The release of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, in May 2013 could be described as a pivotal moment in the field of children’s mental health primarily because of the debates and controversies around the philosophy, orientation, and methods of DSM that significantly affect the assessment and treatment of, and research into, children’s mental health problems. The Children, Adolescent and Young Adult (CAYA) committee has decided to contribute two issues of the CAYA newsletter to the conversation around DSM-5. The current issue includes a commentary from the CAYA committee, “Transitioning to DSM-5: Practical Considerations.” In this commentary, we share our understanding of the context and several practical strategies for practitioners to transit to the new DSM-5. We also introduce disruptive mood dysregulation disorder as a new diagnosis in DSM-5. Mary Elizabeth Alvior and Jonathan Singer have kindly taken the lead on developing this commentary. The second article, “DSM-5: Changes and Implications for Children and Adolescents,” by Danielle Parrish and Micki Washburn, succinctly and clearly summarizes changes in DSM-5 that CAYA social workers will need to know.

Part II, in the next newsletter of the DSM series we will focus on several important diagnostic categories that we hope will benefit CAYA members in their understanding of and practice related to those diagnoses. Current mental health assessment and treatment of children and adolescents is mostly organized around the parts of DSM that emphasizes individual determinants of psychopathology.

The controversies around DSM can lead to helpful discussion. Critical discussions and debates can be used by social workers to facilitate positive changes in children and adolescents lives.

Mo Yee Lee, PhD, MSW, is a Professor at the College of Social Work of The Ohio State University. Professor Lee has a dual focus in her clinical practice and scholarly work that includes practice and research regarding a solution-focused strengths-based systems perspective in social work treatment, as well as cross-cultural integrative clinical practice with individuals and families.

Mo Yee Lee, PhD, MSW
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The two years leading up to the publication of the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5; APA, 2013), in May 2013 have been described as a “war…that has shaken psychiatry to its core” (Greenberg, 2013, p. 3). The chair of the DSM-IV task force, Allen Frances (2013), publicly decried the process and cautioned that the changes in DSM-5 would “turn our current diagnostic inflation into hyperinflation by converting millions of ‘normal’ people into ‘mental patients’” (p. 3). The value of the DSM-5 as a “bible” for mental health practitioners was further questioned when Thomas Insel (2013), director of the U.S. National Institute of Mental Health (NIMH) published a blog post in which he said, “[Mental health research] cannot succeed if we use DSM categories as the gold standard… That is why NIMH will be reorienting its research away from DSM categories.” By the time the DSM-5 was published in May 2013, it seemed quite possible that the addition of 15 new diagnoses and the reorganization of psychiatric diagnoses would lead to a disaster of epic proportions.

A year after its publication, have the dire predictions come true, or, to quote Shakespeare (2002), were these predictions “full of sound and fury, signifying nothing” (p. 179)? Well, we don’t know, because providers are not required to use DSM-5 diagnoses for documentation and billing until October 1, 2014 (to coincide with the update to International Classification of Diseases, (ICD-10). Mental health providers have spent the past year trying to figure out what exactly has changed and how that will affect their practice. Social workers have an ethical obligation “to become and remain proficient in professional practice and the performance of professional functions” ([NASW Code of Ethics, 2008]). NASW has been at the forefront of efforts to educate providers about DSM-5 changes, with the release of a Practice Perspective written by Mirean Coleman earlier this year focusing on the most frequently asked questions regarding the DSM-5 and ICD-10-CM codes (Coleman, 2014). As social workers working with children and families you need to know
system often face significant barriers to academic achievement.

details about diagnostic changes that will affect treatment for children, adolescents, and young adults. For this newsletter we outline two strategies for proficiently applying the new diagnostic criteria into your practice with children and adolescents, and discuss a new diagnosis: disruptive mood dysregulation disorder.

STRATEGIES FOR TRANSITIONING TO THE DSM-5
The organizational structure of DSM-5 has been changed so that diagnostic categories align with current thinking and research. The first strategy for learning about the new organizational structure is to pick a diagnosis with which you were familiar in DSM-IV, and search for it in DSM-5. Does it still exist? If so, how is it classified and why? For example, you work with people who meet criteria for posttraumatic stress disorder (PTSD). In DSM-IV, PTSD was considered an anxiety disorder. What about in DSM-5? It turns out that the explosion of research on trauma has led to PTSD being placed into a distinct category, along with acute stress disorder and the adjustment disorders. The research on PTSD has resulted in the addition of a fourth symptom cluster: re-experiencing, avoidance, negative cognitions and mood, and arousal; each symptom in the cluster is described in greater behavioral detail than before. The manual contains excellent resources that explain the rationale for the reorganization of the categories of disorders and the criteria for the different diagnoses. The DSM-5 Web site offers many resources on the changes and new disorders.

Another strategy to learn DSM-5 is to play a game with yourself to identify the diagnosis you would give under DSM-IV and then check DSM-5 to see if you are correct. Would your client still meet criteria for PTSD on October 2, 2014, after DSM-5 takes effect? Do you have clients who did not meet criteria on October 1, who suddenly do on October 2? When you are sitting with a client in front of you, ask yourself what disorder category they fall under. Is it still anxiety or would this client fall under the obsessive-compulsive and related disorders or the trauma-related disorders? Once you are clear about diagnostic categories, it will be easier to narrow down your diagnostic options. We will all have to work to incorporate the new diagnoses into our thought process and case conceptualization.

NEW DIAGNOSIS: DISRUPTIVE MOOD DYSREGULATION DISORDER
Another significant change in DSM-5 that affects social workers who work with children and adolescents is the addition of the diagnosis disruptive mood dysregulation disorder (DMDD). This diagnosis is considered when the child or youth presents with severe and recurrent explosive outbursts. Previously, clinicians were forced to choose between oppositional defiant disorder and bipolar disorder, and often neither diagnosis fully described the patient’s presentation. In fact, this new category was designed to reduce the overdiagnosis of bipolar disorder as studies clarified that these children do not continue to meet criteria for bipolar disorder long term. Instead, these children are more likely to develop unipolar depression or anxiety as they mature into adulthood. Often, clinicians would opt to use one of the depression diagnoses along with oppositional defiant disorder to capture the combination of depression and irritable defiance. The drawback to this approach is that the clients are often seen as defiant first and depressed second. This new diagnosis captures the essential dynamic for these clients: that they are manifesting dysregulated mood through severe temper outbursts as well as with a chronically negative and irritable affect between outbursts. Working from an understanding that the core issue in youth with DMDD is severe mood dysregulation, which impairs their functioning, will result in more effective treatment strategies. For clients with DMDD, treatment will target depression, emotional regulation, and interpersonal effectiveness, which is very different from the approach used with clients who have oppositional defiant disorder, with a greater emphasis on impulse control through natural and logical consequences and parenting interventions.

The field will formally adopt the new DSM-5 diagnostic system in professional practice by October 1, 2014. We believe that the discussion—and sometimes heated debates—around DSM-5 will further clarify our thinking around the nature, etiology, assessment, treatment, and research of child mental health problems, which will ultimately lead to a more integrative and useful treatment paradigm for children and adolescents and their families who are struggling with mental health issues.

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Mo Yee Lee, PhD, MSW, is a Professor at the College of Social Work at The Ohio State University. Professor Lee has a dual focus in her clinical practice and scholarly work that includes practice and research regarding a solution-focused strengths-based systems perspective in social work treatment, as well as cross-cultural integrative clinical practice with individuals and families.

Jonathan B. Singer, PhD, LCSW, clinical and research interests focus on family-based interventions for suicidal and cyberbullied youth; service access and service utilization; use of technology in education and clinical practice. Dr. Singer is interested in the interpersonal mechanisms that protect against or contribute to youth suicidal risk within families.
REFERENCES


RESOURCES

www.DSM5.org

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A DSM revision occurs roughly every 10 years, with the hope of integrating advances in empirical research to increase the reliability, validity, and clinical utility of the diagnosis of mental health disorders. Although every revision has been faced with some controversy (Lacasse, 2013; Pomeroy & Parrish, 2012), the process of developing DSM-5—viewed by many as nontransparent and lacking sufficient empirical support—has received more criticism from various behavioral health disciplines than earlier revisions (Frances, 2013; Washburn, 2013). Despite this controversy, DSM-5 is now in press (APA, 2013b) and continues to be widely used in medical and social service settings and for the reimbursement of mental health services. As such, to ensure that social workers and other service providers continue to speak the same language, it is essential that we become familiar with the changes to DSM’s organizational structure, the inclusion and exclusion of specific diagnoses, and the new diagnostic labels for existing diagnoses. The purpose of this summary is to highlight key revisions to the diagnostic system and briefly discuss the implications of these changes for children, adolescents, and their families. The most obvious change for social workers working with children and adolescents is the elimination of the section in DSM-IV-TR (APA, 2000) titled “Disorders Usually First Diagnosed in Infancy, Childhood and Adolescence.” Instead, DSM-5 integrates developmental and lifespan considerations across diagnostic chapters, with early chapters focused on diagnoses typically given in childhood and adolescence (e.g., neurodevelopmental) and later chapters focused on those given later in the lifespan (e.g., neurocognitive). This lifespan approach, when applicable, is also followed within each chapter. Finally, the DSM-5 committee, in their commitment to this approach, provided more precise descriptions of how the symptoms of common mental health disorders, previously described using adult symptomology, can manifest in young children and adolescents. The modified DSM-5 structure is provided in Table 1.

Another major change is the elimination of the multi-axial diagnostic format. The new format now combines Axes I–III on one axis and eliminates Axis IV (psychosocial and environmental problems) and Axis V Global Assessment of Functioning (GAF). The rationale given in DSM-5 for these changes was to increase consistency between DSM-5 diagnosis and International Classification of Diseases (ICD) and World Health Organization (WHO) recording procedures, as well as to address criticisms of the frequency of use and reliability of Axes IV and V (APA, 2013b). The loss of Axis IV is concerning from our perspective because it emphasized the examination of contextual and environmental factors in symptom presentation and course of illness. As a matter of practice, we would recommend continuing to consider and document these issues in psychosocial assessment where possible, especially because environmental factors in the home and school are particularly influential on youth and their mental well-being (Cipani, 2014). Likewise, we would recommend consistent use of V and Z codes on Axis I to document and highlight these factors when relevant. Further discussion of the history and elimination of Axis IV and its relationship to social work practice is provided by Barbara Probst (2014) in a recent special Research on Social Work Practice issue on DSM-5.

DSM-5 also has a new subsection on assessment measures (for future study) to support a more dimensional approach to diagnosis. These assessments are available in the text, and online (APA, 2013d). They include both cross-cutting symptom measures for children and adolescents to supplement assessment by identifying symptoms that may not fit neatly into typical diagnostic categories, as well as severity measures that measure disorder-specific symptom severity. These measures may also be administered to establish a baseline and to evaluate the client’s response to treatment over time. Also included in this section is the cultural formulation interview (CFI). This brief semistructured
interview assesses the client’s views and experience with mental health symptoms, and may be particularly useful when working with children and families to enhance cross-cultural communication and better identify environmental/psychosocial stressors and strengths (APA, 2013b). These measures are recommended for pilot use to assess their usability and feasibility in real practice settings, and feedback on their use is welcomed by the APA (2013c).

We have highlighted a few of the most relevant and controversial changes to childhood and adolescent disorders below. A more thorough summary of the key diagnostic changes related to children and adolescents can be found in Table 2.

**AUTISTIC SPECTRUM DISORDER**

DSM-5 autism spectrum disorder (ASD) has now subsumed a spectrum of symptoms that overlap with DSM-IV-TR’s autistic disorder (autism), Asperger’s disorder, childhood disintegrative disorder, and pervasive developmental disorder, Not Otherwise Specified, (NOS) (APA, 2000). The ASD diagnosis indicates the level of symptom severity in two key domains of functioning: (1) deficits in social communication and social interaction and (2) restrictive or repetitive behaviors, interests, and activities. Mental retardation, now known as intellectual disability in DSM-5, is no longer required for this diagnosis, although in more severe cases intellectual disability may co-occur.

This has been one of the most hotly debated changes in DSM-5. Initially, autism advocates protested, citing concerns that the changes may result in greater stigma and confusion for those formerly identified as having Asperger’s disorder and reduce access to or quality of services for those with a current diagnosis (Grant & Nozycz, 2013). Proponents of this change, on the other hand, suggest that the aforementioned DSM-IV-TR disorders differentiated poorly from one another, and were applied inconsistently across treatment settings (APA, 2013a). The rationale for the change was to improve accuracy of diagnosis while also allowing clinicians to better describe idiosyncratic client symptoms. While the future impact of the new DSM-5 ASD criteria on diagnosis and service provision remains to be seen, the DSM-5 ASD criteria explicitly state that individuals with a current DSM-IV-TR diagnosis on the autism spectrum will not lose their current diagnosis (APA, 2013b). As such, individuals currently diagnosed with an autism spectrum disorder should retain their diagnosis and related services in the future (Autism Speaks, 2014).

**ATTENTION DEFICIT HYPERACTIVITY DISORDER**

Attention deficit hyperactivity disorder (ADHD) is the disorder most frequently diagnosed in children and adolescents, with an estimated 8 percent of all U.S. children having the diagnosis at any given time (Merikangas et al., 2010). ADHD was previously conceptualized as a behavioral disorder in DSM-IV-TR. However, emerging research has supported the reconceptualization of ADHD as a neurodevelopmental disorder. The diagnostic criteria now allow for an ADHD diagnosis among individuals for whom significant symptoms were present prior to age 12, rather than age 7. Subtypes of this disorder have also been eliminated in favor of specifiers, and the disorder can now be diagnosed even when intellectual disability, formerly mental retardation, is present. It is important, however, to be mindful during differential diagnosis that the later onset of symptoms may be more easily confused with other psychiatric causes of hyperactivity, distractibility, and attention deficit (Frances, 2013; Sibley, Waxmonsky, Robb, & Pelham, 2013).

**POSTTRAUMATIC STRESS DISORDER AND REACTIVE ATTACHMENT DISORDER**

One significant and overdue change to the organizational structure of DSM was the division of the anxiety disorders category into three distinct categories of disorders with similar etiology, progression, and symptom presentation. One of these categories is trauma- and stressor-related disorders, which has grouped together all diagnoses that occur following a traumatic event or psychosocial stressor, including adjustment disorders, acute stress disorder, posttraumatic stress disorder (PTSD), and reactive attachment disorder (RAD). The two specifiers for RAD—disinhibited and inhibited—have now been separated into two distinct diagnoses, reactive attachment disorder and disinhibited social engagement disorder. While both of these diagnoses require a history of social neglect and unresponsive caregiving during childhood, they are differentiated in DSM-5 given their disparate presentation, course, and response to intervention. Specifically, RAD is characterized by internalized depressive symptoms and withdrawn behavior, whereas children with disinhibited social engagement disorder present with symptoms of disinhibition and externalizing behavior.

Another welcome change in the new manual is the addition of specific PTSD diagnostic information for children 6 years and older, with a specific section providing description of PTSD symptoms in children younger than 6. This addition to the manual should be helpful for social workers who work with young children, given the disparate nature with which trauma symptoms present in the very young. Mental health providers working with children up to age 3 may also be interested in reviewing the criteria for PTSD in the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood, Revised Edition DC-0-3R (Three, 2005).

**DISRUPTIVE MOOD DYSREGULATION DISORDER**

There has been a reported 500 percent increase in diagnosis of childhood bipolar disorder over the past decade (Perou et al., 2013). Although this may be due to increased awareness of this disorder in children, many contend that the diagnostic increase is due to a belief that high levels of irritability and low frustration tolerance were indicative of a pre-manic state in childhood bipolar disorder (Copeland, Angold, Costello, & Egger, 2013). With medication as the first line of treatment for bipolar disorder, more and more children are being prescribed not only antidepressants but also mood stabilizers and atypical antipsychotics (National Institute of Mental Health, 2013). This is of particular concern given the recent proliferation of lawsuits related to the use of risperidone and similar medications with adolescent boys that has resulted in type II diabetes, gynomastia, and other significant health concerns (Drent, Lettinga, Buitleaar,
Glennon, & Hoekstra, 2011; Healy, 2012). To counter this trend, DSM-5 offers a new depressive disorder, disruptive mood dysregulation disorder (DMDD), to reduce the inaccurate diagnosis of childhood bipolar disorder by disentangling the irritability and tantrums that now characterize DMDD from the cyclical or episodic nature of bipolar disorder. Specifically, DMDD is diagnosed in children up to the age of 12 who display persistent irritability and recurrent temper outbursts across at least two settings inconsistent with the child’s current developmental level. Symptoms may be similar and difficult to differentiate from the irritability seen in oppositional defiant disorder (ODD)—if the criteria are met for both ODD and DMDD, a diagnosis of DMDD should be provided. While this is a step in the right direction away from the inflated diagnosis of childhood bipolar disorder, research is needed to further test the validity of this disorder (Frances, 2013) given the potential for its continued use and the development of psychotropic medications that may be harmful for children.

GRIEF AND MAJOR DEPRESSIVE DISORDER
Another controversial change is the removal of the bereavement exclusion from the diagnosis of major depressive disorder (MDD), which used to require that depressive symptoms persist for longer than 2 months following the loss of a loved one. The grief process for children, as for adults, is often marked by irritability, sleep problems, changes in appetite, social isolation, and changes in thought or behavior patterns that strongly resemble the symptomology of major depressive disorder (Pearlman, Swalwelbe, & Cloitre, 2010). Distinguishing between the two can be difficult at best. Concerns are spurred by contradictory evidence (Wakefield & First, 2012; Zisook, Shear, & Kendler, 2007) and a lack of clinical consensus on the removal of the exclusion, which may lead to an increase in the diagnosis of “false positives” in children. In light of this change, we recommend that clinicians become familiar with the varied manifestations of childhood grief and continually assess the grieving process and cultural norms of children and adolescents before rendering a diagnosis of major depressive disorder. In response to the controversy regarding the bereavement exclusion, there is a note in the DSM-5 diagnostic criteria that attempts to differentiate a normal grief response from that of MDD and reinforces the importance of clinical judgment when making a diagnosis.

GENDER DYSPHORIA
DSM-5 has introduced new diagnoses of gender dysphoria in children and gender dysphoria in adolescents and adults, which were formerly known as gender identity disorder. As the new name implies, the diagnostic criteria for childhood gender dysphoria require an overwhelming sense of disconnect between the child’s sense of self and his or her assigned gender, which leads to significant and persistent feelings of distress. DSM-5 includes criteria specific to the diagnosis of gender dysphoria in children that are developmentally informed and more stringent than the diagnostic criteria offered for diagnosis of gender dysphoria in adolescents and adults. We hope that the name change will lead to decreased stigma related to having a “disordered identity.” Many in the field, including the second author, have advocated for removal of this diagnosis from DSM altogether because of its reinforcement of the gender binary and pathologizing of normal variations in gender identity and expression (Lev, 2013; Washburn, 2013). However, proponents of retaining the diagnosis argue that children and adolescents will lack access to the medically necessary therapeutic and hormonal interventions if the diagnosis is removed. Coverage for services related to gender dysphoria differs from state to state for Medicaid and from policy to policy for private insurers. Further complications arise in trying to distinguish coverage and treatment for gender dysphoria with co-occurring disorders of sexual development from dysphoria without, leaving the validity of this diagnosis as a mental disorder still open to debate.

SUMMARY AND RECOMMENDATIONS
With many diagnostic thresholds being lowered and the addition of a number of new diagnoses applicable for children and adolescents, the impact of these changes on the field remains uncertain. On one hand, some of these changes may strengthen the trend of increased identification of mental health problems in our youth and subsequently reduce the epidemic of U.S. youth at risk for suicide, through effective prevention and treatment (Perou et al., 2013; Slovak & Singer, 2012). On the other hand, lowered diagnostic thresholds may lead to a false identification of youth with mental health disorders and the use of unnecessary psychotropic medication with potentially dangerous side effects. Perhaps even more worrisome is the impact a decreased threshold of diagnosis may have on our most vulnerable youth populations—children in child welfare and juvenile justice systems—who have much higher rates of mental health diagnoses and psychotropic medication treatment than the general population (Cohen, Pfeifer, & Wallace, 2012; Rubin et al., 2012). Unfortunately, medication is often the first line of treatment for children in these settings and the long-term effects of many psychotropic medications for youth are still unclear, making it advisable to take a “less is more” approach. The impact of changes in DSM-5 diagnostic criteria on potential overmedication of these at-risk youth remains to be seen.

As social workers, our emphasis on a strengths and person-in-environment perspective for assessment is important for conducting a thorough, contextualized assessment using DSM-5 (Robbins, 2014). Given this emphasis and the potential for lowered diagnostic thresholds, we recommend the consistent use of V and Z codes, “watchful waiting” (Frances, 2013), and the gathering of high-quality information on client strengths and concerns from multiple adult informants before making a DSM diagnosis, especially one that may have serious implications for the client and family. We also recommend staying abreast of the most recent research concerning developments on the reliability and validity of DSM-5 diagnoses, as well as continuing to think critically about these changes.
### Table 1. Modified Developmental Organizational Structure of DSM-5

<table>
<thead>
<tr>
<th>DSM-IV-TR Category</th>
<th>DSM-5 Category or Categories</th>
</tr>
</thead>
</table>
| Disorders usually first diagnosed in infancy, childhood, and adolescence           | • Neurodevelopmental disorders  
• Disruptive, impulse-control, and conduct disorders  
• Feeding and eating disorders  
• Elimination disorders |
| Delirium, dementia, amnestic and amnestic and other cognitive disorders             | • Neurocognitive disorders                                                               |
| Mood disorders                                                                     | • Depressive disorders  
• Bipolar and related disorders                                                       |
| Anxiety disorders                                                                  | • Anxiety disorders  
• Trauma and stressor related disorders  
• Obsessive-compulsive and related disorders |
| Somatoform disorders                                                               | • Somatic symptom and related disorders                                                  |
| Factitious disorders                                                               | • Somatic symptom and related disorders                                                  |
| Sexual and gender identity disorders                                               | • Sexual dysfunctions  
• Gender dysphoria  
• Paraphilic disorders                                                               |
| Adjustment disorders                                                               | • Trauma- and stressor-related disorders                                                   |
| Impulse-control disorders not elsewhere classified                                  | • Disruptive, impulse-control, and conduct disorders                                      |
| Amnestic disorders                                                                 | • Neurocognitive disorders                                                               |

### Table 2. Key Diagnostic Changes in the DSM-5 for Providers of Children, Adolescents, and Families

<table>
<thead>
<tr>
<th>Changes to Diagnoses Formerly in Section on Disorders First Diagnosed in Infancy, Childhood, and Adolescence</th>
</tr>
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</table>
| Mental retardation  
• Now called intellectual disability deficits, evaluated in three domains  
  1. Conceptual domain  
  2. Social domain  
  3. Practical domain  
Rubrics to evaluate severity on pp. 34–36 |
| Reactive attachment disorder—emotionally withdrawn/inhibited  
Reactive attachment disorder—indiscriminately social/disinhibited  
Anxiety disorder—Separated into two distinct disorders:  
• Reactive attachment disorder  
• Disinhibited social engagement disorder |
| Selective mutism  
Anxiety disorder |
| Autistic spectrum disorder  
• Former diagnoses of autistic disorder, Asperger’s disorder, and childhood disintegrative disorder are part of spectrum  
Children are evaluated in two domains of functioning:  
  1. Social communication and social interaction  
  2. Restricted and repetitive behaviors, interests, and activities  
Severity specifiers with examples of functional impairment are listed on p. 52 |
| Attention deficit hyperactivity disorder (ADHD)  
• Can be diagnosed if significant symptoms are present before age 12, rather than age 7  
• Subtypes have been replaced with presentation specifiers  
• Co-occurring diagnosis of autism spectrum disorder is now allowed  
• Specific examples of inattentive or disruptive behaviors have been added for clarity |
| Conduct and oppositional defiant disorder  
Disruptive, impulse-control, and conduct disorders |
| Pica and rumination disorder  
Eating and feeding disorders |
| Encopresis and enuresis  
Elimination disorders |
| Separation anxiety disorder  
Anxiety disorder  
Onset prior to age 18 no longer required |
| Learning disorders, communication disorders, motor skill and tic disorders, stereotypic movement disorder  
Neurodevelopmental disorders  
Minimal refinements in names and diagnostic criteria, except for criteria for social communication disorder |
### Other Key Diagnostic Changes

<table>
<thead>
<tr>
<th>Bipolar I and Bipolar II</th>
<th>Manic and hypomanic episodes must be characterized by changes in <strong>activity</strong> and <strong>energy</strong> as well as <strong>mood</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depressive disorder</td>
<td>Bereavement exclusion eliminated</td>
</tr>
<tr>
<td>Persistent depressive disorder</td>
<td>Depressive disorder, formerly named dysthymia</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>Differentiation between “abuse” and “dependence” has been eliminated, all coded as substance use disorder</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>Feeding and eating disorder characterized by episodic binges and compensatory behavior. Criteria for bingeing and compensatory behavior changed from 2× weekly to 1× weekly for at least 3 months</td>
</tr>
<tr>
<td>Binge eating disorder</td>
<td>Feeding and eating disorder, characterized by binges at least 1× weekly for 3 months</td>
</tr>
</tbody>
</table>
| Posttraumatic stress disorder (PTSD) | Trauma- and stressor-related disorder  
- Separate criteria used for diagnosis in children under age 6  
- Diagnostic thresholds lower for children  
- Four major domains of symptom clusters instead of three:  
  1. Re-experiencing  
  2. Avoidance  
  3. Arousal  
  4. Negative alterations in cognitions and mood |
| Personality disorders | May now be diagnosed in adolescents under age 18 if features have been present for at least one year (except anti-social personality disorder—still diagnose conduct disorder prior to age 18) |
| Gender dysphoria | Formerly, gender identity disorder  
Now in its own category  
- Replacement of term “sex” with more accurate term “gender”  
- Separate criteria sets for adults and children  
- In children: increase from 4 to 6 symptoms present for at least 6 months for diagnosis  
- Can diagnose with co-occurring disorder of sexual development (formerly termed intersex condition)  
- Removal of specifier concerning sexual attraction due to limited clinical utility  
- Now allows for diagnosis in children who may not openly verbalize desire to be other gender due to their social environment |

### REFERENCES


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and what they mean for our clients moving forward.


Practice Perspective
Advancing Health Equality Through the National Culturally and Linguistically Appropriate Services (CLAS) Standards

The U.S. Department of Health and Human Services Office of Minority Health (HHS, OMH) recently released the new and improved National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards). This Practice Perspective provides an overview of the revised CLAS Standards and their implications for social work practice.

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