

The DSM-5: Implications for Children and Adolescents

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The publication of the DSM-5 was preceded with a substantial amount of controversy and concern in regards to some changes related to the pediatric population. Although published in May of 2013, widespread adoption of the new manual has yet to occur. The DSM-5 Task Force acknowledged that the most substantive revisions impact the child and adolescent population (American Psychiatric Association, 2013). This revision was met with a great deal of concern from the public and mental health professionals alike. As can be observed, the most obvious change was away from a Roman numeral system for editions of the DSM. In comparison to other changes, this can appear to be a mere cosmetic detail. However, this change is a representation of larger goals. The American Psychiatric Association (APA) has indicated that this was done in part to make more frequent updates easier as we will see iterations in the coming years of the DSM-5.1 and so forth. Multiple changes were made to the organization of the manual including the transition to a lifespan perspective and the addition of critical cultural considerations. Additional efforts were made to shift diagnoses to a more dimensional model of psychopathology. A comprehensive review of the changes is beyond the scope of this article, however a few of the most significant revisions will be addressed which include changes to the overall organization of the manual, the changing perspective in diagnosis, and the changes to autism spectrum disorder will be utilized as an example of these efforts.

The new edition of the DSM now includes 20 mental disorder chapters as opposed to the 16 found in the DSM-IV TR (APA, 2013). One of the long held criticisms of the DSM is that it is an American document and does not align well with the ICD which is used throughout Europe and other parts of the world. Adjusting the DSM to what is believed to be a lifespan perspective is one such effort to align more closely with the ICD. The organization of the chapters flows from this with the first chapter, neurodevelopmental disorders which first emerge in early life, schizophrenia spectrum disorders which develop in adolescence, and so forth. Surprisingly the depressive disorder and anxiety disorder chapters occur later in the manual although clinicians who work with children will recognize that these disorders are capable of emerging in childhood well before schizophrenia spectrum disorders. Additionally, the multi-axial system has been discarded in favor of a more narrative description and discussion of diagnoses.

This edition of the manual also reflects an effort to align with a more dimensional approach to diagnosis as opposed to the traditional categorical one. Long criticized for its categorical approach to diagnoses, the manual is making an effort to move in a different direction. One of the primary criticisms of the categorical model is that it does not address levels of severity as is commonly seen in mental health diagnoses. One individual suffering from

dysthymia, now renamed persistent depressive disorder, may suffer more severely than another with the same diagnosis.

There are few diagnoses whereby the argument regarding severity level could be made as strongly as that for autism. The changes to this diagnosis has led to significant controversy. Advocates and families of children with autism were concerned with the challenges the new diagnostic criteria would bring. Essentially, the update resulted in more stringent criteria. There has been a growing concern about the rates at which the diagnosis was being made. Findings indicated that clinicians also were not adhering strictly to the criteria. Many in the professional community would indicate that there was little distinguishable difference between those with high functioning autism and those with Aspergers Disorder as well. In concordance with the lifespan perspective, the first chapter of the DSM-5 is now entitled Neurodevelopmental Disorders. It includes the following diagnoses:

- Intellectual disabilities
- Communication disorders
- Autism spectrum disorder
- ADHD
- Specific Learning Disorder
- Motor Disorders
- Other

Note that Aspergers Disorder is no longer included on the list. It has in fact been removed from the DSM-5 altogether. Moreover, pervasive developmental disorder not otherwise specified (PDD-NOS) has also been removed. This was a part of the source of the controversy with the diagnostic changes. The proposed diagnostic manual was published on a website in 2012 and this allowed professionals to review and comment on the changes. It was immediately noted that the criteria for autism spectrum disorder became more stringent and the aforementioned diagnoses were removed. What were the implications of this? How did the public respond? Parents and advocates were concerned that their children would no longer be eligible for the services they currently receive as the new criteria for autism spectrum disorder were believed to be more stringent. Public outcry to APA regarding these concerns was immediate. It is possible that, in part to address this concern, APA added a note that individuals with a previous diagnosis of Aspergers Disorder or PDD NOS should be diagnosed with the new autism spectrum disorder diagnosis. Initially an increase in the rate of diagnosis is expected, but with the newer more stringent criteria, ultimately the rates of autism should decline. To illustrate the changes you will find below a side by side comparison of the diagnostic criteria from the DSM-IV TR and the DSM-5 quoted directly from the manuals (APA, 2005 and APA 2013).

Autism

• DSM- IV TR

- A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

- (1) qualitative impairment in social interaction, as manifested by at least two of the following:
 - (a) marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - (b) failure to develop peer relationships appropriate to developmental level
 - (c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
 - (d) lack of social or emotional reciprocity

• DSM-5

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):
 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

- (2) qualitative impairments in communication, as manifested by at least one of the following:
 - (a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
 - (b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - (c) stereotyped and repetitive use of language or idiosyncratic language
 - (d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).

- (3) restricted, repetitive, and stereotyped patterns of behavior, interests, and activities as manifested by at least one of the following:
 - (a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
 - (b) apparently inflexible adherence to specific, nonfunctional routines or rituals
 - (c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole-body movements)
 - (d) persistent preoccupation with parts of objects

- 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
- 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
- Specify current severity: (see table below)

- B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years:
 - (1) social interaction,
 - (2) language as used in social communication, or
 - (3) symbolic or imaginative play.
- C. The disturbance is not better accounted for by Rett's disorder or childhood disintegrative disorder.

- C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

- **Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.**

- Specify if:
 - With or without accompanying intellectual impairment
 - With or without accompanying language impairment
 - Associated with a known medical or genetic condition or environmental factor
(Coding note: Use additional code to identify the associated medical or genetic condition.)
 - Associated with another neurodevelopmental, mental, or behavioral disorder
(Coding note: Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)
 - With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119-120, for definition)
(Coding note: Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

What you can see in reviewing these changes are an example of movement toward a more dimensional approach as well as a lifespan one that reflects the reality that many people with a neurodevelopmental disorder do change over the lifespan. The following images are an example of the specifiers that have been created in the DSM-5 to assist clinicians in making a level of severity assessment for individuals diagnosed with an autism spectrum disorder.

Severity levels for autism spectrum disorder		
Severity Level	Social Communication	Restricted, repetitive behaviors
Level 3 Requiring very substantial support	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 Requiring substantial support	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 Requiring Support	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to- and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

The changes to this disorder are just one example of the updates made to diagnoses that impact children and adolescents. Clinicians will also find more detailed descriptions of symptoms in part to make it easier to relate symptom presentation to the diagnostic criteria. For example, the diagnosis of post-traumatic stress disorder (PTSD) has received a substantive expansion. The manual also has a special section for PTSD in children under the age of six. These criteria match closely with those established in the DC 0-3 Diagnostic Manual. This disorder along with reactive attachment disorder and disinhibited social engagement disorder (one of the new disorders added to the manual) have been clustered together in a new chapter entitled Trauma and Stress Related Disorders. This in part is an effort to recognize the traumatic nature of relational experiences that give rise to attachment based problems.

From this brief review of some of the changes to the DSM-5 clinicians can become concerned that the manual is radically different from what they were previously trained on. However, although the manual has made some of these transitions, it is essentially in many ways unchanged. The actual codes for diagnoses aren't changing and although there is reorganization in some domains, the actual symptoms for many disorders in the manual remain unchanged. However, those that work with children would likely benefit from additional training and review in order to familiarize themselves with changes.

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