ICD-11 through the lens of Child Adolescent psychiatry

ICD-11 officially out on 1st January 2022

https://icd.who.int/browse11/l-m/en

Elena Garralda - June 2021

Classification in psychiatry

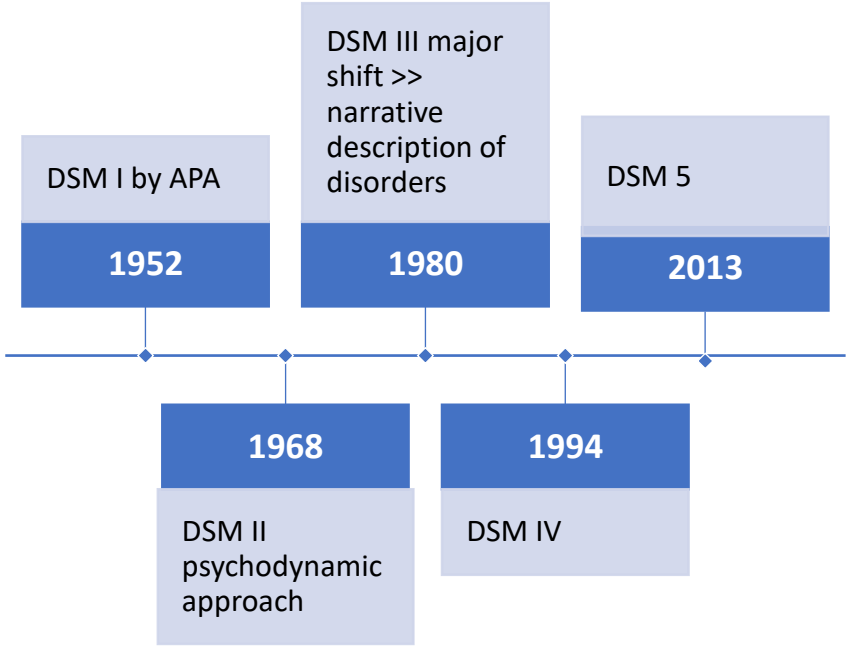
- 1949 - ICD 6 -1st inclusion of mental disorders
- 1955 - ICD 7 list of approved names & codes

  Different classifications proliferated – 28+! - *"the chaotic state of classifications in current use in psychiatry."*
- 1968 - ICD 8
- 1974 - Chapter V of ICD 8

  Modern area starts: Glossary of Mental Disorders and Guide

  Symptomatic rating scales & standardized research psychiatric interviews (Present State Examination, UK; Mental Status Schedule, US)
- 1978 - ICD 9 - Efforts to harmonize classifications
- 1992 - ICD 10

2022 - ICD 11



Psychiatric classification

- To classify is to arrange things in groups with some characteristic in common
- Classificatory systems follow the taxonomical, dichotomous tradition
- The classification of psychiatric disorders remains crucial to communication between all those involved with services
  - a tool for communication for clinicians, families, researchers & policy makers
  - increasingly made a requirement for service function and development

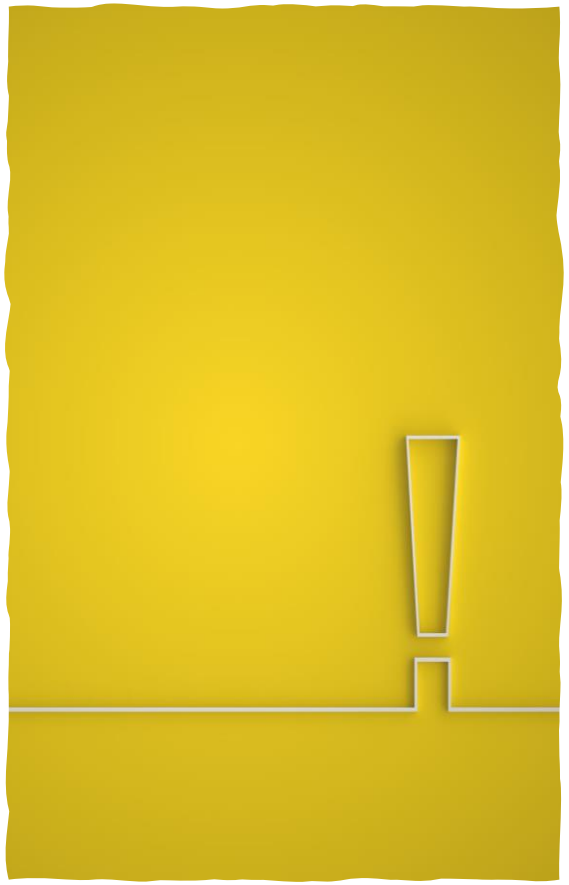
DSM 5 & ICD 11 - Working methods

- DSM 5 developed on the back of scientific expert review meetings, working groups and field tests

- Officials of WHO and APA agreed on a “meta-structure of the classification”

- Overall philosophy
  - reduce number of diagnosable psychiatric disorders leave best validated & clinically helpful

Organizing principles /emphasis on mental, behaviour and neurodevelopmental disorders **in DSM 5** (and ICD11)



- **Phenomenology**
  - hopes for clinico-pathological aetiological approach not realized
  - >> a refinement of DSM-IV: change of category only if strong reason
- **Research** to support disorder classification
  - *eg reduction of subtypes in ASD*
- **Life-span of disorders &** developmental change over time
- Groupings based as possible **on common underlying etiological factors** & association with stressful life circumstances
- **Impairment of function** key principle for diagnosis of disorder
  - separation of functional impairment from diagnostic description
- **Co-existing disorders** recognized
- ***Specifiers*** *(DSM)* used for cause, course, co-existing conditions
  - ***Qualifiers*** *(ICD 11)* for subgroups or severity

Why is ICD 11 important

- ICD-10 most widely used MD classification in the world
- ICD 11 the most global, multilingual, multidisciplinary participative revision process ever implemented for a classification of mental disorders
  - Hundreds of content experts, Advisory and Working Groups, Consultants
    Extensive collaboration with WHO member states.
    funding agencies, professional and scientific societies
- 10 years+ of intensive work for the development of

  ICD-11 CDDG (Clinical Descriptions and Diagnostic Guidelines)
- CDDGs describe essential features of disorder
  - symptoms or characteristics clinicians could expect in all cases of the disorder to make a diagnosis
  - resemble diagnostic criteria but NO arbitrary cut-offs and symptom counts/duration
  - avoided unless empirically established across countries and cultures
- Clinical utility as an organizing principle for CDDGs
  - To aid interface health encounters & health information
  - To be clinically useful, globally applicable, scientifically valid

Adult type disorders

Schizophrenia and Depression

Schizophrenia and primary psychotic disorders

- 6A20 Schizophrenia
- 6A21 Schizoaffective
- 6A22 Schizotypal Disorder
- 6A23 Acute/transient psychotic disorder
- 6Q24 Delusional Disorder

- Elimination of subtypes >> dimensional descriptors

Schizophrenia or other primary psychotic disorders
Schizophrenia 6A20 >> First episode, continuous, multiple episodes

- *6A20.0 Schizophrenia, first episode*
- 6A20.00 currently symptomatic
- 6A20.01 in partial remission
- 6A20.02 in full remission
- 6A20.0Z, unspecified

- *A20.2 Schizophrenia, continuous*
- 6A20.20 currently symptomatic
- 6A20.21 in partial remission
- 6A20.22 in full remission

6A25 Symptomatic manifestations of primary psychotic disorders

Elimination of subtypes >> dimensional descriptors (>>recovery-based rehabilitation approaches)

6A25.0

Positive symptoms

delusions, hallucinations, disorganized thinking and behaviour, experiences of passivity and control

6A25.1

Negative symptoms

6A25.2 Depressive mood symptoms

6A25.3 Manic mood symptoms

6A25.4

Psychomotor symptoms

agitation, retardation, catatonic

6A25.5 Cognitive symptoms

deficits in speed of processing, concentration….

Mood disorders: depressive and bipolar disorders

- Depressive disorder
  - minimal symptoms count required: 5/10
  - 3 clusters: affective, cognitive and neurovegetative
    - hopelessness added as a cognitive symptom

- Depression ***qualifiers***
  - current or in remission; with psychotic symptoms
  - severity; melancholic features; persistent episodes, prominent anxiety
  - panic attacks and rapid cycling
  - *mixed depressive and anxiety disorder* (*primary care settings*)

Obsessive Compulsive and Related Disorders- OCRD Group

- Amalgamation of several disorders
  - with repetitive unwanted thoughts and related repetitive behaviours
    - OCD: expands thoughts to unwanted images/urges/impulses
- Body dysmorphic disorder *(with hypochondriasis before)*
- Olfactory reference disorder
- Excoriation disorder including tricholomania *(with habit & impulse disorders before)*
- Hypochondriasis (health anxiety) *(with anxiety/fear & related disorders before)*

Disorders related to stress

- PTSD now includes *Complex PTSD and Prolonged grief disorder*
  - Complex post-traumatic stress disorder
    - Adds problems with affect regulation, self-concept, and relational functioning

- Reactive and Disinhibited Attachment disorders

- Adjustment disorder

- *Acute stress reaction* no longer MD but normal reaction to stress
    - Diagnosed under factors influencing health status or contact with health services

Dissociative disorder

- Dissociative neurological symptoms disorder
  - *"Conversion" eliminated*
  - 12 subtypes - by bodily area involved
- Separate trance disorder & possession trance disorder
- Dissociative identity disorder *(previous multiple personality disorder)*
- Depersonalization and derealisation

Feeding and Eating disorders

- Integrates eating and feeding disorders of childhood
    - Eliminates atypical categories
    - Adds new binge eating disorder & ARFID
    - Anorexia does not require fat phobia *(to allow for cultural differences)*
        - ***qualifier*** for severity of underweight status
- Bulimia can be diagnosed based on *subjective* binges
- Binge eating disorder (*new)*
    - unlike bulimia no compensatory efforts to prevent weight gain
- Avoidant/restrictive food intake disorder ARFID *(new)*
    - no concerns about body weight or shape
    - expansion of feeding disorder of infancy and childhood (lifespan approach, consistent with DSM 5)

- Elimination disorders: enuresis and encopresis

- Disorders of bodily distress and bodily experience
  - includes somatoform disorder and neurasthenia
    - mild, moderate and severe
  - introduces body integrity dysphoria
    - persistent desire to have specific physical disability since childhood/adolescence

- Factitious Disorder
  - Imposed on self or on another

Impulse control disorders

- Intermittent explosive behaviour
  - if not explained by other disorders such as CD

    (under other habit and impulse disorders before)
- Compulsive sexual behaviour disorder

- Pyromania, kleptomania

Child and Adolescent Psychiatry (ICD-11)

- International Working Group on Classification of Mental and Behavioural Disorders in Children and Adolescents

2010-2012: Advisory Group for revision of ICD-10

- Michael Rutter (Chair) Daniel Pine, David Shaffer, Francisco Rafael de la Pena, Gillian Baird, John Fayyad, John Lochman, Malavika Kapur, Olayinka Omigbodun, Per-Anders Rydelius, Sue Bailey, Tuula Tamminen, Wenhong Chen, Rudolf Uher
  (WHO Senior Officer: Geoffrey Reed)

- Had working relationship with DSM working group, to help harmonize systems: APA Neurodevelopmental working group: Sue Swedo (Chair)

2012-2017+

- Task Force on Neurodevelopmental disorders Elena Garralda (Chair) David Skuse, Gillian Baird **(WHO/ Geoffrey Reed)**

- Task Force on Disruptive Behavior and Dissocial Disorders Elena Garralda (Chair) John Lochman, Jeffrey Burke, Francisco de la Pena, Spencer Evans, Lourdes Ezpeleta, Paula Fite, Walter Matthys, Michael Roberts, Salma Siddiqui **(WHO/ Geoffrey Reed)**

Child psychiatric merged with adult Disorders > the Lifespan Approach

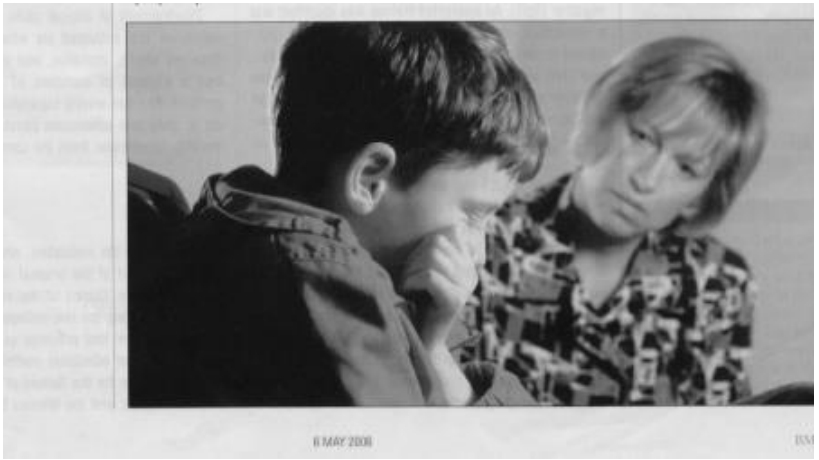
- Increased evidence
  - Adult disorders manifest in childhood with comparable symptomatology
  - There are strong continuities between child and adult disorders (*developmental, emotional and behavioral)* affecting mental health and function
    - Many young adults with psychiatric disorders have had psychiatric diagnoses in adolescence

Lifespan approach

- Emotional disorders with onset usually in childhood & adolescence eliminated
  - distributed to other groupings they share symptoms with
- Separation anxiety disorder

  >> Anxiety and Fear-related disorders
- Feeding disorders

  >> Feeding and Eating disorders
  - Avoidant/restrictive food intake disorder: ARFID
- Each disorder now aims to describe variations in child presentations



The loss CAP: Multi-axial framework

- Multi-axial framework (DSM 5) discarded

BUT

- Psychiatric co-morbidity allowed
  - neurodevelopmental D, genetic or medical, other psychiatric

- Introduction of clinically relevant diagnostic *specifiers **or qualifiers***
  - define homogeneous subgrouping of individuals sharing features that may be relevant for management

- **Culture-related** information systematically incorporated

Child Psychiatric Disorders in ICD-10

1. **Disorders of psychological development** involving early developmental tasks: intellectual, learning and communication

    a. ***Specific*** developmental disorders of speech and language/communication; of scholastic skills/learning; of motor function

    b. ***Pervasive*** developmental disorders, involving social development, communication and behaviour.

2. Behavioural and emotional disorders with onset usually occurring in childhood and adolescence affected by emotional & behavioural immaturities of childhood

    a. Hyperkinetic disorders

    b. Conduct disorders

    c. Emotional disorders with onset specific to childhood

    d. Disorders of social functioning with onset specific to childhood and adolescence

    e. Tic disorders and others including enuresis, encopresis; feeding disorders, pica; stereotyped movement disorder; stuttering, cluttering

3. Disorders that apply across the age and developmental age,

including <u>mental retardation</u>

Disorder groupings in the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders

- Neurodevelopmental disorders
- Schizophrenia and other primary psychotic disorders
- Catatonia
- Mood disorders
- Anxiety and fear-related disorders
- Obsessive-compulsive and related disorders
- Disorders specifically associated with stress
- Dissociative disorders
- Feeding and eating disorders
- Elimination disorders
- Disorders of bodily distress and bodily experience
- Disorders due to substance use and addictive behaviours
- Impulse control disorders
- Disruptive behaviour and dissocial disorders
- Personality disorders
- Paraphilic disorders
- Factitious disorders
- Neurocognitive disorders
- Mental and behavioural disorders associated with pregnancy, childbirth and the puerperium
- Psychological and behavioural factors affecting disorders or diseases classified elsewhere
- Secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere

ICD 11

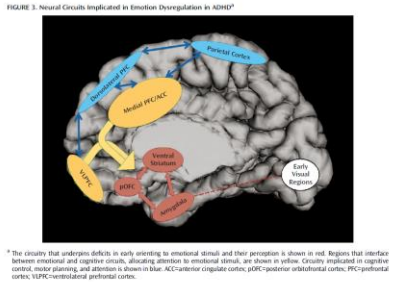


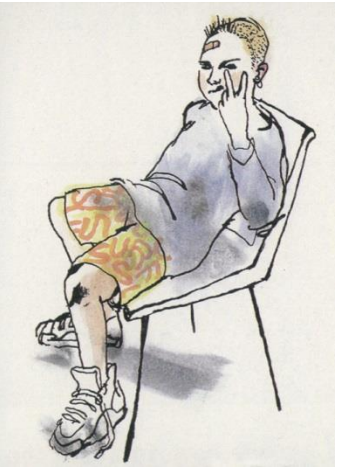
FIGURE 3. Neural Circuits Implicated in Emotion Dysregulation in ADHD[a]

[a] The circuitry that underpins deficits in early orienting to emotional stimuli and their perception is shown in red. Regions that interface between emotional and cognitive circuits, allocating attention to emotional stimuli, are shown in yellow. Circuitry implicated in cognitive control, motor planning, and attention is shown in blue. ACC=anterior cingulate cortex; pOFC=posterior orbitofrontal cortex; PFC=prefrontal cortex; VLPFC=ventrolateral prefrontal cortex.

ICD 11 Neurodevelopmental Disorders

- Disorder of intellectual development
- Specific developmental D *(language, learning, motor/movement)*
- Autism spectrum disorders
- Attention Deficit Hyperactivity Disorders

ICD 11 Disruptive behaviour and dissocial disorders



- Oppositional defiant disorder
  - With chronic irritability-anger
  - With limited prosocial emotions

- Conduct –dissocial disorder
  - With childhood/adolescent onset
  - With limited prosocial emotions

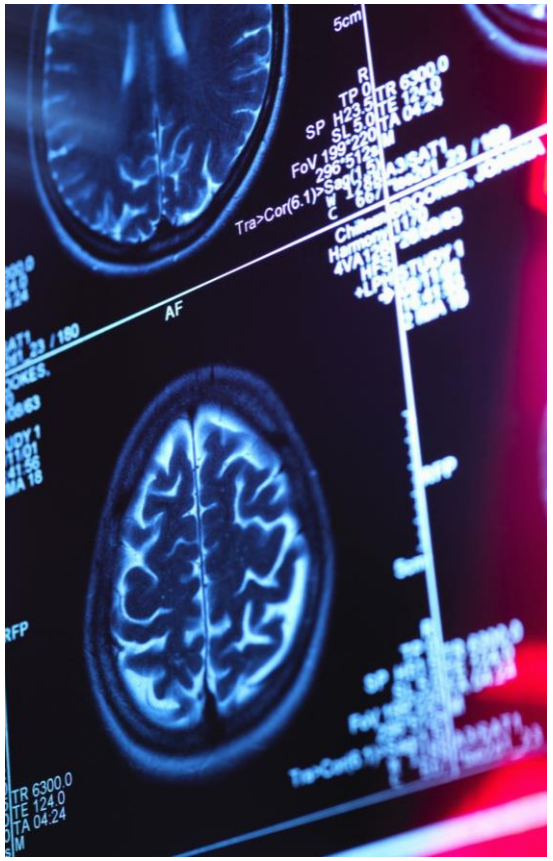
- *Intermittent explosive disorder*

Neurodevelopmental disorders

- Behavioural & cognitive disorders that arise during developmental period
  - significant difficulties in acquisition/execution of specific intellectual, motor, language, social functions

- Only disorders whose core features are neurodevelopmental included
  - although behavioural & cognitive deficits present in mental disorders that may arise during the developmental period (e.g., Schizophrenia, Bipolar disorder)

- The presumptive aetiology is complex and in many individual cases unknown



ICD-11 for Mortality and Morbidity Statistics (Version : 09/2020) Neurodevelopmental disorders

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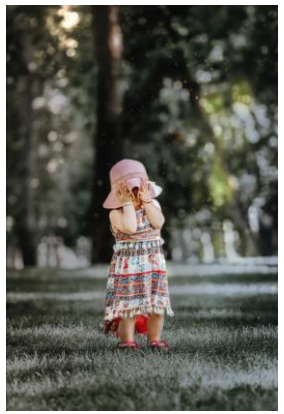
- 6A00 Disorders of intellectual development
- 6A01 Developmental speech or language disorders
- 6A02 Autism spectrum disorder
- 6A03 Developmental learning disorder
- 6A04 Developmental motor coordination disorder
- 6A05 Attention deficit hyperactivity disorder
- 6A06 Stereotyped movement disorder
- 8A05.0 Primary tics or tic disorders
- 6E60 Secondary neurodevelopmental syndrome
- 6A0Y Other specified neurodevelopmental disorders
- 6A0Z Neurodevelopmental disorders, unspecified

Elon Musk reveals he has Asperger's during "Saturday Night Live" monologue



Autism Spectrum Disorder in ICD-11 **Essential features**

A. Persistent deficits in *initiating* and *sustaining* social communication and reciprocal social interactions

that are *outside the expected range of typical functioning* given the individual's age and level of intellectual development

- B. Persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities

that are clearly *atypical or excessive* for the individual's age, gender and sociocultural context

plus lifelong excessive and persistent hypersensitivity or hyposensitivity to *sensory stimuli*

Exclusion from ICD-10

- Asperger syndrome — little general cognitive/language delay; circumscribed interests
- Atypical Autism — onset after 3 years; failure to meet criteria for number of areas of abnormality
- Pervasive Developmental Disorder, unspecified
- Rett's syndrome — >> Diseases of the Nervous System causing regression
- Child disintegrative disorder — " " " "

Qualifiers of ASD diagnosis

- Specify whether with, or without
  - Disorder of Intellectual Development
  - Language
  - Loss of previously acquired skills

A02 Autism spectrum disorder

- 6A02.0 without disorder of intellectual development and with mild or no impairment of functional language
- 6A02.1 with disorder of intellectual development and with mild or no impairment of functional language
- 6A02.2 without disorder of intellectual development and with impaired functional language
- 6A02.3 with disorder of intellectual development and with **impaired** functional language
- 6A02.5 with disorder of intellectual development and **with absence** of functional language
- 6A02.Y Other specified
- 6A02.Z unspecified

Additional Features

Clinical presentation may be late

- ability to function adequately in many contexts *through exceptional effort*

Symptoms of anxiety, or depression may predominate

- + in adolescence and adulthood; can mask underlying social communication disorder

Social naiveté can lead to exploitation by others - social media

Genomic deletions, duplications and mutations

- increasingly recognized

Epilepsy - onset in early childhood or in adolescence

Unusual patterns of cognitive strengths and weaknesses

- In those with average IQ: common and highly variable across individuals

Speech and language disorders

ICD 10

- Specific Speech articulation disorder
- Expressive language disorder
- Receptive language disorder
- Acquired aphasia with epilepsy
- Other or unspecified dev disorder of speech/language – Selective mutism

ICD 11

- Developmental Speech Sound Disorder

  Speech Fluency
- Developmental Language Disorder

  Qualifiers
  1. Receptive/expressive impairment
  2. Predominantly Expressive language impairment
  3. Predominantly with impairment of pragmatic language
- >Secondary language disorder

> >Anxiety & Fear-Related Disorders

ICD 11 Language Disorder Pragmatic Qualifier vs DSM 5 Social Pragmatic Communication Disorder

BOTH INCLUDE

- Development difficulties understanding what not explicitly stated
  - making inferences; nonliteral/ ambiguous meanings
  - idioms, humour, metaphors
  - multiple meanings depending on context for interpretation
- Impairs effective communication
- Not attributable to another disorder, including autism

SPCD (but not LDP Q) also includes

- Deficits in communication for social purposes

Essential in SPCD only

ICD 11 Developmental Language Disorder with impairment of pragmatic language (IPL)

& DSM 5 Social Pragmatic Communication D (SPCD)

- Impaired ability to adjust communication to meet listener need
- Deficits in using language for social purposes
  - such as sharing information
- Deficit in matching communication to social context

- Structural language impairment,
  - impaired phonology, vocabulary and/or grammar
- Deficits in non-verbal communication
  - eye gaze, facial expression, gesture
- Impaired social understanding & social relationships

ADHD in DSM 5

- Classified as a neurodevelopmental disorder
- As in DSM IV - same 18 symptoms, same dimensions (inattention & hyperactivity/impulsivity)
- Age of onset of symptoms causing impairment:
- 7 >> 12 years (also ICD 11)
- 6/9 symptoms from hyperactive impulsive & for inattentive problems remains
- Lowered threshold for adults and ≥ 17 Y 5/9
- Additional examples added to criterion items - especially for adults
- Strengthening of cross-situational requirement
  - several symptoms in each setting required
  - symptoms present when "with friends or relatives" added
- "Impairment" specified
  - As "interfere with or reduce the quality of social, academic, or occupational … functioning"
- Co-existing conditions possible: removal of exclusion for ASD (PDD)
- Discontinued "subtypes" >> specifiers
- **Combined**
- **Predominantly inattentive**
- **Predominantly hyperactive/impulsive**

ICD-11

Attention deficit hyperactivity disorder

- Persistent pattern (6 months+) of inattention &/or hyperactivity-impulsivity with direct negative impact on academic, occupational, or social functioning.
- Symptoms present prior to age 12
  - though some individuals may first come to clinical attention later
- Symptom level outside expected for age & intellectual level

- **Inattention** : difficulty in sustaining attention to tasks that do not provide a high level of stimulation or frequent rewards; distractibility and problems with organisation.
- **Hyperactivity**: excessive motor activity, difficulties remaining still, specially in structured situations requiring behavioural self-control
- **Impulsivity:** tendency to act in response to immediate stimuli, without deliberation or consideration of the risks and consequences

- Relative balance and manifestations of symptoms varies across individuals and may change over the course of development
- Symptoms evident *across multiple situations* or settings *(home, school, work, or with friends or relatives)* but likely to vary according to *structure and demands of setting*
- Symptoms *not better accounted for by* another mental, behavioural, or neurodevelopmental disorder and not due to thee effect of a substance or medication

Qualifiers: predominantly inattentive presentation

predominantly hyperactive-impulsive presentation

combined presentation

Summary - Neuro Developmental Disorders

- Largely aligned with DSM 5 - life span approach
- Include

  ICD10's Mental Retardation > D of Intellectual Development

  Hyperkinetic D > ADHD – Attention Deficit Hyperactivity D

- Some changes in nomenclature
  - *Speech articulation D>> sound & fluency*
  - *Developmental Language Disorder with impairment of pragmatic language vs DSM5 SPCD*

- Autism: >> Autistic Spectrum Disorders
  - amalgamation of earlier disorders
  - 3 > 2 two main dysfunctional areas
  - manifestations with average intellect and in adults
  - *Qualifiers:* intellectual and language development

- ADHD: lifespan approach

The disruptive behaviour and dissocial disorders - DSM 5 & ICD 11

ICD 11

Disruptive behaviour & Dissocial disorders

Oppositional defiant disorder
- **With chronic irritability-anger**
- **With limited prosocial emotions**

Conduct –dissocial disorder
- With childhood vs adolescent onset
- With limited prosocial emotions

Intermittent explosive disorder

DSM 5

Disruptive, **impulse-control** and conduct disorders

Oppositional defiant disorder

Conduct disorder
- With childhood/adolescent/unspecified onset
- With limited prosocial emotions

Intermittent explosive disorder

Pyromania and kleptomania

Disruptive behaviour & Dissocial disorders

Oppositional defiant disorder
- **With chronic irritability-anger**
- **With limited prosocial emotions**

Conduct –dissocial disorder
- **With childhood/adolescent onset**
- **With limited prosocial emotions**

Disruptive behaviour or dissocial disorders

- 6C90 Oppositional defiant D
- 6C90.0 Oppositional defiant disorder
  - with chronic irritability-anger
- 6C90.1 Oppositional defiant disorder
  - **without chronic irritability-anger**
- 6C90.10 Oppositional defiant disorder without chronic irritability-anger
  - with limited *prosocial* emotions
- 6C90.11 Oppositional defiant disorder without chronic irritability-anger
  - with typical *prosocial* emotions
- 6C90.1Z Oppositional defiant disorder without chronic irritability-anger
  - unspecified
- 6C90.Z Oppositional defiant disorder
  - unspecified

- 6C91 Conduct-dissocial disorder
- 6C91.0 Conduct-dissocial disorder, **childhood onset**
- 6C91.00 Conduct-dissocial disorder, childhood onset
  - with limited *prosocial* emotions
- 6C91.01 Conduct-dissocial disorder, childhood onset
  - with typical *prosocial* emotions
- 6C91.0Z Conduct-dissocial disorder, childhood onset,
  - unspecified
- 6C91.1 Conduct-dissocial disorder, **adolescent onset**
- 6C91.10 Conduct-dissocial disorder, adolescent onset
  - with limited *prosocial* emotions
- 6C91.11 Conduct-dissocial disorder, adolescent onset
  - with typical *prosocial* emotions
- 6C91.1Y Other specified conduct-dissocial disorder, adolescent onset
- 6C91.Z Conduct-dissocial disorder
  - unspecified
- 6C9Y **Other** specified disruptive behaviour or dissocial disorders
- 6C9Z Disruptive behaviour or dissocial disorders, **unspecified**

Oppositional defiant disorder

With chronic irritability-anger

With limited prosocial emotions

Oppositional Defiant Disorder (ODD)

- ICD-10: same category name
- Persistent pattern (> 6 months) of markedly defiant, disobedient and provocative behavior
    - More frequently than is typically in others of same age and developmental level, not restricted to siblings.
- Persistent angry or irritable mood
    - often accompanied with severe temper outburst, headstrong argumentative and defiant behavior
- Significant impairment in several areas of functioning.
    - Physical aggression in the preschool years can occur with ODD
        - Expected to be first evident in early childhood

DSM 5 - ODD has 3 symptoms groups but no subtype

Angry/irritable mood

(Review Evans et al, 2017 strongest support)

Often loses temper
Is often touchy or easily annoyed
Is often angry and resentful

Argumentative/defiant behavior

(Spencer Evans et al, moderate support)

Often argues with authority figures (adults for children)
Often actively defies or refuses to comply with requests from authority figures or with rules
Often deliberately annoys people
Often blames others for his or her mistakes or misbehavior

Vindictiveness

(Evans et al, weak support)

Is often spiteful or vindictive

In clinically referred boys, several studies find that irritability dimension of ODD only predicts

- symptoms of depression and neuroticism
- increased risk for mood/anxiety /neuroticism through adolescence and young adulthood

- parent-reported irritability age 14 predicted suicidality 30 years later in the Isle of Wight sample
  - did NOT predict bipolar disorder (Copeland et al., 2017)

- factorial evidence for a broad ODD construct
  - for some children, this includes severe chronic irritability associated with internalizing problems

Subtypes of ODD/Qualifier

- With chronic irritability-anger
  - Prevailing & persistent angry/irritable mood
  - Frequent and severe temper outbursts out of proportion in intensity of the provocation

- Without chronic irritability-anger
  - Not prevailing and persistent angry or irritable mood, but with headstrong argumentative, and defiant behavior

DSM 5 - Disruptive mood dysregulation disorder (DMDD)

- Severe recurrent temper outbursts (more than tantrums) grossly out of proportion in intensity/duration to the situation
  - 3+ each week for 1 year+
- In-between, persistent irritable/angry mood
  - most of the day and nearly every day
  - observable by parents, teachers, or peers (in 2+ settings)
  - Not 3+ consecutive months without symptoms
- Onset of symptoms before age 10
  - diagnosis not made for the first time before age 6 or after 18 y
- Symptoms significantly different to ODD & Bipolar D
- Precursor condition: SMD (Severe Mood Dysregulation)

Severe Mood Dysregulation – SMD and DMDD

- Need to reduce overdiagnosis of Bipolar Disorder in US (⬆ 4,000% in 12 years)
- SMH - chronic levels of anger or sadness, hyperarousal, reactivity
  - predicted later anger & depressive, not bipolar Disorder (Deveney et al., 2014; Stringaris et al., 2010)
- DSM 5 : SMH >> Disruptive Mood Dysregulation Disorder (DMDD)

  listed in DSM Chapter on Depression
  - *Temper outbursts* (3+ per week) & *severe irritability* (daily, most day) ; 12 months+
  - Responds to minor provocations with poor controlled negative emotions & prevailing negative mood (irritable, angry, sad)
  - Present in 2+ settings (home; school; peers); severe in at least in one
  - 6+ years of age, onset before 10; no manic episode

But…

- Insufficient research evidence SMD

  SMD >> DMDD by removing

  - hyperarousal (insomnia, agitation, distractibility, racing thoughts) from essential criteria
  - low intelligence (IQ<80) from exclusionary criteria

- DMDD field studies and secondary analyses
  - limited reliability, lack of psychiatric consensus
  - very high rates of overlap with other disorders

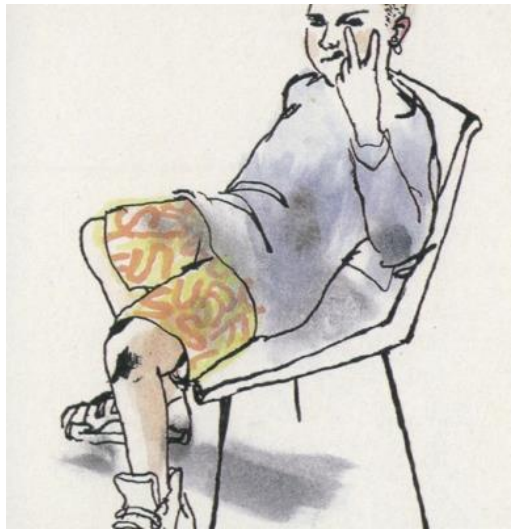
(Spencer Evans et al 2017; John Lochman et al 2015)

Disruptive behaviour & Dissocial disorders

Conduct –dissocial disorder

New qualifiers

With childhood/adolescent onset
With limited prosocial emotions



Conduct/Dissocial Disorder (CDD)

- New category name, substantive changes from ICD 10
- Repetitive and persistent behaviors which violate basic social norms & rights of others
  - aggression towards people/animals
    - bullying, threatening, physical fights, using weapon, stealing with confrontation
  - destruction of property
    - fire-setting, deliberate destruction
  - Deceitfulness & theft
  - serious violation of rules
    - Adolescents - staying out at night, running away, truant
    - Adults - non-paymemt of fines, not keeping work rules
  - Simple criminality, political protest **not** sufficient

CDD – Subtypes Childhood & Adolescent onset Subtypes

Childhood Onset

- Symptoms before 10 years, males
  - frequent display physical aggression toward others

    >> disturbed peer relationships
  - history of ODD in early childhood
  - neurodevelopmental difficulties including ADHD with hyperactivity/impulsivity
  - antisocial behaviour in one/both parents
  - CD more likely to persistent into adulthood than adolescent type

Adolescent onset

- CDD behaviors not evident before 10
- peer relations typically normal
- may have had ODD
- may persist into adult life

Limited Prosocial Emotions

NEW Qualifier for CDD and ODD (DSM 5 for CDD only) (e.g. Herper et al., 2012)

- Diagnostic guidelines
  - Lack of empathy & sensitivity to feelings of others
    - lack of concern for others' distress
  - Lack of remorse, shame or guilt about their own behavior
    - unless prompted by being apprehended
  - Relative indifference to probability of punishment
    - absence of nervousness
  - Lack of concern over poor performance in school or work
  - Limited expression of emotions
    - particularly positive and loving feelings expression is shallow
    - insincere or instrumental
- Assessed: self-report & well-known informant

Limited prosocial emotions qualifier

- Based on research on psychopathic personality
  - Callous and unemotional people
- Comparative early onset, and worse adult prognosis
- Cognitive and emotional deficits
  - Deficits processing signs of fear and distress in others
  - fearless, indifference to punishment
- Significant heritability
- Less responsive to parenting interventions, behaviour therapy or multimodal psychosocial interventions
- BUT only moderate stability over time, and traits may improve with Rx

Summary: ICD 11 - CAPsych D

- Loss of Specific childhood disorders & multi-axial classification

  >> co-morbidity, qualifiers & CYP comments throughout

  >> carefully described disorders, *evidence base*

- Childhood onset persistent disorders

  - Neuro-developmental D *(IDD & ADHD)*

  - Disruptive behaviour & Dissocial disorders

    Qualifiers

    ODD - irritability (vs DSM 5 DMDD) & low prosocial

    CD - age of onset & low prosocial

- Classification and CAMHS

References

- Garralda ME (2016) ICD-11 – Comparison with DSM-5 and implications for child & adolescent psychiatric disorders. Chapter in: Hodes M and Gau S (Editors/IACAPAP): *Positive Mental Health, Fighting Stigma and Promoting Resiliency for Children and Adolescents.* Academic Press/Elsevier, London. Pp 15-35. http://iacapap.org/publications

- Lochman JE, Evans SC, Burke JD, Roberts MC, Fite PJ, Reed GM, de la Peña FR, Matthys W, Ezpeleta L, Siddiqui S, Garralda ME (2015) An empirically based alternative to DSM-5's disruptive mood dysregulation disorder for ICD-11. *World Psychiatry* 14:1, 30-33; doi 10.1002/wps.20176. http://hdl.handle.net/10044/1/27858

ICD-11 through the lens of Child Adolescent psychiatry

ICD-11 officially out on 1st January 2022

https://icd.who.int/browse11/l-m/en