An Introduction to ICD-11 Mental and Behavioural Disorders

Conference Questions and Answers – Tuesday 25 – Wednesday 26 May 2021

The following questions were asked during An Introduction to ICD-11 Mental and Behavioural Disorders held on Tuesday 25 and Wednesday 26 May 2021. Some of these and many others were answered by the speakers during the conference – please watch the relevant session to see these.

Please note: not all questions that were asked are included below. We hope to add to this document as further answers become available.

Tuesday 25 May	
General	
Why is the world still using both DSM and ICD? Wouldn't it make more sense to just stick to one system, globally?	Yes, but MAGA still rules. In an environment where there are no absolute answers and no gold standards there is a scientific advantage to diversity and debate.
Would the panellists like to say anything about the definition of mental disorder in ICD-11 given concerns about increasing rates of diagnosis of MD in the population?	The general definitions on all ICD and DSM systems are often forgotten. 'Mental, behavioural and neurodevelopmental disorders are syndromes characterised by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning.' Dysfunction is the key word here that is forgotten.
Is there a copy of the icd11 available online now?	You can view the ICD-11 coding guide and browser here: https://icd.who.int/en

Is there a better way to label this phenomenon rather than "disorder"...just like the term mental retardation has been phased out in Learning disability services. a lot of patients feel stigmatised by this diagnosis as it seems to be somehow shifting blame about this difficulties to them?	Important point, but difficult to change now.
How do you access ICD11 on "the website"?	You can view the ICD-11 coding guide and browser here: https://icd.who.int/en
Can we get these personality measures from internet?	The journal 'Personality and Mental Health' has most of them.
What is the likelihood of there being a single global classification system for mental disorders at some point in the future rather than the 2 system model (DSM and ICD) we've had for the past few decades with all the dilution of efforts, knowledge and resources the latter system entails? Or is the 2 system model still a useful way of thrashing out and fine tuning our understanding of what still remain complex and not fully understood conditions?	DSM and ICD are moving closer together and will merge eventually.
With the use of ICD 11, will IPDE be replaced too?	Yes, there is a new SCID on the way for ICD-11.
When will see a shift to classification taking into consideration evidence from neuroscience vs symptomatology alone?	Rdoc has unfortunately failed. Agree; RDoc was optimised for basic science and has poor translatability to clinical issues. It has set back clinical research extensively in those countries that adopted it.
If we diagnose almost half of the population with MH difficulties with additional personality	Not if we can help people with these problems, but please note that personality difficulty is not a diagnosed disorder.

difficulty, aren't we not only increasing stigma but also increasing pathologising?	
I am thinking about NICE guidelines - I am assuming they will be updated as well? Any idea by when these changes will finally come out?	NICE moves slowly and has not substantially changed since 2009.
Could you inform where would Complex PTSD and Anxious (avoidant) fit in here?	Complex PTSD has great overlap with personality disorder.
In NHS, lots of senior consultants are actively and proudly moving away from diagnosis in general - for various reasons. They do NOT use ICD categories at all, or make diagnosis based on their own opinion, not on ICD; trainees are taking same route. All in the name of 'patients do not read books, they cannot be given a label or cannot be boxed in a category'. Any thoughts?	This is the route of anti-science, stigma should not be tolerated but nor should it prevent progress.
Thank you. Will ICD 11 also have a "green" and "blue" book for clinical and research criteria?	We hope so.
Was wondering also about organic / cognitive disorders. Will these be covered at all on the programme?	Sorry, no, but these have changed less.
is there anything such as addiction to Social Media and anyone knows any resources/ self-help for patients?	Book coming out in College series on this.
Have the findings of the ICD-11 filed tests been published?	Yes, mainly by Bo Bach and Y-R Kim.

When will the ICD-11 green book (RDC) be published?	Unknown.
Where does the concept of at risk mental state sit in ICD11?	It is not included.
Are there any plans for the DSM5 to be revised to take account of the new ICD11 codes?	We hope so, but they go their own way.
Is Korsakoff psychosis the same or under different category under cognition and memory of ICD11?	It is now called the Wernicke-Korsakoff Syndrome.
Is there a time frame to stop using ICD10 and use ICD11?	This depends on individual countries.
Where is PTSD in ICD11?	In the same place as ICD-10.
In which section is somatoform disorder now in?	Bodily distress and hypochondriasis.
Why did the panel not take the opportunity to recognise conditions that span the obsessive/delusional boundary? For example, hypochondriasis/hypochondriacal delusional disorder, dysmorphophobia/body dysmorphic disorder, morbid/delusional jealousy. As it stands these people move from OCD to psychosis a back with insight/loss of insight.	Loss of insight is a sub-category in many of the new diagnoses. It is not a reason for changing the diagnosis.
Is Maladaptive Daydreaming included in ICD 11?	No.
What about adjustment disorder, acute stress reaction and PTSD? Where are they?	All in the stress disorder grouping.

Are we covering Bodily Distress Disorder? It seems that the ICD-10 section on somatoform presentations has been left out in ICD-11 - is that correct?	Bodily stress disorder included, a little more contentious than most.
Where are Dissociative disorders diagnosed?	Under the general category of Dissociative Disorders.
Are there any changes between ICD 10 and ICD 11 in diagnosing eating disorders specifically, it sounds like they have remained pretty much the same with no further additions unless I've missed something?	Not much change here - big worry is that sub-groups have little implication clinically as transdiagnostic interventions all effective.
Is part of the problem the ongoing use of the descartian mind body split?	Some people think so, others not.
Does having ICD for general population make sense?	It is needed as otherwise we polarise thinking.
Where does dissociative disorder sit in new ICD11?	Under the general category of Dissociative Disorders.
As ICD-11 framework covers the lifespan, one can presumably use sections Disruptive or Dissocial disorders and Neurodevelopmental disorders for people of all ages?	Yes you can.
Regarding disruptive and dissocial disorders, was there consideration of including them within the personality disorder category?	Yes, but child experts worried about early pd diagnosis.
Is there provision in icd11 to specify difficulties due to prenatal issues e.g. exposure to alcohol, or other toxins?	Not to our knowledge.

Any comment in ICD 11 about testing when mentally unwell or after many years of severe mental illness?	Not a purpose of a classification to decide on this.
ICD 11 have a section on Neurocognitive disorders, I wonder why this was not covered today or yesterday?	There was a lack of time in the programme to cover all areas.
Is there a possibility to diagnose pathological demand avoidance within the new ICD 11?	Only as a subgroup of avoidance behaviour.
When can we get hold of the ICD-11 book?	Not known but delay in ICD-11 partly related to simultaneous translation into 5 languages.
Are you going to release an app?	This is for the WHO to decide.
Was ICSD-3 (International Classification of Sleep Disorders) used to help with the ICD11 sleep disorders section?	Yes, a little.
Could American doctors be encouraged to use ICD, which allows for clinical judgement? Does the system of insurance companies limit them to DSM?	Yes.
Where does culture specific disorders fit in the ICD-11?	Not so obviously as in ICD-10 - limited to sub-grouping that are not diagnoses
What contributions were invited and obtained from Middle-eastern countries such as Syria and Iran where historically they made great contributions to mental health?	Every ICD-11 work group had a Middle Eastern group member.

Does the fact that there won't be a research version of ICD11 with specific diagnostic criteria lead to concerns about having to make a study-by-study decision on inclusion criteria?	Decision about research version not yet made.
Personality disorders	
Question	**Answer(s)**
While the revision of classification obviously very welcome given the stigma attached to the diagnosis and the observation that personality disorder has little to do with "personality" as generally understood, was any thought given to changing the terminology (e.g. relational-affective disorder)	This question was answered live – please view the recording.
Is there any validated rating scale to measure the severity of Personality disorders?	This question was answered live – please view the recording.
Can you comment on diagnosis in under 18 year olds?	This question was answered live – please view the recording.
What about dg PD in under 18s?	This question was answered live – please view the recording.
I wonder is there any comment on diagnosing personality disorders in under 18s e.g. the stability of it is a diagnosis.	This question was answered live – please view the recording.
Mood disorders	
Why has the ICD-10 moves away from symptom number to rate severity? Surely that a higher number of symptoms will result in increased severity. It feels more hit and miss with the current proposed rating of severity.	You are right to hint that symptom number and severity re strongly correlated. The shift to severity applies across all diagnoses.

ICD 10 guidelines include at least 2 out of 3 core features of depression, WITH at least 2 other features of depression - to diagnose depression. Has ICD 11 abolished this requirement?	Yes.
I'd welcome hearing views on the merit of the diagnosis of schizoaffective disorder vs severe bipolar disorder.	This question was answered live – please view the recording.
Is the ACE model similar to the RDoC project?	No, the ACE model is just for mood disorders and is not universal (see Bipolar Disorders, 2018 Nov; 20 Suppl 2:4-16).
In someone with a diagnosis of depression, I thought that if there is a manic episode, the diagnosis changes from depression to bipolar.	True.
Will ICD-11 break Bipolar Disorder into types?	Yes, Bipolar I and II, with option to add extras if wanted
Any differentiation between BAD and ADHD in people under the age of 18?	No.
The ICD 11 manic criteria says: "Individuals commonly exhibit rapid changes among different mood states (i.e. mood lability)." I have found the speed of change of emotional states a powerful differentiator between mania and emotional lability from a trauma history i.e. if the emotions rapidly move to and from extremes, then it is much less likely to be BPAD. Is ICD 11 changing this? Can you have BPAD if your mood state changes each week, week after week?	ICD-11 allows rapid cycling to be added as a qualifier to the bipolar diagnosis. Rapid and reactive shifts in mood are indeed more characteristic of those with trauma histories and borderline personality disorder, and sustained mood shifts of primary mood disorders.

Appreciate the BPAD talk. Agree fully with the arbitrary use of BP 1 and 2.	ICD-11 will allow Other as bipolar option.
Would you favour merging bipolar I and bipolar II diagnoses or defining BPAD more narrowly to exclude bipolar II?	Best looked at as a spectrum of bipolarity. The two categories of bipolar disorder do help in choosing treatments, with the prevention and management of mania key to BPI and depression in BPII. this implies different pharmacotherapy priorities, and as such this classification has clinical utility.
Is cyclothymia still an ICD-11 diagnosis?	Yes. Cyclothymic disorder is 'characterised by a persistent instability of mood over a period of at least 2 years, involving numerous periods of hypomanic (e.g., euphoria, irritability, or expansiveness, psychomotor activation) and depressive (e.g., feeling down, diminished interest in activities, fatigue) symptoms that are present during more of the time than not. The hypomanic symptomatology may or may not be sufficiently severe or prolonged to meet the full definitional requirements of a hypomanic episode (see Bipolar type II disorder), but there is no history of manic or mixed episodes (see Bipolar type I disorder). The depressive symptomatology has never been sufficiently severe or prolonged to meet the diagnostic requirements for a depressive episode (see Bipolar type II disorder). The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning' (ICD-11).
Does Flupentixol safe to use in Bipolar patients?	Yes. Usual tolerability issues notwithstanding.
Is work done by Akiskal valid and utilised by ICD-11? Has it been found relevant in treatment?	No, Hagop Akiskal is very good but he has extended bipolar to impossible lengths.
How you differentiate best psychotic depression or mania from schizoaffective disorder and are there any change in ICD11?	This question was answered live – please view the recording.

Would the new classification make it easier to distinguish between Rapid Cycling BAD and Personality Disorders?	Yes, as personality disorder is determined mainly by severity of long-standing traits.
Can rapid cycling in Unipolar/Recurrent Depression be a reliable concept without any evidence of hypomanic/manic symptoms?	Yes, but mainly classified as cyclothymic disorder.
Yes there are problems with the "Hypomania" concept- but in clinical practice we have a flood of "Google-using" patients approaching us with a few days (1-4) of increased energy, and a bit of "retail therapy" and perhaps irritability asking "Do I have Bipolar doctor?" and seeking treatment. Do the speakers advocate pharmacological treatment for these patients with very mild elevated mood for a few days?	No.
How does Schizoaffective Disorder fit into all this?	This question was answered live – please view the recording.
Ones ICD-11 also mention the concept of atypical depression?	No, it does not exist (except as mixed anxiety depression but not quite the same).
I'm still unclear whether or not bipolar II is in ICD 11.	This question was answered live – please view the recording.
I am a bit confused as to why Depression is being talked about as non-specific. Isn't the issue that it is too often diagnosed in people where there are other explanations for the mood and therefore misdiagnosed?	Main problem is comorbidity with lots of other disorders.

What will happen to cyclothymia and dysthymia in ICD 11?	Cyclothymic disorder is 'characterised by a persistent instability of mood over a period of at least 2 years, involving numerous periods of hypomanic (e.g., euphoria, irritability, or expansiveness, psychomotor activation) and depressive (e.g., feeling down, diminished interest in activities, fatigue) symptoms that are present during more of the time than not. The hypomanic symptomatology may or may not be sufficiently severe or prolonged to meet the full definitional requirements of a hypomanic episode (see Bipolar type II disorder), but there is no history of manic or mixed episodes (see Bipolar type I disorder). The depressive symptomatology has never been sufficiently severe or prolonged to meet the diagnostic requirements for a depressive episode (see Bipolar type II disorder). The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning' (ICD-11). Dysthymic disorder definition 'characterised by a persistent depressive mood (i.e., lasting 2 years or more), for most of the day, for more days than not. In children and adolescents depressed mood can manifest as pervasive irritability. The depressed mood is accompanied by additional symptoms such as markedly diminished interest or pleasure in activities, reduced concentration and attention or indecisiveness, low self-worth or excessive or inappropriate guilt, hopelessness about the future, disturbed sleep or increased sleep, diminished or increased appetite, or low energy or fatigue. During the first 2 years of the disorder, there has never been a 2-week period during which the number and duration of symptoms were sufficient to meet the diagnostic requirements for a Depressive Episode. There is no history of Manic, Mixed, or Hypomanic Episodes'.
How does ADHD with mood disorders in childhood and later conversations to bipolar/ ultra-rapid cycling etc and trajectories accounted for?	The diagnosis of bipolar disorder and cyclothymia can be made in childhood.
Where does cyclothymia fit within the classification?	Cyclothymic disorder is 'characterised by a persistent instability of mood over a period of at least 2 years, involving numerous periods of hypomanic (e.g., euphoria, irritability, or expansiveness, psychomotor activation) and depressive (e.g., feeling down, diminished interest in activities, fatigue) symptoms that are present during more of

	the time than not. The hypomanic symptomatology may or may not be sufficiently severe or prolonged to meet the full definitional requirements of a hypomanic episode (see Bipolar type II disorder), but there is no history of manic or mixed episodes (see Bipolar type I disorder). The depressive symptomatology has never been sufficiently severe or prolonged to meet the diagnostic requirements for a depressive episode (see Bipolar type II disorder). The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning' (ICD-11).
Is there any reason to suppose Bipolar and Borderline (affective instability) lie on a spectrum?	Not very good reasons - they could do but medication not valuable in borderline/emotional dysregulation.
Are you suggesting that we could be diagnosing short hypomanic episodes and do these according to the ICD-11 system count towards a Bipolar diagnosis or not?	They would most often be diagnosed as Bipolar II
Asking as a trainee, what would be the implications in clinical practice of this redefining of bipolar vs schizoaffective disorder, especially during a first encounter with a patient who does have cognitive, manic and psychotic symptoms?	An important and difficult question - best to keep options open until better knowledge of patient's progress.
Is there any link with CFS regarding mitochondrial function?	No. There is emerging evidence that this may be the case.
There is evidence that bip 1 is associated with postpartum relapse in a way that bip 2 isn't, is this likely to be due to severity of disorder?	No.
Clinically, if there is any clinical utility of the 1 and 2, it is minimal if existent.	The speakers would say minimal - a question of severity only.

How do you distinguish between BP II and Borderline?	Borderline reactive to events; BPII not.
So is BP 2 a category in ICD 11 or Not?	Yes, it is.
If depression is psychic pyrexia necessitating a return to formulation, does the diagnosis add anything, and might it impede holistic understanding if at a cultural level by the wider public it is conflated with biology.	Not useful in classification at present. Formulation is a way to contextualise a diagnosis in a personalised manner.
Can you please comment on the criteria for Cyclothymia in ICD 11?	Cyclothymic disorder is 'characterised by a persistent instability of mood over a period of at least 2 years, involving numerous periods of hypomanic (e.g., euphoria, irritability, or expansiveness, psychomotor activation) and depressive (e.g., feeling down, diminished interest in activities, fatigue) symptoms that are present during more of the time than not. The hypomanic symptomatology may or may not be sufficiently severe or prolonged to meet the full definitional requirements of a hypomanic episode (see Bipolar type II disorder), but there is no history of manic or mixed episodes (see Bipolar type I disorder). The depressive symptomatology has never been sufficiently severe or prolonged to meet the diagnostic requirements for a depressive episode (see Bipolar type II disorder). The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning' (ICD-11).
What about antidepressant induced hypomania/mania which is short lasting - is that coded separately in ICD 11?	No.
In ICD-11 , is there a sharp line of demarcation between drug induced mood problems and primary mood disorders?	No, there is overlap.

Has the new categories in mood disorders and PD helped us differentiate comorbidity between the two; e.g. negative affectivity PD vs BD rapid cycling?	We think so, but too early to say.
Do the same exclusion criteria apply? i.e. you can't make the diagnosis if alcohol or substance misuse are present and conflate the issue.	Decision needs to be made about which is primary.
You mentioned a dimension of 'cognition'. Is this a nod towards CBT or is it an acknowledgement of cognitive impairment in mood disorders?	It's a nod towards loss of executive function in mood disorders.
Should we be having mild moderate or severe mania Vs hypomania VS mania therefore one bipolar with severity dimensions?	Not yet, but may be in time.
Substance use disorders	
Do you need physical dependence?	Not for the diagnosis of Substance Dependence; it is part of physiological features which is one of the three key features. So the diagnosis of SD can be made with "impaired control" and "increased priority" present, without physiological features.
Can you capture laxative abuse as a substance dependence in cases of Anorexia bulimic type when the person appears addicted as opposite to being driven by drive to weight loss? How can you help distinguish?	Laxative abuse would be diagnosed in this situation as Harmful Pattern of Laxative use.
Does Craving not fall under "Strong Internal Drive" rather than "Impaired Control"? And therefore would still be needed for a dependency diagnosis?	Strong internal drive is manifested as the behaviours of impaired control and increased priority. Craving, as a cognitive experience, is an associated feature but not an obligatory one. There are also problems of social desirability bias with it.

How do you classify psychosis which occurs after several years of cannabis use?	Is the psychosis temporally related to the cannabis use (amount, frequency, duration)?
Does harmful use include social harms such as loosing job etc?	Social harms do not fulfil the diagnostic guidelines for either form of Harmful Substance Use and this is a longstanding ICD rule. However, a diagnosis of Substance Dependence can be made if substance use persists despite various forms of harm, including social harm. The reason for this is consistency of diagnosis across different countries and cultures.
Is instances of dangerous driving charges counted as harm to others?	If harm has occurred e.g. physical trauma or a diagnosable mental health disorder in the other person.
Consultant addiction psychiatrist here - thanks for informative talk so far - just looking for clarification on "harmful use of administration" - is this essentially all forms except oral? Is rectal or inhalation/insufflation "harmful"? Or conversely just IVDU?	This question was answered live – please view the recording.
What is the difference between 'episode of harmful use' and 'substance intoxication'?	You can diagnose both. Episode of Harmful Use would be diagnosed if there were clear physical or mental harm.
A young person using cannabis weekly with his friends would be considered hazardous substance use since he is increasing risk of harm, given that there is no evidence of actual harm?	This question was answered live – please view the recording.
Hazardous use - there are few substances that cannot cause harm (tobacco, alcohol, cannabis).	Yes. It depends on the amount epidemiological evidence linking the level, duration and frequency of use of the substance. Lot available for alcohol, nicotine/tobacco, some for cannabis (future anxiety, depression, suicidality).
I provide Medicolegal reports sometimes in Forensic settings. Can the ICD-11 Classification of	You could and would quote the definition on the ICD-11 Browser, which has been public information for a year.

Episode of Harmful Subs Use only be applied after January 2022?	
When does "drug induced psychosis" become severe and enduring psychosis in an ICD-11 context? As we know, a significant minority transition into longer-term illnesses, and many addiction psychiatrists pick up on this early but our general psychiatric colleagues may have other ideas!	Yes! ICD-11 does not specify an exact time, but after 6 months of psychotic symptoms (e.g. from alcohol, amphetamine), most have an ongoing chronic psychosis.
Can you please comment on how antidepressants are included with substances and how the same criteria of the 14 apply to antidepressants?	All four primary diagnoses can apply to antidepressants. It's up to the clinician to make the diagnosis of "other specified substance".
Is it likely to experience physiological features without some loss of control?	Yes, with prescribed medications in particular.
Do all 3 criteria (impaired control, increasing priority and harmful use) have to be present to make the diagnosis of substance dependence?	No, just two of the key features.
Psychotic disorders	
Should we also be assessing disorders of self as they appear to differentiate schizophrenia spectrum from other psychotic disorders?	These are not coded.
For schizophrenia, has the term salience dysregulation syndrome been discarded?	Yes.
If there are some disorders which now have WORSE diagnostic reliability in ICD-11 than ICD-	Small changes in agreement should not be regarded as sacrosanct; they could be chance findings.

10 (e.g. PTSD based on some slides), have the classifiers failed in their task?	
I work in a first episode psychosis service. How would you differentiate between a prolonged intoxication state and substance induced psychosis/ psychotic disorder? Many people get started on medication as soon as they are seen, does the use of medication change the way in which to differentiate them?	You have to wait a little to decide if the diagnosis.
Obviously it is so long, the delays in development of psychiatry in general, compared to other sciences, probably we are paddling in the wrong lake without biological markers. Until now we hear the confusion about the diagnosis.	May have to wait a little longer.
Having worked in India during my formative years, we used to see Catatonic Schizophrenia quite frequently.	Catatonia is a subsidiary diagnosis you can add to schizophrenia.
What counts as disorganised behaviour?	Unplanned, incoherent and purposeless behaviour
Is persistent delusional disorder still separate?	Yes.
Does the profile of psychotic disorders differ in children?	Not substantially.
This coding structure is too complex for day to day clinical use in busy clinics.	Can be shortened in practice.
So if we have a patient with schizophrenia with significant depressive symptoms that would otherwise meet criteria for moderate or severe	Comorbid depression I would judge.

depression, would we diagnose comorbid depression or just code it in the depressive symptom domain?	
In ICD 11 how do you differentiate Schizoaffective and Schizophrenia with Manic symptoms?	Not easy, if aspects equal use Schizoaffective.
How would you anticipate such complex code strings to be used? There will be a huge number of possibilities. Who will be able to synthesise such variations?	Not yet decided.
What is the advantage of coding partially resolved?	Allows further field testing.
ICD-11 refers to disorganised thinking but DSM-5 refers to disorganised speech. Why the difference?	ICD-11 allows the clinician to decide, not just the recording of speech.
Do the same exclusion criteria apply? i.e. you can't make the diagnosis if alcohol or substance misuse are present and conflate the issue	Yes.
Has very late onset schizophrenia-like psychosis (late paraphrenia) been addressed? Would this still be coded under schizophrenia?	Paraphrenia no longer listed, use schizophrenia.
Can bizarre delusions be diagnosed as delusional disorder if other features are consistent with that diagnosis?	Yes.
Functional impairment or not functional impairment for a diagnosis?	No, function a separate part of classification.

What in ICD 11 has happened to "post-schizophrenic depression"?	It is a category under schizophrenia unspecified.
Did you say that psychotic symptoms can appear in moderate depression (ICD10 says only severe)?	Yes.
Always found hebephrenia a useful category clinically, but it has been ditched, whereas other dubious diagnoses e.g. schizoaffective disorder retained?	Sorry, that's the position, hebephrenia out.
Sometimes inpatients have antipsychotics prescribed quickly and symptom resolution occurs. So would the month duration of symptoms for diagnosis of schizophrenia still be applicable?	Yes.
Can depression with psychotic symptoms now be classified as schizoaffective disorder?	Rarely, when prominent symptoms appear together.
If Schizophrenia no longer requires functional impairment will this be difficult when it is just delusional symptoms as if this is Schizophrenia or a delusional disorder?	No, the symptom structure and encapsulation of delusional disorder.
If it was one use of a substance causing psychosis then where will you classify it?	As a substance misuse psychosis (see John Saunders presentation).
I'm thinking of patients who've smoked it heavily for years, then with no particular change in usage, present with a psychosis.	Still substance misuse.
Is there any progress in differentiating depression and anxiety and if not what does this mean?	See presentation by Prof Chris Dowrick.

In First Episode Psychosis services we are discouraged from using a Schizophrenia diagnosis for the first episode. Will this mean that the Schizophrenia First Episode diagnosis is redundant in places with this ethos?	Yes.
What is the practical difference between schizoaffective disorder multiple episodes (e.g. a patient on maintenance treatment but relapsing over a year) vs schizoaffective disorder continuous (e.g. a patient who has not received treatment and had been symptomatic for a year or so)?	None.
Can I please clarify, to differentiate severe depression with psychotic features and schizoaffective disorder, the psychotic features should persist for at least a month, then it would transfer to schizoaffective. Is that right?	Yes.
How does one incorporate socio-cultural contexts into classifying substance use related and also psychotic disorders?	By good knowledge of the cultural context.
Why keep Schizotypal disorder?	Schizotypal disorder is characterised by an enduring pattern (i.e. characteristic of the person's functioning over a period of at least several years) of eccentricities in behaviour, appearance and speech, accompanied by cognitive and perceptual distortions, unusual beliefs, and discomfort with— and often reduced capacity for— interpersonal relationships.
What is happening to post psychotic depression in ICD 11?	As a form of unspecified schizophrenia.

What is the difference between Schizophrenia with the 'Manic Mood Symptoms' qualifier and Schizoaffective Disorder?	Not very much, if any.
Is a diagnosis of post-schizophrenic depression retained in ICD-11?	As a form of unspecified schizophrenia.
How is the post-psychotic / schizophrenic depression incorporated in ICD11?	As a form of unspecified schizophrenia.
What is the difference between psychotic depression and schizoaffective disorder? Can one meet criteria for both?	Only if psychotic symptoms not congruent with mood.
Patient who have a diagnosis of bipolar disorder who develop cognitive problems. People use SA in these patients- but is this correct?	No.
Do you happen to know the current evidence base for antipsychotic response in Schizotypal Disorder symptomatology?	Not relevant to classification.
Wednesday 26 May	
Anxiety and obsessional disorders	
Can the speaker explain distinction between expected and unexpected panic attacks please?	Expected is when the person knows the attack is more or less certain (e.g. an agoraphobic who gets panic attacks whenever going out of the house. Unexpected is when they occur out of the blue.
Does avoidance of crowds be considered agoraphobia?	Yes, when accompanied by anxiety as a reason for avoidance.
It is commonly seen in young people with ASD.	Yes, but many ASD patients not anxious.

It is said that agoraphobia starts off as fear of the crowded market place. How does this fit with seeing it as a fear of open spaces?	Not a good term, but fear of the market place was meant to include fear of the empty market place too.
Will we be able to diagnose Generalised Anxiety Disorder in presence of Schizophrenia even?	You can do, but it will be very minor.
Can you explain the rationale for changing "elective" mutism to "selective" mutism? Selective sounds broader.	Elective is actually broader than selective. Selective allows more control.
Can research now clearly differentiate anxiety and depression?	No.
Why mixed depressive and anxiety disorder rather than the other way round as in F41.2?	No good reason.
There seems to be a greater emphasis in ICD 11 on apprehension- but also on the patient's sense of humiliation and embarrassment. What is the special significance of this humiliation and embarrassment.	A lot of this comes from Japanese research showing humiliation and embarrassment are major reasons for avoidance in many cultural settings.
How can we tell the difference between body dysmorphic disorder and gender dysphoria?	Body Dysmorphic Disorder is characterised by persistent preoccupation with one or more perceived defects or flaws in appearance that are either unnoticeable or only slightly noticeable to others.
Biological studies of OCD do not need very large sample sizes comparing with other psychiatric studies? Do you agree?	No quite relevant to classification but generally true.
How will ICD-11 deal with skin picking disorder? I read that it will be a separate diagnosis.	Yes it is, entitled excoriation disorder, characterised by recurrent picking of one's own skin leading to skin lesions, accompanied by unsuccessful attempts to decrease or stop the behaviour. The most commonly picked sites are the face, arms and hands,

	but many individuals pick from multiple body sites. Skin picking may occur in brief episodes scattered throughout the day or in less frequent but more sustained periods.
How is Tourette's disorder coded in ICD-11?	Under 'primary tic disorders'. Tourette syndrome is a chronic tic disorder characterised by the presence of both chronic motor tics and vocal (phonic) tics, with onset during the developmental period. Motor and vocal tics are defined as sudden, rapid, non-rhythmic, and recurrent movements or vocalizations, respectively. In order to be diagnosed as Tourette syndrome, both motor and vocal tics must have been present for at least one year, although they may not manifest concurrently or consistently throughout the symptomatic course.
Do obsessions need to be 'unwanted' as per ICD-11? Where do we place ego-syntonic obsessions then?	These would be best classified as personality disorder within the anankastic domain.
Self-injurious behaviour in severe intellectual disability appears to run on a continuum from pleasurable self-stimulation (over-enthusiastically applied) to severe self-injury. Would this suggest therefore that SIB, because it can be seen to have a pleasurable component, should not be included in the OCRD group (as against the previous, all-embracing habit disorders)?	At the bottom of the scale - pleasurable self-stimulation is close to being non-diagnosed.
Is healthy anxiety disorder coded separately within hypochondriacal disorder as a subtype or is it considered to be the same condition?	Health anxiety is coded as 'hypochondriasis unspecified'. This is a mistake; it should be a separate disorder.
Neurobiologically, is BDD with absent insight different from delusional disorder?	No, body dysmorphic disorder with absent insight is a subgroup classified under BDD.
In the context of OCD, are we going to diagnose & treat their delusional belief as OCD?	Depends on how firmly they are believed.

Sorry I did not formulate my question. Is there any place of OCD pure O? Many patients have requested this diagnosis.	No, if you are asking if obsessional disorder is included as a diagnosis.
What is the diagnostic cut-off between olfactory reference disorder and delusional halitosis?	Very little difference. Olfactory Reference Disorder is characterised by persistent preoccupation with the belief that one is emitting a perceived foul or offensive body odour or breath and this is very similar to delusional halitosis, which is not an ICD-11 disorder.
There has been a debate about whether restrictive and repetitive behaviours in ASD form a separate entity to OCD. I had thought they were being seen as distinct, but this sounds like they may be less so from a neurodevelopmental perspective - can you clarify?	Best viewed as distinct.
What is your definition of psychosis?	In ICD-11 psychoses are 'characterised by significant impairments in reality testing and alterations in behaviour manifest in positive symptoms such as persistent delusions, persistent hallucinations, disorganised thinking (typically manifest as disorganised speech), grossly disorganised behaviour, and experiences of passivity and control, negative symptoms such as blunted or flat affect and avolition, and psychomotor disturbances.' This applies to all psychoses, including substance misuse disorders.
Are there not strong OCD relationships with Tourette's and Autism - Neurodevelopmental Disorders - so why is OCD not grouped with Neurodevelopmental Disorders?	Need not be neurodevelopmental.
Why is hypochondriasis grouped with OCD and related disorders?	It should not be, but there are strong obsessional components to health anxiety.

Temporary obsessionality is often seen in young children when they are stressed. will this be distinguished from OCD in ICD-11?	If temporary (and very common) do not diagnose.
At what point do you decide that a focal interest, expressed in collections, in ASD becomes a Hoarding Disorder - or would they be considered (very frequent) co-occurring disorders? (I've thought of hoarding as a symptom in ASD rather than a separate disorder and would have been inclined to avoid calling it a disorder per se).	May be co-occurring but many with hoarding disorder not ASD.
I like olfactory reference disorder being separated out because I think they are not suitable for early intervention in psychosis teams - do you agree?	Not a relevant reason for classification; it has long been a diagnosis with different terminology.
Not sure how to treat hoarding disorder?	Not relevant in a classification structure.
DSM differentiated health between health anxiety and symptom anxiety, would both fall under health anxiety in ICD-11? also, where do somatoform pain fall under ICD 11?	DSM was in error as bodily symptoms common in health anxiety too, but interpreted differently. Bodily distress disorder for somatic and pain problems.
If Hoarding Disorder is labelled as a mental disorder then there may be an expectation that such individuals be detained in hospital.	I'm not sure I understand the logic here. Specific phobia is a mental disorder, but we don't therefore detain people with specific phobia.
Do you think that neuroimaging at childhood OCD of any use?	Brain imaging remains a research tool. Of course there are clinical indications for scanning e.g. neurological deficits, very unusual symptoms, etc.
PTSD? Also, is so-called "Complex PTSD" in ICD-11 and, if so, in Anxiety and Fear-related Disorders or with Personality Disorders??	Please see the talk by Chris Brewin.

What's the position with Acute Stress Disorder?	Please see the talk by Chris Brewin.
are there any changes for f44 conversion disorder and / or PTSD?	Please see the talk by Chris Brewin.
Wondering why such a long period required before selective mutism can be used as a diagnosis?	I'm not sure it's such a very long period?
Are comorbidities across major diagnostic categories as OCRDs and Mood disorders permitted in ICD 11?	Absolutely.
Primary care	
Hi, in NI we have mental health practitioners based in GP practices who mostly appear to be triaging and referring (instead of / on behalf of the GP's). However in CAMHS we feel they are best placed to provide short term early intervention which may avoid the need for specialist intervention or offer service users some psychoeducation / guided help whilst they await specialist care - unfortunately this does not happen. I am interested to hear your views on this?	It is great if mental health practitioners can provide some psychoeducation etc, as well as offering triage and signposting.
SNOMED is embedded in our electronic patient record along with ICD but is just too time consuming to use, so I don't!	It's hard not to use SNOMED-CT if its embedded in the system, but I would encourage you to use ICD where possible.
SNOMED CT - What is your view on those who see SNOMED CT as an alternative diagnostic classification system? From your description it is	Yes you are correct, SNOMED CT is not a classification system despite having the appearance of being one!

merely a coding tool possibly better linked to insurance and costing for billing as opposed to a clinical diagnostic tool?	
In my experience GPs are fond of diagnosing 'Anxiety and depression', and starting an antidepressant, for most emotional difficulties/distress. It does medicalise unhappiness. GPs tend not to use ICD based diagnoses. Is this due to SNOMED-CT? Can use of ICD to diagnose be promoted amongst GPs?	I agree we need to encourage GPs to do adequate assessments and make diagnoses based on well-considered criteria, such as ICD or ICPC. This would most likely have the effect of reducing overall diagnostic rates and hence unnecessary medical interventions.
Can you repeat what you mentioned about orthorexia please? Is that in ICD-11 or SNOMED?	It's in SNOMED: it refers to 'an unhealthy obsession with healthy eating'.
Have the concepts of somatisation disorder and neurasthenia been lost in ICD 11?	They are not in proposals for ICD-11 PHC; I do not know is they appear in the main ICD-11 classifications.
My experience has been that the type of code is less important than their use - both knowledge of the system and how to code within it, and knowledge of the definitions behind it. As an example, errors in coding around intellectual disability seem to be common in primary care, and when we have looked into this it has been due to misunderstandings of what intellectual disability is, and (likely a UK only issue) a lack of understanding of the difference between "learning disability" and "specific learning difficulties". Everyone here is obviously keen to be up to date, but what about those who are not?	I agree!

I thought there was already a PHC version of ICD 10. is that correct? Was it used at all?	Yes there is an ICD-10 PHC, published many years ago. It was used a bit, but not as much as it could have been.
Should we be moving away from the distinction between mental and somatic disorders? Depression and Anxiety Disorders are experienced in the body and the mind, and similarly with “physical” illnesses.	I agree, hence my slides on the overlap between depression, anxiety and somatic symptoms. Descartes has a lot to answer for!
Do you think medically unexplained can be unsatisfactory as it relies on how many investigations are available and carried out and how good the doctor is at recognising the causes of symptoms?	It is complicated, you are right. That's why we suggest using the term medically unexplained symptoms as a 'working hypothesis' and not as a diagnosis: as an acknowledgement of uncertainty and a willingness to continue to discuss and review with the patient.
Are these symptoms really ‘medically unexplained’? If anything, it only seems to reflect the lack of medical knowledge on somatic pathology...	Sometimes that's true, it depends on the definition of the term - usually refers to 'physical symptoms not explained by known medical pathology'.
The SNOMED system explains the reasons why some of referrals from GPs have the old fashioned terms of reactive depression and endogenous depression.	Yes!
'Medically unexplained' is like dismissing the suffering of the patient and can be patronizing. There is nearly always an explanation, even if psychologically.	You are right, that is a risk with this terminology. However I suggest it is best used as a 'working hypothesis' rather than a diagnosis, as an acknowledgment of current uncertainty and a willingness to continue to discuss symptoms and problems with the patient, that is not usually seen as pejorative but rather as a genuine desire to work together to make things better.
Stress related disorders	

What about Complex PTSD? Is it included in the ICD-11?	Yes- see talk on stress-related disorders.
Is there an objective definition of stress?	No, this relies on clinical judgement.
Can NEW stressors (e.g. immigration uncertainty) prolong an adjustment disorder?	Not discussed in the CDDG but likely yes.
With that criteria of adjustment disorder in the ICD-11, if someone experiences a significant stressor, could it also not be seen as a normal reaction to the stressor?	The clinician should consider the length of the reaction and the presence of functional impairment.
Adjustment disorder - how to assess what is significant functional impairment? (This applies to other diagnoses too).	This reflects individual circumstances but must represent a considerable degree of impact or disruption on the person's life.
What if the underlying stressor does not resolve and is permanent, e.g. becoming paraplegic following a spinal cord injury. Does this mean the Adjustment Disorder would be a lifelong condition, if symptoms never meet threshold for any other psychiatric disorder? This would seem to run counter to the notion that these are time-limited disorders?	They are only time-limited if the stressor is time-limited. Hopefully treatment would resolve the condition.
How to differentiate prolonged grief from depression? We heard yesterday thar depression in ICD 11 doesn't exclude grief and judges by symptoms range, severity, etc.	See the CDDG section on PGD for differential diagnosis.
Why has Traumatic Grief has not been included as a category? This is different to Prolonged Grief.	If grief is accompanied by symptoms of PTSD this can be captured by using both diagnoses comorbidly.

Is 6 months too short for grief (especially if a child or spouse for example)? This seems a very brief period in which one is expected to adjust.	6 months is only a guideline (although evidence-based) and clinical judgement will be necessary.
Would low mood and poor functioning in response to sever pain fit into the diagnosis of adjustment disorder?	AD should be diagnosed in relation to an event or events rather than to other symptoms.
Many of my patients with learning disability suffer with prolonged grief, indeed they may show no signs of recognising a significant loss for over a year at times. Should I be making this diagnosis more often?	You can consider whether the diagnostic requirements for PGD fit. In the longer term alternative requirements might be needed for this group.
I am interested in the position on diagnosing depression in the grieving bereaved.	There is no barrier to diagnosing depression and PGD comorbidly.
Does that mean intrusive memories without that 'nowness' don't count?	They are common in many conditions and without the 'nowness' are not characteristic of PTSD.
One of the main issues with ICD-11 and DSM-5 is the drive to label everything (whether illness or not). Grief is a wholly normal process and has never conformed to constraints of time. We have now got a diagnostic label, because someone continues to experience grief beyond the "social, cultural or religious" expectation - who am I or anyone, for example, to tell a mother how long is normal to grieve for a lost child?	The existence of the diagnosis does not define what is 'normal'. The 6-month guideline merely suggests that the clinician should consider at that point whether the grieving process is stuck and whether the patient would benefit from help to allow it to continue normally.
Does ICD11 comment on whether event has to have been personally experienced (vs e.g. watching traumatic events on TV news)?	No, this relies on clinical judgement.

Can self-harm be a feature of complex PTSD?	Yes.
How can you differentiate between complex PTSD and a personality disorder?	See the CDDG section on PGD for differential diagnosis.
PTSD or borderline PD- How does one differentiate?	See the CDDG section on PGD for differential diagnosis.
How do you distinguish between complex PTSD and EUPD and PTSD?	See the CDDG section on PGD for differential diagnosis.
Is complex PTSD going to replace borderline personality disorder as a more acceptable and explanatory diagnosis?	No, they have different clinical presentations - See the CDDG section on Complex PTSD for differential diagnosis.
Can someone have complex PTSD and personality disorder? How does a clinician distinguish between the two?	See the CDDG section on PGD for differential diagnosis.
How would you differentiate between cPTSD and Personality Disorder?	See the CDDG section on PGD for differential diagnosis.
Can complex PTSD be diagnosed to children who have been exposed to adverse environment from early age? Does premorbid personality play a role in giving the diagnosis (arguably there is little in premorbid personality for children exposed to trauma from early life)?	Yes. Premorbid personality is not involved in the diagnosis.
Does the ICD11 explain the overlap between the symptoms Complex PTSD and Borderline Personality Disorder?	It is important to know that the 'borderline pattern specifier' in ICD-11 is not a diagnosis. It is a domain option if clinicians do not want to use the domain structure– negative affectivity, dissociality, detachment, disinhibition and anankastic. None of the personality disorder descriptions mention aetiology so if the clinician feels the disorder is a direct result of past trauma use Complex PTSD.

Is there a difference in the longitudinal expression of cPTSD and BPD disorders in young people with history of childhood adverse events?	There is no indication of the longitudinal course in either of the descriptions, but there can be a long period between the trauma and expression of disorder in Complex PTSD. The diagnosis of personality disorder can now be made at any age.
Why is complex PTSD not just a severity qualifier of PTSD? What qualifies it to be a separate diagnosis?	Empirical evidence based on techniques such as latent class analysis and latent profile analysis suggests they are separate disorders.
Does the panel have a view about whether the experience of e.g. sexual abuse in childhood or witnessing/experiencing domestic violence in childhood might be considered as horrific series of events - and does the panel have a view about comorbidity with EUPD?	Such events would qualify as traumatic exposure. Comorbidity of PTSD or complex PTSD with EUPD is possible
Will complex PTSD in ICD11 be an umbrella term for chronic (treatment resistant) PTSD, EUPD and F62? If not, what is the difference between these three conditions?	See the CDDG section on PGD for differential diagnosis.
Should we consider the affective dysregulation in patients after severe historical childhood trauma as consistent with Complex PTSD and do these need pharmacological treatment?	It could be consistent with a complex PTSD diagnosis if the other symptoms are present.
How to differentiate EUPD and complex PTSD?	See the CDDG section on PGD for differential diagnosis.
There is often an overlap between Borderline PD and CPTSD, and the two can co-exist. How can one distinguish one from the other? There are some Psychologists who are now over-diagnosing CPTSD when the diagnosis is very clearly Borderline PD.	See the CDDG section on PGD for differential diagnosis.

Clinically many patients with current ICD 10 Dx of Personality Disorder (EUPD in particular), would prefer to be diagnosed with Complex PTSD. Will this have any impact on the treatment they will receive (we know what is evidence based treatment for EUPD)?	Treatment for complex PTSD will normally include a specific trauma-focussed component to address intrusive memories and avoidance.
Is complex PTSD in adolescents considered the preliminary formulation which may then develop into Borderline personality disorder?	These are two distinct disorders with no pathway of this kind in mind.
Can complex PTSD diagnosis be used in children who have experienced extreme threatening behaviours and abuse from parent/ carers and happen in the first few years of life and is internalised in small children who may not be able to explain the symptoms accurately but show symptoms?	The diagnosis can be used in young children but other stress-related disorders of childhood should be considered.
How do we distinguish a complex PTSD from a personality disorder? Is it possible that it would become a preferred go to diagnosis that patients will seek because of the stigma associated with a PD diagnosis?	See the CDDG section on PGD for differential diagnosis.
Complex PTSD is often diagnosed in patients with Borderline PD.	See the CDDG section on PGD for differential diagnosis.
Are hallucinations included under complex PTSD? Also, If someone has excessive numbing and memory "gaps" is this also under C-PTSD?	They may be accompanying features but are not required for the diagnosis.

It was mentioned that PTSD could include bullying or stalking. This does not appear to be mentioned in the ICD 11 draft (in the course reading materials). Rather it states that the event must be of extremely threatening or horrific nature. Which is correct? Or both?	Clinicians can use their own judgement about whether the bullying or stalking constitute an extremely threatening event or series of events.
How is cPTSD be differentiated from Borderline Personality Disorder as this is a significant issue in the clinics and referrals?	See the CDDG section on PGD for differential diagnosis.
I don't think distinction between complex PTSD and borderline PD in clinical practice is as clear cut as often presented. Will new ICD 11 criteria for both complex PSTD and personality disorder likely lead to both being commonly diagnosed comorbidly?	This is certainly a possibility.
Ongoing difficulty in classifying those who seem to be responding to childhood abuse, but do not remember the abuse?	This is not addressed at present.
Can PTSD and complex PTSD be diagnosed together in an individual? Or are they mutually exclusive?	Mutually exclusive.
Where has the criteria of being "avoidant" of relationships come from? Most of the traumatised people I have met are not avoidant of relationships, surely having "unstable" relationships is a well-known consequence of being a victim of relational trauma because victims are often abused by multiple people?	The requirement is not avoidance but "Difficulties in sustaining relationships or feeling close to others".

The diagnosis of PTSD usually means the sufferer gets financial benefits. Do you think the ICD 11 definition will make it easier for the impartial psychiatrist as it is still highly dependent on the history?	It will probably have little impact on this.
Would you agree that repeated self-harm and suicide attempts are much more likely to be consistent with Borderline PD rather than CPTSD?	See the CDDG section on PGD for differential diagnosis.
Is there empirical evidence around 6 months cut off for prolonged grief?	Yes, the guideline is based on this evidence.
In theory, it may well be possible to differentially diagnose BPD?EUPD from CPTTSD. However, in clinical practice, BPD/EUPD will become a far more stigmatising; hence unacceptable diagnosis when CPTSD will become available.	It will be important to adhere to the diagnostic guidelines and resist a CPTSD diagnosis if this is not indicated.
Can PTSD like symptoms be seen in adjustment disorders? Alternately, if somebody has a difficult life event and develops PTSD symptoms after that, do we diagnose PTSD or adjustment disorder?	These symptoms can be seen in adjustment disorders. PTSD should not be diagnosed without an extremely threatening or horrific event(s).
Is there really not an overlap between CPTSD and borderline PD?	Overlaps may in some cases require both diagnoses to be used.
Do you think that some people might best be described as having PD and CPTSD and get more appropriate treatment, and also, for it to feel less stigmatising?	A comorbid diagnosis is likely to fit some patients well and hopefully will suggest more appropriate treatment.

Pre-trauma, flash forwards (rather than flashbacks)? How do we formulate future fear?	Imagining frightening situations is common in many psychiatric conditions so general guidelines are hard to give.
Can Complex PTSD and EUPD be co-diagnosed?	Yes.
Could Professor Brewin make a comment about the close relation between PTSD and Psychotic Symptoms?	Symptoms such as voice-hearing are common in complex PTSD and may be dissociative in origin. Paranoid ideas are also common and may be part of the ongoing sense of threat.
My experience in C&A inpatients is there is a mixture and overlap with CPTSD and EUPD - also there remains the reluctance to diagnose PD in under 18s and certainly under 16s. The key point though is how this affects treatment.	Diagnosing Complex PTSD would suggest the value of considering an additional trauma-focussed element to treatment.
Could the panel comment on complex PTSD and differentiation with borderline pd?	See the CDDG section on PGD for differential diagnosis.
Is there any space for the recognition of Dissociative Identity Disorders in the Complex PTSD?	Dissociative disorders remain a separate category of disorder that may be an alternative or comorbid diagnosis.
Child and adolescent disorders	
For the purpose of diagnosis/ICD-11, what is the developmental period? Is there a specific cut off time for diagnosing a developmental disorder?	This is the definition: Neurodevelopmental Disorders are behavioural and cognitive disorders arising during the **developmental period that involve significant difficulties in the acquisition and execution of specific intellectual, motor, language, or social functions. In this context, arising during the developmental period is typically considered to mean that these disorders have their onset prior to the age of 18**, regardless of the age at which the individual first comes to clinical attention. Although behavioural and cognitive deficits are present in many mental and behavioural disorders that can arise during the developmental period (e.g., Schizophrenia, Bipolar Disorder), only disorders whose core features are neurodevelopmental are included in this grouping

Why is ICD11 calling autism "ASD" and not Autistic Spectrum Condition?	Because the diagnosis requires not just the presence of the relevant features but in addition: "The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning".
Would that mean that without a cognitive assessment it would not be possible to code for ASD?	The cognitive assessment does not need to be a formal IQ test or cognitive assessment. If a person with ASD fails to show any clinically obvious developmental problems they would be diagnosed as having Autism without intellectual or language impairment.
Can selective mutism have an adult onset?	Interesting question. I think ICD 11 says that it can; this may be for the sake of completeness, to make sure that all disorders have a life span dimension: it is a quintessential child disorder; I have never seen it diagnosed in adults.
Could Professor Garralda comment between the comorbidity between ADHD and personality disorders?	This is what ICD 11 says on this topic in the **ADHD section: Boundary with Personality Disorder:** Individuals with Attention Deficit Hyperactivity Disorder often experience problems with psychosocial functioning and interpersonal relationships, including regulation of emotions and negative emotionality. If Attention Deficit Hyperactivity Disorder persists into adolescence and adulthood, it may be difficult to distinguish from Personality Disorder with prominent personality features of Disinhibition, which includes irresponsibility, impulsivity, distractibility, and recklessness; and Negative Emotionality, which refers to a habitual tendency to manifest a broad range of distressing emotions including anxiety, anger, self-loathing, irritability, and increased sensitivity to negative stimuli. The utility of assigning an additional diagnosis of Personality Disorder in situations where there is an established diagnosis of Attention Deficit Hyperactivity Disorder depends on the specific clinical situation.
ICD-11 approach to distributing child & adolescent disorders along with adult conditions supports including children in adult clinical trials. Was this the intent?	I do not think this was the intent. Generally speaking research with children and adolescents has quite different requirements and methodology to adult research.

What if a child has restrictive interests without social / communication difficulties? What diagnosis would they attract?	Restrictive interests that are not impairing are unlikely to lead to a diagnosis or consultation. A possible diagnosis otherwise could turn out to be OCD, if the relevant symptomatology is present.
Limited prosocial emotional qualifies = callous unemotional?	Yes, the research on callous/unemotional applies to the limited emotions qualifier. Limited prosocial is a kinder term.
What does prosocial emotion mean?	Defined in my slide: Lack of empathy & sensitivity to feelings of others, lack of remorse/shame/guilt, etc.
'Pragmatic language disorder' may not take account for cultural differences in social discourse. It may simply be secondary to a low IQ or poor socialisation. Should this really be pathologised? What would be the clinical utility of this?	Pragmatic difficulties are a qualifier in people with language developmental disorder: this implies impairment caused by the language difficulties leading to significant limitations in communication and functional impact in daily life at home, school, or work. It should take context and cultural differences into account as follows: **"Regional, social, or cultural/ethnic language variations (e.g., dialects) must be considered** when an individual is being assessed for language abilities. A language history documenting all the languages the child has been exposed to since birth can assist in determining whether individual language variations are better explained by exposure multiple languages rather than a speech or language pathology per se".
In ICD11, how are comorbid ADHD and ASD diagnosed?	When the essential features (carefully described in ICD 11) of the two disorders are present in one individual.
Also what about Pathological Demand Avoidance along with ASD?	PDS is no recognised as valid separate category. In a child with autism it may well be an expression of the autistic difficulties, or of co-morbid ODD or anxiety disorders.
What sort of treatment for limited prosocial emotions?	Treatments for ODD and CD such as parenting interventions (incorporating emotional recognition training) or parenting training, behavioural therapy augmented if appropriate with stimulants; multimodal psychosocial interventions; CBT.
Isn't the concept of limited prosocial emotions the equivalent of Asperger's "autistic psychopathy"?	In ICD 11 this is a qualifier of the Disruptive and Dissocial disorders. This means that it would only be ascribed in the presence of ADD or Conduct Disorder as primary diagnoses.

How do you differentiate between limited prosocial emotions vs lack of empathy as a part of social/communication difficulties in ASD?	The main differentiation is inherent in the main diagnostic categories. Limited emotions is a qualifier of conduct disorder. If a person with autism also has a conduct disorder, clinicians will decide whether to add the limited emotions qualifier or whether to regard the anomalies as related to the autistic deficits. A common view is that in autism - unlike in CD - the lack of "caring" comes from lack of understanding social relationships.
How would you conceive/classify problem behaviours (e.g. aggression to persons and property) that are commonly experienced forms of distress in children and adults with disorders of intellectual development, but really don't fit into the descriptions of ODD or CDD?	If the difficulties are a response to frustration related to intellectual deficits and do not fit in with the main diagnostic criteria for of ODD or CD, I would regard them as an expression of their learning disability and would consider whether their special needs are being adequately met.
Why ASD was excluded from persistent disorders?	ASD was also a Developmental Disorder in ICD 10.
Were there any changes in ICD-11 to attachment disorders?	They have been moved from Disorders specific to childhood to Disorders related to Stress. I am not sure it is a good home for them.
Challenge of diagnosing developmental disorders late in life is often absence of reliable lifespan history.	I agree, but the lifespan approach might help clinicians explore development in a more focused way than has been the case so far.
Do we need IQ test?	Not for diagnosis. They can help, but ICD 11 provides helpful tables to assess developmental levels.
Time of onset of symptoms for a neurodevelopmental disorder. Why has DID gone for approximately 16, while ADHD has selected a clear cut 12 years as a cut-off?	The 18-year cut-off applies to the definition of the developmental period in relation to neurodevelopmental disorders in general. The ADHD cut-off applies only to this specific neurodevelopmental disorder and reflects the fact that ADHD is normally diagnosed by the relevant cut-off age.

British Psychological Society guidelines slightly different for adaptive functioning- 2 SD below mean in General adaptive functioning or conceptual/social/practical domain. Also before 18. This definition is tighter?	There was considerable discussion about this. The definition chosen was thought to be the most applicable and useful in terms of clinical utility across different countries.
If brain injury/tumour occur before age 16 affecting learning and development, would there need to be a qualifier to diagnose a disorder of intellectual development?	This is what ICD 11 says: **Boundary with Secondary Neurodevelopmental Syndrome**: If the diagnostic requirements of a Disorder of Intellectual Development are met and the symptoms are attributed to medical conditions with onset during the prenatal or developmental period, both Disorder of Intellectual Development and the underlying medical conditions should be diagnosed. If the diagnostic requirements of a Disorder of Intellectual Development are not met (e.g., limitations in intellectual functioning without limitations in adaptive functioning) and the symptoms are attributed to medical conditions with onset during the prenatal or developmental period, a diagnosis of Secondary Neurodevelopmental Syndrome should be assigned, together with the diagnosis corresponding to the underlying medical condition.
Is the suggestion is to bundle out difficult to transition in CAMHS under the diagnosis of Autism and ADHD?	Do you mean that adult services will not accept young people with these diagnoses? The change in terminology from Pervasive Developmental Disorders and Hyperkinetic disorder should not in itself further impede transition to AMS. It is unfortunately still the case that a number of adult services are not geared at managing adult ASD and ADHD. I may be too optimistic here, but I understand this is slowly changing for the better.
What is opinion around pathological demand avoidance please?	PDS is not recognised as a valid separate category. In a child with autism it may well be an expression of the autistic difficulties, or of co-morbid ODD or anxiety disorders. In children without autism it is also likely to reflect alternative psychopathology, such oppositional defiant disorders, or possible some anxiety disorders.
Intellectual disability disorders	
Would it be disorder of Intellectual development if there is a decline in intellect and adaptive functions at age 14 years due to brain	No, not an intellectual **developmental** disorder - an organic one. 6E.60 Neurodevelopmental syndrome due to health condition not classified under mental and behavioural disorders.

tumour/acquired brain injury when there was normal development prior to this?	Yes, as the tumour/injury occurred during the “developmental phase” (that is, in childhood, before development was completed). Additionally, the cause of the disorder of intellectual disorder should be classified e.g. NA07.Z intracranial injury, unspecified.
Some concern that the level of intellectual disability can ‘alter’ depending on supports - this may well impact people with lower IQ’s and severe mental illness.	Diagnosis need not be fixed. An example is a child with mild disorder of intellectual development who requires support for learning at school, but who gradually acquires skills and by adult age can live without support, and so no longer meets the required criteria of “significant limitations in adaptive behaviour”, and therefore is no longer classed as having a disorder of intellectual development. However, the criteria are explicit that where the limitations in intellectual functioning and adaptive behaviour are better accounted for by another mental or behavioural disorder, than a disorder of intellectual development should not be diagnosed. This requires clinical judgement. The determination of level of severity depends on both adaptive behaviour and intellectual functioning. This differs from DSM, which is entirely based on adaptive behaviour functioning at the time of assessment. Because ICD-11 considers intellectual functioning, it is anticipated that the level of severity will be more stable than in DSM-5. There is also guidance on determining level of severity according to the goals of the assessment as well as a caveat that level of functioning does vary across the lifespan and any single assessment should not be considered a final determination of level of severity.
By discarding borderline intellectual disability aren't we in danger of excluding a significant group from access to services that could help improve their functional impairments?	Important point that should not be ignored by services. Borderline intellectual disability is not a disorder. Borderline intellectual disability was not included in ICD-10, so has not been discarded. ICD-11 does state when considering boundaries with normality: “What is sometimes termed ‘borderline intellectual functioning’, defined as intellectual functioning between approximately 1 and 2 standard deviations below the mean, is not a diagnosable disorder. Nonetheless, such individuals may present many needs

	for supports and interventions that are similar to those of persons with disorders of intellectual development.”
Did the group think about significant and severe DID based on 2 and 3 SD below mean rather than the 4 categories?	Cannot answer this but question important. ICD-11 considers the IQ range for mild DID to be 2-3 standard deviations, moderate DID to be 3-4 standard deviations, severe DID and profound DID to be more than 4 standard deviations from the mean with the distinction between severe and profound based on extent of impairment of adaptive functioning (due to the limitations in IQ testing at this range). This is similar to ICD-10 in which the actual IQ ranges are provided, range than referring to standard deviations from the mean.
Considering intellectual difficulties as a diagnosis for adult patients that difficult to co-operate in assessments?	Need for further assessments here, not enough on own. There is a provisional specifier that can be used.
would the behaviour indicator table help us dispense the IQ test?	No, still necessary – intellectual function testing should be undertaken “wherever possible”, and in the UK there are services available to make this possible. In countries where the use of standardized tests is not possible there should be further clinical assessments with a greater reliance on clinical judgement based on assessment. Standardized, normed instruments are considered the gold standard. The purpose of the BI tables is not to replace the IQ test but rather to provide an alternative when these tests are not available or not appropriate to be administered (e.g., no norms for a particular population).
Whether someone is diagnosed with mild, moderate of severe disorder of ID, can depend on their experiences, resources available to support them, learning opportunities before diagnosis. So a 'moderate' ID could potentially have been 'mild'. Does the diagnostic assessment take this in account?	Yes. There is always the possibility of readjusting the diagnosis. People with disorders of intellectual development continue to learn over the years, and a child with mild disorder of intellectual development could become an adult without this disorder if they no longer have limitations in adaptive functioning. Education and support can improve longer term outcomes. Yes. The determination of level of severity depends on both adaptive behaviour and intellectual functioning at the time of assessment.

Following the above question I assume having the provisional LD diagnosis is helpful until getting the IQ assessment or this diagnosis should be removed if no progress to assessment after certain period of time?	Yes, the category is for infants and children under the age of 4 in whom a disorder of intellectual development is suspected, but a valid assessment cannot yet be completed especially in the presence of other medical conditions or impairments. Yes. Used when but the individual is an infant or child under the age of four, making it difficult to ascertain whether the observed impairments represent a transient delay or it is not possible to conduct a valid assessment of intellectual functioning and adaptive behaviour because of sensory or physical impairments (e.g., blindness, pre-lingual deafness), motor or communication impairments, severe problem behaviours, or symptoms of another mental disorder.
There is the DM-ID book on adapting the DSM-5 diagnostic criteria for people with intellectual disabilities, which goes through disorder by disorder reviewing the research and giving guidance. Is there any plan to do something similar with ICD-11?	Yes there is. It is currently in development while awaiting more data. Not that I am aware of. However, there is guidance in the Neurodevelopmental Disorders grouping on general considerations for making mental disorder diagnoses in individuals with DID.
What evidence is there is using psychotropic medication in managing challenging behaviours in people with disorders of ID who do not have a mental illness?	This is not a purpose of classification. You may wish to look at the “STOMP” campaign for more information, or the NICE guideline on intellectual disabilities and behaviour that challenges. This questions seems out of scope with the presentation but I refer the person to a the following chapter in the Oxford Textbook of Psychiatry: Chapter 24, Ayuso-Mateos, J-L and Kogan, C.S., p 231.
You mention that problem behaviours are commonly experienced by people with intellectual disabilities (they are the most common reason for health contact of all disorders including physical disorders in this population), but that the ICD10 "with behaviour impairment" qualifier has been dropped from	This is a very important point and is likely to be addressed in the new book. At present they are coded outside the main classification: QE27 Problem with behaviours related to psychological health or wellbeing. There are other codes in the ICD-11 that can be used when appropriate. For example in 21 Symptoms, signs or clinical findings, not elsewhere classified, one can use MB23.0 Aggressive Behaviour. In Neurodevelopmental Disorder there is a category of 6A06.1 Stereotyped movement disorder with self-injury may also be relevant.

ICD11. How should these disorders/health care contacts be coded in ICD-11?	
Would behaviours that occur secondary to say metabolic disorders e.g. Lesch- Nyhan be classified as "stereotyped disorders" with disorders of intellectual development?	No, under organic. Classify both the disorder of intellectual development, and also classify the cause of it e.g. Lesch-Nyhan syndrome (5C55.01 in the metabolic disorder section of ICD-11). There are also options to additionally code chorea and/or dystonia in Lesch-Nyhan syndrome, and if it seems the best fit for a clinically significant problem in the syndrome, additionally code stereotyped movement disorder with self-injury. No, this would be coded as 6E.60 Neurodevelopmental syndrome due to health condition not classified under mental and behavioural disorders.
How does the new coding map to the use of the mental health act for intellectual disability?	To the best of my knowledge this has not been addressed yet. I expect it will be in due course. ICD-11 is designed for international use, it is not tied to English or Scottish legal definitions in mental health/capacity legislation.
If DID is the new term now, time for yet another RCPsych Faculty name change then?	To Faculty of Disorders of Intellectual Development? Again I expect this will be considered by the Faculty in due course, probably dependent upon whether the term passes into common usage in the UK or not.
Will IQ tests still be used in diagnosis?	Yes.
How do we know that "medically unexplained symptoms" are absolutely not acceptable to patients?	We don't.