TRAUMA-AND STRESSOR-RELATED DISORDERS

PTSD

Slides will start with Adults

Children 6 & under Slides After

Posttraumatic Stress Disorder (PTSD)

DSM-IV-TR CODE(S)	DESCRIPTION DSM-5	DSM-5 CODE(S)	DESCRIPTION ICD-10	NEW ICD-10 OPTION(S)
309.81	PTSD	F43.10	PTSD	F43.1
			PTSD, unspecified	F43.10
			PTSD, acute	F43.11
			PTSD, chronic	F43.12

The State may not recognize Acute versus Chronic, yet the ICD-10 Coding and Documentation Guidelines (required by HIPAA) indicate that the most specific diagnosis is to be assigned……

Posttraumatic Stress Disorder (Trauma- and Stress-Related Disorders)

Disorder-specific change

The stressor criterion (Criterion A) is more explicit (e.g., elimination of "non-violent death of a loved one" as a trigger) and subjective reaction (Criterion A2) is eliminated

- Direct and indirect exposure to trauma are still reflected in the criteria, but a review of the literature indicated more restrictive wording was needed.
- Criterion A2 is not well-supported by the data and rarely endorsed by military and other professionals who otherwise would meet full criteria for PTSD.

Posttraumatic Stress Disorder (Trauma- and Stress-Related Disorders)

Disorder-specific change

Expansion to four symptom clusters (intrusion symptoms; avoidance symptoms; negative alterations in mood and cognition; alterations in arousal and reactivity), with the avoidance/numbing cluster divided into two distinct clusters — avoidance, and persistent negative alterations in cognitions and mood

- Confirmatory factor analyses suggest PTSD is best conceptualized by four factors rather than three.
- Further, active avoidance and emotional numbing have been shown to be distinct; thus they have been separated here (with numbing expanded to include negative mood and cognitive symptoms).

DSM-IV-TR to DSM-5: Posttraumatic Stress Disorder (PTSD)

Diagnostic Criteria	
Overall	Hallmark criteria are changed: 1. Emotional response to trauma removed from diagnostic criteria 2. More attention is paid to behavioral symptoms accompanying PTSD
Changes of note	1. Moved from "Anxiety Disorders" to "Trauma- and Stressor-related Disorders" chapter 2. Stressor criteria is more explicit and now includes sexual assault and recurring exposures (such as experienced by first responders and police officers) 3. Avoidance/numbing symptom requirement is now split into two symptom clusters: • Avoidance and persistent negative alterations in cognitions • Mood (roughly equivalent to numbing as described under DSM-IV) 4. Eliminates acute and chronic phases of PTSD as specifiers, but retains delayed expression and adds presence of dissociative symptoms 5. Diagnostic thresholds are lowered for children and adolescents • Separate criteria added for children aged 6 years or younger

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Posttraumatic Stress Disorder: 6 & Under (Trauma- and Stress-Related Disorders)

Disorder-specific change

Separate criteria are now available for PTSD occurring in preschool-age children (6 years and younger)

- First developmental subtype of a psychiatric disorder specific to preschool-age children
- DSM-IV criteria for PTSD were not developmentally sensitive to very young children. For instance, young children are limited in their capacity to describe cognitions and internal experiences.
- Numerous studies indicate that children exposed to trauma can exhibit significant anxiety and other forms of distress that warrant treatment but, due to the inadequacy of the adult criteria, do not meet threshold for PTSD in DSM-IV.

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DSM-IV-TR to DSM-5: PTSD for Children 6 Years & Younger

Diagnostic Criteria	
Overall	New subtype specifically for children younger than 6 years of age: 1. Can develop at any age ***after 1 year of age*** 2. More developmentally sensitive 3. Lowers diagnostic thresholds for PTSD, e.g., cluster C threshold lowered from three to one symptom 4. Focuses on behaviorally expressed PTSD symptoms
Changes specific to preschool children of note	1. Includes caregiver-child–related losses as a main source of trauma 2. Arousal cluster now includes irritability or angry outbursts and reckless behaviors 3. Clinical re-experiencing can vary according to developmental stage, with young children having frightening dreams not specific to the trauma 4. Excludes symptoms such as negative self-beliefs and blame, which are dependent on the ability to verbalize cognitive constructs and complex emotional states

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Hallmark Symptoms of PTSD in Children

- **RE-ENACTMENT**
  - Play
  - Drawing
  - Nightmares
  - Intrusive ideations
- **AVOIDANCE**
  - Being withdrawn
  - Daydreaming
  - Avoiding other children
- **PHYSIOLOGICAL HYPERREACTIVITY**
  - Anxiety
  - Sleep problems
  - Hypervigilance
  - Behavioral impulsivity

- Preschool ages do not require negative self-beliefs and blame
- Loss of caregiver through death, abandonment, foster care placement can be experienced as trauma
- Children rely on caregiver to feel safe—if that relationship is disrupted, it can threaten their sense of safety and survival

Table 8. DSM-IV to DSM-5 Post-traumatic Stress Disorder Comparison Children 6 Years and Younger

DSM-IV: PTSD	DSM-5: PTSD
Disorder Class: Anxiety Disorders	Disorder Class: Trauma- and Stressor-Related Disorders
A. The person has been exposed to a traumatic event in which both of the following were present: 1. The person experienced, witnessed or was confronted with an event or events 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. Note: In children, this may be expressed instead by disorganized or agitated behavior.	A. Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: 1. Directly experiencing the traumatic event(s). 2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers. 3. Learning that the traumatic event(s) occurred to a parent or caregiving figure. Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

Table 8. DSM-IV to DSM-5 Post-traumatic Stress Disorder Comparison Children 6 Years and Younger (continued)

DSM-IV: PTSD	DSM-5: PTSD
Disorder Class: Anxiety Disorders	Disorder Class: Trauma- and Stressor-Related Disorders
B. The traumatic event is persistently re-experienced in one or more of the following ways. 1. Recurrent and intrusive distressing recollections of the event, including images thoughts or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma expressed. 2. Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content. 3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur. 4. Intense psychological distress at exposure to the internal or external cues that symbolize or resemble an aspect of the traumatic event. 5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.	B. Presence of one or more of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: 1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment. 2. Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s). 3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma reenactment may occur in play. 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). 5. Marked psychological reactions to reminders of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the trauma and the numbing of general responsiveness (not present before trauma), as indicated by three or more of the following: 1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma. 2. Efforts to avoid the activities, places, or people that arouse recollections of the trauma. 3. Inability to recall important aspect of the trauma. 4. Markedly diminished interest or participation in significant activities. 5. Feelings of detachment or estrangement from others. 6. Restricted range of affect (e.g., unable to have loving feelings). 7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).	C. One or more of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s), or negative alterations in cognitions and mood associated with the traumatic event, must be present, beginning after the traumatic event(s) or worsening after the event. Persistent avoidance of stimuli 1. Avoidance of or efforts to avoid places or physical reminders that arouse recollections of the traumatic event(s). 2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s). Negative alterations in cognitions 3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion). 4. Markedly diminished interest or participation in significant activities, including constriction play 5. Social withdrawn behavior 6. Persistent reduction in expression of positive emotions.

DSM-IV: PTSD	DSM-5: PTSD
Disorder Class: Anxiety Disorders	Disorder Class: Trauma- and Stressor-Related Disorders
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following: 1. Difficulty falling or staying asleep 2. Irritability or outbursts of anger 3. Difficulty concentrating 4. Hyper vigilance 5. Exaggerated startle response	D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidence by two (or more) of the following: 5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep). 1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums). 4. Problems with concentration. 2. Hyper-vigilance. 3. Exaggerated startle response.
E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month.	E. Duration of the disturbance is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	F. The disturbance causes clinically significant distress or impairment in relationships with parents, sibling, peers, or other caregivers or with school behavior.
Specify if: Acute: if duration of symptoms is less than 3 months. *Specify* if: Chronic: if duration of symptoms is 3 months or more.	DROPPED

	Specify whether: With dissociative symptoms: The individual's symptoms meet the criteria for post-traumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following: 1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly). 2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts) or another medical condition (e.g., complex partial seizures).
Specify if: With delayed onset: If onset of symptoms is at least 6 months after the stressor.	*Specify* if: With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

DSM-IV-TR to DSM-5: Adjustment Disorders

Diagnostic Criteria	
Overall	Hallmark criteria unchanged
Changes of note	No longer is a separate category/chapter, but is included within the new chapter, "Trauma and Stressor Related Disorders" • Subtypes marked by depressed mood, anxious symptoms, or disturbances in conduct are retained and unchanged

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Adjustment Disorders

- Key is a stressor; Feels overwhelmed by stressor
- As a result, they develop emotional or behavioral symptoms
- Unspecified is not helpful!
- Onset within 3 months onset of stressor; no more than 6 months
- If underlying chronic stressor (never-ending divorce, chronic illness) may exceed 6 months

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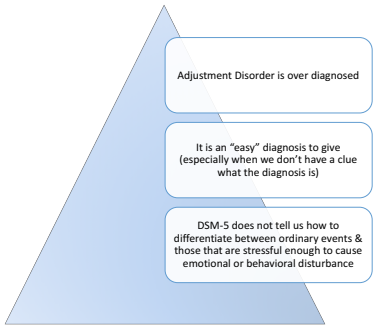
Diagnosis of Last Resort



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Functional Consequences of Adjustment Disorders

Decreased work performance or at school	Temporary change in social relationships
Makes illnesses worse, possibly by decreased compliance with medication regimens	Common with medical diagnoses (cancer, spinal surgery, etc.)

DISSOCIATIVE DISORDERS

DSM-IV-TR to DSM-5: Dissociative Identity Disorder

Diagnostic Criteria	
Overall	Hallmark criteria unchanged
Changes of note	Additional text added to support Criterion D (exclusion based on cultural or religious practices) • This acknowledges that possession states are commonly recognized in cultures around the world and do not necessarily indicate presence of DID or any other mental disorder. • In contrast, possession-form DID is recurrent and unwanted, leads to distress or impairment, and is not part of a broadly accepted cultural or religious practice.

SOMATIC DISORDERS

DSM-IV-TR to DSM-5: Somatic Symptom Disorder

Diagnostic Criteria	
Overall	Hallmark criteria changed: • The central focus of medically unexplained symptoms has been de-emphasized throughout the chapter, and instead emphasis is placed on disproportionate thoughts, feelings, and behaviors that accompany symptoms.
Changes of note	1. Replaces somatoform disorders with somatic symptom and related disorders 2. DSM-5 classification criteria reduces the number of somatic symptom and related disorders to reduce overlap across the somatoform disorders and clarify their boundaries. • Eliminated diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder

FEEDING AND EATING DISORDERS

DSM-IV-TR to DSM-5: Anorexia Nervosa

Diagnostic Criteria	
Overall	Hallmark criteria are changed: 1. Requirement for amenorrhea eliminated 2. Adds "persistent behavior that interferes with weight gain" to "intense fear of gaining weight" diagnostic criteria 3. Drops reference to an individual's refusal to gain weight
Changes of note	Two sub-types are now separately coded: 1. Restricting 2. Binge-eating/purging

Partial and Full Remission Defined

Partial remission: After full criteria met, low bodyweight has not been met for sustained period, BUT at least one of the following two criteria still met: intense fear of gaining weight/becoming obese or behavior that interferes with weight gain OR disturbed by weight and shape.
Full remission: After full criteria met, none of the criteria met for sustained period of time.

Anorexia Nervosa

DSM-IV-TR CODE(S)	DESCRIPTION DSM-5	DSM-5 CODE(S)	DESCRIPTION ICD-10	NEW ICD-10 OPTION(S)
307.1	Anorexia nervosa		Anorexia nervosa, unspecified	F50.00
		F50.01	Anorexia nervosa, restricting type	F50.01
		F50.02	Anorexia nervosa, binge eating / purging type	F50.02

DSM-IV-TR to DSM-5: Bulimia Nervosa

Diagnostic Criteria	
Overall	Hallmark criteria unchanged
Changes of note	Reduces required minimum average frequency of binge eating and inappropriate compensatory behavior from twice per week to once per week

C. The binge eating and inappropriate compensatory behaviors occur, on average, at least twice a week for 3 months.	C. The binge eating and inappropriate compensatory behaviors occur, on average, at least once a week for 3 months.

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

DSM-IV-TR to DSM-5: Oppositional Defiant Disorder

Diagnostic Criteria	
Overall	Hallmark criteria unchanged
Changes of note	1. Moved from "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" to newly created chapter, "Disruptive, Impulse-Control, and Conduct Disorders" 2. Symptoms now grouped by type: • Angry/irritable mood • Argumentative/defiant behavior • Vindictiveness 3. Provides more specific guidance on behavior frequency before an individual is considered symptomatic 4. Drops "conduct disorder" exclusion

Also: DSM-5 indicates to add specifiers of Mild Moderate and Severe but this does not change the coding. It is just reflected in the documentation.

Notes About ODD

- A young-child version of Conduct DO
- Emerges mostly in preschool (before age 5): aggression & defiance present but the acts less severe
- If symptoms include chronic irritability along with anger and severe tantrums, then consider DMDD instead!

DSM-IV-TR to DSM-5: Intermittent Explosive Disorder

Diagnostic Criteria	
Overall	Hallmark criteria are changed: 1. Adds verbal aggression and non-destructive / non-injurious physical aggression to physical aggression as diagnostic criteria 2. Minimum age of 6 specified
Changes of note	1. Provides more specific criteria defining frequency needed to meet criteria 2. Notes diagnosis can be made in addition to other disorders — ADHD, conduct disorder, oppositional defiant disorder, or autism spectrum disorder— when outbursts are in excess of those seen in those disorders and warrant independent clinical attention

DSM-IV-TR to DSM-5: Conduct Disorders

Diagnostic Criteria	
Overall	Hallmark criteria unchanged
Changes of note	Adds specifier for limited prosocial emotions

Code based on age at onset: 312.81 Conduct Disorder, Childhood-Onset Type: onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years 312.82 Conduct Disorder, Adolescent-Onset Type: absence of any criteria characteristic of Conduct Disorder prior to age 10 years 312.89 Conduct Disorder, Unspecified Onset: age at onset is not known	*Specify* whether: 312.81 (F91.1) Conduct Disorder, Childhood-Onset Type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years 312.82 (F91.2) Conduct Disorder, Adolescent-Onset Type: Individuals show now symptom characteristic of conduct disorder prior to age 10 years 312.89 (F91.9) Conduct Disorder, Unspecified Onset: Criteria for a diagnosis or conduct disorder are met, but there is not enough information available to determine whether the onset of the first symptom was before or after
N/A	With limited prosocial emotions: To qualify for this specifier, an individual must have displayed at least two of the following characteristics persistently over at least 12 months and in multiple relationships and setting. These characteristics reflect the individual's typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. Thus, to assess the criteria for the specifier, multiple information sources are necessary. In addition to the individual's self-report, it is necessary to consider reports by others who have known the individual for extended periods of time (e.g., parents, teachers, coworkers, extended family members, peers). expressed only when caught and/or facing punishment). The individual shows a general lack of concern about the negative consequences of his or her actions. For example, the individual is not remorseful after hurting someone or does not care about the consequences of breaking rules. Callous—lack of empathy: Disregards and is unconcerned about the feelings of others. The individual is described as cold and uncaring. The person appears more concerned about the effects of his or her actions on himself or herself, rather than their effects on others, even when they result in substantial harm to others.

DSM-IV: Conduct Disorder	DSM-5: Conduct Disorder
Disorder Class: Attention deficit and disruptive behavior disorders	Disorder Class: Disruptive, Impulse-Control, and Conduct Disorders
	Unconcerned about performance: Does not show concern about poor/problematic performance at school, work, or in other important activities. The individual does not put forth the effort necessary to perform well, even when expectations are clear, and typically blames others for his or her poor performance. Shallow or deficient affect: Does not express feelings or show emotions to others, except in ways that seem shallow, insincere, or superficial (e.g., actions contradict the emotion displayed; can turn emotions "on" or "off" quickly) or when emotional expressions are used for gain (e.g., emotions displayed to manipulate or intimidate others).
Specify severity: Mild: few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others Moderate: number of conduct problems and effect on others intermediate between "mild" and "severe" Severe: many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others	*Specify* current severity: Mild: Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others (e.g., lying, truancy, staying out after dark without permission, other rule breaking). Moderate: The number of conduct problems and the effect on others are intermediate between those specified in "mild" and those in "severe" (e.g., stealing without confronting a victim, vandalism). Severe: Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).

Conduct Disorders

DSM-IV-TR CODE(S)	DESCRIPTION DSM-5	DSM-5 CODE(S)	DESCRIPTION ICD-10	NEW ICD-10 OPTION(S)
312.81	Conduct disorder, childhood-onset type	F91.1	Conduct disorder, childhood-onset type	F91.1
312.82	Conduct disorder, adolescent-onset type	F91.2	Conduct disorder, adolescent-onset type	F91.2
312.89	Conduct disorder, unspecified onset	F91.9	Conduct disorder, unspecified onset	F91.9
			Conduct disorder confined to family context	F91.0
			Other conduct disorders	F91.8

NEURODEVELOPMENTAL DISORDERS

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Background on Neurodevelopmental Disorders

- Group of conditions with onset in the developmental period of life (early)
- Impairments in: personal, social, academic, or occupational functioning
- Frequently co-occur with each other (ADHD and Learning DO's)

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ADHD General Overview

- Same 18 symptoms
- Divided into the same 2 groups>inattention and hyperactive/impulsivity
- 6 symptoms in ONE domain are required
- Most DSM-5 changes in ADHD were done to improve detection in ADULTS
- Except: Onset criterion changed from: "symptoms present before age 7" TO "several symptoms present prior to age 12"

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Comments on ADHD

- Changing from age 7 to 12 conveys the importance of a substantial clinical presentation during childhood
- Preschool Ages: main manifestation is hyperactivity
- Elementary Ages: main manifestation is inattention
- Adolescence: Fidgetiness, or inside feelings of jitteriness, restlessness, impatience *(sounds normal, huh?!)*

Functional Consequences of ADHD

- Red school performance, academic attainment, social rejection
- More likely to develop Conduct DO and Anti-Social PD >
  - Increased vulnerability to substance use, incarceration
- More likely to be injured (impulsivity)
- Traffic accidents
- Difficulty with sustained effort can be interpreted as: lazy, irresponsibility, failure to cooperate
- Family relations may experience discord, negative interactions
- Peer rejection, neglect, teasing

DSM-IV-TR to DSM-5: Attention-Deficit Hyperactivity Disorders (ADHD)

Diagnostic Criteria	
Overall	Hallmark criteria unchanged
Changes of note	1. Moved from "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" to "Neurodevelopmental Disorders" chapter 2. Examples added to facilitate application across life span 3. Symptom thresholds reduced from six for children to five for older adolescents and adults (age 17 and older) 4. Sub-types directly crosswalk to presentation specifiers 5. Comorbid diagnosis with autism spectrum disorder is now allowed

DSM-IV-TR to DSM-5: Autism Spectrum Disorder (ASD)

Diagnostic Criteria	
Overall	Hallmark criteria are changed: 1. ASD replaces four DSM-IV disorders: Autistic Disorder, Asperger's Disorder, Childhood Disintegration Disorder, and Pervasive Developmental Disorder Not Otherwise Specified • Clinicians applied the DSM-IV criteria for these disorders inconsistently and incorrectly. As a result, reliability data to support their continued separation was found to be poor.
Changes of note	Specifiers can be used to describe variants of ASD (e.g., the former diagnosis of Asperger's can now be diagnosed as ASD, without intellectual impairment and without structural language impairment)

Autism Spectrum

OLD DSM-IV-TR CODE (s)	Description DSM-5	DSM-5	DESCRIPTION (ICD-10)	NEW ICD-10 OPTIONS
299.00 to 299.80	Autism Spectrum Disorder	F84.0	Autistic Disorder	F84.0
			Rett's Syndrome	F84.2
			Other Childhood Disintegrative Disorder	F84.3
			Asperger's Syndrome	F84.5
			Other Pervasive Developmental Disorder	F84.8
			Unspecified Disorder of Psychological Development	F84.9

GENDER ISSUES IN THE DSM-5

Summary of Changes to Gender Diagnoses

- New NAME: GID to Gender Dysphoria (note dysphoria = "distress")
- Own chapter: not with sexual dysfunctions/paraphilia's anymore
- Deliberate use of term "incongruence" between one's experience vs. assigned gender
- DSM-IV-TR: required 2 sets of clinical indicators; DSM-5 merged them
- Children: DSM-5 is more conservative than the IV-TR and "strong desire to be of the other gender or an insistence that he/she is the other gender" REQUIRED
- Why the conservation? To make the distinction between true gender variance versus normative gender fluidity all children experience

DSM-IV-TR to DSM-5: Gender Dysphoria

Diagnostic Criteria	
Overall	Hallmark criteria changed: 1. Added as a separate diagnostic class in DSM-5 2. Separate criteria sets are provided for gender dysphoria in children, and in adolescents and adults.
Changes of note	1. Creation of a new diagnostic class reflects a change in the conceptualization of gender identity disorder's (GID) defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification, as in DSM-IV. 2. Name change responds to concerns from consumers and advocates that the term gender identity disorder was stigmatizing.

Gender Dysphoria

OLD DSM-IV-TR CODE (s)	Description DSM-5	DSM-5	DESCRIPTION (ICD-10)	NEW ICD-10 OPTIONS
302.85	Gender dysphoria in adolescents and adults	F64.1	Gender Identify disorder in adolescence and adulthood	F64.1
302.6	Gender dysphoria in children	F64.2	Gender identity disorder of childhood	F64.2
302.6	Other specified gender dysphoria	F64.8	Other gender identity disorders	F64.8
302.6	Other unspecified gender dysphoria	F64.9	Gender identity disorder, unspecified	F64.9

Clinical Presentation In Children

- Cross-gender behaviors often begin by age 3
- Effeminate boys more at risk for bullying & rejection than tomboy girls
- Key element is one of "persistence" over time
- Manifestations in children are similar to adolescents, but are more age-appropriate (play, fantasy, toys, games, etc.)
- Number of criteria required is 6 out of 8; for adults, it is 2 out of 8

SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

DSM-IV-TR to DSM-5: Schizoaffective Disorder

Diagnostic Criteria	
Overall	Hallmark criteria changed: • DSM-5 addresses ambiguousness of language in DSM-IV regarding the duration of illness. Now based on the lifetime (rather than episodic) duration of illness in which the mood and psychotic symptoms described in Criterion A occur.
Changes of note	Two codes in DSM-5 – one for each type (Bipolar type or Depressive type)

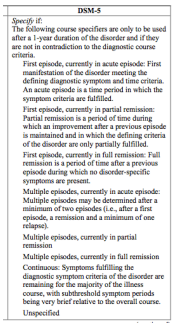
Main Schizophrenia Changes

- 1 diagnosis in DSM-5, subtypes eliminated due to poor validity, low reliability, and limited diagnostic stability
- Criterion A changes: 1. bizarre delusions & Schneiderian first-rank auditory hallucinations = GONE. Why: poor reliability between bizarre and non-bizarre (!)
- Individual MUST have 1 of 3 positive symptoms: delusions, hallucinations, or disorganized speech

Schizophrenia

OLD DSM-IV-TR CODE (s)	DESCRIPTION (ICD-10)	DSM-5	NEW ICD-10 OPTION(S)
295.90	Schizophrenia (Unspecified)	F20.9	F20.9
295.30	Paranoid Schizophrenia	Subtype eliminated	F20.0
295.10	Disorganized Schizophrenia	Subtype eliminated	F20.1
295.20	Catatonic Schizophrenia	Subtype eliminated	F20.2
295.90	Undifferentiated Schizophrenia	Subtype eliminated	F20.3
295.60	Residual Schizophrenia	Subtype eliminated	F20.5
295.80	Other Schizophrenia	F20.8	F20.8
295.40	Schizophreniform Disorder	F20.81	F20.81
295.00	Other Schizophrenia (Simple and Cenesthopathic types)	F20.6	F20.89

New in DSM-5: Specifiers of First versus Multiple Episodes



DSM-5

Specify if:
The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the symptom criteria are fulfilled.

First episode, currently in partial remission: Partial remission is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

First episode, currently in full remission: Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present.

Multiple episodes, currently in acute episode: Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).

Multiple episodes, currently in partial remission

Multiple episodes, currently in full remission

Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

Unspecified

Schizophrenia in DSM-5 to ICD-10

1 Type in DSM-5	Multiple Types in ICD-10 CM

SO: This is a DSM-5 Training. But you put ICD-10-CM codes into Avatar. But the DSM-5 doesn't have a Paranoid Schizophrenia.

NOW WHAT??

SUBSTANCE USE

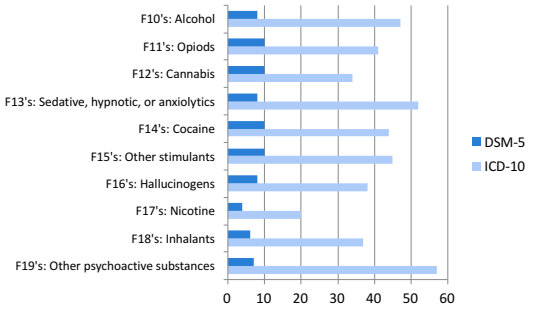
Big Changes

Characteristic	DSM-IV	DSM-5
Disorder Class	Substance-related disorders, included only SUDs	Substance-related and addictive disorders class now includes SUDs and gambling disorder (formerly pathological gambling)
Disorder Types[1]	Abuse and dependence hierarchical diagnostic rules meant that people ever meeting criteria for dependence did not receive a diagnosis of abuse for the same class of substance	SUD, substance abuse and dependence have been eliminated in favor of a single diagnosis, SUD
Substances Assessed	11 classes of substances assessed, plus 2 additional categories	10 classes of substances assessed, plus 2 additional categories
	• Alcohol	• Alcohol
	• Amphetamine and similar sympathomimetics	• Stimulant use disorder, which includes amphetamines, cocaine, and other stimulants
	• Caffeine (intoxication only)	• Caffeine (intoxication and withdrawal)
	• Cannabis (no withdrawal syndrome)	• Cannabis (with withdrawal syndrome)
	• Cocaine	• Combined with other stimulants (e.g., amphetamines) under stimulant use disorder
	• Hallucinogens • Phencyclidine and similar arylcyclohexylamines	• Separated into phencyclidine use disorder and other hallucinogen use disorder
	• Inhalants (no withdrawal syndrome)	• Inhalants (no withdrawal syndrome)
	• Nicotine (dependence only)	• Tobacco
	• Opioids	• Opioids
		• Merged with hallucinogens
	• Sedatives, hypnotics, and anxiolytics	• Sedatives, hypnotics, and anxiolytics
	• Other drug abuse/dependence	• Any other SUD
	• Polysubstance dependence	• Dropped polysubstance use disorder

DSM-IV-TR to DSM-5: Substance Use Disorder (SUD)

Diagnostic Criteria	
Overall	Hallmark criteria changed: 1. Substance abuse disorders no longer separate out "abuse" from "dependence." The two are merged into a single category, "substance use disorder," or SUD. • Recognizes that substance abuse and dependence occur on a continuum • ICD-10 retains the categories of use, abuse, and dependence. As a result, there are significantly more substance use diagnoses in the ICD-10 than there are in the DSM-5
Changes of note	1. Removal of the DSM-IV abuse criteria (legal consequences) • Legal criterion had poor clinical utility 2. Addition of new criterion (craving or strong desire or urge to use the substance) • Well validated, based on clinical trials and brain imaging data, and may hold potential as a future biomarker for the diagnosis of SUD

Substance Use Disorder (SUD): Difference in Number of Diagnostic Codes



DIAGNOSING DIFFERENCES BETWEEN PROVIDERS

Multiple Providers, Different Diagnoses

What We Found

- Nothing specific to California/Medi-Cal to help you resolve
- 2016 Annals of Clinical Psychiatry: Study on Split Treatment
- 2005 Psychiatry: Split Treatment Coordination
- 2002 Primary Psychiatry: Study on Split Treatment & Coordinated Care
- 2000 Archives of Psychiatric Nursing: On Practice Collaboration

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Split Treatment is the Official Term

Defined:

Split treatment refers to the involvement of 2 mental health professionals in the care of a psychiatric patient-one providing psychotherapy and the other psychopharmacologic management.

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Highlights (2016 Study)

Despite the widespread use of split treatment in outpatient psychiatric care, little data exist on its core features or cost-effectiveness compared with other models of treatment

Few data-based studies have examined the split treatment model. Both prescribing psychiatrists and psychotherapists have specific and unique concerns and sensitivities in the split model that are likely to affect the overall success of treatment. ***Among the concerns are respect for the other treating professional, staying within the appropriate boundaries of one's expertise, efficient communication with the co-treater, and parallel accessibility in emergency situations.***

Application of "proper care principles" are likely to result in better outcomes

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2002 Study Items to Note

- Clinical and Risk Management Concerns
  - Certain issues of risk management are unique to split treatment. Both clinicians need to be aware that they have independent and interdependent duties for ongoing risk assessment. Psychotherapists will have more frequent opportunities. Psychiatrists and psychotherapists will be privy to different types of information from the same patient, partly based on the different relationships and partly on the different focus of inquiry for psychopharmacology and psychotherapy. Both therapists have the responsibility for sufficient direct examination of the patient consistent with the patient's clinical status. Both therapists have a responsibility to let the other clinician know about any substantive change in the patient and/or treatment.
- Study more about developing protocols, professional boundaries, etc..

2000: The Clinical Nurse and Psychiatrist

Good communication, trust, shared goals for patient outcomes, shared professional values, and respect for clinical competency were identified as important characteristics for effective collaboration

2005: Adherence Rates of Psychiatrists to the APA Standards

Coordination of Care is a Standard of Practice

Psychiatrists have been encouraged to coordinate with non-physician providers

- Results:
  - When providers are in different locations, this increases chances of a disconnect
  - Frequent multi-disciplinary meetings reduce conflict
  - Impressing upon certain providers that not coordinating is a risk management problem
  - Competition, not collaboration or coordination, increases risk

BHS's Thoughts For Yolo County

- Determine barriers that perpetuate the problem
- Have an aspirational statement, or policy and procedure, with a clear expectation about collaboration and coordination is critical
- Consider a policy statement about how a single unified diagnoses is maintained consistently
- Emphasize the role of an effective Compliance Program that audits and monitors the collaboration efforts
  - Should be documented in the record
  - Coordination meetings also clearly auditable
- Give a hand-out to certain providers that bullet points the risks
- Get buy-in and sign-off from the Medical Director