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DSM 5 and child psychiatric disorders: What is new? What has changed?

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ABSTRACT

The significant changes in DSM 5 as these relate to a number of the child psychiatric disorders are reviewed by several authors in this special issue: In this paper we address some of the changes in the conceptual organisation of DSM 5 and specifically focus on anxiety and related disorders. In the case of child and adolescent psychiatry, the most notable feature is that the chapter on *Disorders Usually First Diagnosed in infancy, Childhood or Adolescence* has been deleted. Instead, a new chapter in DSM 5 describes *Neurodevelopmental Disorders* which typically manifest early in development. Further, an expectation had been built that DSM would be based on the latest data in neuroscience and that a clear direction towards a mixed dimensional and categorical approach would be evident. This has been the case with some disorders and a notable example is the removal of Obsessive Compulsive Disorder (OCD) from the *Anxiety Disorder* chapter and placement with other related disorders that share similar neurobiology and treatment response. In this regard, the addition in DSM 5 of a new specifier "tic-related" to OCD is worth noting as there is emerging evidence that differential treatment response exists when tics are associated with OCD. The same situation applies to tics with ADHD, thus presenting the argument for a dimensional approach to Tic Spectrum Disorder (TSD) incorporating categories such as those with tics only, tics with OCD, tics with ADHD etc. to be given due consideration in the future. Another important change that clinicians in the field of child psychiatry will no doubt notice is the demise of the multiaxial classification. Instead, DSM 5 has moved back to a nonaxial documentation of diagnosis with separate notations for important psychosocial and contextual factors as well as level of functioning and disability. Clinicians are urged, however, to continue to recognise the need to understand how symptoms and behaviours might have arisen and assess relevant contextual factors such as the family relationships, quality of care, any history of abuse, and so on. Further, the move to harmonise DSM 5 with the structure of ICD 11 (scheduled for release in 2015) should make understanding and familiarising oneself with the two major classificatory systems easier in the future.

Preface

Twenty years after the last edition of the Diagnostic and Statistical Manual (DSM) series, the DSM IV, was published and after 13 years in the development, the publication of DSM 5 in May 2013 has been met with renewed optimism from some quarters and disappointment from others. Since the publication there has already been much debate and controversy. In this regard, concerns have been raised that some patients who need assistance but fall short of fulfilling revised criteria under DSM 5, such as in the case of Autism Spectrum Disorder (ASD), might miss out - while there have been criticisms that developmentally appropriate mood regulation difficulties such as behavioural and emotional outbursts and irritability in adolescents may be labelled as Disruptive Mood Dysregulation Disorder, a new diagnostic entity in DSM 5, and be subjected to unnecessary treatment. The clinical implications of the changes in DSM 5 for day to day practice will depend on a number of factors including individual clinician's training and theoretical orientation, as well as the nature of the specific disorder, the setting in which patients

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are seen, and the access to medical insurance or public resources available to treat the disorder, both psychological and pharmacological. Further, in DSM 5, a clear direction towards a mixed dimensional and categorical approach was expected. This has been the case with only some disorders such as the removal of Obsessive Compulsive Disorder (OCD) from the *Anxiety Disorder* chapter and placement with other related disorders that share similar neurobiology and treatment response. In this regard, the addition of a new specifier "tic-related" to OCD is worth noting as those with OCD and tics often benefit from augmentation with a neuroleptic in conjunction with an SSRI. There is emerging evidence that a similar differential treatment response exists when tics are associated with ADHD, thus presenting the argument for a dimensional approach to Tic Spectrum Disorder (TSD) incorporating categories such as those with tics only, tics with OCD, tics with ADHD, tics with ASD etc. to be given consideration in the future.

The significant changes in DSM 5 as these relate to several of the child psychiatric disorders are reviewed by several authors in this issue. In this paper we review some of the changes in the conceptual organisation of DSM 5 and specifically focus on anxiety and related disorders. The most notable change in child and adolescent psychiatry is that the chapter on *Disorders Usually First Diagnosed in infancy, Childhood or Adolescence* has been deleted. Instead, a new chapter in DSM 5 describes *Neurodevelopmental Disorders* which typically manifest early in development. This change has been inspired by the general life-span approach taken in DSM 5 with disorders starting in childhood and adolescence found virtually throughout the manual. For example, Separation Anxiety now sits within the *Anxiety Disorders* chapter of DSM 5 and Pica within the *Feeding and Eating Disorders* chapter. Another important change that clinicians in the field of child psychiatry will no doubt notice is the demise of the multiaxial classification which in DSM IV allowed the integrated conceptualisation of the child's primary mental health disorder within the context of their intellectual level, associated physical/medical conditions, psychosocial situation and overall level of functioning. Instead, DSM 5 has moved to a nonaxial documentation of diagnosis with separate notations for important psychosocial and contextual factors, as well as for the level of functioning and disability. Clinicians should however continue to assess how symptoms and behaviours might have arisen and assess relevant contextual factors such as the child's relationships, quality of care, any history of abuse, and so on. Further, it is expected that the move to harmonise DSM 5 with the structure of ICD 11 (scheduled for release in 2015) will make it easier for clinicians in the future.

1. Introduction

At the time DSM 5 was released in 2013 (American Psychatric Association, 2013) nearly two decades had elapsed since the last major revision to the DSM series, DSM IV was published in 1994 (American Psychatric Association, 1994). The subsequent text revision of DSM IV, DSM IV TR, published in 2000 contained relatively minor changes that necessitated only modest adjustments for clinicians. A preface to the DSM 5 highlights that enhancements made include better representation both of developmental issues related to diagnosis and of the research literature. Thus, a relatively substantial overhaul to the main nosological system underpinning one's practice happens several times in one's career, with each of these new editions and revisions necessitating the process of adapting and coming to understand the nature of these changes within one's own unique setting, which can be challenging. Given that the structure of the DSM 5 is analogous to the upcoming ICD 11, however, clinicians working within these major nosological frameworks may ultimately need to acquaint themselves with the changes such as they are. This special issue attempts to facilitate the process of clinicians' adaptation to DSM 5 by providing an overview of the main changes as these relate to disorders with onset in infancy, childhood or adolescence.

It may be important to observe at the outset that the DSM 5, or any other nosological system, should not dictate our practice. Clinicians must continue to assess individual patients including in their relational context, define their symptoms, make an accurate and comprehensive formulation of why they are presenting with these symptoms at this time, and then offer targeted psychological and pharmacological therapies. Notwithstanding the concerted and unprecedented efforts to link the DSM 5 to the scientific literature, perhaps we ought to consider all nosological systems, especially at this time of change, with a grain of proverbial historical salt. Related to this, a particular difficulty for child and adolescent clinicians is that the DSM 5 would appear in general terms to have been attributed in the community with a level of certainty and comprehensiveness that it was never meant to-and cannot-have.

Within this special issue the reader will find a range of manuscripts discussing changes within the DSM 5 with respect to specific disorders, including ASD, disruptive behavioural disorders a new diagnostic category of Disruptive Mood Dysregulation Disorder, Separation Anxiety Disorder and Tourette's Disorder. In this paper we endeavour to introduce the reader to some of the conceptual and overarching changes within the DSM 5 that are of relevance to the child and adolescent clinician, and also to focus some attention upon changes with the anxiety disorders and OCD.

2. Major conceptual and criterion changes in DSM 5

The reader may already be aware of changes to the meta-structure of the DSM 5 – specifically of the ordering and content of chapters dealing with mental disorders. With the removal of the DSM IV *Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence* chapter, disorders of childhood and adolescence may now be found virtually throughout the manual. Age-related aspects of disorders are identified 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.

A useful example relates to anxiety disorders where the *Anxiety Disorders* chapter in DSM IV has been replaced with three adjacent chapters in DSM 5: *Anxiety Disorders*, *Obsessive-Compulsive and Related Disorders*, and *Trauma- and Stressor-Related Disorders*, the latter two of which are new to the DSM. In general terms the chapters in DSM 5 are designed to cluster together around current understanding of antecedent, concurrent and predictive validators. For example, the separation of *Obsessive-Compulsive and Related Disorders* from the *Anxiety Disorders* has occurred in response to the accumulating evidence over the past several decades with regard to the distinct neurocircuitry and treatment response of obsessive compulsive disorders (Phillips et al., 2010a). This arrangement of chapters holds the potential to aide in clinical decision making, as related disorders are more likely to be found within the same or adjacent chapters. A further chapter change to highlight to child and adolescent clinicians is the new chapter on *Disruptive, Impulse-control and Conduct Disorders* which addresses disorders characterised by problems in emotional and behavioural self-control, and that are frequently comorbid with ADHD. The articles in this special issue by Florence levy and David Hawes relating to disruptive behavioural disorders covers many of the changes in this area. One notable change in the case of Conduct Disorder is the