Using *DSM-5*: A Brief Summary

**HANDOUT PACKET   # 2**

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DSM-5: *Obsessive-Compulsive and Related Disorders*

*In DSM-4 Anxiety Disorders section*

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

Co-occurring OCD can make other disorders more severe, e.g. depressive disorders, anxiety Disorder, and substance disorders
**Hoarding Disorder**

Persistent difficulty discarding or parting with possessions, regardless of actual value. The behavior usually has harmful effects (emotional, physical, social, financial and legal) for a hoarder and family members.

**DSM-IV-TR Symptom Description p.726 DSM-IV-TR**

“Individuals with this disorder may be unable to discard worn-out or worthless objects even when they have no sentimental value (Criterion 5). Often these individuals will admit to being “pack rats.” They regard discarding objects as wasteful because “you never know when you might need something” and will become upset if someone tries to get rid of the things they have saved. Their spouses or roommates may complain about the amount of space taken up by old parts, magazines, broken appliances, and so on.”

**O-C PD**

1. Preoccupied
2. Perfectionistic
3. Excessive work
4. Over-conscientious
5. Hoarding
6. No delegation
7. Miserly
8. Rigidity

Hoarding not mention in DSM-I, II, or III
**DSM-5 Hoarding Rationale**

- Neuroimaging studies support the new diagnosis by showing when hoarders make decisions about what to keep or discard, brain activity is markedly different from people with OCD and people with no mental disorder.

- Hoarders take far longer to make up their minds and show more activity in the **anterior cingulate cortex**, (brain region important in decision-making & show higher activity in the **insula**, (brain area that aids interpretation of emotions and physiological responses).

- Hoarders form strong emotional attachments to objects that most people would not hesitate to discard.

- Antidepressants, such as SSRIs, & cognitive behavioral therapy help OCD, but their success is mixed in changing hoarding behaviors.
A. Recurrent pulling out of one's hair, resulting in hair loss.
B. Repeated attempts to decrease or stop hair pulling.
C. The hair pulling causes clinically significant distress or impairment in social occupational or other important areas of functioning.
D. The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).

The hair pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder).
DSM-5: Excoriation (skin-picking) Disorder (ED)

- Excoriation (skin-picking) disorder new to DSM-5
- Dermatillomania (also known as neurotic excoriation, pathologic skin picking (PSP), compulsive skin picking (CSP) or psychogenic excoriation) is an impulse control disorder characterized by repeated urge to pick skin, often to extent of injury
- Research shows urge to pick similar to OCD, but others argue condition associated with substance abuse disorder
- 2 Tx. strategies are pharmacological and behavioral intervention
- See, Stein, D.J. et. al. (2010). Trichotillomania (hair pulling disorder), skin picking disorder, and stereotypic movement disorder: toward DSM-5, Depression And Anxiety 27, 611–626.
- **Rationale**: Unclear
**DSM-5: Trauma- and Stressor-Related Disorders**  
*In DSM-IV Anxiety Disorders section*

Reactive Attachment Disorder  
Moved from ICA

Disinhibited Social Engagement Disorder

Posttraumatic Stress Disorder

Acute Stress Disorder

Adjustment Disorders

Other Specified Trauma- and Stressor-Related Disorder

Unspecified Trauma- and Stressor-Related Disorder

VAMC NATIONAL CENTER FOR PTSD
A. Consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifest by both of the following:
1. Rarely or minimally seeks comfort when distressed.
2. Rarely or minimally responds to comfort offered when distressed.

B. Persistent social & emotional disturbance characterized by at least 2 of following:
1. Minimal social & emotional responsiveness to others.
2. Limited positive affect.
3. Episodes of unexplained irritability, sadness, fearfulness evident during nonthreatening interactions with adult caregivers

C. Child experienced pattern of extreme insufficient care as evidenced by 1+ of following:
1. Social neglect or deprivation in form of persistent lack of having basic emotional needs for comfort/stimulation, and affection met by caregiving adults.
2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child to caregiver ratios).

D. Care in cC presumed to be responsible for disturbed behavior in cA (e.g., disturbance in cA began following lack of adequate care in cC).

E. The criteria for Autistic Spectrum Disorder are not met.

G. Child has developmental age of at least 9 months.

Specify if:
**Persistent**: Disorder present for more than 12 months

Specify current severity: **RAD severe** when child exhibits all symptoms of disorder with all Sx. At relatively high levels.

*Was Inhibited Subtype in RADS*

**DSM-5 pp. 265-266**

**DSM-IV-TR p. 130**

8/16/2013

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Disinhibited Social Engagement Disorder

A. Behavior pattern of child approaches & interacts with unfamiliar adults by exhibiting 2+ of following:
   1. Reduced or absent reticence to approach and interact with unfamiliar adults.
   2. Overly familiar behavior (verbal/physical violation of culturally sanctioned social boundaries).
   3. Diminished/absent checking with adult caregiver after venturing away, even in unfamiliar settings.
   4. Willingness to go with unfamiliar adult with minimal hesitation.

B. Behavior in cA not limited to impulsivity (as in ADHD) but includes socially disinhibited behavior.

C. Child has experienced extremes of insufficient care as evidenced by 1+ of following:
   1. Social neglect or deprivation in form of persistent lack of having basic emotional needs for comfort/stimulation, and affection met by caregiving adults.
   2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
   3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child to caregiver ratios).

D. Care in cC presumed to be responsible for disturbed behavior in cA (e.g., disturbance in cA began following lack of adequate care in cC).

E. Child has developmental age of at least 9 months.

Specify if:

**Persistent**: Disorder present for more than 12 months

Specify current severity: RAD severe when child exhibits all symptoms of disorder with all Sx. At relatively high levels.
Sample Dx.

Diagnostic Formulation
Brief Diagnostic Background Information
Ravac Glasser was evaluated for attachment to his biological parents and foster parents. Based on the clinical interview, scales administered and collateral information, the following diagnoses were made as part of this assessment:

Diagnoses
313.89 Disinhibited social engagement disorder, Moderate
R/O V62.89 Borderline intellectual functioning

Notations
995.52 Child Neglect Confirmed: both parents indicated by DSS CPS for neglect with no criminal charges
V61.8 Upbringing away from home: Removed from patents care at 13 months of age, CA is 5y 9m and in foster care 81% of life
V62.5 Problems related to Other Legal Circumstances: Court hearing scheduled 12/29/2013 to consider change of permamcy plan to adoption.

Disability Severity
Sx. range from mild to moderate and vary in presence of foster parents and biological parents

Medical Conditions
None reported by biological or foster parents
PTSD

Exposure to traumatic event with:

1. Experienced/witnessed events with actual/threatened death, serious injury, threat to physical integrity of self/others
2. Response of intense fear, helplessness, horror

B. Re-experiencing

1. Recollections
2. Dreams
3. Feelings of recurrence
4. Psychological distress from cueing
5. Physical distress from cueing

C. Avoidance

1. Thoughts, feelings
2. Conversations
3. Activities, places, people
4. Inability to recall event
5. No activity interest
6. Detachment
7. Restricted affect
8. Limited future sense

D. Arousal increase

1. Sleep problems
2. Anger outbursts
3. Poor concentration
4. Hypervigilance
5. Increased startle response

Specifiers:

- Acute (Symptoms less <3 mos.)
- Chronic (Symptoms >3 mos.)
- With Delayed Onset (onset of symptoms after 6 mos.)

3-factor PTSD replaced by 4 Criteria:

(cB) Intrusion Symptoms,
(cC) Persistent Avoidance,
(cD) Negative Alterations in Cognitions & Mood, &
(cE) Arousal and Reactivity Symptoms

All 17 DSM-IV PTSD symptoms retained with clarification or revision
3 new symptoms have been added:

- Erroneous self- or other-blame regarding the trauma
- Negative mood states
- Reckless and maladaptive behavior

DSM-IV irritability now aggressive behavior

DSM-IV-TR p. 468

Has forensic implications

Dr. Frances article

More sensitive for C & A by lowering threshold criteria & separate criteria for children age 6 & under

Distinction between acute and chronic PTSD eliminated

? Delayed Onset

ADDED to cA1 People with close relative/friend exposed to Traumatic events qualify
Professionals exposed to traumatic events (military, mortuary, EMTs, etc.) included
Posttraumatic Stress Disorder

Note: Criteria apply to adults, adolescents, & children 6+ years, below 6 corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in 1+ of 4 ways
   1. Direct
   2. Witness
   3. Learning it occurred to close family/friend
   4. Repeated extreme exposure as a professional

   2. Note cA4 does not apply to exposure thru media, television, movies or pictures unless exposure is work related

B. 1+ intrusive symptoms

C. Persistent avoidance by memories or dreams

D. Negative alteration in cognitions and mood associated with Te

E. Marked alteration in arousal and reactivity associated with Te

F. Duration for B, C, D, & E 1+ month

G. Clinically sig. distress...

H. Disturbance not attributable to a substance..

Specify whether:
   With dissociative symptoms
      1. Depersonalization
      2. Derealization

Specify if:
   With delayed expression: 6+ months after Te
Diagnostic Formulation
Koma McClellan is entering outpatient therapy for the first time after a lengthy stay at Boise VAMC due to reaction to shooting of a refuge with an M420B machine gun while serving on a USCG medium response boat performing drug interdiction. Based on the clinical interview, and collateral information from VISN facilities the following diagnoses were made as part of this assessment:

Diagnoses

- **309.81 PTSD with panic attacks, with dissociative symptoms-Derealization, with delayed onset**
- **303.90 Alcohol use disorder, Moderate, in early remission**

Notations

- **V62.5 Problems Related to Other Legal Circumstances: Article 32 hearing scheduled 12/19/2013 to review shooting incident**
- **V61.03 Disruption of Family by Separation or Divorce: Wife separated during deployment with intent to divorce**
- **V62.21 Problem Related to Current Military Deployment Status: see previous entry**

Disability Severity

Sx. In mild to moderate range

Medical Conditions

- **No severity specifiers listed for PTSD**
- Recovering from gunshot wound to leg during incident
A. Child under 6 exposure to actual or threatened death, serious injury, or sexual violence in 1+ ways
   1. Direct
   2. Witness in person Te to others especially caregivers
   3. Learning Te occurred to caregiver
   Note: Witnessing does not include Te witnessed only in electronic media, television, movies or pictures
B. Presence of 1+ intrusive symptoms:
   1. Intrusive memories
   2. Recurrent distressing dreams
   3. Dissociative reactions
   4. Intense, prolonged, psychological distress
   5. Marked physiological reactions to reminders of Te.
C. 1+ of persistent avoidance, negative alteration of cognitions and mood associated with Te must be present beginning after event(s) or worsening after the event(s):
   Persistent avoidance of stimuli (see list of 2 symptoms)
   Negative alterations in cognitions (see list of 4 symptoms)
   Alteration in arousal and reactivity (see list of 5 symptoms)
D. Marked alteration in arousal and reactivity associated with Te
E. Duration for B, C, D, & E 1+ month
F. Clinically sig. distress...
G. Disturbance not attributable to a substance..
Specify whether:
   With dissociative symptoms
      1. Depersonalization
      2. Derealization
Specify if:
   With delayed expression: 6+ months after Te
Acute Stress Disorder

A. Exposure to actual or threatened death, serious injury, or sexual violence in 1+ of following ways
   - Direct
   - 2. Witness
   - 3. Learning it occurred to close family/friend
   - 4. Repeated extreme exposure as a professional
   
   Note: A4 does not apply to exposure thru media, television, movies or pictures unless exposure is work related

B. 9+ of following Sx. From any of the 5 categories of intrusion, negative mood, dissociation, avoidance, arousal, beginning or worsening after Te.
   Marked alteration in arousal and reactivity associated with Te.

C. Duration of cB 3 days to 1 month after trauma exposure.

D. Clinically sig. distress...

E. Disturbance not attributable to a substance...

Note that there are no specifiers for ASD

See DSM-5 for detailed symptoms of these categories
Adjustment Disorders

pp. 286-287

Diagnostic Criteria:
A. Emotional or behavioral symptoms due to identifiable stressor in 3 month onset
B. Symptoms are clinically significant with:
   1. Marked distress out of proportion to the severity/intensity of stressor, taking into account external context & cultural factors influencing Sx. severity & presentation
   2. Sig. Impairment in SOOF* areas of functioning
C. Not due to other disorder or part of existing disorder
D. Symptoms do not represent normal bereavement
E. When stressor or consequences end, Sx. do not last more than additional 6 months

Specify whether:  Adjustment disorder…

309.0 (F43.21) With depressed mood: low mood, tearfulness, hopelessness
309.24 (F43.22) With anxiety: Nervous, worry, jittery, & separation anxiety
309.28 (F43.23) With mixed anxiety and depressed mood: Depression & anxiety
309.3 (43.24) With disturbance of conduct: Disturbed conduct predominates
309.4 (F43.25) With mixed disturbance of emotions and conduct: Depression & anxiety
309.9 (F43.20 Unspecified: Maladaptation not in other subtypes

*SOCIAL, OCCUPATIONAL & OTHER FUNCTIONING
Dissociative Identity Disorder

Dissociative Amnesia

Depersonalization/Derealization Disorder

Other Specified Dissociative Disorder

Unspecified Dissociative Disorder

This is surprising because a reaction to the DSM-IV TR DID was “this disorder is a figment of the imaginations of the patients who have it and the therapists who treat them.”
Anorexia Nervosa

Diagnostic Criteria

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat or persistent behavior that interferes with weight gain, even though that at significantly low weight.

C. Disturbance in the way and which body weight 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.

Specify whether:

(F50.01) **Restrictive type**: During the last 3 months, the individual has not engaged in recurrent episodes of binge-eating or purging behavior.

(F50.02 **Binge-eating/purging type**: During the last 3 months the individual has engaged in recurrent episodes of binge eating or purging behavior.

Specify if:

In partial remission: After full criteria for anorexia nervosa were previously met, criterion A has not been met for sustained period, but either criterion B. criterion and C is still met.

In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

**Mild**: BMI > 17 kg/m²

**Moderate**: BMI 16-16.99 Kg/m²

**Severe**: BMI 15-15.99 kg/m²

**Extreme**: BMI <15kg/m²
A. A period recurrent episodes of binge eating characterized by both of the following:
   1. Eating in a discrete period of time (within any 2-hour period) an amount of food larger than what most individuals eat in a similar time under similar circumstances.
   2. A sense of lack of control over eating during the episode (a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

C. Binge eating and inappropriate compensatory behaviors both occur at least once a week for 3 months.

D. Self evaluation is unduly influenced by body shape and weight.

D. Disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify if in partial remission: After full criteria for bulimia nervosa were previously met, some but not all, of the criteria have been met for a sustained period of time.

In full remission: After full criteria for bulimia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on frequency of inappropriate compensatory behaviors.

The level of severity may be increased to reflect other symptoms and the degree of functional disability.

**Mild:** Average of 1-3 episodes of inappropriate compensatory behavior per week.

**Moderate:** Average of 4-7 episodes of inappropriate compensatory behaviors per week.

**Severe:** Average of 8-13 episodes of inappropriate compensatory behaviors per week.

**Extreme:** An average of 14 or more episodes of inappropriate compensatory behavior per week.
# Diagnostic Criteria

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<thead>
<tr>
<th>A.</th>
<th>A period recurrent episodes of binge eating characterized by both of the following:</th>
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<tr>
<td></td>
<td>1. Eating in a discrete period of time (within any 2-hour period) an amount of food larger than what most individuals eat in a similar time under similar circumstances.</td>
</tr>
<tr>
<td></td>
<td>2. A sense of lack of control over eating during the episode (a feeling that one cannot stop eating or control what or how much one is eating).</td>
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<thead>
<tr>
<th>B.</th>
<th>The binge eating episodes are associated with 3+ on the following:</th>
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<tbody>
<tr>
<td></td>
<td>1. Eating much more rapidly than normal.</td>
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<td></td>
<td>2. Eating until feeling uncomfortably full.</td>
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<td></td>
<td>3. Eating large amounts of food when not feeling physically hungry.</td>
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<td></td>
<td>4. Eating alone because of feeling embarrassed by how much one is eating.</td>
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<td></td>
<td>5. Feeling disgusted with one's self, depressed, or very guilty afterward.</td>
</tr>
</tbody>
</table>

| C. | Marked distress regarding binging is present |

| D. | Binge eating occurs, on average, at least once a week for 3 months. |

| E. | Binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa. |

*Specify if:*

**In partial remission:** After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than 1 episode per week for a sustained period of time.

**In full remission:** After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

**Mild:** 1-3 binge-eating episodes per week.

**Moderate:** 4-7 binge-eating episodes per week.

**Severe:** 8-13 episodes of binge-eating per week.

**Extreme:** 14 or more binge-eating episodes per week.
DSM-5: Elimination Disorders

New Section same disorders from ICA

Enuresis

Encopresis

Other Specified Elimination Disorder

Unspecified Elimination Disorder
Delayed Ejaculation

Erectile Disorder  Male

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

Other Specified Sexual Dysfunction

Unspecified Sexual Dysfunction
Oppositional Defiant Disorder  Moved form ICA

Intermittent Explosive Disorder

Conduct Disorder  Moved from ICA

Antisocial Personality Disorder  contained here and in PDs section of DSM-5

Pyromania

Kleptomania

Other Specified Disruptive, Impulse-Control, and Conduct Disorder

Unspecified Disruptive, Impulse-Control, and Conduct Disorder
Oppositional Defiant Disorder

A. Pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months with 4+ Sx. from any of the following categories, and exhibited in interaction with 1+ individual not a sibling.

**Angry/Irritable Mood**
1. Often loses temper.
2. Is often touchy or easily annoyed.
3. Is often angry and resentful.

**Argumentative/Defiant Behavior**
4. Often argues with authority figures or for children and adolescents with adults.
5. Often actively defies or refuses to comply with requests from authority figures or rules.
6. Often deliberately annoys others.
7. Often blames others for his or her mistakes or misbehavior.

**Vindictiveness**
8. has been spiteful or vindictive 2+ within past 6 months.

See **Note**...

B. Disturbance in behavior associated with distress in individual or others in immediate context or it impacts negatively on social, educational, or other important areas of functioning.

C. Behaviors do not occur exclusively in the course of a psychotic, substance use, depressive, or Bipolar Disorder. Also, criteria are not met for disruptive, mood dysregulation disorder.

**Specify current Severity:**
- **Mild:** Sx. In only 1 setting (Home, school, work, peers).
- **Moderate:** Some Sx. Present in 2+ settings.
- **Severe:** Some Sx. Present in 3+ settings.
A. Recurrent behavior outbursts with failure to control aggressive impulses as manifested by either of the following:
   1. Verbal aggression.
   2. Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period.

B. Magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors.

C. The recurrent aggressive outburst are not premeditated.

D. Recurrent outbursts cause either marked distress in the individual or impairment in occupational, or interpersonal functioning, or associated with financial or legal consequences.

E. Age 6+ years (or equivalent developmental level).

F. Recurrent aggressive outbursts are not better explained by another mental disorder (e.g., major depressive disorder, Bipolar Disorder, disruptive, mood dysregulation disorder, a psychotic disorder, antisocial personality disorder...
Conduct Disorder

Diagnostic Criteria

A. Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules or violated manifested by the presence of at least 3 of the following 15 criteria in the past 12 months from any of the categories below with at least one criterion present in the past 6 months:
   - Aggression to people or animals
   - Destruction of property
   - Deceitful or theft
   - Serious violations of rules

   See symptom list p. 470.

B. Disturbance in behavior calls as clinically significant impairment in social academic or occupational functioning.

C. If an individual is age 18 years or older criteria are not met for antisocial personality disorder.

Specify whether:

312.81 (F91. One) childhood onset type: 1+ symptom prior to age 10.
312.82 (F91. 2) adolescent onset type: No symptoms prior to age 10.
312.89 (F9 1.9) unspecified onset: Information not available to determine whether onset before or after age 10 years.

Specify if:

With limited pro social emotions: See text P. 470
Lack of remorse or guilt: See text P4 70
Callous-lack of empathy:
Unconcerned about performance:
Shallow or deficient affect:

Specify current severity:

Mild: Few if any Sx.
Moderate: Intermediate Sx. between those specified in “mild” and those in “severe.”
Severe: Many problems...

See more details p. 470.
All the disorders in the chapter involve problems in emotional and behavioral regulation, the source of variation in the disorders is the relative emphasis on problems of the 2 types of self-control.

**Conduct Disorder** relates to poorly controlled behaviors that are violation of rights of others and violation of social norms. Behavioral symptoms can be the result of poorly controlled emotions such as anger (e.g., Bullies, threatens, intimidates, initiates physical fights, used weapon to harm others, cruel, stolen, forced sexual activity with others, deliberate fire setting, destroyed property, burglary, lies to obtain goods, run away from home, forgery, truant).

**Intermittent Explosive Disorder** is at the other extreme and focuses on poorly controlled emotional outbursts of anger disproportionate to interpersonal or other provocation or to other psychosocial stressors (e.g., temper tantrums, tirades, arguments, fights, physical aggression to property, property, animals, or individuals that does not result in destruction or injury).

**Oppositional Defiant Disorder** involves criteria are more evenly divided between emotions (anger and irritation) and behavior (argumentativeness and defiance) (e.g., Temper, touhy, easily annoyed, angry, resentful, argues, defiance, refuses authority, annoys others, blames others).
**Nutshell Criteria**

cA. Persistent basic rights of others violated in 6m 3 of 15 Sx of:
- Aggression to people/animals
- Property destruction
- Deceitfulness or theft
- Serious violations of rules

c. Sig. SAO distress
- If over 18yo criteria for

cC. Antisocial PD not met

Specify whether:
- Childhood, adolescent, unspecified onset

Specify if:
- With limited prosocial emotions:
  - lack of remorse/guilt
  - Callous-lack of empathy
  - unconcern about performance
  - Shallow or deficient affect

Specify current severity:
- Mild
- Moderate
- Severe

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312.82 conduct disorder, childhood onset type, with limited prosocial emotions, Severe,
995.54 child physical abuse, confirmed
995.52 child neglect, suspected
995.51 child psychological abuse, confirmed
V62.89 borderline intellectual functioning
V62.3 educational problem
V62.89 victim of crime
V62.89 discord with probation officer

IP has Hx. Of 4 episodes of mental heath treatment with Dx. of:
299.80 PDD NOS
314.01 ADHD, Combined Type and
313.81 Oppositional Defiant Disorder

IP is not currently threat to self, but is threat to others and awaiting hearing for consideration of return to residential care.
Disruptive, Impulse-Control & Conduct Disorders

Problems in self-control of emotions & behaviors unique in that violate rights of others and societal norms (p.461)

312.33 (F63.1) Pyromania
1+ deliberate purposeful fire setting with tension/affect arousal, pleasure, gratification, or relief & not for money or ideology & no other disorder explains.

312.32 (F63.3) Kleptomania
No resistance to impulse to steal objects not needed with tension before theft and pleasure, gratification, or relief. Is not for anger or vengeance and not delusion or hallucinatory or due to other mental disorder.

312.9 (F89.8) Other Specified Disruptive, impulse-control, and Conduct Disorder
This category used when clinician chooses to communicate specific reason the presentation does not meet the full criteria for any specific disorder in this section. This is done by recording, “other specified disruptive, impulse, and conduct disorder” followed by the specific reason.

312.9 (F91.9) Unspecified Disruptive, impulse-control, and Conduct Disorder
This category used when clinician chooses to communicate specific reason the presentation does not meet the full criteria for any specific disorder in this section. Used when clinician does NOT want to specify reason criteria unmet. Perhaps b/o insufficient information.

In DSM-IV Impulse-Control Disorders Not Elsewhere Classified (pp. 663-677)
Moved in: ODD and CD
Moved out: Pathological Gambling moved to Non-Substance-Related Disorders and changed to Gambling Disorder (p.585)
Trichotillomania moved to OCD disorders (p.251)
**DSM-5: SUBSTANCE-RELATED and Addictive DISORDERS**

Note: “... addiction is not applied as a diagnostic term. The more neutral term substance use disorder used to describe... a mild form to a severe state of chronically relapsing, compulsive drug taking. Some clinicians will choose to use word addiction to describe extreme presentations, but the word is omitted from DSM-5... diagnostic terminology because of its uncertain definition and is potentially negative connotation” (p. 485)

**Abuse and Dependence transformed to diagnosis of severity measures of Mild (2-3 Sx.), moderate (4-5 Sx.), or severe (6+ Sx.)” (P. 485)**

**Record Dx. Using code applying to class of substances, but name the specific substance (e.g., see (P. 485)**

**Course specifiers are:**
- “in early remission,”
- “in sustained remission.,”
- “on maintenance therapy, ”
- “in controlled environment.”

**Definitions provided in specific criteria sets**

**Substance-Induced Disorders (divided into 2 groups)**

- Intoxication
- Withdrawal

**Work Group’s analysis of data from Dr. Grant’s NESARC random sample of 43,000 Americans indicates no significant change in prevalence. Several smaller studies also reported no significant change.**
Course and Remission Specifiers

**DSM-5 course specifiers (p. 484)**

“in early remission”
“in sustained remission”
“on maintenance therapy”
“in a controlled environment”
Definitions provided in each specific substance criteria set

Polysubstance dependence removed
All substance disorders diagnosed (p. 485)

**DSM-IV remission specifiers (p. 196)**

The following Remission specifiers can be applied only after no criteria for Dependence or Abuse have been met for at least 1 month. Note that these specifiers do not apply if the individual is on agonist therapy or in a controlled environment (see below).

- **Early Full Remission.** This specifier is used if, for at least 1 month, but for less than 12 months, no criteria for Dependence or Abuse have been met.

- **Early Partial Remission.** This specifier is used if, for at least 1 month, but less than 12 months, one or more criteria for Dependence or Abuse have been met (but the full criteria for Dependence have not been met).

- **Sustained Full Remission.** This specifier is used if none of the criteria for Dependence or Abuse have been met at any time during a period of 12 months or longer.

- **Sustained Partial Remission.** This specifier is used if full criteria for Dependence have not been met for a period of 12 months or longer; however, one or more criteria for Dependence or Abuse have been met.
DSM-5: Substance-Related and Addictive Disorders
Was Substance-Related Disorders

“Addiction’ is not a proposed disorder for DSM-5”

Substance-Related Disorders
   Substance Use Disorders
   Substance-Induced Disorders
      Substance Intoxication
      Substance Withdrawal
   Substance/Medication-Induced Disorders Included Elsewhere in the Manual

Alcohol-Related Disorders
   Alcohol Use Disorder
   Alcohol Intoxication
   Alcohol Withdrawal
   Unspecified Alcohol-Related Disorder
   Other Alcohol-Induced Disorders

Caffeine-Related Disorders
   Caffeine Intoxication
   Caffeine Withdrawal
   Unspecified Caffeine-Related Disorder
   Other Caffeine-Induced Disorders

Substance abuse & substance dependence replaced with “substance use disorder”
**DSM-5 Diagnosis**

Mr. Perry reported he has never received a mental health diagnosis in the past. Based on the clinical interview, scales administered and collateral information, the following diagnoses were made as part of this evaluation:

**Diagnosis**
- 296.31 Major depressive disorder, recurrent episode, Mild, with anxious distress, mild
- 305.00 Alcohol use disorder, in early remission
- 305.20 Cannabis use disorder, in sustained remission
- R/O 312.31 Gambling Disorder Episodic, Mild

**Notations**
- V61.8 High expressed emotion level within family
- V60.2 Insufficient social insurance or welfare support

**Disability Severity**
- Moderate

**Medical Conditions**
- Back injury from ATV accident with significant pain
- Asthma as reported by IP
TABLE 1. Diagnoses associated with substance class

<table>
<thead>
<tr>
<th>Substance</th>
<th>Psychotic disorders</th>
<th>Bipolar disorders</th>
<th>Depressive disorders</th>
<th>Anxiety disorders</th>
<th>Obsessive-compulsive and related disorders</th>
<th>Sleep disorders</th>
<th>Sexual dysfunctions</th>
<th>Delirium</th>
<th>Neurocognitive disorders</th>
<th>Substance use disorders</th>
<th>Substance intoxication</th>
<th>Substance withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</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/P</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Caffeine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>I/W</td>
<td>I/W</td>
<td>I/W</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
<td>I/W</td>
<td>I/W</td>
<td></td>
<td>I/W</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Hallucinogens</td>
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<tr>
<td>Phencyclidine</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>I/W</td>
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<td></td>
<td>I</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Other hallucinogens</td>
<td></td>
<td>I</td>
<td>I</td>
<td>I</td>
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<tr>
<td>Inhalants</td>
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<td></td>
<td></td>
<td>I</td>
<td>I/P</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Opioids</td>
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<tr>
<td>Sedatives, hypnotics, or anxiolytics</td>
<td>I/W</td>
<td>I/W</td>
<td>I/W</td>
<td>W</td>
<td></td>
<td>I/W</td>
<td>I/W</td>
<td>I/W</td>
<td>I/W/P</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Stimulants**</td>
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<tr>
<td>Tobacco</td>
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<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Other (or unknown)</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/P</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Note.** X = The category is recognized in DSM-5.
I = The specifier “with onset during intoxication” may be noted for the category.
W = The specifier “with onset during withdrawal” may be noted for the category.
I/W = Either “with onset during intoxication” or “with onset during withdrawal” may be noted for the category.
P = The disorder is persisting.
DSM-5: Substance-Related and Addictive Disorders

Was Substance-Related Disorders

Substance-Related Disorders

Cannabis-Related Disorders
Cannabis Use Disorder
Cannabis Intoxication
Cannabis Withdrawal
Unspecified Cannabis-Related Disorder
Other Cannabis-Induced Disorders

Hallucinogen-Related Disorders
Phencyclidine Use Disorder
Other Hallucinogen Use Disorder
Phencyclidine Intoxication
Other Hallucinogen Intoxication
Hallucinogen Persisting Perception Disorder
Unspecified Phencyclidine-Related Disorder
Unspecified Hallucinogen-Related Disorder
Other Phencyclidine-Induced Disorders
Other Hallucinogen-Induced Disorders
DSM-IV Sample Diagnosis: Pathological Gambling

AXIS I: 312.31 Pathological Gambling, Severe
          300.4 Dysthymic Disorder, Moderate
          303.90 Alcohol Dependence
          304.20 Cocaine Abuse, Early Partial Remission
          3314.01 ADHD, Combined Type, Moderate by Prior Hx.

Axis II: 301.7 Antisocial Personality Disorder

AXIS III: 401.9 Hypertension, Essential
          346.90 Migraine, common
          531.70 Ulcer, Gastric, Chronic

AXIS IV: Psychosocial Problems
Primary support group: Marital separation / estrangement from children
Social environment: Conflict with coworkers
Education: Dropout in 10th grade
Housing: Home foreclosure by bank/living in small apartment
Economic: Significant debt
Health care access: No health insurance coverage
Legal system: Probation for embezzlement
Other: None
DSM-5 Sample Diagnosis: Gambling Disorder

**Diagnosis**
312.31 Gambling disorder, Severe
300.4 Persistent depressive Disorder, with anxious distress, with melancholic features, Late onset, with pure dysthyemic syndrome, Moderate
305.90 Alcohol use disorder
304.20 Cocaine use, moderate
314.01 ADHD, combined presentation, moderate
301.7 Antisocial personality disorder

**Notations**
V61.3 Disruption of family by separation
V61.21 Occupational problems
V62.3: Housing:
V60.9 Unspecified economic problem
V60.2 Insufficient social insurance or welfare support
V62.5 Conviction in criminal proceeding without imprisonment

**Medical Conditions**
401.9 Hypertension, essential
346.90 Migraine, common
531.70 Ulcer, gastric, chronic
**DSM-5: Rejection of Behavioral Addiction**

- APA rejected a new category “Behavioral Addictions”
- *DSM-5* includes gambling disorder in substance use disorders section
  - *DSM-IV* classified "pathological gambling" as an impulse control disorder
- Behavioral addiction Internet use gaming disorder in section 3
- Hypersexual disorder, (‘sex addiction”) was rejected for *DSM-5*
DSM-5: Neurocognitive Disorders
Was Delirium, Dementia, & Amnestic and Other Cognitive Disorders

Delirium
Other Specified Delirium
Unspecified Delirium

Major & Mild Neurocognitive Disorders
Major or Mild Neurocognitive Disorder Due to Alzheimer’s Disease
Major or Mild Frontotemporal Neurocognitive Disorder
Major or Mild Neurocognitive Disorder with Lewy Bodies
Major or Mild Vascular Neurocognitive Disorder
Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury
Major or Mild Neurocognitive Disorder Due to HIV Infection
Major or Mild Neurocognitive Disorder Due to Prion Disease
Major or Mild Neurocognitive Disorder Due to Parkinson’s Disease
Major or Mild Neurocognitive Disorder Due to Huntington’s Disease
Neurocognitive Disorder Due to Another Medical Condition
Major or Mild Neurocognitive Disorder Due to Multiple Etiologies
Unspecified Neurocognitive Disorder

By 2050 33% of elderly will be Dx Alzheimer’s Disease

In 1990s I stuck my neck out [and] said that by the time DSM-5 comes out, Alzheimer’s will be the first diagnosis that has a laboratory test.” Michael First
-There is lab test to diagnose Alzheimer’s.
-Migraine headaches have no lab test.
Diagnosis of a migraine vs. a cluster headache depends on the description of the symptoms.
“So psychiatry is not unique.” M. First
DSM-5: Personality Disorders

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
  *Cross Listed*
- Antisocial Personality Disorder
  *Cross Listed*
- 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

**Change:**
- *DSM-5* maintains categorical model and criteria for 10 personality disorders in *DSM-4*.
  - ABC clusters remain
  - *DSM-5* includes new trait-specific criteria in Section 3 to encourage further study of use in clinical practice
  - APA Board not persuaded to change PDs in spite of huge opposition to current formulations

**Rationale:** Unknown, Reportedly reforms considered too complex for clinicians

Which PD has shown a significant increase in last 15 years, especially in women?
General Personality Disorder

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture. The pattern is manifested in 2+ of the following areas:

1. Cognition (Perception/interpretation of self/others & events)
2. Affectivity (Variable emotional response)
3. Interpersonal functioning
4. Impulse control

B. Enduring pattern is inflexible and pervasive in a broad range of personal/social situations.

C. Enduring pattern leads to clinically significant distress or impairment in SOOF

D. Long enduring pattern since adolescence or early adulthood.

E. Enduring pattern not explained by another mental disorder

F. Enduring pattern not due to substances or other medical condition
General Personality Disorder

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   1. Cognition (Perception/interpretation of self/others & events)
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C. Enduring pattern leads to clinically significant distress or impairment in SOOF

D. Long enduring pattern since adolescence or early adulthood.

E. Enduring pattern not explained by another mental disorder

F. Enduring pattern not due to substances or other medical condition
301.83 Borderline Personality Disorder
995.54 Child physical abuse, confirmed
IP has Hx. of 4 episodes of mental health treatment beginning in adolescence with Dx. of:
314.01 ADHD, Combined Type
296.52 Bipolar I Disorder, Moderate
IP is not currently threat to self or others

**Nutshell Criteria**
- Pervasive instability of relationships
- Self image, & affects, w impulsivity through 5+ of:
  1. Frantic efforts to avoid real/imagined abandonment
  2. Relationships alternate in idealization & devaluation
  3. Persistent unstable self-image or self sense
  4. Potentially self damaging impulsivity in 2+ areas
  5. Recurrent suicidal behavior/gestures/threats
  6. Affective instability due to mood reactivity
  7. Chronic emptiness feelings
  8. Intense anger or difficulty controlling anger
  9. Transient, stress-related paranoia or dissociative Sx.

**Nutshell General Personality Disorder Criteria**
- A. Enduring pattern of behavior deviating from cultural expectations in 2+ areas of:
  1. Cognition (ways of perceiving)
  2. Affectivity (emotional responses)
  3. Interpersonal functioning
  4. Impulse control
- B. Enduring pattern in personal & social areas
- C. Clin. sig. distress in SOA functioning
- D. Stable long duration traced to adolescence
- E. Pattern not explained by other mental disorder
- F. Pattern not due to substances or medical condition
**DSM-5: Paraphilic Disorders**

*Paraphilias*  “disorders” added to category title & all disorders

- **Voyeuristic Disorder**  *Voyeurism*
- **Exhibitionistic Disorder**  *Exhibitionism*
- **Frotteuristic Disorder**  *Frotteurism*
- **Sexual Masochism Disorder**
- **Sexual Sadism Disorder**
- **Pedophilic Disorder**  *Pedophilia*
- **Fetishistic Disorder**  *Fetishism*
- **Transvestic Disorder**
- **Other Specified Paraphilic Disorder**
- **Unspecified Paraphilic Disorder**

**Other Mental Disorders**
Other Specified Mental Disorder Due to Another Medical Condition
Unspecified Mental Disorder Due to Another Medical Condition
Other Specified Mental Disorder
Unspecified Mental Disorder

**Change:** Pedophilic disorder criteria remain unchanged from *DSM-IV*, but the disorder name revised from pedophilia to pedophilic disorder.
**Diagnostic Criteria**

**Pedophilic Disorder**

**Diagnostic Criteria Set (DSM-5, pp. 697-698)**

A. Over a period of at least 6 months, recurrent, and tense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).

B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

C. The individual is at least age 16 years and at least 5 years older than child or children in cA.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12-or 13-year old.

Specify whether:

- Exclusive type (attracted only to children)
- Nonexclusive type

Specify if:

- Sexually attracted to males
- Sexually attracted to females
- Sexually attracted to both

Specify if:

- Limited to incest

Interesting in relation to statement DSM-5, p. 686:

**Paraphilic Disorder:** A paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others...A paraphilia is a necessary, but not sufficient condition for having a disorder and a paraphilia by itself does not necessarily justify or require clinical intervention.... the term *diagnosis* should only be applied to individuals who meet both cA and cB... if an individual meets cA but not cB for a particular paraphilia – a circumstance that might arise when a benign paraphilia is discovered during the clinical investigation of some other condition – then the individual may be said to have that paraphilia but not a paraphilic disorder.
**Paraphilic Disorders**

<table>
<thead>
<tr>
<th>Disorders (DSM-5, pp. 685-705)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voyeuristic Disorder</td>
</tr>
<tr>
<td>Exhibitionistic Disorder</td>
</tr>
<tr>
<td>Frotteuristic Disorder</td>
</tr>
<tr>
<td>Sexual Masochism Disorder</td>
</tr>
<tr>
<td>Sexual Sadism Disorder</td>
</tr>
<tr>
<td>Pedophilic Disorder</td>
</tr>
<tr>
<td>Fetishistic Disorder</td>
</tr>
<tr>
<td>Transvestic Disorder</td>
</tr>
<tr>
<td>Other Specified Paraphilic Disorder</td>
</tr>
<tr>
<td>UnSpecified Paraphilic Disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Brief Definition (DSM-5, p. 685)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spying on others in private activities</td>
</tr>
<tr>
<td>Exposing the genitals</td>
</tr>
<tr>
<td>Touching/rubbing against nonconsenting individual</td>
</tr>
<tr>
<td>Undergoing humiliation, bondage, or suffering</td>
</tr>
<tr>
<td>Inflicting humiliation, bondage, or suffering</td>
</tr>
<tr>
<td>Sexual focus on children</td>
</tr>
<tr>
<td>Using nonliving objects/having highly specific focus on nongenital body parts</td>
</tr>
<tr>
<td>Engaging in sexually arousing cross dressing</td>
</tr>
</tbody>
</table>

**Terminology**

*Paraphilia*: Any intense and persistent sexual interest other than interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners.

*Paraphilic Disorder*: A paraphilia that is currently causing distress or impairment for the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others.

**NOTE**: A paraphilia is a necessary, but not sufficient condition for having a disorder and a paraphilia by itself does not necessarily justify or require clinical intervention.

In diagnostic sets for Paraphilic disorders cA specifies paraphilia qualitative nature (i.e., erotic focus on children or exposing genitals to strangers) and cB specifies paraphilia negative consequences (i.e., distress, impairment, or harm to others), **THEREFORE, the term diagnosis should only be applied to individuals who meet both cA and cB.**
DSM-5: V and Z codes

Z Codes are new they are ICD-10 of DSM-4 Axis 4

- Persons with potential health hazards related to socioeconomic and psychosocial circumstances
- Z55  Problems related to education and literacy
- Z56  Problems related to employment and unemployment
- Z57  Occupational exposure to risk factors
- Z59  Problems related to housing and economic circumstances
- Z60  Problems related to social environment
- Z62  Problems related to upbringing
- Z63  Other problems related to primary support group, including family circumstances
- Z64  Problems related to certain psychosocial circumstances
- Z65  Problems related to other psychosocial circumstances

"Z" Codes classify routine health check reasons as a replacement for "V" codes in ICD-9. New codes in ICD-10-CM, which have more coding classification choices will not be implemented until 10/01/2014. 119 Z codes listed in DSM-5 related to psychosocial problems. 92 V codes are listed on pages 873-876 of DSM-5. These codes are available for use.
Abuse and Neglect

Maltreatment by a family member (e.g., caregiver, intimate adult partner) or by a nonrelative can be the area of current clinical focus, or such maltreatment can be an important factor in the assessment and treatment of patients with mental or other medical disorders. Because of the legal implications of abuse and neglect, care should be used in assessing these conditions and assigning these codes. Having a past history of abuse or neglect can influence diagnosis and treatment response in a number of mental disorders, and may also be noted along with the diagnosis.

For the following categories, in addition to listings of the confirmed or suspected event of abuse or neglect, other codes are provided for use if the current clinical encounter is to provide mental health services to either the victim or the perpetrator of the abuse or neglect. A separate code is also provided for designating a past history of abuse or neglect.

Coding Note for ICD-10-CM Abuse and Neglect Conditions
For T codes only, the 7th character should be coded as follows:

A (initial encounter)—Use while the patient is receiving active treatment for the condition (e.g., surgical treatment, emergency department encounter, evaluation and treatment by a new clinician); or
D (subsequent encounter)—Use for encounters after the patient has received active treatment for the condition and when he or she is receiving routine care for the condition during the healing or recovery phase (e.g., cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow-up visits).

Child Maltreatment and Neglect Problems

Child Physical Abuse

Child physical abuse is nonaccidental physical injury to a child—ranging from minor bruises to severe fractures or death—occurring as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or any other method that is inflicted by a parent, caregiver, or other individual who has responsibility for the child. Such injury is considered abuse regardless of whether the caregiver intended to hurt the child. Physical discipline, such as spanking or paddling, is not considered abuse as long as it is reasonable and causes no bodily injury to the child.

Child Physical Abuse, Confirmed
995.54 (T74.12XA) Initial encounter
995.54 (T74.12XD) Subsequent encounter

Child Physical Abuse, Suspected
995.54 (T76.12XA) Initial encounter
995.54 (T76.12XD) Subsequent encounter
Other Conditions That May Be a Focus of Clinical Attention

Other Circumstances Related to Child Physical Abuse

V61.21 (Z69.010) Encounter for mental health services for victim of child abuse by parent
V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child abuse
V15.41 (Z62.810) Personal history (past history) of physical abuse in childhood
V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child abuse
V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child abuse

Child Sexual Abuse

Child sexual abuse encompasses any sexual act involving a child that is intended to provide sexual gratification to a parent, caregiver, or other individual who has responsibility for the child. Sexual abuse includes activities such as fondling a child’s genitals, penetration, incest, rape, sodomy, and indecent exposure. Sexual abuse also includes noncontact exploitation of a child by a parent or caregiver—for example, forcing, tricking, enticing, threatening, or pressuring a child to participate in acts for the sexual gratification of others, without direct physical contact between child and abuser.

Child Sexual Abuse, Confirmed
995.53 (T74.22XA) Initial encounter
995.53 (T74.22XD) Subsequent encounter

Child Sexual Abuse, Suspected
995.53 (T76.22XA) Initial encounter
995.53 (T76.22XD) Subsequent encounter

Other Circumstances Related to Child Sexual Abuse

V61.21 (Z69.010) Encounter for mental health services for victim of child sexual abuse by parent
V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child sexual abuse
V15.41 (Z62.810) Personal history (past history) of sexual abuse in childhood
V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child sexual abuse
V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child sexual abuse

Child Neglect

Child neglect is defined as any confirmed or suspected egregious act or omission by a child’s parent or other caregiver that deprives the child of basic age-appropriate needs and thereby results, or has reasonable potential to result, in physical or psychological harm to the child. Child neglect encompasses abandonment; lack of appropriate supervision; failure to attend to necessary emotional or psychological needs; and failure to provide necessary education, medical care, nourishment, shelter, and/or clothing.

Child Neglect, Confirmed
995.52 (T74.02XA) Initial encounter
995.52 (T74.02XD) Subsequent encounter
Other Conditions that may be a Focus of Clinical Attention

This section covers conditions and problems that may affect the diagnosis, course, prognosis, or treatment of a patient’s mental disorder... A condition in this section may be coded if it is a reason for the current visit or helps to explain the need for a test, procedure or treatment... The conditions in this section are not mental disorders....

Sections in this chapter:
Relational Problems
Abuse and Neglect
Educational and Occupational Problems
Housing and Economic Problems
Other Problems Related to the Social Environment
Other Health Service Encounters for Counseling and Medical Advice
Problems Related to Other Psychosocial, Personal, and Environmental Circumstances
Other Circumstances of Personal History
Problems Related to Family Upbringing
V61.20 (Z62.820) Parent Child Relational Problem
V61.8 (Z62.891) Sibling Relational problem
V61.8 Z62.29 Upbringing Away From Parents
V61.29 (Z62.898) Child Affected by Parental Relationship Distress

Other Problems Related to Primary Support Group
V61.10 (Z63.0) Relationship Distress With Spouse or Intimate Partner
V61.03 (Z63.5 Disruption of Family by Separation or Divorce
V61.8 (Z63.8) High Expressed Emotion Level Within Family
V62.82 (Z63.4) Uncomplicated Bereavement
Other Conditions that may be a Focus of Clinical Attention

Abuse and Neglect

Child Maltreatment and Neglect Problems

Child Physical Abuse, Confirmed
995.54 (T74 12XA) Initial encounter
995.54 (T74.12 XD) Subsequent encounter

Child Physical Abuse, Suspected
995.54 (T76.12XA) Initial encounter
995.54 (T76.12XD) Subsequent encounter

Other Circumstances Related To Child Physical Abuse
V61.21 (Z69.010) Encounter for mental health services for victim of child abuse by parent
V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child abuse
V15.41 (Z62.810) Personal history (past history) of physical abuse in childhood
V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child abuse
V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child abuse

Child Sexual Abuse
Repeat same sequence as above

Child Neglect
Repeat same sequence as above
Child psychological abuse
Repeat same sequence as above
Other Conditions that may be a Focus of Clinical Attention

Abuse and Neglect

**Child Psychological Abuse**

Child Psychological Abuse, Confirmed
995.51 (T74.32XA) Initial encounter
995.51 (T74.32XD) Subsequent encounter

Child Psychological Abuse, Suspected
995.51 (T76.32XA) Initial encounter
995.51 (T76.32XD) Subsequent encounter

**Other Circumstances Related To Child Psychological Abuse**

V61.21 (Z69.010) Encounter for mental health services for victim of child psychological abuse by parent
V61.21) Z69. 020) Encounter for mental health services for victim of non-parental child psychological abuse
V15.42 (Z.62. 810) Personal history (past history) of psychological abuse in childhood
V61.22 (Z.69. 811) Encounter for mental health services for perpetrator of parental child psychological abuse
V62. 83 ( Z69. 021) Encounter for mental health services for perpetrator of nonparental child abuse
Other Conditions that may be a Focus of Clinical Attention

Adult Maltreatment and Neglect Problems

Spouse or Partner Violence, Physical
  Repeat same sequence as above

Spouse or Partner Violence, Sexual
  Repeat same sequence as above

Spouse or Partner Abuse, Psychological
  Repeat same sequence as above

Adult Abuse By Nonspouse or Nonpartner
  See detailed typologies in DSM-5
Educational and Occupational Problems

Educational Problems
V62.3 (Z55.9) Academic or Educational Problem

Occupational Problem
V62.29 (Z56.82) Problem Related to Current Military Deployment Status
V62.29 (56.9) Other Problem Related to Employment

Housing and Economic Problems

Housing problems
V60.0 (Z59.0) Homelessness
V60.1) (Z59.1) Inadequate Housing
V60.89 (Z59.2) Discord With Neighbor, Lodger, or Landlord
V60.6 (Z.59.3) Problem Related to Living in a residential Institution

Economic Problems
V60.2 (Z59.4) Lack of Adequate Food or Safe Drinking Water
V60.2 (Z59.5) Extreme Poverty
V60.2 (Z59.6) Low Income
V60.2 (Z59.7) Insufficient Social Insurance Support
V60.2 (Z59.9) Unspecified Housing and Economic Problem
DSM-5 Coding Corrections As of May 14, 2013

On page xiii – Neurodevelopmental Disorders (31)

319
* ___._
(.__)
(F70) (F71) (F72) (F73)
(.__)

Intellectual Disability (Intellectual Developmental Disorder) (33) Specify current severity: Mild, Moderate, Severe, Profound

317 (F70) **318.0** (F71) **318.1** (F72) **318.2** (F73)

Correct the listed ICD-9-CM codes for intellectual disability severity levels: Mild 317, Moderate 318.0, Severe 318.1, Profound 318.2.

On page 33 – Intellectual Disability (Intellectual Developmental Disorder)

Coding note: The ICD-9-CM code for intellectual disability (intellectual developmental disorder) is 319, which is assigned regardless of the severity specifier. The ICD-10-CM code depends on the severity specifier (see below).

Specify current severity (see Table 1): *(F70)* Mild *(F71)* Moderate *(F72)* Severe *(F73)*

Profound

* Specify current severity (see Table 1): **317** **318.0** **318.1** **318.2** *(F70)* Mild *(F71)* Moderate *(F72)* Severe *(F73)* Profound
DSM-5 Coding Corrections As of May 14, 2013

On page 848 - ICD-9-CM ICD-10-CM Disorder, condition, or problem 319
F70 F71 F72 F73
Intellectual disability (intellectual developmental disorder) Mild Moderate Severe Profound
Intellectual disability (intellectual developmental disorder) Mild Moderate Severe Profound
* 317 F70 318.0 F71 318.1 F72 318.2 F73
Correct the listed ICD-9-CM codes for intellectual disability severity levels: Mild 317, Moderate 318.0, Severe 318.1, Profound 318.2.
**DSM-5 Coding Corrections As of May 14, 2013**

On page 872 - ICD-9-CM Disorder, condition, or problem

*317 318.0 318.1 318.2*

Intellectual disability (intellectual developmental disorder)
Intellectual disability (intellectual developmental disorder), Mild Intellectual disability (intellectual developmental disorder), Moderate Intellectual disability (intellectual developmental disorder), Severe Intellectual disability (intellectual developmental disorder), Profound

Correct the listed ICD-9-CM codes for intellectual disability severity levels: Mild 317, Moderate 318.0, Severe 318.1, Profound 318.2.

On page xix – Obsessive-Compulsive and Related Disorders (235) 312.39 (F63.2)
Trichotillomania (Hair-Pulling Disorder) (251)

*312.39 (F63.3) Trichotillomania (Hair-Pulling disorder) (251) Correct the listed ICD-10-CM code for Trichotillomania (Hair-Pulling Disorder) to F63.3.*
DSM-5 Coding Corrections As of May 14, 2013

On page 251 – Trichotillomania (Hair-Pulling Disorder) Diagnostic Criteria 312.39 (F63.2)
*Diagnostic Criteria 312.39 (F63.3) Correct the listed ICD-10-CM code for Trichotillomania (Hair-Pulling Disorder) to F63.3.

On page 861 – ICD-9-CM ICD-10-CM Disorder, condition, or problem 312.39 (F63.2) Trichotillomania (hair-pulling disorder)
*312.39 (F63.3) Trichotillomania (hair-pulling disorder) Correct the listed ICD-10-CM code for Trichotillomania (hair-pulling disorder) to F63.3.

On page 890 – ICD-10-CM Disorder, condition, or problem (F63.2) Trichotillomania (hair-pulling disorder)
*(F63.3) Trichotillomania (hair-pulling disorder) Correct the listed ICD-10-CM code for Trichotillomania (hair-pulling disorder) to F63.3.

On page xxiv – Disruptive, Impulse-Control, and Conduct Disorders (461) ___._ (._._)
Conduct Disorder (469) Specify whether:
312.81 (F91.1) 312.32 (F91.2) 312.89 (F91.9)
Childhood-onset type Adolescent-onset type Unspecified-onset type ___._ (._._) Conduct Disorder (469) Specify whether: 312.81 (F91.1) Childhood-onset type *312.82 (F91.2) Adolescent-onset type 312.89 (F91.9) Unspecified-onset type Correct the listed ICD-9-CM code for conduct disorder, adolescent-onset type to F312.82.
On page 846 – ICD-9-CM ICD-10-CM Disorder, condition, or problem Conduct Disorder
312.32   F91.2    Adolescent-onset type Conduct Disorder
*312.82  F91.2 Adolescent-onset type Correct the listed ICD-9-CM code for conduct disorder, adolescent-onset type to F312.82

On page 871 - ICD-9-CM Disorder, condition, or problem 312.32 Conduct disorder, Adolescent-onset type
* 312.82 Conduct disorder, Adolescent-onset type Correct the listed ICD-9-CM code for conduct disorder, adolescent-onset type to F312.82

On page xxiv - Disruptive, Impulse-Control, and Conduct Disorders (461) 312.32 (F63.3) Kleptomania (478) *312.32 (F63.2) Kleptomania (478)
Correct the listed ICD-10-CM code for Kleptomania to F63.2.

On page 478 – Kleptomania Diagnostic Criteria 312.39 (F63.3)
*Diagnostic Criteria312.39 (F63.2) Correct the listed ICD-10-CM code for Kleptomania to F63.2.
On page 848 - ICD-9-CM ICD-10-CM Disorder, condition, or problem

DSM-5 Coding Corrections As of May 14, 2013

312.32 F63.3 Kleptomania

*312.32 F63.2 Kleptomania Correct the listed ICD-10-CM code for Kleptomania to F63.2.

On page 890 - ICD-10-CM Disorder, condition, or problem F63.3 Kleptomania

*F63.2 Kleptomania Correct the listed ICD-10-CM code for Kleptomania to F63.2.

On page xiii – Neurodevelopmental Disorders (31)

319

* ___

(__)

(F70) (F71) (F72) (F73)

(__)

Intellectual Disability (Intellectual Developmental Disorder) (33) Specify current severity: Mild, Moderate, Severe, Profound

317 (F70) 318.0 (F71) 318.1 (F72) 318.2 (F73)

Correct the listed ICD-9-CM codes for intellectual disability severity levels: Mild 317, Moderate 318.0, Severe 318.1, Profound 318.2.
DSM-5 Coding Corrections As of May 14, 2013

On page 33 – Intellectual Disability (Intellectual Developmental Disorder)

Coding note: The ICD-9-CM code for intellectual disability (intellectual developmental disorder) is 319, which is assigned regardless of the severity specifier. The ICD-10-CM code depends on the severity specifier (see below).

Specify current severity (see Table 1): (F70) Mild (F71) Moderate (F72) Severe (F73) Profound

* Specify current severity (see Table 1): 317 318.0 318.1 318.2

(F70) Mild (F71) Moderate (F72) Severe (F73) Profound

On page 848 - ICD-9-CM ICD-10-CM Disorder, condition, or problem

319

F70 F71 F72 F73

Intellectual disability (intellectual developmental disorder) Mild Moderate Severe Profound

Intellectual disability (intellectual developmental disorder) Mild Moderate Severe Profound

* 317 F70 318.0 F71 318.1 F72 318.2 F73

Correct the listed ICD-9-CM codes for intellectual disability severity levels: Mild 317, Moderate 318.0, Severe 318.1, Profound 318.2.
On page 872 - ICD-9-CM Disorder, condition, or problem 319

*317 318.0 318.1 318.2

Intellectual disability (intellectual developmental disorder)

Intellectual disability (intellectual developmental disorder), Mild Intellectual disability (intellectual developmental disorder), Moderate Intellectual disability (intellectual developmental disorder), Severe Intellectual disability (intellectual developmental disorder), Profound

Correct the listed ICD-9-CM codes for intellectual disability severity levels: Mild 317, Moderate 318.0, Severe 318.1, Profound 318.2.

On page xix – Obsessive-Compulsive and Related Disorders (235) 312.39 (F63.2)

Trichotillomania (Hair-Pulling Disorder) (251)

*312.39 (F63.3) Trichotillomania (Hair-Pulling disorder) (251) Correct the listed ICD-10-CM code for Trichotillomania (Hair-Pulling Disorder) to F63.3.

DSM-5 Coding Corrections As of May 14, 2013

On page 251 – Trichotillomania (Hair-Pulling Disorder) Diagnostic Criteria 312.39 (F63.2)

*Diagnostic Criteria312.39 (F63.3) Correct the listed ICD-10-CM code for Trichotillomania (Hair-Pulling Disorder) to F63.3.
On page 861 – ICD-9-CM ICD-10-CM Disorder, condition, or problem 312.39 (F63.2) Trichotillomania (hair-pulling disorder)  
*312.39 (F63.3) Trichotillomania (hair-pulling disorder) **Correct the listed ICD-10-CM code for Trichotillomania (hair-pulling disorder) to F63.3.**

On page 890 – ICD-10-CM Disorder, condition, or problem (F63.2) Trichotillomania (hair-pulling disorder)  
*(F63.3) Trichotillomania (hair-pulling disorder) **Correct the listed ICD-10-CM code for Trichotillomania (hair-pulling disorder) to F63.3.**

On page xxiv – Disruptive, Impulse-Control, and Conduct Disorders (461) __._ (_._) Conduct Disorder (469) Specify whether:  
312.81 (F91.1) **312.32** (F91.2) 312.89 (F91.9) Childhood-onset type Adolescent-onset type Unspecified-onset type  
__._ (_._) Conduct Disorder (469) Specify whether: 312.81 (F91.1) __._ (._._) Conduct Disorder (469) Specify whether: 312.82 (F91.2) Adolescent-onset type 312.89 (F91.9) Unspecified-onset type  
**Correct the listed ICD-9-CM code for conduct disorder, adolescent-onset type to F312.82.**
On page 846 – ICD-9-CM ICD-10-CM Disorder, condition, or problem Conduct Disorder 312.32 F91.2 Adolescent-onset type Conduct Disorder  
*312.82 F91.2 Adolescent-onset type Correct the listed ICD-9-CM code for conduct disorder, adolescent-onset type to F312.82

On page 871 - ICD-9-CM Disorder, condition, or problem 312.32 Conduct disorder, Adolescent-onset type  
* 312.82 Conduct disorder, Adolescent-onset type Correct the listed ICD-9-CM code for conduct disorder, adolescent-onset type to F312.82

On page xxiv - Disruptive, Impulse-Control, and Conduct Disorders (461) 312.32 (F63.3) Kleptomania (478) *312.32 (F63.2) Kleptomania (478)

Correct the listed ICD-10-CM code for Kleptomania to F63.2.

On page 478 – Kleptomania Diagnostic Criteria 312.39 (F63.3)  
*Diagnostic Criteria 312.39 (F63.2) Correct the listed ICD-10-CM code for Kleptomania to F63.2.

On page 848 - ICD-9-CM ICD-10-CM Disorder, condition, or problem DSM-5 Coding Corrections As of May 14, 2013 312.32 F63.3 Kleptomania  
*312.32 F63.2 Kleptomania Correct the listed ICD-10-CM code for Kleptomania to F63.2.

On page 890 - ICD-10-CM Disorder, condition, or problem F63.3 Kleptomania  
*F63.2 Kleptomania Correct the listed ICD-10-CM code for Kleptomania to F63.2.
CPT Code Changes

• If you are:
  – Psychiatrist go to:
    • http://psychiatryonline.org
  – LCPC go to:
    • http://thriveworks.com
  – Clinical social worker go to:
    • http://www.socialworkers.org/practice/clinical/2012/092012.asp
    • http://www.clinicalsocialworkassociation.org
  – Psychologist go to:
    • http://www.apapracticecentral.org/reimbursement/billing/
Alternative Diagnostic Systems: Zero to Three