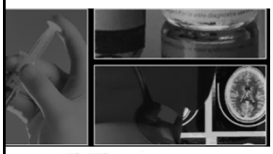
A Potential Full Court Press: Some of the Forensic Implications of the Transition to the DSM-5



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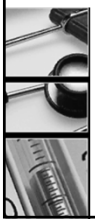
If not now then when?

- APA indicates the transition to DSM 5 has already occurred during January
- The way you are recording DSM-5 diagnosis codes is no different from how these were recorded using DSM-IV. As was the case with DSM-IV, the codes within DSM-5 represent valid codes of the ICD-9-CM (the International Classification of Diseases, 9th edition, Clinical Modification).
- The ICD-9-CM is the coding system that the Department of Health and Human Services has designated for use in all health transactions in the United States.
- You do not need a “crosswalk” to use the codes found in DSM-5.

Moving from ICD-9 to ICD-10 is a large adjustment:



- The ICD-10 applies to all HIPAA entities, so it affects everyone.
- ICD-10 requires greater specificity, and more exacting details to support the diagnosis.
- Transitioning to the ICD-10 code set will require clinical judgment, and more time.
- Some payers will also require DSM codes for prior authorizations.

ICD-10-CM

- Note that on October 1st, 2014, the United States will no longer use ICD-9-CM as its official coding system.
- Effective on that date, the ICD-10-CM (the International Classification of Diseases, 10th edition, Clinical Modification) will be the official system that must be used.
- The ICD-10-CM codes are already included in the DSM-5. The ICD-10-CM codes are listed in parentheses next to each disorder title.
- On October 1st, 2014, simply begin using the codes listed in parentheses to code your diagnoses.

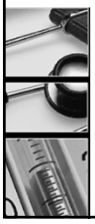
ICD-10 "F code" format

- F is found in Chapter 5 from the ICD-10
- Last 4 digits represent the clinical state: etiology, severity, manifestation, and placeholders

- *Note: Some T codes, Y codes, and R codes are applicable to SU diagnosing (T50.905= Adverse effect of unspecified drugs, medicaments and biological substances).*

Reference

- Chapter 5: Mental, Behavioral and Neurodevelopmental disorders (F01 – F99)
- a. Pain disorders related to psychological factors
- c. Mental and behavioral disorders due to psychoactive substance use



- http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf

Dates Effective

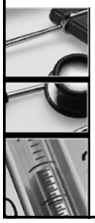
- Many payers are stating they will require use of DSM-5 for "clinical purposes" (ie: prior authorizations) while ICD-10 codes must be used for claims transactions.
- Therefore: you need to know the 2 code sets, and learn about the differences between the ICD-10 descriptors and DSM-5 descriptions.

Brief DSM History

- 7th version since 1952
- There have been 7 to 16 years between revisions
- The DSM-IV was published in 1994, later TR
- The current DSM 5 is a dynamic document
- DSM changes necessitated by:
  - research
  - politics
  - cultural changes
  -

New DSM Approach

- More than one axes to grind
- No more GAFS (WHODAS)
- A dimensional approach to diagnosis
- Including developmental and lifespan considerations
- Greater emphasis on cultural and gender differences

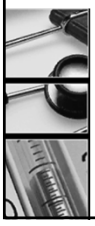


WHODAS

- The World Health Organization Disability Assessment Schedule (WHODAS 2.0) was judged by the DSM-5 Disability Study Group to be the best current measure of disability for routine clinical use.
- The WHODAS 2.0 is based on the International Classification of Functioning, Disability, and Health (ICF) and is applicable to patients with any health condition.
- The scale, as well as scoring information is included in Section III of DSM-5.

Dimensional

- DSM – 5 has moved to a non-axial documentation of diagnosis.
- Separate notations for important psychosocial and contextual factors and disability however are still included.
- Axes I and II have been combined however clinicians are expected to continue to list medical conditions that are important to understanding or the management of an individual's mental disorder.



What we list

- Severity rating (mild, moderate, severe, extreme)
- Course of the disorder (in partial remission, full remission, etc.
- Descriptors (insight level, in a controlled environment, etc.)

Dimensional Diagnostic indicators

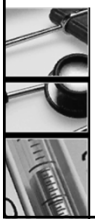
- Shared neural substrates, family traits
- Genetic risk factors
- Specific environmental risk factors
- Biomarkers, temperamental antecedents
- Abnormalities of emotional or cognitive processing
- Symptom similarity, course of illness
- High comorbidity and shared treatment response

Definition

- A mental disorder is a syndrome characterized by clinically significant disturbance in individuals cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.
- Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder.
- Socially deviant behavior (eg., Political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless deviance or conflict results from dysfunction in the individual, as described above.

In the press last year

- That the NIMH Withdraw Support for the DSM-5
- This volume will tweak several current diagnostic categories, from autism spectrum disorders to mood disorders. While many of these changes have been contentious, the final product involves mostly modest alterations of the previous edition, based on new insights emerging from research since 1990 when DSM-IV was published. Sometimes this research recommended new categories (e.g., mood dysregulation disorder) or that previous categories could be dropped (e.g., Asperger's syndrome). http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml



More NIMH

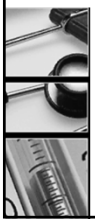
- While DSM has been described as a “Bible” for the field, it is, at best, a dictionary, creating a set of labels and defining each.
- The strength of each of the editions of DSM has been “reliability” – each edition has ensured that clinicians use the same terms in the same ways.
- The weakness is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure.

Patients with mental disorders deserve better

- NIMH has launched the Research Domain Criteria (RDoC) project to transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system.
- Through a series of workshops over the past 18 months, we have tried to define several major categories for a new nosology (see below). This approach began with several assumptions:

RDoC Research not clinical tool

- A diagnostic approach based on the biology as well as the symptoms must not be constrained by the current DSM categories,
- Mental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion, or behavior,
- Each level of analysis needs to be understood across a dimension of function,
- Mapping the cognitive, circuit, and genetic aspects of mental disorders will yield new and better targets for treatment.



The major RDoC research domains:

- Negative Valence Systems
- Positive Valence Systems
- Cognitive Systems
- Systems for Social Processes
- Arousal/Modulatory Systems

Supporters

- "Given the challenges in a field where objective lines are hard to draw, they did a solid job," said Dr. Michael First, a psychiatrist at Columbia who edited a previous version of the manual and was a consultant on this one.

Detractors

- "This is the saddest moment in my 45-year career of practicing, studying and teaching psychiatry," wrote Dr. Allen Frances, the chairman of a previous committee who has been one of the most vocal critics, in a blog post about the new manual, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, or DSM5.

Dr. Allen Frances

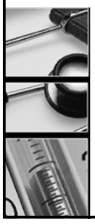
- Gives a warning to mental health practitioners that we need to avoid mislabeling everyday problems as mental illness. To do so has shocking applications for both the society and individuals. It also leads to the misallocation of medical resources draining both families and the budgets of the nation. He dressed the focus on are naturally resilient and self-healing abilities. He worries that over labeling mentally illness plays into the pockets of the pharmaceutical companies. Finally he is concerned that we will experience a diagnostic hyperinflation.

Allen Frances on Forensic Risks

- I do not believe that the DSM-V work group includes anyone skilled in the highly technical art of writing criteria.
- The few criteria sets that have surfaced display internal incoherence and some external inconsistency.
- The more general papers meant to describe the DSM-V process are difficult to decipher.
- Confusing criteria sets are a prescription for forensic confusion.

More Allen Frances on Forensic Risks

- The shroud of secrecy covering the development of the DSM-V does not allow us access to even minimal information about timelines, methods for revising work group drafts, and the possibility of a forensic review.
- I do not have the impression that there is a sound method at work for identifying and eliminating errors.
- An application to the National Institutes of Health to fund field trials has been rejected, which suggests that any field trials that are conducted will be poorly executed.



Dr. Frances summary

- Those preparing the DSM-V have had the unrealizable ambition of promoting a paradigm shift in psychiatric diagnosis, and they have articulated their openness to change. Their plan is not good news for forensic practice. Anything new is more likely to have unintended forensic consequences than are old standbys that have never caused trouble.

- Frances, A. (2010). The forensic risks of DSM-V and how to avoid them. *Journal of the American Academy of Psychiatry and the Law Online, 38*(1), 11-14. http://jaapl.org/content/38/1/11.full

Reliability of the DSM 5

- From these results, to see a κ_l for a DSM-5 diagnosis above 0.8 would be almost miraculous; to see κ_l between 0.6 and 0.8 would be cause for celebration. A realistic goal is $\kappa_l$between 0.4 and 0.6, while $\kappa_l$between 0.2 and 0.4 would be acceptable.

- We expect that the reliability (intraclass correlation coefficient) of DSM-5 dimensional measures will be larger, and we will aim for between 0.6 and 0.8 and accept between 0.4 and 0.6. The validity criteria in each case mirror those for reliability.
- Source: Kraemer, H.C., Kupfer, D.J., Clarke, D.E., Narrow, W.E., Regier, D.A. (2012) DSM-5: How reliable is reliable enough? *The American Journal of Psychiatry, 169*(1) http://ajp.psychiatryonline.org/article.aspx?articleID=181221

Challenges

- Inter-rater reliabilities are reported in terms of kappa coefficients. Kappa coefficients correct for chance levels of agreement between two diagnosticians. A kappa coefficient of 1.00 indicates perfect agreement between two or more diagnosticians. A kappa coefficient of 0.00 indicated no agreement whatsoever between two or more diagnosticians.

- Traditionally, a kappa coefficient of .70 has been the benchmark of an acceptable level of inter-rater reliability for diagnostic purposes.
- "Reliability is expressed using the kappa statistic which indexes chance-corrected agreement. A high kappa (generally 0.7 and above) indicates good agreement as to whether or not the patient has a disorder within that diagnostic class, even if there is disagreement about the specific disorder within the class" (p. 468).
- American Psychiatric Association (1980). DSM-III: Diagnostic and statistical manual of mental disorders-3rd Edition. Washington, DC: Author.

Initial field trials of DSM-V

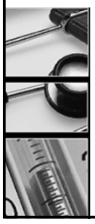
	DSM-5	DSM-IV	ICD-10	ICD-11
Major Neurocognitive Disorder	.78			
Postraumatic Stress Disorder	.67	.59		
Complex Somatic Symptom Disorder		.61		
Hoarding Disorder	.59			
Bipolar I disorder	.56	.69		
Binge Eating Disorder	.56			
Borderline Personality Disorder	.54			
Schizoaffective Disorder	.50			
Mild Neurocognitive Disorder	.48			
Schizophrenia	.46	.76		

- Freedman, R., Leewis, D.A., Michels, R. et al. (2013). The initial field trials of DSM-5: New blooms and old thorns. American Journal of Psychiatry, 170, 1-5.

Attenuated Psychotic Symptoms	.46	
Alcohol Use Disorder	.40	
Bipolar II Disorder	.40	
Mild Traumatic Brain Injury	.36	
Obsessive Compulsive Disorder	.31	
Major Depressive Disorder	.28	.59
Antisocial Personality Disorder	.21	
Generalized Anxiety Disorder	.20	.65
Mixed Anxiety-Depressive Disorder	-.004	

Child Disorders

Autism Spectrum Disorder	.69	.85
ADHD	.61	.59
Bipolar I Disorder	.52	
Avoid/Restrict Food Intake	.48	
Conduct Disorder	.46	.57
Oppositional Defiant Disorder	.40	.55
Posttraumatic Stress Disorder	.34	
Major Depressive Disorder	.28	
Callous/Unemotional Specifier	.28	
Disruptive Mood Dysreg Disorder	.25	
Mixed Anxiety-Depressive Disorder	.05	
Nonsuicidal Self-Injury	-.03	



Critique of DSM-V Field Trials

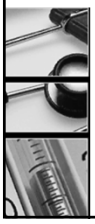
- "The field trials have been plagued with repeated delays and missed deadlines" (p. 517).
- “Most psychiatric treatment occurs in primary care settings, and patients in those settings typically present with milder symptoms as compared with patients in specialty settings. Without evaluating patients in primary care setting, it is impossible to determine the true prevalence rate changes in those settings with the highest risk of false-positives" (p. 518).
- "By including well-written, operationalized criteria, the DSM-III field trials established that decent reliability could by achieved by clinicians in actual practice settings" (p. 518).

Critique of DSM-V Field Trials

- "However, making wholesale changes in the wording of criteria, as is being done in DSM-5, could jeopardize the reliability of psychiatric diagnoses as operationalized by the DSM-5, thus justifying the need for a rigorous reliability study as is being conducted in the academic settings" (p. 518).
- "In early 2012, the DSM-5 Task Force recently announced that the 'acceptable' reliability level for DSM-5 is a kappa between 0.2 and 0.4. This diverges from all traditional standards of acceptable levels of reliability" (p. 518).

Critique of DSM-V Field Trials

- "Historically, kappas for diagnostic agreement less than .40 are poor, from 0.4 to .06 are fair, from .60 to .80 are good, and greater than .80 are excellent." (p. 518).
- "Kappas of .20 to to .40 have universally been considered unacceptable, coming perilously close to no agreement. As a comparison, the personality disorder section in DSM-III was widely criticized when its kappas were around .50" (p. 518).
- "There are many reasons why diagnostic reliability levels in the DSM-5 field may end up being so low. First, the DSM-5 Task Force chose not to use a structured diagnostic interview in the field trials" (p. 518).



Jones, K.D. (2012). A critique of the DSM-5 field trials. Journal of Nervous and Mental Disease, 200 (6), 517-519.

- "The trials experienced problems early on - they were poorly planned, started late, used the wrong testing sites, were disorganized in administration, constantly missed deadlines, did not evaluate validity, did not evaluate prevalence rate changes, had an extremely high attrition rate in the routine trials, and may well have unacceptably low reliabilities" (p. 519).
- "Most clinicians who use the DSM are non-psychiatric mental health professionals. If the field trials do not include a representative sample of the typical clinician, then there will be no data available to establish that these proposals are feasible for implementation and not likely to be overly burdensome" (p. 519).

Typical Disorders in FMHA

- Substance related disorders
- Schizophrenia and other psychotic disorders
- Disorders of personality
- Paraphilic Disorders
- Trauma and other stress related disorders

Forensic use

- This manual is now described as a reference for the courts and attorneys in assessing the forensic consequences of mental disorders.
- However the definitions of the mental disorders included were developed to meet the needs of clinicians public health professionals, and research investigators rather than the technical needs of courts and the legal professions.
- Juxtaposed is another statement that indicates that the use should be informed by an awareness of the risk and limitations in forensic settings. In part because there is a imperfect fit between questions of ultimate concerns the law and the information contained in clinical diagnosis.

Forensic Use

- However if used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations. The example given is the presence of a mental disorder that predicts the need for involuntary civil commitment.

- Further a compendium will be printed that reviews the pertinent clinical and research literature that is viewed as potentially helping the legal decision-makers in understanding relevant characteristics of a mental disorder.

Last forensic caveat

- Further it is written, "Even when diminished control over one's behavior is the feature of the disorder, having the diagnosis itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time."

NOS

- An important clinical tool in the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders" (DSM-5) is the revised diagnoses of "other specified" and "unspecified" mental disorders.

- Revised from DSM-IV's "Not Otherwise Specified" categories, these diagnoses give clinicians the flexibility necessary in some settings to provide patients with the best care.

More NOS

- For example, if a patient comes into an emergency department and is acutely psychotic, it might not be immediately clear if this is due to schizophrenia, bipolar disorder, drug use or severe hyperthyroidism.
- These diagnoses allow a clinician to be as specific as possible, without needing to declare that all criteria are met for a more definitive diagnosis.

Binge eating disorder

- Previously considered part of eating disorder NOS but DSM 5 made it its own disorder.
- Considered one of the common eating disorders according to the National Eating Disorder Association.

Autism Spectrum Disorder

- Asperger's was removed
- Will someone with ASD be able to function effectively within a trial context?
- Will his or her symptoms alter his or ability to be fit to stand trial, understand to their criminal responsibility and moral blameworthiness for the actions for which they are being tried for?

http://www.intechopen.com/books/recent-advances-in-autism-spectrum-disorders-volume-ii/forensic-issues-in-autism-spectrum-disorder-learning-from-court-decisions

Addictive disorders

- Abuse and dependence collapsed
- Substance use disorders
- Substance induced disorders described by intoxication and withdrawal
- Pathological pattern of behaviors and symptoms seen in:
  - Impaired control
  - Social Impairment
  - Risky patterns of use

Neurocognitive Dysfunction

- DSM-5 recognizes specific etiologic subtypes of neurocognitive dysfunction, such as Alzheimer disease, Parkinson disease, HIV infection, Lewy body disease, and vascular disease.
- Each subgroup can be further divided into mild or major degrees of cognitive impairment on the basis of cognitive decline, especially the inability to perform functions of daily living independently. In addition, a sub-specifier "with" or "without behavioral disturbances" is available.

Neurocognitive

- Mild neurocognitive disorder requires "modest" cognitive decline which does not interfere with "capacity for independence in everyday activities" like paying bills or taking medications correctly.
- Cognitive decline meets the "major" criteria when "significant" impairment is evident or reported and when it does interfere with a patient's independence to the point that assistance is required. In other words, the diagnostic distinction relies heavily on observable behaviors.

PD

- In the field trials, only borderline personality disorder had good interrater reliability. In contrast, obsessive-compulsive personality disorder and antisocial personality disorder were in the questionable reliability range, and too few patients with other personality disorders were included to test their reliability.
- Although all original 10 personality disorders from DSM-IV were finally retained, DSM-5 has moved from the multiaxial to a monoaxial system that removes the arbitrary boundaries between personality disorders and other mental disorders.

Paraphilia's

- The paraphilia diagnostic criteria remain unchanged from DSM-IV, however there is in DSM –V a distinction between paraphilic behaviors, or paraphilias, and paraphilic disorders.
- The disorder is described as a "paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others."
- The new approach to paraphilias de-medicalizes and de-stigmatizes unusual sexual preferences and behaviors, if they are not distressing or detrimental to one's self or others. Clinicians are thus tasked with deciding if a behavior qualifies as a disorder, based on a thorough history obtained from the patient and qualified informants.

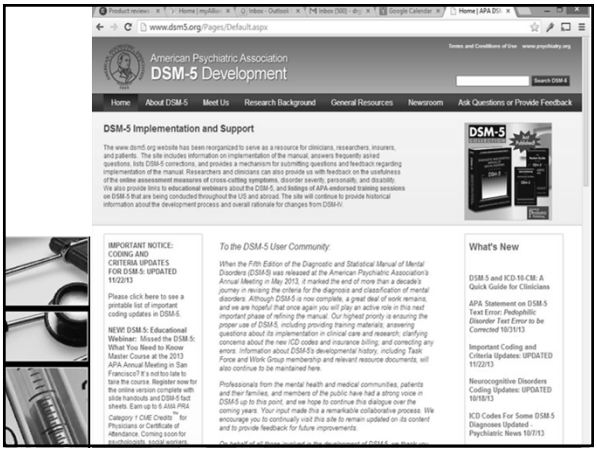
Paraphilic disorders

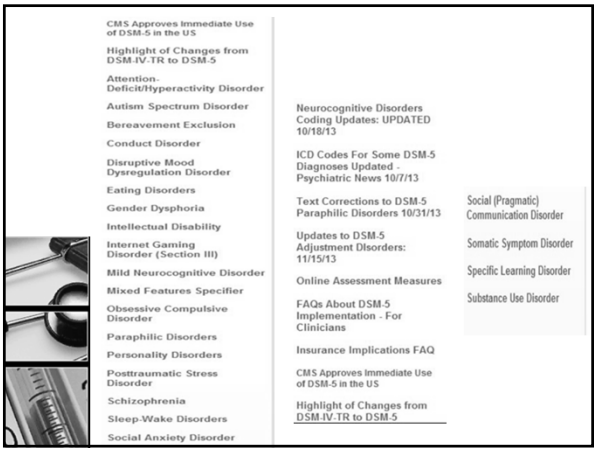
- Paraphilia
  - Abnormal intense and persistent sexual interest
  - Does not cause distress, impairment, harm to others
  - NOT A DIAGNOSIS
- Paraphilic Disorder
  - A parahilia resulting impairment and distress
  - A paraphilia whose practice causes personal harm and risks to others
  - In "a controlled environment" and "in remission"
- Specifications added:
  - Exclusive or non-exclusive
  - Sexually attracted to males, females or both
  - Limited to incest

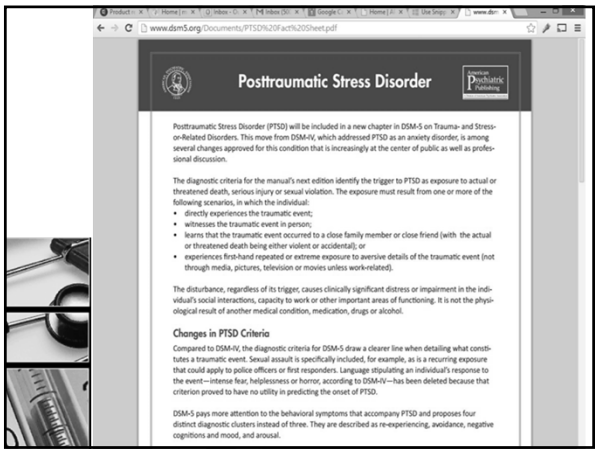
APA Corrections 10/31/2013

"Sexual orientation" is not a term used in the diagnostic criteria for pedophilic disorder and its use in the DSM-5 text discussion is an error and should read "sexual interest." In fact, APA considers pedophilic disorder a "paraphilia," not a "sexual orientation." This error will be corrected in the electronic version of DSM-5 and the next printing of the manual.

- Corrections maybe found at: http://www.dsm5.org/







www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf

Posttraumatic Stress Disorder

Posttraumatic Stress Disorder (PTSD) will be included in a new chapter in DSM-5 on Trauma- and Stressor-Related Disorders. This move from DSM-IV, which addressed PTSD as an anxiety disorder, is among several changes approved for this condition that is increasingly at the center of public as well as professional discussion.

The diagnostic criteria for the manual's next edition identify the trigger to PTSD as exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual:

- directly experiences the traumatic event;
- witnesses the traumatic event in person;
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
- experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).

The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning. It is not the physiological result of another medical condition, medication, drugs or alcohol.

Changes in PTSD Criteria

Compared to DSM-IV, the diagnostic criteria for DSM-5 draw a clearer line when detailing what constitutes a traumatic event. Sexual assault is specifically included, for example, as is a recurring exposure that could apply to police officers or first responders. Language stipulating an individual's response to the event—intense fear, helplessness or horror, according to DSM-IV—has been deleted because that criterion proved to have no utility in predicting the onset of PTSD.

DSM-5 pays more attention to the behavioral symptoms that accompany PTSD and proposes four distinct diagnostic clusters instead of three. They are described as re-experiencing, avoidance, negative cognitions and mood, and arousal.

PTSD

- Formerly under "Anxiety Disorders" in the DSM-5 posttraumatic stress disorder (PTSD) is in a new chapter titled "Trauma- and Stressor-Related Disorders."
- A fourth diagnostic cluster (in addition to Criteria B, C, and D) focusing on behavioral symptoms has been added.
- Mostly minor revisions, with 2 additional criteria added: (1) negative alterations in cognition and mood associated with the traumatic event, beginning or worsening after the event, and (2) the disturbance is not attributed to the direct physiologic effects of a substance or another medical condition.

More Trauma

- A new diagnostic subtype includes preschool-aged children with PTSD symptoms.
- The prior distinction between acute and chronic PTSD has been removed.
- Under A 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) busted been violent or accidental.

Section III

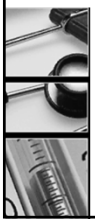
- Contain formulations that need additional scientific evidence that is not yet available in sufficient strength to support widespread clinical use.
- There is a new proposed system for Personality Disorders
- This alternative model suggests that personality disorders are characterized by impairments in personality functioning and pathological personality traits.
- The specific personality disorder diagnoses that can be derived from this model include antisocial, avoiding, borderline, narcissistic, obsessive – compulsive, and schizotypal personality disorders.
- This approach also includes a diagnosis of personality disorder – trait specified PD-TS that can be made when a personality disorder is considered present the criteria for specific disorder are not met.

Section III APD

- Impairment moderate or greater in; 1. Identity,2. Self-direction, 3. Empathy, 4. Intimacy
- And six more of the following seven pathological personality traits;
- Manipulativeness, Callousness
- Deceitfulness, Hostility
- Risk taking
- Impulsivity
- Irresponsibility

Not over yet

- One of the committee's most ambitious proposals was perhaps the least noticed: a commitment to update the book continually, when there's good reason to, rather than once every decade or so in a giant heave. That was approved without much fanfare.
- Mini Updates (5.1, 5.2, 5.3)
- Work in progress
- Computer versions-

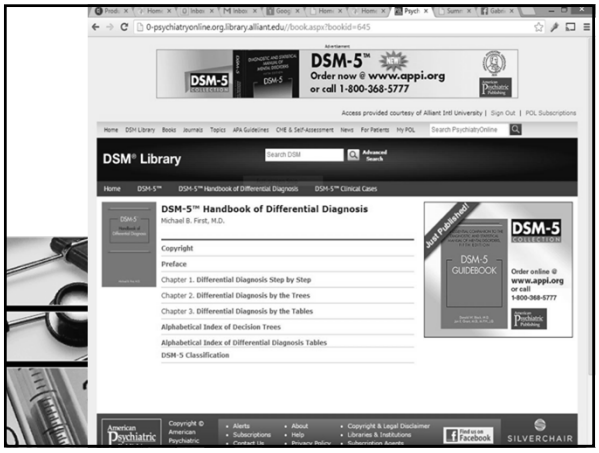


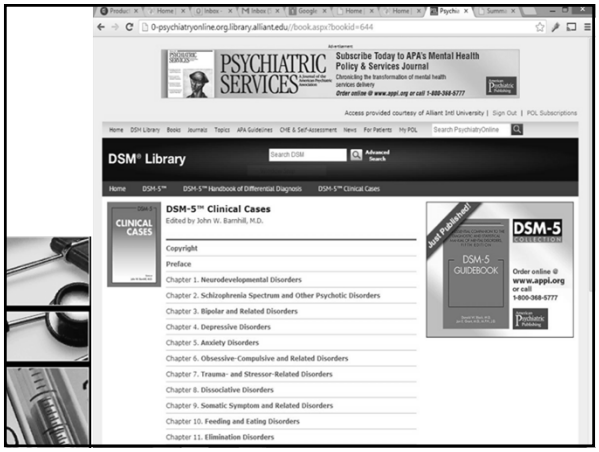
DSM-5™ Handbook of Differential Diagnosis

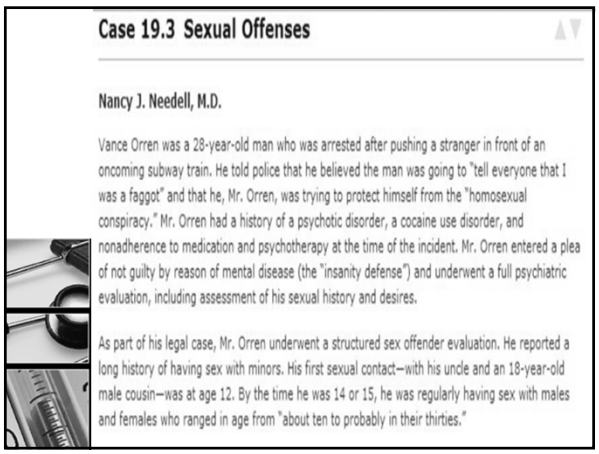
- Step 1: Rule Out Malingering and Factitious Disorder
- Step 2: Rule Out Substance Etiology (Including Drugs of Abuse, Medications)
- Step 3: Rule Out a Disorder Due to a General Medical Condition

Differential Diagnosis Step by Step

- Step 4: Determine the Specific Primary Disorder(s)
- Step 5: Differentiate Adjustment Disorders From the Residual Other Specified or Unspecified Disorders
- Step 6: Establish the Boundary With No Mental Disorder
- And Finally: Differential Diagnosis and Comorbidity







Case 19.3 Sexual Offenses

Nancy J. Needell, M.D.

Vance Orren was a 28-year-old man who was arrested after pushing a stranger in front of an oncoming subway train. He told police that he believed the man was going to "tell everyone that I was a faggot" and that he, Mr. Orren, was trying to protect himself from the "homosexual conspiracy." Mr. Orren had a history of a psychotic disorder, a cocaine use disorder, and nonadherence to medication and psychotherapy at the time of the incident. Mr. Orren entered a plea of not guilty by reason of mental disease (the "insanity defense") and underwent a full psychiatric evaluation, including assessment of his sexual history and desires.

As part of his legal case, Mr. Orren underwent a structured sex offender evaluation. He reported a long history of having sex with minors. His first sexual contact—with his uncle and an 18-year-old male cousin—was at age 12. By the time he was 14 or 15, he was regularly having sex with males and females who ranged in age from "about ten to probably in their thirties."

- Two conditions in DSM-5 are characterized by feigning: Malingering and Factitious Disorder.
- These two conditions are differentiated based on the motivation for the deception.
- When the motivation is the achievement of a clearly recognizable goal (e.g., insurance compensation, avoiding legal or military responsibilities, obtaining drugs), the patient is considered to be Malingering.
- When the deceptive behavior is present even in the absence of obvious external rewards, the diagnosis is Factitious Disorder.

ICD-10

Diagnostic Criteria **300.19 (F68.10)**

Factitious Disorder Imposed on Self

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.

B. The individual presents himself or herself to others as ill, impaired, or injured.

C. The deceptive behavior is evident even in the absence of obvious external rewards.

D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

Factitious Disorder Imposed on Another (Previously Factitious Disorder by Proxy)

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.

B. The individual presents another individual (victim) to others as ill, impaired, or injured.

C. The deceptive behavior is evident even in the absence of obvious external rewards.

D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Note: The perpetrator, not the victim, receives this diagnosis.

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

A Civil DSM-V Change

- Although the motivation for many individuals with Factitious Disorder is to assume the sick role, this criterion was dropped in DSM-5 because of the inherent difficulty in determining an individual's underlying motivation for his or her observed behavior.

Suspicion Raised for Malingering When

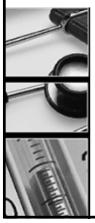
- When there are clear external incentives to the patient's being diagnosed with a psychiatric condition (e.g., disability determinations, forensic evaluations in criminal or civil cases, prison settings).
- When the patient presents with a cluster of psychiatric symptoms that conforms more to a lay perception of mental illness rather than to a recognized clinical entity.
- When the nature of the symptoms shifts radically from one clinical encounter to another.
- When the patient has a presentation that mimics that of a role model, or movie character (e.g., another patient on the unit, a mentally ill close family member).

Conditions for further study

- Attenuated Psychosis Syndrome
- Depressive episodes with short-duration hypomania
- Persistent complex bereavement disorder
- Caffeine use disorder
- Internet gaming disorder
- Neurobehavioral disorder due to prenatal alcohol exposure
- Suicidal behavior disorder
- Non-suicidal self-injury

Karl Menninger and the DSM

- Meaning
- Motivation and impulses
- Discontinuities
- Defenses
- Resources
- Relationship between thought and action
- Affect Management
- View of Self and Others
- Life challenges
- Protective factors



Thank You

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