

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* updates disorder criteria to more precisely capture the experiences and symptoms of children. The book also features a new lifespan approach to mental health. Rather than isolating childhood conditions, DSM-5's organization underscores how they can continue to manifest at different stages of life and may be impacted by the developmental continuum that influences many disorders.

Changes affecting children are evident before the manual's first page of text. Its table of contents reflects a new framework that recognizes age-related aspects of disorders by arranging each diagnostic chapter in a chronological fashion, with diagnoses most applicable to infancy and childhood listed first, followed by diagnoses more common to adolescence and early adulthood, and ending with those relevant to adulthood and later years. Thus, disorders previously addressed in a single "infancy, childhood and adolescence" chapter are now integrated throughout the book.

Individual disorders, diagnostic categories and criteria were revised to better serve young patients. In revising DSM-5, several factors motivated the Work Groups, including:

- Working with parents
- Defining a diagnostic home
- Developing more precise criteria

Parents' Integral Role

Throughout the development process for DSM-5, family and consumer advocacy organizations served an important function in giving feedback on proposed changes and, in some cases, meeting with members of the DSM-5 Work Groups. All revisions to the manual were made to more precisely describe and diagnose the symptoms and behaviors of those seeking clinical help. Parents provided a particularly valuable perspective on the framing around changes.

DSM-5 is a clinical guidebook for assessment and diagnosis of mental disorders and does not include treatment guidelines or recommendations on services. That said, determining an accurate diagnosis is the first step toward appropriate care. As with any medical issue, no child should ever be diagnosed without a careful, comprehensive evaluation, and no medication should be prescribed without equal vigilance. Parents play an integral role in this process as many of the DSM criteria require that symptoms be observed by them or individuals who interact regularly with the child.

It is both appropriate and essential for parents to ask questions and provide information to clinicians during a child's assessment. Parents' specific questions about their child's care should always be discussed with the child's mental health clinician or pediatrician.

A Diagnostic Home

Clinicians and families often were frustrated that DSM-IV did not define or describe some of the clinically significant behaviors and symptoms they observed in children. In an effort to improve diagnosis and care, two new disorders are among the changes made to DSM-5 to provide children with an accurate diagnostic home.

[Social communication disorder \(SCD\)](#) is characterized by a persistent difficulty with verbal and nonverbal communication that cannot be explained by low cognitive ability. The child's acquisition and use of spoken and written language is problematic, and responses in conversation are often difficult. Since previous manuals did not provide an applicable diagnosis for individuals with such symptoms, there was inconsistent treatment across clinics and treatment centers. SCD brings these children's social and communication deficits out of the shadows of a "not otherwise specified" or similarly inexact diagnosis.

Also added to DSM-5 is [disruptive mood dysregulation disorder \(DMDD\)](#). It is characterized by severe and recurrent temper outbursts that are grossly out of proportion to the situation in intensity or duration. The outbursts occur, on average, three or more times each week for a year or more. The unique features of DMDD necessitated a new diagnosis to ensure that children affected by this disorder get appropriate clinical help.

More Precise Criteria

Existing criteria have been updated in DSM-5 to provide more precise descriptions and reflect the scientific advances and clinical experience of the last two decades. Below are brief summaries of changes to select disorders.

[Autism spectrum disorder \(ASD\)](#) incorporates four disorders from the previous manual: autistic disorder, Asperger's disorder, childhood disintegrative disorder, and the catch-all diagnosis of pervasive developmental disorder not otherwise specified. Researchers found that those four diagnoses were inconsistently applied across clinics and treatment centers and, rather than distinct disorders, actually represented symptoms and behaviors along a severity continuum. ASD reflects that continuum and is a more accurate and medically and scientifically useful approach. People diagnosed with one of the separate DSM-IV disorders should still meet the criteria for autism spectrum disorder or a different DSM-5 diagnosis.

[Attention deficit/hyperactivity disorder \(ADHD\)](#) now requires an individual's symptoms to be present prior to age 12, compared to 7 as the age of onset in DSM-IV. Substantial research published since 1994 found no clinical differences between children with earlier versus later symptom onset in terms of their disorder course, severity, outcome, or treatment response. Other criteria for diagnosing children with ADHD remain unchanged.

[Posttraumatic Stress Disorder \(PTSD\)](#) includes a new subtype for children younger than 6. This change is based on recent research detailing what PTSD looks like in young children. Adding the developmental subtype should help clinicians tailor treatment in a more age-appropriate and age-effective way.

[Specific Learning Disorder](#) no longer limits learning disorders to reading, mathematics and written expression. Rather, the DSM-5 criteria describe shortcomings in general academic skills and provide detailed specifiers. Just as in DSM-IV, dyslexia is included in the descriptive text.

[Eating disorders](#) previously listed among Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence are now listed in the Feeding and Eating Disorders chapter. They include pica, rumination and avoidant/restrictive food intake disorder.

[Section III](#) of DSM-5 lists conditions warranting more scientific research and clinical experience before they might be considered for inclusion in the main book as formal disorders. Two conditions listed here are particularly relevant for children and adolescents; both are regarded as major problems and public health issues that need to be better understood. Nonsuicidal self-injury defines self-harm without the intention of suicide. [Internet gaming disorder](#) deals with the compulsive preoccupation some people develop in playing online games, often to the exclusion of other needs and interests.

More information about children with these and other challenging behaviors is available from:

- American Academy of Child and Adolescent Psychiatry at www.aacap.org
- The Balanced Mind Foundation at www.thebalancedmind.org
- National Alliance on Mental Illness at www.nami.org
- Mental Health America at www.mentalhealthamerica.net.

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process.

APA is a national medical specialty society whose more than 37,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org. For more information, please contact APA Communications at 703-907-8640 or press@psych.org.

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