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Learning objectives for this issue:

1. Describe how *DSM-5* approaches diagnostic comorbidity. **2.** Explain how the diagnosis of PTSD differs in *DSM-5* and *DSM-IV.* **3.** Recount some criticisms of *DSM-5.* **4.** Understand some of the current findings in the literature regarding psychiatric treatment.

Diagnostic Comorbidity in DSM-5: More of the Same

David A. Frenz, MD, Medical Director, Addiction Medicine, HealthEast Care System
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Dr. Frenz has disclosed that he has no relevant relationships or financial interests in any commercial company related to this educational activity.

The epidemic of psychiatric comorbidity has been a problem since *DSM-III* appeared way back in 1980. Not much has been done to improve this area in the subsequent editions of the manual. Nonetheless, in this article we'll explore psychiatric comorbidity in *DSM-5:* its origins, current status, and potential solutions for the next go-around.

Comorbidity is the concept that individuals can have more than one distinct disease. Shortly after epidemiologist Alvan Feinstein began exploring the concept of *comorbidity* in internal medicine in the 70s, the idea found fertile ground

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In Summary

- National Comorbidity Survey has found a 48% lifetime prevalence of mental illness; among these, 27% have more than one illness. But is this comorbidity just a diagnostic artifact?
- *DSM-5* does little to address issues with diagnostic comorbidy
- Dimensional solutions to artifactual comorbidity could include looking at connections between closely related mental disorders and/or viewing symptoms on a continuum instead of in a yes/no way

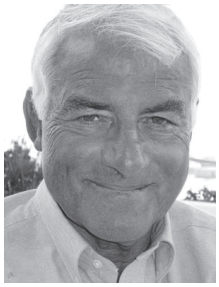
Q&A With the Expert

The Problem with Child Psychiatry in *DSM-5*
Allen Frances, MD

Chair, DSM-IV Task Force
Professor Emeritus
Duke University School of Medicine

Dr Frances has disclosed that he receives book royalties from HarperCollins Publishing and the Guilford Press. Dr. Fisher has reviewed this interview and found no evidence of bias in this educational activity.

CCPR: Dr. Frances, please tell us about your background with DSM.
Dr. Frances: I am a psychiatrist. I was chair of the *DSM-IV* task force. I have been quite critical of *DSM-5* and concerned about the fact that too many people in the United States are already getting diagnoses and medicine they don't need. I am worried that *DSM-5* will make that worse.



CCPR: What makes you think that *DSM-5* will make that worse?
Dr. Frances: There are a number of new diagnoses that will capture millions of people, and existing diagnoses like ADHD have been watered down, so it will be a lot easier for people to get the diagnosis. Twenty-five percent of the American public currently would quality for a mental disorder diagnosis (Reeves WC et al, *Morbidity and Mortality Weekly Report* 2011:60(03);1–32) and 20 percent are taking psychotropic medications (Medco Health Solutions, *America's State of Mind Report* 2011: http://bit.ly/17VyHqK). An amazing Canadian study of a million kids showed that the best predictor

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Diagnostic Comorbidity in DSM-5: More of the Same
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in psychiatry. Some authorities, however, think the jump from general medicine to psychiatry was a huge mistake. Scott Lilienfeld and collaborators stated that "the application of the term and concept of comorbidity to psychopathological syndromes is almost invariably misleading and arguably has led to more confusion than clarification" (Lilienfield SO et al, *Clin Psychol Sci Pract* 1994;1(1):71–83).

Prevalence

Prevalence data concerning mental illness and comorbidity come from the National Comorbidity Survey (NCS), a study that begin in 1990. Household surveys of representative samples of the US population have been conducted at intervals using structured clinical interviews and reported over the years.

The first wave of data demonstrated a 48% lifetime prevalence of mental illness with a roughly equal rate for both men and women (Kessler RC et al, *Arch Gen Psychiatry* 1994;51(1);8–19). The corresponding 12-month prevalence was about 30%. Major Depressive Disorder (MDD) was most common (17% lifetime prevalence), followed by social phobia (13%) and alcohol dependence (14%).

A second round of the study found that of patients with any mental disorder, 21% had just one diagnosis, 13% had two diagnoses and 14% had three or more diagnoses on a lifetime basis. The 12-month prevalence rates were in the same ballpark. A replication survey was conducted starting in 2001 and found similar numbers (Kessler RC et al, *Arch Gen Psychiatry* 2005;62(6):593–602; Kessler RC et al, *Arch Gen Psychiatry* 2005;62(6):617–627).

These data likely underestimated the true prevalence of mental illness. People who were homeless and institutionalized were excluded from the study, and primary psychotic disorders and most personality disorders were not assessed.

Causes of the Controversy

A moment of sober reflection raises a question: Our patients are ill, to be sure, but can they really be *that* ill? We know patients can have tremendous symptom burdens, which would lead one to say, "Yes." But do they have multiple illnesses? Perhaps not.

Michael First, editor of *DSM-IV,* observed "in psychiatry, cases of *true comorbidity* are relatively rare since, for most disorders, we do not know enough about the underlying pathophysiology to be able to determine whether the disorders are truly clinically distinct" (First MB, *Psychopathology* 2005(4);38:206–210).

Other authors have offered various explanations for apparent comorbidity (Dell'Osso L and Pini S, *Clin Pract Epidemiol Ment Health* 2012;8:180–184). The primary causes are artifacts of DSM's categorical structure involving hundreds of criteria sets. For example, patients with MDD often meet criteria for generalized anxiety disorder (GAD). When one parses symptoms, however, dysregulated sleep, fatigue, and cognitive problems are common to both criteria sets. Instead of two mental disorders, maybe we are really dealing with just one underlying illness with various manifestations.

Dimensional Solutions

Various DSM luminaries have pointed out that psychiatry wasn't always so confused (Pincus HA et al, *World Psychiatry* 2004;3(1):18–23). Previously, clinicians were more parsimonious and employed a "one disease, one diagnosis" model to describe patient presentations. This lumping was achieved through the use of various "qualifying phrases" to capture all of the texture.

A dimensional approach to diagnosis, which is a sophisticated throwback to this earlier era, has been proposed as a possible solution to artifactual comorbidity (Goldberg D, *Br J Psychiatry Suppl* 1996;30:44). This involves looking carefully at the connections between various mental disorders that seem to be closely related, such as affective and anxious symptoms. Other dimensional solutions view symptoms on a continuum—for example, the degree or severity of anhedonia—rather than the current yes/no criteria involving clinical thresholds (eg, "most of the day, nearly every day").

There is considerable empirical support for lumping mental disorders together. Robert Krueger, using NCS data, derived a three-factor model that organizes mental disorders into broad themes or patterns: internalizing problems and externalizing problems (Krueger RF, *Arch Gen Psychiatry* 1999;56(10):921–926). The former is further divided into two groups: anxious-misery and fear.

Using this approach, DSM categories cluster together. MDD, dysthymic disorder, and GAD become related forms of anxious-misery; panic disorder, agoraphobia, and various phobias represent fear; and addiction and antisocial personality disorder are lumped into externalizing problems.

DSM-5 strongly considered some dimensional solutions. One involved mixed anxiety/depression (MAD), which is already recognized by the World Health Organization's International Classification of Diseases and was buried at the back of *DSM-IV-TR* for further study. Ultimately,

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however, MAD was torpedoed and does not appear in *DSM-5*.

Another dimensional solution involved completely retooling personality disorders (PDs). Some of this was driven by studies that demonstrated that patients often meet criteria for multiple PDs (Torgersen S et al, *Arch Gen Psychiatry* 2001;58(6):590–596), which is a little hard to wrap your mind around using categorical constructs.

The model that *DSM-5* floated involved two components: personality functioning and pathological personality traits (*Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition. Arlington, VA: American Psychiatric Association, 2013, p. 761–781). Personality functioning was further divided into an assessment of identity, self-direction, empathy and intimacy, all of which were rated on scales from 0 (little or no impairment) to 4 (extreme impairment). Patients with at least moderate impairment in personality functioning were diagnosed with a personality disorder if they also had pathological personality traits.

Like MAD, this proposal didn't make the final cut. It has, however, been retained toward the back of *DSM-5* as an "alternative model" that might be ready for prime time in the future.

CCPR'S VERDICT

DSM-5 does little to resolve our issues with diagnostic comorbidity. It remains narrowly categorical and took a pass on some attempts at dimensional constructs. But that doesn't mean we should limit ourselves. Get creative and start adding some texture to your diagnoses (eg, generalized anxiety disorder, moderate, improved). This will better describe the nuances of each patient and improve communication with other clinicians. Plus, just because the DSM categories don't fit our patients, doesn't mean we have to use *just* those. Dust off the descriptors and dimensions. We don't have to limit our formulations to insurance reimbursed diagnostic coding for anything other than the bill.

Expert Interview

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of ADHD was whether a child was born in December or January, especially for boys. There is almost twice the rate of ADHD in the youngest kid in the class as opposed to the oldest kid in the class (Morrow RL et al, *CMAJ* 2012;184(7):755–762). Immature kids are being diagnosed with ADHD and often treated with medication. Twenty percent of high school boys in America get the diagnosis of ADHD and 10 percent of high school boys are on medication (Centers for Disease Control and Prevention, 2011–2012 National Survey on Children's' Health; http://1.usa.gov/Mb5D9L). This is ridiculous.

CCPR: One of your criticisms of *DSM-5* is that the diagnoses don't necessarily predict a clear prognosis or treatment approach.

Dr. Frances: My point regarding *DSM-5* is that you don't suddenly say that 10 million people have a mental disorder unless you know a lot more, unless you have evidence that that diagnosis is going to be useful. In *DSM-5,* diagnoses have been accepted on descriptive grounds. But this is not enough. We shouldn't be adding diagnoses unless we know what the consequences are. The experience of the past is that every time we add a diagnosis it tends to be misused. And in this instance, the most likely misuse will be that people will begin treating it; the drug industry will be involved, and way before we know whether a medication is helpful, people are on medication. In 35 years of working with experts on diagnosis, I have never met one who said, "My area needs to be reduced." Every expert wants to increase the purview; they always worry about missed patients; and they overvalue the research in their area, and their own research, so the system gets burdened with new diagnoses that are largely untested, just at the very beginning of understanding of whether they are useful or not, and then the unintended consequences come in.

CCPR: For example?

Dr. Frances: We have had a tripling in the last 20 years in ADHD (CDC op. cit) and a 40 times increase in autism since *DSM-IV* (CDC autism data, http://1.usa.gov/Gi1Nx). We have had a 40 times increase in childhood bipolar disorder (Moreno C et al, *Arch Gen Psychiatry* 2007;64(9):1032–1039)—even though we rejected the concept of childhood bipolar disorder in *DSM-IV*—because drug companies and thought leaders trumpet it and convince people that this is a phenomenon. A 40 times increase and a tremendous increase in the use of inappropriate antipsychotics in children. So the diagnostic system has to be protected. We shouldn't be adding or changing diagnoses unless we know the consequences, and the one thing we have learned from past experience is that a likely consequence of any change is a lot of misdiagnosis and a lot of excessive treatment.

CCPR: You say in your book, *Saving Normal,* "Child psychiatrists often dare to go where no one has gone before and children wind up paying the price. They keep inventing new ways to wildly overdiagnose psychiatric illness in kids."

In Defense of Child Psychiatry: A Note from the Editors

We, the editorial board, do not feel that Dr. Frances's assessment of child psychiatrists or child psychiatric practice is entirely correct. Inappropriate and excessive use of medication is a real concern, however, and the solution is, in our view, two-fold.

First, because primary care physicians—many of whom had just six weeks of psychiatry training in medical school—prescribe 80+% of the psych meds to kids in the US, education for primary care and pediatric clinicians is crucial, as is education on psychotherapy and other non-psychopharmacologic treatments for training child psychiatrists.

Second, we must improve access to care and break down the barriers (financial and administrative) that keep our patients from the high-quality services that they need, at home, at school, and in the community. Child psychiatrists can be at the forefront of these changes through advocacy and education, both in our local communities and around the world.

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PTSD in DSM-5

Alysia Cirona Singh, MD
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Dr. Cirona Singh has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

"The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma." Judith Lewis Herman, MD, Trauma and Recovery

Unfortunately, children are exposed to traumatic events—isolated ones such as natural disasters or serious accidents, and recurring traumas such as domestic violence and sexual abuse. However, throughout history, most people didn't believe that children experienced lasting psychic trauma as a result of these events. It wasn't until the publication of *DSM-III-R* in 1987 that we recognized in a formal way that some children go on to develop post-traumatic stress disorder (PTSD). Here, we will review the changes to the diagnosis of PTSD in *DSM-5,* with a focus on those specific to children and adolescents.

Big Moves and Big Changes

The biggest structural change is the removal of PTSD from the anxiety disorder section and its inclusion in a new section on trauma and stressor-related disorders. Perhaps more clinically pertinent is the removal of criterion A2, which in *DSM-IV* specified a subjective reaction of intense fear, helplessness, or horror (in children, this could have been disorganization or agitation). This criterion has been problematic for many of us who treat PTSD, especially for young children who may not be able to recall or describe their subjective reaction to a traumatic event. Instead, *DSM-5* focuses more on the behavioral and affective symptoms and subjective reactions, while important to address in treatment, are not part of the diagnostic criteria.

In addition, Criterion A1, "exposure to actual or threatened death, serious injury, or sexual violence" (ie, directly experiencing the traumatic event), has been narrowed and refined, and in *DSM-5* no longer includes the death of family or a close friend due to natural causes. It also explicitly includes sexual assault as a traumatic event, important for those working with children because of kids' vulnerability to this type of mistreatment.

Symptom Clusters

Symptom clusters have been rearranged and expanded from three to four, based on data showing that this four-factor model more accurately describes what we see clinically than does the three-factor model in *DSM-IV* (Friedman MJ et al, *Depression and Anxiety* 2011;28:750–769).

The avoidance symptom cluster has been separated into two clusters: avoidance and negative cognition/mood symptoms. Hyperarousal and re-experiencing symptom clusters remain distinct groups in the *DSM-5.* For assessment of re-experiencing in children, there is an emphasis on behavior and observable symptoms, such as repetitive play with themes of the trauma and frightening dreams without recognizable trauma. Further, there is no longer a distinction between acute and chronic phases of PTSD.

Finally, a new signifier, PTSD with prominent dissociative symptoms, was added because people with dissociative features (about one third of people with PTSD) seem to require more stabilization and support before they can benefit from exposure-based CBT treatment (Friedman MJ et al, *Depression and Anxiety* 2011:28:737–749).

Diagnostic Criteria for Children

There is a distinct set of diagnostic criteria for PTSD in children under six years in *DSM-5.* PTSD looks quite different in young kids, compared to older children and adults, and likely has been missed and underdiagnosed as a result of a misfit between the DSM criteria and the manifestation of the illness in preschool-aged kids (Scheeringa MS et al, *Depression and Anxiety* 2011;28:770–783).

Kids this age may not appear distressed by memories or discussion of the event, and may instead appear excited or excessively positive. In addition, PTSD symptoms that are experienced internally can be difficult to assess since children may not have the language or capacity to describe what they are experiencing. For example, it is nearly impossible for a young child to describe psychological avoidance of thoughts or feelings about a trauma, and they may not have the ability to recall the symptoms they are experiencing or convey the burden of memories.

CCPR'S VERDICT

The changes to PTSD in *DSM-5* reflect a greater understanding of the impact of trauma on children, and set the stage for increased recognition and improved treatment.

Expert Interview
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Dr. Frances: Because insurance requires a diagnosis on the first visit, kids get a label that may last for life, and may be irrelevant to their long-term needs. But the labels don't go away; they cause stigma and they haunt children and they lead to unnecessary treatment. We need to be careful. Diagnosis is a really serious thing and medication is a serious decision that needs to be made much more carefully with much more time and much more expertise. The thing we have to be aware of is that 80% of medications are given out in primary care.

CCPR: If your criticism is really about primary care doctors, why say that child psychiatrists wildly overdiagnose?

Dr. Frances: There are lots of things that are overdiagnosed in our field, but the three things that have come in the last 20 years—ADHD, autism, and bipolar disorder—have all been in child psychiatry and the primary specialties that deal with children. Children are the most vulnerable, there is the least research on how diagnosis and treatment affects them, and we shouldn't be bathing them in so many drugs without much greater evidence than we have that they will be helpful.

CCPR: You say that Disruptive Mood Dysregulation Disorder (DMDD) is really just a proxy for temper tantrums. Other experts say that this is a diagnosis for those kids who are very disabled but don't fit the category of childhood bipolar disorder.

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Expert interview

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Dr. Frances: I think that there needs to be a tremendous re-education in the field about the fallacy of bipolar disorder and the carelessness with which antipsychotic and mood stabilizing medicines have been given to kids with sometimes outrageous consequences. To counteract the drug company conferences, there should have been conferences sponsored by the American Psychiatric Association, child psychiatry groups, pediatricians, and family care practitioners teaching their members that this diagnosis is not official, has gotten out of hand, and led to harmful treatments. The solution of handing down a new diagnosis meant to counteract the problems of the old diagnosis just sets up the new target. The research on temper dysregulation disorder or disruptive mood dysregulation disorder, however it is labeled, is markedly thin.

CCPR: So what do you do with those kids that are clearly in distress, whose families are also distress, but who don't fall into any of the diagnostic criteria of the DSM?

Dr. Frances: I think the crucial point here is to recognize the value of not-otherwise-specified (NOS) diagnoses. We can't ever have a system that is going to cover all the great turmoil and great difficulty of human life. But when you make a diagnosis official, it takes on a life of its own and leads to unintended consequences that can be particularly dangerous. I am not against treating with medication a kid who is having all sorts of problems that we don't have a diagnosis for. But in these situations, I trust the individual clinical judgment of the practitioner to make the NOS diagnosis, rather than having an official diagnosis that makes it sound like we know what we are doing, that we studied it carefully, and that we understand the risks and benefits. Once something gets a separate diagnostic label and a code it takes on a life of its own. For some kids, we should admit our uncertainly. In lots of situations in life we just don't know what is best, and for those kids it doesn't make sense to make up a diagnosis if we don't understand.

Because insurance requires a diagnosis on the first visit, kids get a label that may last for life, and may be irrelevant to their long-term needs.

Allen Frances, MD

CCPR: Is your primary criticism of the *DSM-5* process that the consequences of new diagnostic categories were not fully considered?

Dr. Frances: Yes, I think that *DSM-IV* was meant to be conservative, and even with *DSM-IV* we had lots of unintended consequences. *DSM-5* was ambitiously innovative in an attempt to be prematurely paradigm shifting. It started out with the dream of having a more biological method of diagnosis. When this failed, it reduced the thresholds for defining mental disorders in the hope of stimulating preventive psychiatry. But for none of the new conditions introduced by *DSM-5,* and for none of the reduction of thresholds for old diagnoses, is there any evidence at all that we can meet the three standards that are important before you can safely make a change. Those are:

1) Accurately identify the patients that are being described or we have a lot of false positives.
2) Have treatments that will help the people you do identify.
3) Ensure that treatment is safe.

For none of the *DSM-5* changes are these criteria met. In each instance there will be tons of false positives. There has been no study showing treatment is effective, and in each instance there are risks that treatments that will be used in real life may be harmful.

CCPR: What do you propose as a solution?

Dr. Frances: I think that the American Psychiatric Association should no longer be controlling a document that has gained such enormous societal implications—at this point, not just for clinical work but for determining insurance, disability, school services, who goes to prison, who gets to have custody over a child, who gets to fly a plane or buy a gun, and so on. All sorts of things are determined by psychiatric diagnosis beyond the clinical. For safety's sake, we need a more FDA-type of approach to vetting the diagnostic system. New diagnoses in psychiatry now are much more dangerous than new drugs because they can lead to millions of people being misdiagnosed and getting drugs that they don't need. Drug companies marketing to consumers, which occurs really just in the United States, needs to end. We need to stop the idea that drug companies can market diseases the way they market beer or cars. I think the insurance industry needs to have a different perspective. They created a requirement for a diagnosis on first visits thinking that this would be a screen that would reduce costs. In actual fact, over the long run it greatly increases costs. It would be much better to have a moratorium period early in evaluations where you didn't have to have a diagnosis—where it is just an evaluation visit. Parents and consumers need to be better educated about the risks as well as the benefits of psychiatric diagnosis. I think the really tragic thing is the misallocation of resources. We are spending billions of dollars on unnecessary medication for people who would do better without it. At the same time, we have a million psychiatric patients in prison for nuisance crimes that would have been avoided had they had adequate community treatment and housing. We have closed a million psychiatric beds in the last 50 years, and not so coincidentally, we have opened a million prisons beds for psychiatric patients (US Department of Justice, Bureau of Justice Statistics Special Report 2006; http://1.usa.gov/17nLjdm). The NIMH shouldn't just be a brain institute advocating for brain research that may help people in the future. Past experience shows that the translation from basic neuroscience to helping patients in a practical way is painfully slow.

CCPR: Thank you, Dr. Frances.

Dr. Frances is the author of *The Essentials of Psychiatric Diagnosis* (Guilford 2013) and *Saving Normal* (HarperCollins 2013).

Research Updates IN PSYCHIATRY

PEDIATRIC PTSD

Does Guanfacine Work for Pediatric PTSD?

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Dr. Fort has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Treatment options for pediatric PTSD and trauma symptoms are limited, and the symptoms are clearly detrimental to youths' functioning, particularly in the presence of comorbid disorders. As recommended treatments, trauma-focused cognitive behavioral therapy (TF-CBT) and SSRIs rarely lead to a quick remission of symptoms, so child psychiatrists are in need of a larger pharmacologic toolbox.

A recent open-label pilot study was conducted investigating the tolerability and effectiveness of guanfacine XR (GXR) for children and adolescents with trauma symptoms, including re-experiencing, avoidance, and hyperarousal. (This study was sponsored by Shire Pharmaceuticals, the makers of Intuniv, a branded version of guanfacine.)

Seventeen subjects were enrolled, having been recruited through psychiatrists' offices, advertisements, or word of mouth. Inclusion criteria included being six to 18 years old, having trauma symptoms as measured by standard rating instruments, and being free of other psychotropic medications.

Children were allowed to have comorbid conditions, and many did: 89.5% met criteria for ADHD, 68.4% for PTSD, 47.4% for GAD, 21.1% for depression, 10.6% for separation anxiety disorder, and 5.3% for reactive attachment disorder.

Subjects were started on 1 mg of GXR at bedtime during week one, which was titrated as needed by 1 mg weekly to maximum dose of 4 mg/day by week five. Thirteen of the original 17 children completed the trial, with an average does of GXR of 1.19 mg/day over the course of the 8 week trial. Four dropped out due to worsening depression, side effects (sedation/fatigue), lack of effectiveness, and transportation issues.

How well did the treatment work? Pretty well. Thirteen children completed the treatment: 70.6% were rated by clinicians as very much improved or much improved on the CGI, and 82.4% showed a greater than 30% reduction on the UCLA-RI, a measure of PTSD. Subjects also reported significant improvements in hyperactivity and inattention as well as anxiety symptoms. At study conclusion, 12 of the original 17 elected to continue GXR treatment (Connor D et al, *J Child Adolesc Psychopharmacology* 2013;23:244–251)

CCPR's Take: Generalizability of these results is limited because this was not a double blind trial and the sample size was small. Nonetheless, given the paucity of treatment options for pediatric PTSD, low dose guanfacine—either as the branded XR or the cheaper immediate release generic—may be worth a try.

ANTISOCIAL BEHAVIOR

Are there Really *Two Types of Antisocial Behavior in Children?*

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Dr Kahler has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Two decades ago, Terrie Moffitt first proposed that there are two distinct kinds of antisocial behavior in children: one that starts when kids are young, is life-long and is neurobiolgically-based, and one that develops in adolescence and that kids can grow out of. For those interested in the jargon of this field, the early onset version has been labeled "life-course persistent (LCP)" type, while the adolescent onset has been called "adolescent limited" (AL). This theory that these are distinct types of antisocial children has been influential and widely accepted over the years.

However, a recent research review suggests that the theory may need to be reformulated. The group conducted literature searches for relevant studies from 1993 through 2013, finding 61 applicable empirical studies that distinguished between LCP and AL antisocial behavior. The first major finding of the review is that children with LCP and those with AL antisocial behavior show similar neurobiological changes, contradicting the suggestion that AL is less biologically based.

Specifically, studies examining cortisol secretion and stress reactivity showed reduced HPA responses in both LCP and AL subtypes, with no significant differences between the two. Similarly, structural and functional neuroimaging studies demonstrated changes in the brains of both groups. And while genetic studies gave mixed results, the evidence did not clearly support the developmental taxonomic theory.

Other major findings of the review included the following:

- Both types have shown the same kinds of atypical personality traits;
- Both show similar neuropsychological impairments in facial emotion recognition, decision-making, and emotional reactivity;
- Perhaps most importantly, the epidemiologic research could not support a distinction between the outcomes of the two: antisocial behavior emerging in adolescence often persists into adulthood and prognosis is frequently poor, while a significant proportion of childhood onset cases will remit.

The authors concluded that there are no clear biological, clinical or epidemiological differences between early and late onset antisocial behavior. They are likely the same disorder, with differences in onset probably caused by differences in early childhood environment (Fairchild G et al, *J Child Psychol Psychiatry* 2013; July: online ahead of print).

CCPR's Take: The authors cast considerable doubt on the validity of the developmental taxonomic theory, which may have significant implications for our understanding of antisocial behavior given the widespread influence the theory has had, including on prior research, and on the *DSM-IV* and *5*.

CME Post-Test

CME Notice: The test below is intended to be for **practice only.** All subscribers must take their tests online at www.thecarlatchildreport.com. If you cannot take your test online, please call 866-348-9279 or email info@thecarlatreport.com.

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Below are the questions for this month's CME post test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on page 1.

1. In the second wave of the National Comorbidity Survey (NCS), what percentage of patients with any mental disorder had three or more diagnoses on a lifetime basis (Learning Objective #1)?
   [ ] a) 13% [ ] b) 14% [ ] c) 21% [ ] d) 40%

2. Criterion A2: "A subjective reaction of intense fear, helplessness, or horror" from *DSM-IV* has been removed from *DSM-5* (LO #2).
   [ ] a) True
   [ ] b) False

3. Which of the following is not a criteria that should be met in order to make a change to DSM, according to Dr. Allen Frances (LO #3)?
   [ ] a) Accurately identify the patients that are being described
   [ ] b) Have treatments that will help the people you do identify
   [ ] c) Ensure that treatment is safe
   [ ] d) Prove the diagnosis is biologically based

4. In the Connor et al study of guanfacine, of the 13 completers, how many were rated by clinicians as very much improved or much improved on the CGI (LO #4)?
   [ ] a) 30% [ ] b) 47.4% [ ] c) 70.6% [ ] d) 82.4%

5. In the Fairchild et al study of antisocial behavior, what was observed of the HPA responses in the life-course persistent (LCP) subtype compared to adolescent limited (AL) subtype (LO #4)?
   [ ] a) Reduced HPA responses in both LCP and AL subtypes, with no significant differences between the two
   [ ] b) Increased HPA responses in both LCP and AL subtypes, with no significant differences between the two
   [ ] c) Reduced HPA responses in LCP; increased responses in AL
   [ ] d) Increased HPA responses in LCP; reduced in AL

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News of Note

CHILD ABUSE

Neglect Most Common Form of Child Abuse

More than 75% of cases of child abuse in the US involve neglect, according to a consensus report from the Institute of Medicine released in September 2013. In the report, neglect is defined as failing to provide food, clothing, adequate supervision, protection from known dangers, safe/hygienic shelter, education, medical care, or nurturing/affection. Among the risk factors identified are parental issues such as depression, personality disorder, or substance abuse; young and/or single parents; and contextual factors including poverty, violence, social isolation, and stress. Those children most at risk are ages three and younger.

Childhood neglect can lead to various long-term negative outcomes, both psychological and social, including poor social relationships and risky behavior. The report's authors suggest a more coordinated approach to conducting child abuse research in order to better inform policy.

The study can be read at http://bit.ly/17T4sF3.

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ALCOHOL

Report: 10% of high school seniors "extreme" binge drinkers

Ten percent of high school seniors report drinking more than 10 drinks at one time, and 5.6% report drinking more than 15, according to a recent study in *JAMA Pediatrics* (Patrick ME et al, Online First September 16, 2013). Twenty percent reporting drinking 5+ drinks in one sitting, which is the traditional definition of "binge drinking."

These data are a result of a nationally representative sample of high school seniors gathered as part of the annual Monitoring the Future study between 2005 and 2011. Use of other substances, such as cigarettes and marijuana, predicted all three levels of excess drinking.

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