more marijuana to get high</td>
<td>D. Recurrent substance use in situations in which it is physically hazardous.</td>
</tr>
</tbody>
</table>
Anton’s diagnosis

What diagnosis might you consider for Anton, including severity ratings?

Bao

Bao, a 35-year-old man, has been married for 15 years and has an 11 year old daughter. He is a musician and works in hotel reception as a day job. Bao is having significant substance use trouble and meets with his physician, Dr. Vuong, to get help.

Which of the diagnoses might the behaviors, physical symptoms, or problems on the next slides indicate? Please indicate the specific symptom using the supplemental handout.

1. Substance Use Disorder
2. Alcohol Intoxication
3. Alcohol Withdrawal
4. Cannabis Intoxication
5. Cannabis Withdrawal
Bao #1

Bao tells his doctor: “I’ve been calling in sick too often to my work, I’m afraid I might get fired.”

1. Substance Use Disorder
2. Alcohol Intoxication
3. Alcohol Withdrawal
4. Opioid Intoxication
5. Opioid Withdrawal

Bao #2

Dr. Voung asks Bao if he is missing work because of his back pain. Bao says: “the injury was about a year ago and I am managing the pain with codeine but sometimes I’m too tired to go to work or my memory is so bad I just don’t think I can get the job done.”

1. Substance Use Disorder
2. Alcohol Intoxication
3. Alcohol Withdrawal
4. Opioid Intoxication
5. Opioid Withdrawal
**Bao #3**

Dr. Young asks Bao if he ever followed up with the physical therapist to address his back pain. Bao says: “No, I tried to go a few times, but it didn’t help. Doc, I’m an addict through and through. I don’t think I’ve ever stopped being an addict, even when I was going to AA every day. I wasn’t using, but I thought about using every day. My wife cleaned up when she was pregnant with Linh (our daughter), and she just got her 12-year chip. She moved on with her life, but I’m stuck. My back injury really threw me into a tailspin. At first, I really needed the codeine, but now I’m just sucking them up to stave off heroin withdrawal. We’ve got to be really careful here. If my wife finds I’m back on the needle, she’ll be out the door this time.”

1. Substance Use Disorder
2. Alcohol Intoxication
3. Alcohol Withdrawal
4. Opioid Intoxication
5. Opioid Withdrawal

---

**Bao #4**

Dr. Young asks Boa if he is using any other drugs beside codeine and heroine. Bao reports: “about 15 years ago I was drinking more and more and would find myself falling down drunk when I was out partying with friends. I stopped drinking over 10 years ago.”

1. Substance Use Disorder
2. Alcohol Intoxication
3. Alcohol Withdrawal
4. Opioid Intoxication
5. Opioid Withdrawal
Bao #5

Dr. Young asks Bao how he did when he first stopped drinking. Bao says: “it was terrible because I became very anxious and had awful insomnia. After a couple of months, I was a wreck so a friend from the AA turned me on to heroine. I figured I’d just take it for a little while, until I got caught up on sleep. But before I knew it, I was using it all the time. I had to go to rehab.”

1. Substance Use Disorder
2. Alcohol Intoxication
3. Alcohol Withdrawal
4. Opioid Intoxication
5. Opioid Withdrawal

Bao #6

Dr. Young asks Bao how he did in the rehab program. He replied “I felt so ashamed, I was achy, my nose was running all the time, I threw up a bunch and I was so depressed. I just don’t know if I can go through that again.”

1. Substance Use Disorder
2. Alcohol Intoxication
3. Alcohol Withdrawal
4. Opioid Intoxication
5. Opioid Withdrawal
Bao #7

Bao mentions to Dr. Voung that his wife, who is in recovery, insisted that he return to treatment after she discovered he was taking large quantities of codeine pills from several doctors for his back injury. She is unaware that he was also shooting heroin at least once daily.

1. Substance Use Disorder
2. Alcohol Intoxication
3. Alcohol Withdrawal
4. Opioid Intoxication
5. Opioid Withdrawal

Bao #8

Bao says to Dr. Voung: “You know how much I loved playing drums in my band, well, I missed so many band practices that the band told me not to come back.”

1. Substance Use Disorder
2. Alcohol Intoxication
3. Alcohol Withdrawal
4. Opioid Intoxication
5. Opioid Withdrawal
Bao’s Diagnoses

1. What substance abuse diagnoses would you consider for Bao, including severity ratings?

2. What Z-codes would you consider?

Other Substance/Medication-Induced Mental Disorders

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance-Induced Psychotic Disorder</td>
<td>Substance-Induced Psychotic Disorder</td>
</tr>
<tr>
<td>Substance-Induced Mood Disorder</td>
<td>Substance-Induced Bipolar Disorder</td>
</tr>
<tr>
<td>Substance-Induced Mood Disorder</td>
<td>Substance-Induced Depressive Disorder</td>
</tr>
<tr>
<td>Substance-Induced Anxiety Disorder</td>
<td>Substance-Induced Anxiety Disorder</td>
</tr>
<tr>
<td>Substance-Induced Anxiety Disorder</td>
<td>Substance-Induced Obsessive-Compulsive or Related Disorders</td>
</tr>
<tr>
<td>Substance-Induced Sleep Disorder</td>
<td>Substance-Induced Sleep-Wake Disorder</td>
</tr>
<tr>
<td>Substance-Induced Sexual Dysfunction</td>
<td>Substance-Induced Sexual Dysfunction</td>
</tr>
<tr>
<td>Substance Intoxication Delirium and Substance Withdrawal Delirium</td>
<td>Substance-Induced Delirium</td>
</tr>
<tr>
<td>Substance-Induced Persisting Dementia</td>
<td>Substance-Induced Neurocognitive Disorder</td>
</tr>
<tr>
<td>Substance-Induced Sleep-Wake Disorder</td>
<td>Substance-Induced Sleep-Wake Disorder</td>
</tr>
</tbody>
</table>
Other Substance/Medication-Induced Mental Disorders

- Potentially severe
- Usually temporary
- Sometimes persisting central nervous system syndrome
- Develop in the context of the effects of substance abuse, medication or several toxins
- May be induced by the 10 classes of substance that produces SUDs or by a great variety of other medication used in medical treatment
- Each disorder is described in the relevant chapter
  - depression
  - neurocognitive

Common Features of Substance Induced Mental Disorders

- The disorder represents a clinically significant symptomatic presentation of a relevant mental disorder
- There is evidence from the history, physical exam or lab work of
  - The disorder developed during or within one month of substance intoxication, withdrawal or taking medications
  - The involved substance/medication is capable of producing the mental disorder
- The disorder is not better explained by an independent mental disorder (one that is not substance- or medication induced)
- The disorder does not occur exclusively during the course of a delirium
- The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
## Substance/Medication-Induced Mental Disorders

<table>
<thead>
<tr>
<th>DISORDERS</th>
<th>Alcohol</th>
<th>Caffeine</th>
<th>Cannabis</th>
<th>PCP</th>
<th>Other Hallucinogens</th>
<th>Opioids</th>
<th>Sedatives, hypnotics, or anxiolytics</th>
<th>Stimulants</th>
<th>Tobacco</th>
<th>Other (or unknown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychotic</td>
<td>I/W</td>
<td>I/ W</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td></td>
</tr>
<tr>
<td>bipolar</td>
<td>I/W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td></td>
</tr>
<tr>
<td>depressive</td>
<td>I/W</td>
<td>I</td>
<td>I</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td></td>
</tr>
<tr>
<td>anxiety</td>
<td>I/W</td>
<td>I</td>
<td>I</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td></td>
</tr>
<tr>
<td>OCD</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td></td>
</tr>
<tr>
<td>sleep</td>
<td>I/W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td></td>
</tr>
<tr>
<td>sexual dysfunction</td>
<td>I/W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td></td>
</tr>
<tr>
<td>delirium</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td></td>
</tr>
<tr>
<td>neurocog</td>
<td>I/W/ P</td>
<td>I/ P</td>
<td>I/ W/ P</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td>I/ W</td>
<td></td>
</tr>
</tbody>
</table>

With onset during: Intoxication or Withdrawal
Persisting disorder

Adapted from table on page 482

---

## Behavioral Addictions

- **Gambling Disorder**
  - Brain reward system is activated
- **Other Behavioral Addiction**
  - Research is not clear
    - Internet gaming
      (conditions for further study)
    - Sex addiction
    - Exercise addiction
    - Shopping addiction
Gambling Disorder

Symptoms
Persistent and recurrent problematic gambling behavior lead to clinically significant impairment or distress, as indicated by the individual exhibiting 4 (or more) of the following in a 12-month period:
1. Needs to gamble with increasing amount of money in order to achieve the desired excitement
2. Is restless or irritable when attempting to cut down or stop
3. Has made repeated unsuccessful efforts to control, cut back, or stop
4. Is often preoccupied with gambling
5. Often gambles when feeling distresses
6. After losing money gambling, often returns another day to get even
7. Lies to conceal the extent of involvement with gambling
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
9. Relies on other to provide money to relieve desperate financial situations caused by gambling

Behavior is not explained by a manic episode

Personality Disorders
## Personality Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid Personality Disorder</td>
<td>Paranoid Personality Disorder</td>
</tr>
<tr>
<td>Schizoid Personality Disorder</td>
<td>Schizoid Personality Disorder</td>
</tr>
<tr>
<td>Schizotypal Personality Disorder</td>
<td>Schizotypal Personality Disorder</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>Antisocial Personality Disorder</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>Borderline Personality Disorder</td>
</tr>
<tr>
<td>Histrionic Personality Disorder</td>
<td>Histrionic Personality Disorder</td>
</tr>
<tr>
<td>Narcissistic Personality Disorder</td>
<td>Narcissistic Personality Disorder</td>
</tr>
<tr>
<td>Avoidant Personality Disorder</td>
<td>Avoidant Personality Disorder</td>
</tr>
<tr>
<td>Dependent Personality Disorder</td>
<td>Dependent Personality Disorder</td>
</tr>
<tr>
<td>Obsessive-Compulsive Personality Disorder</td>
<td>Obsessive-Compulsive Personality Disorder</td>
</tr>
<tr>
<td>— none —</td>
<td>Personality Change Due to Another Medical Condition</td>
</tr>
<tr>
<td>Personality Disorder Not Otherwise Specified</td>
<td>Other Specified Personality Disorder</td>
</tr>
<tr>
<td>Personality Disorder Not Otherwise Specified</td>
<td>Unspecified Personality Disorder</td>
</tr>
</tbody>
</table>

## Paraphilic Disorders

336

335
### Paraphilic Disorders

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voyeurism</td>
<td>Voyeuristic Disorder</td>
</tr>
<tr>
<td>Exhibitionism</td>
<td>Exhibitionistic Disorder</td>
</tr>
<tr>
<td>Frotteurism</td>
<td>Frotteuristic Disorder</td>
</tr>
<tr>
<td>Fetishism</td>
<td>Fetishistic Disorder</td>
</tr>
<tr>
<td>Sexual Masochism</td>
<td>Sexual Masochism Disorder</td>
</tr>
<tr>
<td>Sexual Sadism</td>
<td>Sexual Sadism Disorder</td>
</tr>
<tr>
<td>Pedophilia</td>
<td>Pedophilic Disorder</td>
</tr>
<tr>
<td>Transvestic Fetishism</td>
<td>Transvestic Disorder</td>
</tr>
<tr>
<td>Paraphilia Not Otherwise</td>
<td>Other Specified Paraphilic</td>
</tr>
<tr>
<td>Specified</td>
<td>Disorder</td>
</tr>
<tr>
<td>Paraphilia Not Otherwise</td>
<td>Unspecified Paraphilic Disorder</td>
</tr>
<tr>
<td>Specified</td>
<td></td>
</tr>
</tbody>
</table>

### Medication-Induced
Movement Disorders
and Other Adverse
Effects of Medication
Medication-Induced Movement Disorders and Other adverse Effects of Medication

<table>
<thead>
<tr>
<th>DSM-IV-R</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuroleptic-Induced Parkinsonism</td>
<td>Neuroleptic-Induced Parkinsonism</td>
</tr>
<tr>
<td>— none —</td>
<td>Other Medication-Induced Parkinsonism</td>
</tr>
<tr>
<td>Neuroleptic Malignant Syndrome</td>
<td>Neuroleptic Malignant Syndrome</td>
</tr>
<tr>
<td>Neuroleptic-Induced Acute Dystonia</td>
<td>Medication-Induced Acute Dystonia</td>
</tr>
<tr>
<td>Neuroleptic-Induced Acute Akathisia</td>
<td>Medication-Induced Acute Akathisia</td>
</tr>
<tr>
<td>— none —</td>
<td>Tardive Dyskinesia</td>
</tr>
<tr>
<td>— none —</td>
<td>Tardive Dystonia</td>
</tr>
<tr>
<td>— none —</td>
<td>Tardive Akathisia</td>
</tr>
<tr>
<td>Medication-Induced Postural Tremor</td>
<td>Medication-Induced Postural Tremor</td>
</tr>
<tr>
<td>Medication-Induced Movement Disorder NOS</td>
<td>Other Medication-Induced Movement Disorder</td>
</tr>
<tr>
<td>— none —</td>
<td>Antidepressant Discontinuation Syndrome</td>
</tr>
<tr>
<td>— none —</td>
<td>Other Adverse Effect of Medication</td>
</tr>
</tbody>
</table>

Jonathon

Jonathan is a 22 year old, unemployed man who has been seeing a psychiatrist since he was 15 years old. Throughout his childhood Jonathan had done well in school, had friends and enjoyed participating in track and field when he started high school. At age 15 he started to feel depressed most of the time, lost interest in everything, had low energy, poor concentration and hypersomnia. He also had recurrent panic attacks (sudden onset of palpitations, diaphoresis, thoughts he was going to die).
Jonathon

He had two very severe episodes of depression and panic. When he was not having severe symptoms of depression, Jonathon was sad, irritable and lacked motivation. By tenth grade his school performance declined and never got better.

To manage his symptoms he began to drink and smoke marijuana daily. He had not intended to use this frequently, but he had easy access to the substances and found it was the only way he could feel comfortable. He also found that he needed more in order to feel OK.

Jonathon

After high school he stayed at home and found odd jobs in the neighborhood.

He had two very severe episodes of depression and panic which were treated with an SSRI, sertraline (100mg daily), and psychotherapy. Both times when he took the medication the worst symptoms lifted within a few weeks but he stopped the medication within a few months.
Jonathon

What diagnoses might you consider?

Jonathon

When he was 20, Jonathon developed a psychotic episode. He had a conviction that he had murdered people when he was 6 years old. He heard continuous voices accusing him of being a murderer.

He started fearing for his own life as he was sure he would be punished for what he did when he was 6 years old. He became guilt-ridden and pre-occupied with the idea that he should kill himself by slashing his wrists. He was psychiatrically hospitalized at this time.
Jonathon

Upon admission his affect was anxious but within a few days he became very depressed with symptoms of anhedonia, poor sleep, decreased appetite and poor concentration.

Four weeks after he started taking antipsychotic and antidepressant medication his symptoms remitted. Thus, for 7 weeks he had had a psychotic episode and for 4 of those 7 weeks he also had symptoms of a major depression.

By the time he was 22 he had been hospitalized two more times with a similar clinical picture. (several weeks of delusions and hallucinations related to his convictions that he had murdered someone when he was a child, followed by severe depression lasting an additional month.) He was taking his antipsychotic and antidepressant medications when he relapsed.
Jonathon

Recently he has been taking clozapine and has not had hallucinations and delusions. He has also taken his antidepressant medication and attended supportive therapy but continues to have a depressed mood, irritability and amotivation.

Jonathon had used marijuana and alcohol daily from age 15 to 20, when he had his first experience of psychosis. He tried to stop use on his own and then began attending AA and NA before he was 21 and has remained clean and sober since that time.

Jonathon

Currently, what diagnosis would you consider for Jonathon?
Other Resources

• DSM-5 Update (search “DSM5 update September 2016”)  

• Online 3-hour course (includes most of the new dx)  
  – www psyte online com (CEUs available)

• In-person DSM-5 trainings with Rachel:  
  – DSM-5 for Medi-Cal Specialty Mental Health Services  
  – Applying DSM-5 to current cases  
  contact: rachel@rachelmichaelsen.com

• DSM-5 Clinical Cases Edited by John W. Barnhill, MD