

Deconstructing the DSM-5

By Jason H. King

Assessment and diagnosis of neurocognitive disorders

In contrast to the DSM-IV-TR, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) no longer uses the classification title “Delirium, Dementia, and Amnesic and Other Cognitive Disorders.” The preferred term is neurocognitive.

In 2011, Mary Ganguli and her colleagues on the DSM-5 Neurocognitive Disorders Work Group discussed in an article how they initially considered labeling this group of disorders “cognitive disorders.” Cognitive impairments are present in most mental disorders, including schizophrenia, bipolar disorder, depression, attention-deficit/hyperactivity disorder and autism.

But the Neurocognitive Disorders Work Group focused on those disorders for which the cognitive deficit is the primary one and is attributable to known structural or metabolic brain disease. Hence the designation neurocognitive.

The addition of the prefix neuro provides further specificity because the term cognitive has a broad meaning in psychiatry and psychology, covering all mental representations of information processing, including all conscious activity. The term neurocognitive describes cognitive functions closely linked to particular brain regions, neural pathways or cortical/subcortical networks in the brain.

The new landscape

An additional change in the DSM-5 is the use of “mild” and “major” to represent the spectrum, or dimension, of neurocognitive disorder (NCD) presentations — particularly the prodromal symptom manifestations that persist beyond normal aging and that are of concern to family members and close friends of affected individuals. This is similar to what we see in psychotic and schizophrenia spectrum disorders.

The concept of mild NCD is not of recent origin. The DSM-IV-TR (published in 2000) presented mild NCD in “Appendix B: Criteria Sets and Axes Provided for Further Study.” According to Dan Blazer, who co-chaired the DSM-5 Neurocognitive Disorders Work Group after Dilip V. Jeste was elected American Psychiatric Association president-elect in early 2011, “The movement to diagnose NCDs upstream reflects an emerging literature that confirms both the improvement in early diagnostic determinations and the recognition that the neuropathology underlying these disorders emerges well before the onset of clinical symptoms.”

Blazer further commented in *The American Journal of Psychiatry* that “In the Alzheimer’s field, where it goes by the name of ‘mild cognitive impairment,’ this is a train that has already left the station. Our work group included a neurologist (Ronald Peterson) who

informed us that if we did not have this category, we would be very much behind what is going on in the mainstream of Alzheimer's treatment and research."

Although mild NCD syndrome is new to the DSM-5, its presence is consistent with its use in other fields of medicine, where it is a significant focus of care and research. Mild NCD is characterized by modest cognitive decline. The disorder does not interfere with an individual's complex activities of daily living such as paying bills or managing medications, although greater effort, compensatory strategies or accommodation may be required). Neuropsychological testing results for mild NCD are one to two standard deviations from the mean.

Major NCD syndrome provides consistency with the rest of medicine and with prior DSM editions and necessarily remains distinct to capture the care needs for this group. In contrast to mild NCD, major NCD is characterized by significant cognitive decline that interferes with an individual's activities of daily living and impairs independence. Results of neuropsychological testing on these individuals fall two or more standard deviations from the mean. However, the DSM-5 advises that "the distinction between major and mild NCD is inherently arbitrary, and the disorders exist along a continuum."

Major NCD replaces the term dementia in the DSM-5 and conveys a somewhat broader syndrome and underlying pathology compared with dementia. Differential diagnosis between mild and major NCD requires that counselors use the Table 1 Neurocognitive Domains in the DSM-5 to determine cognitive decline in 32 neuropsychological domains manifest in complex attention, executive function, learning and memory, language, perceptual-motor abilities and social cognition.

According to the manual, this table "provides for each of these key domains a working definition, examples of symptoms or observations regarding impairments in everyday activities, and examples of assessments. The domains thus defined, along with guidelines for clinical thresholds, form the basis on which the neurocognitive disorders, their levels and their subtypes may be diagnosed."

Distinct features of NCDs include psychosis, paranoia and other delusions (disorganized speech and disorganized behavior are not characteristic of psychosis in NCDs), mood disturbances, depression, anxiety and elation. Additional associated features include agitation, confusion, frustration, sleep disturbances, apathy (marked declines in motivation, goal-directed behavior and emotional responsiveness), wandering, disinhibition, hyperphagia and hoarding.

Etiological or pathological entities underlying the client's cognitive decline, including major or mild vascular NCD and major or mild NCD due to Alzheimer's disease, have been retained in the DSM-5. New and separate criteria are now presented for major or mild NCD due to frontotemporal NCD, Lewy bodies, traumatic brain injury, Parkinson's disease, HIV infection, Huntington's disease, prion disease, another medical condition and multiple etiologies. Substance/medication-induced NCD and unspecified NCD are also included as diagnoses.

The DSM-5 also requires use of descriptive and severity specifiers to more precisely indicate the client's symptom level and to promote clinical utility. For example, counselors should descriptively specify NCD without behavioral disturbance or with behavioral disturbance (psychotic symptoms, mood disturbance, agitation, apathy or other behavioral symptoms). For mild NCD, behavioral disturbance cannot be coded but should still be indicated in writing.

When diagnosing major NCD, counselors should specify current severity:

- Mild (difficulties with instrumental activities of daily living such as housework or managing money)
- Moderate (difficulties with basic activities of daily living such as feeding and dressing)
- Severe (fully dependent)

This specifier applies only to major NCD, including "probable" or "possible" designations. Probable is defined as evidence of a causative disease genetic mutation from family history or genetic testing, whereas possible does not include this objective evidence.

Case study: Bradley

Let me share how I used the DSM-5 in the assessment of mild NCD due to traumatic brain injury (TBI) in a recent client. (Postconcussional disorder has been replaced by TBI in the DSM-5). Bradley, a male client in his mid-40s, has suffered three TBIs, each resulting from independent automobile accidents.

His mild NCD is characterized by postconcussion syndromes reflected in physical symptoms (headaches, dizziness, fatigue, noise/light intolerance, insomnia, nausea, physical weakness), cognitive symptoms (memory complaints, poor concentration), and emotional symptoms (depression, anxiety, irritability, increased aggression, mood lability).

I used the DSM-5's Severity Ratings for TBI, reference to three neuropsychological tests provided by my client and the DSM-5's Table 1 Neurocognitive Domains to diagnose Bradley (see below).

During treatment, Bradley's attorney served me with a subpoena to turn over all of my clinical records to assist with his lawsuit against his insurance company (for allegedly not covering his medical and mental health treatments, especially his resulting depression from the three TBIs).

In compliance with the 2011 American Mental Health Counselors Association Code of Ethics ("mental health counselors ... do not release information by request unless accompanied by a specific release of information or a valid court order. Mental health counselors make every attempt to release only information necessary to comply with the request or valid court order"), I produced the following letter:

"Per a referral from Vocational Rehabilitation, I began treatment on 6/11/13 with Bradley that focused on his manifest depression resulting from multiple traumatic brain injuries (TBIs). The treatment goal was to help Bradley resolve his depression, improve his

cognitive performance and stimulate overall wellness to resume with gainful employment (as his employment capabilities became significantly impaired due to his prior TBIs).

Using a clinical interview, three prior clinical neuropsychological testing records, and my further clinical evaluation procedures, I diagnosed Bradley with Mild Neurocognitive Disorder (NCD) Due to TBI; Moderate-Severe Depressive Disorder Due to TBI, With Major Depressive-Like Episode; Occupational Problem Due to TBI; and Partner-Relational Problem Due to TBI. This is in accordance with the 5th edition (2013) of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Bradley's diagnoses are justified as this manual instructs (pages 181; 625-627):

- Traumatic brain injury is defined as brain trauma with specific characteristics that include at least one of the following: loss of consciousness, posttraumatic amnesia, disorientation and confusion, or in more severe cases, neurological signs.
- To be attributable to TBI, the NCD must be present either immediately after the brain injury occurs or immediately after the individual recovers consciousness after the injury and persist past the acute post-injury period.
- With moderate and severe TBI, in addition to persistence of neurocognitive deficits, there may be associated neurophysiological, emotional and behavioral complications. These may include ... depression, sleep disturbance, fatigue, apathy, inability to resume occupational and social functioning at pre-injury level, and deterioration of interpersonal relationships.
- Moderate and severe TBI have been associated with increased risk for depression.
- Repeated concussions can lead to persistent NCD.
- Worse outcome from moderate to severe TBI is associated with older age (older than 40 years).
- Individuals with TBI histories report more depressive symptoms, and these can amplify cognitive complaints and worsen functional outcome.
- There are clear associations, as well as some neuroanatomical correlates, of depression with ... traumatic brain injury.

However, this manual cautions: 'It is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals and research investigators rather than all of the technical needs of courts and legal professionals' (p. 25)."

My hope is that by reading my letter concerning Bradley, you will capture the increased clinical utility that the DSM-5 offers to counselors.

Delirium

The DSM-5 retains delirium (a disturbance in attention, awareness and cognition) as a diagnosis that can result from substance intoxication, substance withdrawal, medication, another medical condition or multiple etiologies. Delirium can now be course specified as acute (lasting a few hours or days) or persistent (lasting weeks or months) and descriptive specified as hyperactive, hypoactive or mixed level of activity.

Important NCD updates

Counselors should be aware of several changes that took effect in October concerning the NCD codes in the DSM-5. The World Health Organization's International Classification of Diseases (ICD) coding system is subject to revisions at conferences held twice per year. The ICD is the official system of assigning codes to diagnoses in the United States, whereas the DSM-5 is a "user's manual" on how to properly diagnose mental disorders and report coding as required by the ICD.

According to this update, the coding changes ensure that insurance reimbursement can be obtained when the specifier "with behavioral disturbance" is used for the possible major NCDs. These changes require that etiological medical codes be coded first in major NCDs due to either probable or possible etiologies.

The published codes for all major NCDs with possible medical etiologies should be replaced by the same codes used for their respective major NCDs with probable etiologies. The specific changes and updates to NCDs can be accessed at the American Psychiatric Association's DSM-5 website at dsm5.org/Documents/IMPORTANT-NeurocogCodingNoteUpdates-10-18-13.pdf.

Until next year, be well!

Bio

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