**Chapter 17 Other Conditions That May Be a Focus of Clinical Attention**

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Introduction

This section covers other conditions or problems that may be a focus of clinical attention. These are related to the mental disorders described previously in this manual in one of the following ways: 1) the problem is the focus of diagnosis or treatment and the individual has no mental disorder (e.g., a Partner Relational Problem in which neither partner has symptoms that meet criteria for a mental disorder, in which case only the Partner Relational Problem is coded); 2) the individual has a mental disorder but it is unrelated to the problem (e.g., a Partner Relational Problem in which one of the partners has an incidental Specific Phobia, in which case both can be coded); 3)Â the individual has a mental disorder that is related to the problem, but the problem is sufficiently severe to warrant independent clinical attention (e.g., a Partner Relational Problem sufficiently problematic to be a focus of treatment that is also associated with Major Depressive Disorder in one of the partners, in which case both can be coded). The conditions and problems in this section are coded on Axis I.

Psychological Factors Affecting Medical Condition

316 Psychological Factor Affecting Medical Condition

316 . . . [Specified Psychological Factor] Affecting . . . [Indicate the General Medical Condition]

•A general medical condition (coded on Axis III) is present.

•Psychological factors adversely affect the general medical condition in one of the following ways:◦the factors have influenced the course of the general medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the general medical condition

◦the factors interfere with the treatment of the general medical condition

◦the factors constitute additional health risks for the individual

◦stress-related physiological responses precipitate or exacerbate symptoms of the general medical condition

Choose name based on the nature of the psychological factors (if more than one factor is present, indicate the most prominent):

•Mental Disorder Affecting . . . Â [Indicate the General Medical Condition] (e.g., an Axis I disorder such as Major Depressive Disorder delaying recovery from a myocardial infarction)

•Psychological Symptoms Affecting . . . Â [Indicate the General Medical Condition] (e.g., depressive symptoms delaying recovery from surgery; anxiety exacerbating asthma)

•Personality Traits or Coping Style Affecting . . . Â [Indicate the General Medical Condition] (e.g., pathological denial of the need for surgery in a patient with cancer; hostile, pressured behavior contributing to cardiovascular disease)

•Maladaptive Health Behaviors Affecting . . . Â [Indicate the General Medical Condition] (e.g., overeating; lack of exercise; unsafe sex)

•Stress-Related Physiological Response Affecting . . . Â [Indicate the General Medical Condition] (e.g., stress-related exacerbations of ulcer, hypertension, arrhythmia, or tension headache)

•Other or Unspecified Psychological Factors Affecting . . . Â [Indicate the General Medical Condition] (e.g., interpersonal, cultural, or religious factors)

Diagnostic Features

The essential feature of Psychological Factor Affecting Medical Condition is the presence of one or more specific psychological or behavioral factors that adversely affect a general medical condition. There are several different ways in which these factors can adversely affect the general medical condition. The factors can influence the course of the general medical condition (which can be inferred by a close temporal association between the factors and the development or exacerbation of, or delayed recovery from, the medical condition). The factors may interfere with treatment of the general medical condition. The factors may constitute an additional health risk for the individual (e.g., continued overeating in an individual with weight-related diabetes). They may precipitate or exacerbate symptoms of a general medical condition by eliciting stress-related physiological responses (e.g., causing chest pain in individuals with coronary artery disease, or bronchospasm in individuals with asthma).

The psychological or behavioral factors that influence general medical conditions include Axis I disorders, Axis II disorders, psychological symptoms or personality traits that do not meet the full criteria for a specific mental disorder, maladaptive health behaviors, or physiological responses to environmental or social stressors.

Psychological or behavioral factors play a potential role in the presentation or treatment of almost every general medical condition. This category should be reserved for those situations in which the psychological factors have a clinically significant effect on the course or outcome of the general medical condition or place the individual at a significantly higher risk for an adverse outcome. There must be reasonable evidence to suggest an association between the psychological factors and the medical condition, although it may often not be possible to demonstrate direct causality or the mechanisms underlying the relationship. Psychological and behavioral factors may affect the course of almost every major category of disease, including cardiovascular conditions, dermatological conditions, endocrinological conditions, gastrointestinal conditions, neoplastic conditions, neurological conditions, pulmonary conditions, renal conditions, and rheumatological conditions.

The Psychological Factor Affecting Medical Condition diagnosis is coded on Axis I, and the accompanying general medical condition is coded on Axis III. (See Appendix G for a list of diagnostic codes for general medical conditions.) To provide greater specificity regarding the type of psychological factor, the name is chosen from the list below. When more than one type of factor is present, the most prominent should be specified.

•Mental Disorder Affecting .Â .Â . Â [Indicate the General Medical Condition]. A specific Axis I or Axis II disorder significantly affects the course or treatment of a general medical condition (e.g., Major Depressive Disorder adversely affecting the prognosis of myocardial infarction, renal failure, or hemodialysis; Schizophrenia complicating the treatment of diabetes mellitus). In addition to coding this condition on Axis I, the specific mental disorder is also coded on Axis I or Axis II.

•Psychological Symptoms Affecting . . . [Indicate the General Medical Condition].Â Symptoms that do not meet full criteria for an Axis I disorder significantly affect the course or treatment of a general medical condition (e.g., symptoms of anxiety or depression affecting the course and severity of irritable bowel syndrome or peptic ulcer disease, or complicating recovery from surgery).

•Personality Traits or Coping Style AffectingÂ . . . Â [Indicate the General Medical Condition]. A personality trait or a maladaptive coping style significantly affects the course or treatment of a general medical condition. Personality traits can be subthreshold for an Axis II disorder or represent another pattern that has been demonstrated to be a risk factor for certain illnesses (e.g., "type A," pressured, hostile behavior for coronary artery disease). Problematic personality traits and maladaptive coping styles can impede the working relationship with health care personnel.

•Maladaptive Health Behaviors Affecting . . . Â [Indicate the General Medical Condition]. Maladaptive health behaviors (e.g., sedentary lifestyle, unsafe sexual practices, overeating, excessive alcohol and drug use) significantly affect the course or treatment of a general medical condition. If the maladaptive behaviors are better accounted for by an Axis I disorder (e.g., overeating as part of Bulimia Nervosa, alcohol use as part of Alcohol Dependence), the name "Mental Disorder Affecting Medical Condition" should be used instead.

•Stress-Related Physiological Response Affecting . . . Â [Indicate the General Medical Condition]. Stress-related physiological responses significantly affect the course or treatment of a general medical condition (e.g., precipitate chest pain or arrhythmia in a patient with coronary artery disease).

•Other or Unspecified Factors Affecting . . . Â [Indicate the General Medical Condition]. A factor not included in the subtypes specified above or an unspecified psychological or behavioral factor significantly affects the course or treatment of a general medical condition.

Differential Diagnosis

A temporal association between symptoms of a mental disorder and a general medical condition is also characteristic of a Mental Disorder Due to a General Medical Condition, but the presumed causality is in the opposite direction. In a Mental Disorder Due to a General Medical Condition, the general medical condition is judged to be causing the mental disorder through a direct physiological mechanism. In Psychological Factor Affecting Medical Condition, the psychological or behavioral factors are judged to affect the course of the general medical condition.

Substance Use Disorders (e.g., Alcohol Dependence, Nicotine Dependence) adversely affect the prognosis of many general medical conditions. If an individual has a coexisting Substance Use Disorder that adversely affects or causes a general medical condition, Mental Disorder Affecting General Medical Condition can be coded on Axis I in addition to the Substance Use Disorder. For substance use patterns affecting a general medical condition that do not meet the criteria for a Substance Use Disorder, Maladaptive Health Behaviors Affecting Medical Condition can be specified.

Somatoform Disorders are characterized by the presence of both psychological factors and physical symptoms, but there is no general medical condition that can completely account for the physical symptoms. In contrast, in Psychological Factors Affecting Medical Condition, the psychological factors adversely affect a diagnosable general medical condition. Psychological factors affecting pain syndromes are not diagnosed as Psychological Factor Affecting Medical Condition but rather as Pain Disorder Associated With Psychological Factors or Pain Disorder Associated With Both Psychological Factors and a General Medical Condition.

When noncompliance with treatment for a general medical condition results from psychological factors but becomes the major focus of clinical attention, Noncompliance With Treatment (see V15.81 Noncompliance With Treatment) should be coded.

Medication-Induced Movement Disorders

The following Medication-Induced Movement Disorders are included because of their frequent importance in 1) the management by medication of mental disorders or general medical conditions; and 2) the differential diagnosis with Axis I disorders (e.g., Anxiety Disorder versus Neuroleptic-Induced Akathisia; catatonia versus Neuroleptic Malignant Syndrome). Although these disorders are labeled "medication induced," it is often difficult to establish the causal relationship between medication exposure and the development of the movement disorder, especially because some of these movement disorders also occur in the absence of medication exposure. The term neuroleptic is used broadly in this manual to refer to medications with dopamine-antagonist properties. Although this term is becoming outdated because it highlights the propensity of antipsychotic medications to cause abnormal movements, the term neuroleptic remains appropriate. Although newer antipsychotic medications are less likely to cause Medication-Induced Movement Disorders, these syndromes still occur. Neuroleptic medications include so-called conventional or typical antipsychotic agents (e.g., chlorpromazine, haloperidol, fluphenazine), the newer "atypical" antipsychotic agents (e.g., clozapine, risperidone, olanzapine, quetiapine), certain dopamine receptor blocking drugs used in the treatment of symptoms such as nausea and gastroparesis (e.g., prochlorperazine, promethazine, trimethobenzamide, thiethylperazine, and metoclopramide), and amoxapine, which is marketed as an antidepressant. Medication-Induced Movement Disorders should be coded on Axis I.

332.1 Neuroleptic-Induced Parkinsonism

Parkinsonian tremor, muscular rigidity, or akinesia developing within a few weeks of starting or raising the dose of a neuroleptic medication (or after reducing a medication used to treat extrapyramidal symptoms). (See Research criteria for 332.1 Neuroleptic-Induced Parkinsonism for suggested research criteria.)

333.92 Neuroleptic Malignant Syndrome

Severe muscle rigidity, elevated temperature, and other related findings (e.g., diaphoresis, dysphagia, incontinence, changes in level of consciousness ranging from confusion to coma, mutism, elevated or labile blood pressure, elevated creatine phosphokinase [CPK]) developing in association with the use of neuroleptic medication. (See Research criteria for 333.92 Neuroleptic Malignant Syndrome for suggested research criteria.)

333.7 Neuroleptic-Induced Acute Dystonia

Abnormal positioning or spasm of the muscles of the head, neck, limbs, or trunk developing within a few days of starting or raising the dose of a neuroleptic medication (or after reducing a medication used to treat extrapyramidal symptoms). (See Research criteria for 333.7 Neuroleptic-Induced Acute Dystonia for suggested research criteria.)

333.99 Neuroleptic-Induced Acute Akathisia

Subjective complaints of restlessness accompanied by observed movements (e.g., fidgety movements of the legs, rocking from foot to foot, pacing, or inability to sit or stand still) developing within a few weeks of starting or raising the dose of a neuroleptic medication (or after reducing a medication used to treat extrapyramidal symptoms). (See Research criteria for 333.99 Neuroleptic-Induced Acute Akathisia for suggested research criteria.)

333.82 Neuroleptic-Induced Tardive Dyskinesia

Involuntary choreiform, athetoid, or rhythmic movements (lasting at least a few weeks) of the tongue, jaw, or extremities developing in association with the use of neuroleptic medication for at least a few months (may be for a shorter period of time in elderly persons). (See Research criteria for 333.82 Neuroleptic-Induced Tardive Dyskinesia for suggested research criteria.)

333.1 Medication-Induced Postural Tremor

Fine tremor occurring during attempts to maintain a posture that develops in association with the use of medication (e.g., lithium, antidepressants, valproate). (See Research criteria for 333.1 Medication-Induced Postural Tremor for suggested research criteria.)

333.90 Medication-Induced Movement Disorder Not Otherwise Specified

This category is for Medication-Induced Movement Disorders not classified by any of the specific disorders listed above. Examples include 1) parkinsonism, acute akathisia, acute dystonia, or dyskinetic movement that is associated with a medication other than a neuroleptic; 2) a presentation that resembles neuroleptic malignant syndrome that is associated with a medication other than a neuroleptic; or 3) tardive dystonia.

Other Medication-Induced Disorder

995.2 Adverse Effects of Medication Not Otherwise Specified

This category is available for optional use by clinicians to code side effects of medication (other than movement symptoms) when these adverse effects become a main focus of clinical attention. Examples include severe hypotension, cardiac arrhythmias, and priapism.

Relational Problems

Relational problems include patterns of interaction between or among members of a relational unit that are associated with clinically significant impairment in functioning, or symptoms among one or more members of the relational unit, or impairment in the functioning of the relational unit itself. The following relational problems are included because they are frequently a focus of clinical attention among individuals seen by health professionals. These problems may exacerbate or complicate the management of a mental disorder or general medical condition in one or more members of the relational unit, may be a result of a mental disorder or a general medical condition, may be independent of other conditions that are present, or can occur in the absence of any other condition. When these problems are the principal focus of clinical attention, they should be listed on Axis I. Otherwise, if they are present but not the principal focus of clinical attention, they may be listed on Axis IV. The relevant category is generally applied to all members of a relational unit who are being treated for the problem.

V61.9 Relational Problem Related to a Mental Disorder or GeneralÂ MedicalÂ Condition

This category should be used when the focus of clinical attention is a pattern of impaired interaction that is associated with a mental disorder or a general medical condition in a family member.

V61.20 Parent-Child Relational Problem

This category should be used when the focus of clinical attention is a pattern of interaction between parent and child (e.g., impaired communication, overprotection, inadequate discipline) that is associated with clinically significant impairment in individual or family functioning or the development of clinically significant symptoms in parent or child.

V61.10 Partner Relational Problem

This category should be used when the focus of clinical attention is a pattern of interaction between spouses or partners characterized by negative communication (e.g., criticisms), distorted communication (e.g., unrealistic expectations), or noncommunication (e.g., withdrawal) that is associated with clinically significant impairment in individual or family functioning or the development of symptoms in one or both partners.

V61.8 Sibling Relational Problem

This category should be used when the focus of clinical attention is a pattern of interaction among siblings that is associated with clinically significant impairment in individual or family functioning or the development of symptoms in one or more of the siblings.

V62.81 Relational Problem Not Otherwise Specified

This category should be used when the focus of clinical attention is on relational problems that are not classifiable by any of the specific problems listed above (e.g., difficulties with co-workers).

Problems Related to Abuse or Neglect

This section includes categories that should be used when the focus of clinical attention is severe mistreatment of one individual by another through physical abuse, sexual abuse, or child neglect. These problems are included because they are frequently a focus of clinical attention among individuals seen by health professionals. The appropriate V code applies if the focus of attention is on the perpetrator of the abuse or neglect or on the relational unit in which it occurs. If the individual being evaluated or treated is the victim of the abuse or neglect, code 995.52, 995.53, or 995.54 for a child or 995.81 or 995.83 for an adult (depending on the type of abuse).

V61.21 Physical Abuse of Child

This category should be used when the focus of clinical attention is physical abuse of a child.

Coding note: Specify 995.54 if focus of clinical attention is on the victim.

V61.21 Sexual Abuse of Child

This category should be used when the focus of clinical attention is sexual abuse of aÂ child.

Coding note: Specify 995.53 if focus of clinical attention is on the victim.

V61.21 Neglect of Child

This category should be used when the focus of clinical attention is child neglect.

Coding note: Specify 995.52 if focus of clinical attention is on the victim.

Physical Abuse of Adult

This category should be used when the focus of clinical attention is physical abuse of an adult (e.g., spouse beating, abuse of elderly parent).

Coding note: Code

V61.12

if focus of clinical attention is on the perpetrator and abuse is by partner

V62.83

if focus of clinical attention is on the perpetrator and abuse is by person other than partner

995.81

if focus of clinical attention is on the victim

Sexual Abuse of Adult

This category should be used when the focus of clinical attention is sexual abuse of an adult (e.g., sexual coercion, rape).

Coding note: Code

V61.12

if focus of clinical attention is on the perpetrator and abuse is by partner

V62.83

if focus of clinical attention is on the perpetrator and abuse is by person other than partner

995.83

if focus of clinical attention is on the victim

Additional Conditions That May Be a Focus of Clinical Attention

V15.81 Noncompliance With Treatment

This category can be used when the focus of clinical attention is noncompliance with an important aspect of the treatment for a mental disorder or a general medical condition. The reasons for noncompliance may include discomfort resulting from treatment (e.g., medication side effects), expense of treatment, decisions based on personal value judgments or religious or cultural beliefs about the advantages and disadvantages of the proposed treatment, maladaptive personality traits or coping styles (e.g., denial of illness), or the presence of a mental disorder (e.g., Schizophrenia, Avoidant Personality Disorder). This category should be used only when the problem is sufficiently severe to warrant independent clinical attention.

V65.2 Malingering

The essential feature of Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Under some circumstances, Malingering may represent adaptive behaviorâ€”for example, feigning illness while a captive of the enemy during wartime.

Malingering should be strongly suspected if any combination of the following is noted:

• Medicolegal context of presentation (e.g., the person is referred by an attorney to the clinician for examination)

• Marked discrepancy between the person's claimed stress or disability and the objective findings

• Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen

• The presence of Antisocial Personality Disorder

Malingering differs from Factitious Disorder in that the motivation for the symptom production in Malingering is an external incentive, whereas in Factitious Disorder external incentives are absent. Evidence of an intrapsychic need to maintain the sick role suggests Factitious Disorder. Malingering is differentiated from Conversion Disorder and other Somatoform Disorders by the intentional production of symptoms and by the obvious, external incentives associated with it. In Malingering (in contrast to Conversion Disorder), symptom relief is not often obtained by suggestion or hypnosis.

V71.01 Adult Antisocial Behavior

This category can be used when the focus of clinical attention is adult antisocial behavior that is not due to a mental disorder (e.g., Conduct Disorder, Antisocial Personality Disorder, or an Impulse-Control Disorder). Examples include the behavior of some professional thieves, racketeers, or dealers in illegal substances.

V71.02 Child or Adolescent Antisocial Behavior

This category can be used when the focus of clinical attention is antisocial behavior in a child or adolescent that is not due to a mental disorder (e.g., Conduct Disorder or an Impulse-Control Disorder). Examples include isolated antisocial acts of children or adolescents (not a pattern of antisocial behavior).

V62.89 Borderline Intellectual Functioning

This category can be used when the focus of clinical attention is associated with borderline intellectual functioning, that is, an IQ in the 71â€“84 range. Differential diagnosis between Borderline Intellectual Functioning and Mental Retardation (an IQ of 70 or below) is especially difficult when the coexistence of certain mental disorders (e.g., Schizophrenia) is involved.

Coding note: This is coded on Axis II.

780.93 Age-Related Cognitive Decline

This category can be used when the focus of clinical attention is an objectively identified decline in cognitive functioning consequent to the aging process that is within normal limits given the person's age. Individuals with this condition may report problems remembering names or appointments or may experience difficulty in solving complex problems. This category should be considered only after it has been determined that the cognitive impairment is not attributable to a specific mental disorder or neurological condition.

V62.82 Bereavement

This category can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a Major Depressive Episode (e.g., feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss). The bereaved individual typically regards the depressed mood as "normal," although the person may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of "normal" bereavement vary considerably among different cultural groups. The diagnosis of Major Depressive Disorder is generally not given unless the symptoms are still present 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode. These include 1) guilt about things other than actions taken or not taken by the survivor at the time of the death; 2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; 3) morbid preoccupation with worthlessness; 4) marked psychomotor retardation; 5) prolonged and marked functional impairment; and 6) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person.

V62.3 Academic Problem

This category can be used when the focus of clinical attention is an academic problem that is not due to a mental disorder or, if due to a mental disorder, is sufficiently severe to warrant independent clinical attention. An example is a pattern of failing grades or of significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for the problem.

V62.29 Occupational Problem

This category can be used when the focus of clinical attention is an occupational problem that is not due to a mental disorder or, if it is due to a mental disorder, is sufficiently severe to warrant independent clinical attention. Examples include job dissatisfaction and uncertainty about career choices.

313.82 Identity Problem

This category can be used when the focus of clinical attention is uncertainty about multiple issues relating to identity such as long-term goals, career choice, friendship patterns, sexual orientation and behavior, moral values, and group loyalties.

V62.89 Religious or Spiritual Problem

This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution.

V62.4 Acculturation Problem

This category can be used when the focus of clinical attention is a problem involving adjustment to a different culture (e.g., following migration).

V62.89 Phase of Life Problem

This category can be used when the focus of clinical attention is a problem associated with a particular developmental phase or some other life circumstance that is not due to a mental disorder or, if it is due to a mental disorder, is sufficiently severe to warrant independent clinical attention. Examples include problems associated with entering school, leaving parental control, starting a new career, and changes involved in marriage, divorce, and retirement.

References

NOTE:

Citing articles are presented as examples only. In non-demo SCM6 implementation, integration with CrossRefâ€™s â€œCited Byâ€ API will populate this tab (http://www.crossref.org/citedby.html).