DSM-5 CHANGES: IMPLICATIONS FOR CHILD SERIOUS EMOTIONAL DISTURBANCE

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1. Introduction

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is the manual used by clinicians and researchers to diagnose and classify mental disorders (including substance use disorders [SUDs]). The DSM specifically classifies child disorders by symptoms, duration, and functional impact across home, school, and other community settings. The American Psychiatric Association (APA) published the DSM-5 in 2013, culminating a 14-year revision process. This latest revision takes a new approach to defining the criteria for mental disorders—a lifespan perspective. This perspective is very relevant to diagnosing childhood mental disorders. The perspective recognizes the importance of age and development in the onset, manifestation, and treatment of mental disorders. The purpose of this report is to describe the differences between the DSM-IV and DSM-5 diagnostic criteria that could affect national estimates of childhood serious emotional disturbance (SED). The report also provides a description of DSM-5 updates that have been made (or are being made) to existing diagnostic instruments and screeners of childhood emotional and behavioral health.

1.1 Definition of SED

The DSM has never offered a definition of SED. This term has been defined historically by the Substance Abuse and Mental Health Services Administration (SAMHSA) and released as a *Federal Register* notice. The SAMHSA definition was crafted in order to inform state block grant allocations for community mental health services provided to children with an SED and adults with a serious mental illness (SMI). The *Federal Register* definition is intended to identify and estimate the size of the group of children with SED within the general population of each state. An accurate and up-to-date estimate of childhood SED is critical for SAMHSA to plan future block grant allocations and financial supports to states serving children with SED.

The *Federal Register* notice defines the terms "children with a serious emotional disturbance" and "adults with a serious mental illness" (SAMHSA, 1993, p. 29422). Pub. L. 102-321 defines children with an SED to be people "from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R; American Psychiatric Association, 1987) that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities" (SAMHSA, 1993, p. 29425).

The 1992 and 1993 *Federal Register* notices also offer several notes that are helpful in considering the age, symptom duration, and diagnostic exclusions related to the definition of childhood SED:

- Age: "Although the definition of SED in children is restricted to persons up to age 18, it is recognized that some states extend this age range to persons less than age 22. To accommodate this variability, states using an extended age range for children's services should provide separate estimates for persons below age 18 and persons aged 18 to 22 within block grant applications" (SAMHSA, 1993, p. 29425).

- Duration: "The reference year…refers to a continuous 12-month period because this is a frequently used interval in epidemiological research and because it relates to commonly used [state] planning cycles" (SAMHSA, 1993, p. 29425).
- Diagnostic exclusions: "These disorders include any mental disorders listed in the DSM-III-R…with the exception of DSM-III-R "V" codes, substance use and developmental disorders, which are excluded unless they co-occur with another diagnosable serious emotional disturbance" (SAMHSA, 1993, p. 29425).

A November 6, 1992, *Federal Register* notice requests public comments to a preliminary definition of childhood SED (SAMHSA, 1992). The May 20, 1993, *Federal Register* describes responses to public comments received in response to the 1992 notice. Public comments to the proposed SED definition primarily focused on the impairment criteria, with support for considering a broad definition of impairment and also concerns that including less impairing disorders would dilute resources for those with the most severely debilitating conditions. A smaller set of comments focused on the inclusion or exclusion of certain disorders such as substance abuse, developmental disorders, and attention deficit disorder.

The 1993 *Federal Register* offers clarification on final decisions about disorders to be included and excluded in the SED definition. Public comments included concerns about whether attention-deficit disorder (ADD) should be included for two main reasons: (1) parental concerns about the negative stigma associated with labelling ADD as a "serious emotional disturbance" and (2) treatment providers/educators noting difficulties making definitive ADD diagnoses. Ultimately, ADD was included in the definition of SED because "a significant group of children with functional impairments associated with this disorder might otherwise be excluded from service" (p. 29423). SUDs were excluded based upon the rationale that the federal government administered a separate state block grant intended to fund substance abuse treatment and prevention services. Developmental disorders (mental retardation, autism, pervasive developmental disorders) were also excluded. The rationale described for this decision was as follows: "while comments received cited the frequent involvement of mental health practitioners in treatment planning and service delivery for these individuals (particularly autistic children), separate Federal block grant funds and processes for needs assessment cover these population groups" (SAMHSA, 1993, p. 29424). Finally, DSM-III "V" codes were excluded because "they represent conditions that may be a focus of treatment but are not attributed to a mental disorder" (p. 29424).

In summary, DSM mental disorder classifications are relevant to SED as they form the basis for an essential part of the SED criteria—the presence of a DSM-based mental disorder. Changes in the number of mental disorders (as defined by the DSM) that fall under the operationalized definition of SED, and breadth of the diagnostic criteria for existing DSM-based mental disorders might impact the prevalence rates of SED. The current operationalized definition of SED may need to be updated to ensure consistent and precise measurement of the prevalence of SED within epidemiological studies at the national level.

1.2 Published SED Estimates

Three large-scale epidemiological studies have provided estimates of SED based upon the administration of child and adolescent diagnostic interviews. These studies include a

supplemental study to the National Health and Nutrition Examination Survey (NHANES; Merikangas et al., 2010), the National Comorbidity Survey Adolescent Cohort (NCS-A; Kessler et al., 2012), and the Great Smoky Mountain Study (GSMS; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). These three studies assess slightly different age groups, use different diagnostic instruments, and include the assessment of slightly different childhood mental disorders (see Table 1). The disorders assessed in these studies reflect diagnostic categories to be considered when estimating the prevalence of SED.

Table 1. DSM-IV Childhood Mental Disorders Assessed in Leading Studies with Published Estimates of SED

Disorder Category	NCS-A (13–17 years) Composite International Diagnostic Interview (CIDI)	NHANES (8–15 years) Diagnostic Interview Schedule for Children (DISC)	GSMS (9–16 years) Child and Adolescent Psychiatric Assessment (CAPA)
Mood Disorder	Major depression Dysthymia Bipolar disorder	Major depression Dysthymia	Major depression Dysthymia Bipolar disorder Mania Depression NOS
Anxiety Disorders	Generalized anxiety disorder Panic disorder Agoraphobia Specific phobia Separation anxiety disorder Posttraumatic stress disorder Social phobia	Generalized anxiety disorder Panic disorder	Generalized anxiety disorder Panic disorder Agoraphobia Simple phobia Separation anxiety disorder Posttraumatic stress disorder Obsessive compulsive disorder
Behavior Disorders	ADHD Conduct disorder Oppositional defiant disorder	ADHD Conduct disorder	ADHD Conduct disorder Oppositional defiant disorder
Substance Disorders	Alcohol abuse Drug abuse		Alcohol abuse Drug abuse
Other	Eating disorders	Eating disorder	Eating disorders Trichotillomania Enuresis Encopresis Psychosis

ADHD = attention-deficit/hyperactivity disorder; NOS = not otherwise specified.

Each study defines SED to include any assessed DSM-IV Axis I disorder. The R.C. Kessler et al. (2012) and Costello et al. (2003) publications include substance disorders within the SED estimates, while the *Federal Register* definition of SED excludes substance abuse. "Serious functional impairment" is defined differently in each study based upon how the study's diagnostic interview measured impairment. One study, (Costello et al., 2003), defined SED using the Child and Adolescent Psychiatric Assessment (CAPA) as any Axis I disorder with "significant functional impairment." CAPA-based definitions of SED include a child who (1) meets diagnostic criteria for at least one of the assessed Axis I disorders by parent or child report, and (2) has a report of any partial or severe impairment rating by parent or child report

(personal communication with G. Keeler, October 2012). R.C. Kessler et al. (2012) defined the serious impairment criteria for SED as a Children's Global Assessment Scale (CGAS) score of 50 or less (having moderate functional impairment in most areas of living or severe impairment in at least one area). Moderate impairment was defined as one or more Axis I disorders plus a CGAS score of 51 to 60 (variable functioning with sporadic difficulties in several but not all areas of living). Meanwhile, Merikangas and colleagues (2010) operationalized four levels of impairment for each disorder assessed: level A, intermediate or severe rating on ≥ one question; level B, intermediate or severe rating on ≥ two questions (level A and B are not mutually exclusive); level C, severe rating on ≥ one question; and level D (severe impairment), included meeting criteria for either level B or C. Impairment items assessed impairment in six domains, including interference with the respondent's own life, family life, social life, peers, teachers, and school performance. "Any DSM-IV Disorder with Severe Impairment," or SED, was defined as a case with level D impairment.

These definitions of SED result in prevalence estimates that range from 6.8 to 11.5 percent depending on the study and age of children included (see Table 2). The following sections of this report describe how recent updates to the DSM may or may not result in likely changes to these prevalence estimates of SED. This report does not summarize DSM-IV to DSM-5 changes to SUDs since they are excluded from the *Federal Register* definition of SED. Another SAMSHA report *Impact of the DSM-IV to DSM-5 Conversion on the National Survey on Drug Use and Health and the Mental Health Surveillance Study* includes a detailed description of changes from DSM-IV to DSM-5 for SUDs among youths aged 12 to 17 years (Center for Behavioral Health Statistics and Quality, in review).

Table 2. Past 12-month Prevalence of Mental Disorders Based upon the NCS-A, NHANES Special Study, and GSMS, by Functional Impairment and Child Age

	Prevalence Estimate (%, SE)			
	NCS-A (13-17 years) Past 12 Months	**NHANES Special Study (12-15 years) Past 12 Months**	**NHANES Special Study (8-11 years) Past 12 Months**	**GSMS (9-16 years) Past 3 Months**
Any DSM-IV Disorder	42.6 (1.2)	13.4 (1.2)	12.8 (1.3)	13.3
SED (and associated definition)	8.0 (1.3) *Moderate impairment rating in most areas of living or severe in 1 area*	11.5 (1.3) *Level A or B: Intermediate impairment rating on 2 of 6 items or at least 1 severe rating*	11.0 (1.1) *Level A or B: Intermediate impairment rating on 2 of 6 items or at least 1 severe rating*	6.8 *Any Axis I plus "significant functional impairment"*
Disorder with moderate or severe impairment in any area of living	17.8 (n/a) *Moderate impairment was defined as variable functioning, with sporadic difficulties in several, but not all areas of living.*	Not provided	Not provided	Not provided

2. DSM-IV to DSM-5 Changes: Overview

The American Psychiatric Association (APA) published the DSM-5 in 2013. This latest revision takes a lifespan perspective recognizing the importance of age and development on the onset, manifestation, and treatment of mental disorders. Other changes in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM-5) include eliminating the multi-axial system; removing the Global Assessment of Functioning (GAF score); reorganizing the classification of the disorders; and changing how disorders that result from a general medical condition are conceptualized. Many of these general changes from *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV) to DSM-5 are summarized in the report *Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health*. This report will supplement that information by providing details specifically about changes to disorders of childhood and their implications for generating estimates of child serious emotional disturbance (SED).

2.1 Elimination of the Multi-Axial System and GAF Score

One of the key changes from DSM-IV to DSM-5 is the elimination of the multi-axial system. DSM-IV approached psychiatric assessment and organization of biopsychosocial information using a multi-axial formulation (American Psychiatric Association, 2013b). There were five different axes. Axis I consisted of mental health and substance use disorders (SUDs); Axis II was reserved for personality disorders and mental retardation; Axis III was used for coding general medical conditions; Axis IV was to note psychosocial and environmental problems (e.g., housing, employment); and Axis V was an assessment of overall functioning known as the GAF. The GAF scale was dropped from the DSM-5 because of its conceptual lack of clarity (i.e., including symptoms, suicide risk, and disabilities in the descriptors) and questionable psychometric properties (American Psychiatric Association, 2013b).

Although the impact of removing the overall multi-axial structure in DSM-5 is unknown, there is concern among clinicians that eliminating the structured approach for gathering and organizing clinical assessment data will hinder clinical practice (Frances, 2010). However, the direct impact on the prevalence rates of childhood mental disorders is likely to be negligible as it will not affect the characteristics of diagnoses.

2.2 Disorder Reclassification

DSM-IV and DSM-5 categorize disorders into "classes" with the intent of grouping similar disorders (particularly those that are suspected to share etiological mechanisms or have similar symptoms) to help clinician and researchers use of the manual. From DSM-IV to DSM-5, there has been a reclassification of many disorders that reflects a better understanding of the classifications of disorders from emerging research or clinical knowledge. Table 3 lists the disorder classes included in DSM-IV and DSM-5. In DSM-5, six classes were added and four were removed. As a result of these changes in the overall classification system, numerous individual disorders were reclassified from one class to another (e.g., from "mood disorders" to "bipolar and related disorders" or "depressive disorders"). The reclassification of disorder classes

will not have a direct effect on any SED estimation; however, it does warrant consideration when documenting disorders that may have changed classes.

Table 3. Disorder Classes Presented by the DSM-IV and DSM-5, as Ordered in DSM-IV

DSM-IV	DSM-5
1. Disorders usually first diagnosed in infancy, childhood, or adolescence	Dropped[1]
2. Delirium, Dementia, and Amnestic and other cognitive disorders	17. Neurocognitive Disorders
3. Mental Disorders due to a general medical condition	Dropped[1]
4. Substance-related disorders	16. Substance-Related and Addictive Disorders
5. Schizophrenia and other psychotic disorders	2. Schizophrenia Spectrum and Other Psychotic Disorders
6. Mood Disorders	3. Bipolar and Related Disorders
	4. Depressive Disorders
7. Anxiety Disorders	5. Anxiety Disorders
8. Somatoform Disorders	9. Somatic Symptom and Related Disorders
9. Factitious Disorders	Dropped[1]
10. Dissociative Disorders	8. Dissociative Disorders
11. Sexual and Gender Identity Disorders	13. Sexual Dysfunctions
	14. Gender Dysphoria
	19. Paraphilic Disorders
12. Eating Disorders	10. Feeding and Eating Disorders
13. Sleep Disorders	12. Sleep-Wake Disorders
14. Impulse-Control Disorders not elsewhere classified	15. Disruptive, Impulse-Control, and Conduct Disorders
15. Adjustment Disorders	Dropped[1]
16. Personality Disorders	18. Personality Disorders
N/A	1. Neurodevelopmental Disorders
N/A	6. Obsessive-Compulsive and Related Disorders
N/A	7. Trauma- and Stressor-Related Disorders
N/A	11. Elimination Disorders
N/A	20. Other Mental Disorders
N/A	21. Medication-Induced Movement Disorders and Other Adverse Effects of Medication

[1] A notation of "dropped" does not imply that the specific disorders were removed; rather the overall classification is not included in DSM-5. Disorders in those classes were mainly recategorized.

Of particular note for childhood mental disorders, the DSM-5 eliminated a class of "disorders usually first diagnosed in infancy, childhood, or adolescence." Those disorders are now placed within other classes. See Table 4 for a summary the new DSM-5 disorder classes for those disorders formally classified as "disorders usually first diagnosed in infancy, childhood, or adolescence."

Table 4. Disorder Classification in the DSM-IV and DSM-5 for Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

Disorder Types (version)	DSM-IV Disorder Class	DSM-5 Disorder Class
Mental Retardation (DSM-IV) Intellectual Disabilities (DSM-5)	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental Disorders
Learning Disorders	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental Disorders
Motor Skills Disorder	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental Disorders
Communication Disorders	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental Disorders
Pervasive Developmental Disorders (DSM-IV) Autism Spectrum Disorder (DSM-5)	Disorders usually first diagnosed in infancy, childhood, or adolescence	Neurodevelopmental Disorders
Attention-Deficit/Hyperactivity Disorder	Disorders usually first diagnosed in infancy	Neurodevelopmental Disorders
Conduct Disorder	Disorders usually first diagnosed in infancy	Disruptive, Impulse-Control, and Conduct Disorders
Oppositional Defiant Disorder	Disorders usually first diagnosed in infancy	Disruptive, Impulse-Control, and Conduct Disorders
Feeding and Eating Disorders of Infancy or Early Childhood	Disorders usually first diagnosed in infancy	Feeding and Eating Disorders
Tic Disorders	Disorders usually first diagnosed in infancy	Neurodevelopmental Disorders
Elimination Disorders	Disorders usually first diagnosed in infancy	Elimination Disorders
Separation Anxiety Disorder	Disorders usually first diagnosed in infancy	Anxiety Disorders
Selective Mutism	Disorders usually first diagnosed in infancy	Anxiety Disorders
Reactive Attachment Disorder	Disorders usually first diagnosed in infancy	Trauma- and Stressor-Related Disorders

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3. DSM-5 Child Mental Disorder Classification

The *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM-5) includes changes to some key disorders of childhood. Two new childhood mental disorders were added in the DSM-5: social communication disorder (or SCD) and disruptive mood dysregulation disorder (or DMDD). There were age-related diagnostic criteria changes for two other mental disorder categories particularly relevant to the definition of serious emotional disturbance (SED): attention-deficit/hyperactivity disorder (ADHD) and post-traumatic stress disorder (PTSD). An ADHD diagnosis now requires symptoms to be present prior to the age of 12 (rather than 7, the age of onset from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. [DSM-IV]). PTSD includes a new subtype specifically for children younger than 6 years of age.

Sections 3.1 and 3.2 provide detailed descriptions of these disorders as well as summaries of the research that has been conducted around their impact on the prevalence of childhood mental disorders. Other disorders did not have specific DSM-5 changes related to childhood, but these changes would be relevant to both adults and children (e.g., major depressive disorder [MDD], generalized anxiety disorder [GAD]). Section 3.3 provides a brief overview of DSM-5 changes to these remaining disorders. In the report sections that follow we reference prevalence rates found in studies of community samples using the DSM-5. For some disorders, we also reference prevalence rates in clinical samples where direct comparisons were performed between DSM-IV and DSM-5 ratings. The prevalence rates from clinical samples are relevant to this report in demonstrating the magnitude of change that might be expected in prevalence rates from DSM-IV to DSM-5.

3.1 New Childhood Mental Disorders Added to the DSM-5

3.1.1 Social (Pragmatic) Communication Disorder (SCD, under Neurodevelopmental Disorders)

Description. The DSM-5 communication disorders include a new condition for persistent difficulties in the social uses of verbal and nonverbal communication: social (pragmatic) communication disorder or SCD. SCD is characterized by a primary difficulty with pragmatics—the social use of language or communication—resulting in functional limitations in effective communication, social participation, development of social relationships, and academic achievement (see Table 5 for a description of DSM-5 SCD diagnostic criteria). Symptoms of SCD include difficulties in the acquisition and use of spoken language and inappropriate responses in conversation. Although diagnosis is rare for children younger than 4 years old, symptoms must be present in early childhood even if not recognized until later. Individuals with SCD have never had effective social communication. This new disorder cannot be diagnosed if social communication deficits are part of the two main characteristics of the new autism spectrum disorder (ASD). ASD is characterized by (1) deficits in social communication and social interaction and (2) restricted repetitive behaviors, interests, and activities (RRBs). Because both components are required for an ASD diagnosis, SCD is diagnosed if no RRBs are present or there is no past history of RRBs. As described by the American Psychiatric Association (APA), the symptoms of some patients

diagnosed with DSM-IV pervasive developmental disorder not otherwise specified (PDD-NOS) may meet the DSM-5 criteria for SCD (American Psychiatric Association, 2013c).

Table 5. DSM-IV Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS) to DSM-5 Social (Pragmatic) Communication Disorder (SCD) Comparison

DSM-IV	DSM-5
Disorder Class: Pervasive Developmental Disorders	Disorder Class: Neurodevelopmental Disorders
Severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests, and activities are present but are not met for a specific pervasive developmental disorder. This category includes "atypical autism" (late age of onset, atypical symptomatology).	A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following: 1. Deficits in using communication for social purposes 2. Impairment of the ability to change communication to match context 3. Difficulties for following rules for conversation (taking turns, use of verbal/nonverbal signs to regulate interaction) 4. Difficulties understanding what is not explicitly stated
	B. The deficits result in functional limitations in effective communication, social participation, social relationships, and academic achievement.
	C. The onset of the symptoms is in the early development period, but may not fully manifest until social communication demands exceed limited capabilities.
	D. The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains of word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability, or developmental delay.

Estimated Prevalence. Although a few studies have reported empirical support for a conceptualization of SCD distinguishable from ASD (Gibson, Adams, Lockton, & Green, 2013) and ADHD (St Pourcain et al., 2011), there is one practitioner review publication describing concern that the inclusion/exclusion criteria and differential diagnosis with ASD, ADHD, social anxiety disorders, intellectual disabilities, and developmental delays, may mean that very few individuals will meet diagnostic criteria for SCD (Norbury, 2014).

No study was found on the general population's prevalence of SCD. In one study that analyzed three datasets (1) data from the Simons Simplex Collection, a genetic consortium study focusing on families having just one child with an ASD; (2) the Collaborative Programs of Excellence in Autism, a multicenter study of ASD; and (3) the University of Michigan Autism and Communication Disorders Center data bank that included a total of 4,453 children with DSM-IV clinical PDD diagnoses and 690 with non-PDD diagnoses (e.g., language disorder), the proposed ASD DSM-5 criteria identified 91 percent of children with clinical DSM-IV PDD diagnoses (Huerta, Bishop, Duncan, Hus, & Lord, 2012). In this samples of children with DSM-IV diagnosis for PPD (86.6 percent of the pooled sample) and non-PPD (13.4 percent of the pooled sample), only 75 of 5,143 (1.5 percent) met social communication criteria for ASD, but did not meet threshold criteria for RRBs. This study concluded that few children with ASD are likely to be misclassified as having SCD or will be reclassified as SCD under the DSM-5 (Huerta

et al., 2012). In contrast, a second study based on the multisite field trial of the DSM-IV of adults and children (mean age 9 years old), of which 657 had a clinical diagnosis of PDD and 276 had a diagnosis other than PDD (mental retardation, language disorders, childhood schizophrenia), almost 40 percent of cases with a clinical diagnosis of PDD and 71.7 percent of those with PDD-NOS did not met revised DSM-5 diagnostic criteria for ASD, concluding that proposed DSM-5 criteria could substantially alter the composition and estimate of the autism spectrum (McPartland, Reichow, & Volkmar, 2012). In the DSM-5 field trials in the United States and Canada based on child clinical populations (general child psychiatry outpatient services), one of the sites (Baystate Medical Center, Springfield, MA) found the DSM-IV and DSM-5 prevalence of ASD was almost the same (23 percent and 24 percent), but a second site (Stanford University Hospital, Palo Alto, CA) found the prevalence of ASD decreased from 26 percent to 19 percent. A review of the data (no tables provided in the publication) showed that the decrease at Stanford was offset by movement into the new SCD diagnosis (Regier et al., 2013).

Overall, these studies suggest that between 1.5 percent to 40 percent or more of children who would have been classified as PDD before, will not meet diagnostic criteria of ASD under the DSM-5 and some of them would likely be reclassified as SCD and be included in the SED estimate, if SCD is part of the SED definition (McPartland, Reichow, & Volkmar, 2012). It should be noted that there is concern in the field that SCD could be over diagnosed by speech-language pathologists. If SCD is treated as a residual category (like the previous PDD-NOS) for communication disorders diagnosed by speech-language pathologists, children who should be diagnosed as ASD would be classified as SCD since identifying ASD may prove challenging for speech-language pathologists (Norbury, 2014).

Implications for Estimate of SED. As SCD would be under the purview of speech-language pathology, the inclusion/exclusion of SCD on the *Federal Register* definition of SED needs to be determined. If SCD is included in the definition of SED, some increase can be expected in the estimate of SED from the reclassification of children previously classified as PDD and PDD-NOS to SCD. An additional increase in the SED estimate can be expected from the diagnoses of SCD by speech-language pathologists if they are not obtaining differential diagnosis from other professionals.

3.1.2 Disruptive Mood Dysregulation Disorder (or DMDD) (under Depressive Disorders)

Description. DMDD is a new addition to DSM-5 that aims to combine bipolar disorder that first appears in childhood with oppositional behaviors (Axelson, 2013). DMDD is characterized by severe and recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation. These occur, on average, three or more times each week for 1 year or more (see Table 6 for a description of DSM-5 DMDD diagnostic criteria). The key feature of DMDD is chronic irritability that is present in between episodes of anger or temper tantrums. A diagnosis requires symptoms to be present in at least two settings (at home, at school, or with peers) for 12 or more months, and symptoms must be severe in at least one of these settings. Onset of DMDD must occur before age 10, and a child must be at least 6 years old to receive a diagnosis of DMDD. The main driver behind the conceptualization of DMDD was concern that diagnosis of bipolar disorder was being applied inconsistently across clinicians because of the disagreement about how to classify irritability in the DSM-IV. In addition, chronic childhood irritability has not been shown to predict later onset of bipolar disorder,

suggesting that irritability may be best contained within a separate mood dysregulation category (Leigh, Smith, Milavic, & Stringaris, 2012).

Table 6. DSM-IV Bipolar Disorder-Manic Episode and Oppositional Defiant Disorder to DSM-5 Disruptive Mood Dysregulation Disorder (or DMDD) Comparison

DSM-IV Criteria		DSM-5
Disorder Class: Mood Disorders Manic Episode	Disorder Class: Attention-Deficit and Disruptive Behavior Disorders Oppositional Defiant Disorder	Disorder Class: Depressive Disorders Disruptive Mood Dysregulation Disorder
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).	A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present 1. Often loses temper 2. Often argues with adults 3. Often actively defies or refuses to comply with adults' requests or rules 4. Often deliberately annoys people 5. Often blames others for his or her mistakes 6. Is often touchy or easily annoyed by others 7. Is often angry or resentful 8. Is often spiteful or vindictive	A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and or behaviorally (e.g., physical aggression) that are grossly out of proportion in intensity or duration to the situation or provocation
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree: 1. Inflated self-esteem or grandiosity 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep) 3. More talkative than usual or pressure to keep talking 4. Flight of ideas or subjective experience that thoughts are racing 5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation 7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)		B. The temper outbursts are inconsistent with developmental level

(continued)

Table 6. DSM-IV Bipolar Disorder-Manic Episode and Oppositional Defiant Disorder to DSM-5 Disruptive Mood Dysregulation Disorder (or DMDD) Comparison (continued)

DSM-IV Criteria		DSM-5
Disorder Class: Mood Disorders Manic Episode	Disorder Class: Attention-Deficit and Disruptive Behavior Disorders Oppositional Defiant Disorder	Disorder Class: Depressive Disorders Disruptive Mood Dysregulation Disorder
		C. The temper outbursts occur, on average, three or more times per week.
		D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and it is observable by others
		E. Criteria A-D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in criteria A-D.
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.	B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning	F. Criteria A-D are present in at least two of three settings (home/school/peers) and are severe in at least one setting
	D. Criteria are not met for conduct disorder, and if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.	G. The diagnosis should not be made for the first time before age 6 or after 18
		H. The age oat onset of criteria A-E is before 10 years

(continued)

Table 6. DSM-IV Bipolar Disorder-Manic Episode and Oppositional Defiant Disorder to DSM-5 Disruptive Mood Dysregulation Disorder (or DMDD) Comparison (continued)

DSM-IV Criteria		DSM-5
		I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met. Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.
Disorder Class: Mood Disorders Manic Episode	Disorder Class: Attention-Deficit and Disruptive Behavior Disorders Oppositional Defiant Disorder	Disorder Class: Depressive Disorders Disruptive Mood Dysregulation Disorder
		J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, PTSD, separation anxiety disorder).
	C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder	Note: This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, thought it can coexist with others, including major depressive disorder, ADHD, conduct disorder, and substance use disorders (SUDs). Individuals whose symptoms meet criteria for both DMDD and oppositional defiant disorder (ODD) should only be given the diagnosis of DMDD. If an individual has ever experienced a manic or hypomanic episode, the diagnosis o DMDD should not be assigned.

(continued)

Table 6. DSM-IV Bipolar Disorder-Manic Episode and Oppositional Defiant Disorder to DSM-5 Disruptive Mood Dysregulation Disorder (or DMDD) Comparison (continued)

DSM-IV Criteria		DSM-5
E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism). Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.		K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition

Estimated Prevalence. A study combining data from three community surveys: (1) a representative sample of 918 preschoolers (aged 2-5) attending a large primary care pediatric clinic in central North Carolina; (2) a representative sample of 1,420 children aged 9, 11, and 13 years in 11 predominantly rural counties of North Carolina; and (3) representative study of 920 children aged 9 to 17 years from four rural counties in North Carolina, found that prevalence of DMDD ranges from less than 1 percent to 3.3 percent depending on child age. DMDD is most prevalent among young children (aged 2 to 5) whose parents report high rates of temper tantrums and irritable moods (Copeland, Angold, Costello, & Egger, 2013). However, according to DSM-5, DMDD cannot be diagnosed in children under 6 years old; therefore, the real DSM-5 prevalence in the population will be closer to 1 percent. In the DSM-5 field trials in the United States and Canada based on child clinical populations (general child psychiatry outpatient services), estimates for DSM-IV were considered "not applicable because the diagnosis is new to DSM-5," and the DSM-5 prevalence was 5 percent for Baystate Medical Center, 8 percent for Columbia, and 15 percent for Colorado (Regier et al., 2013). Importantly, estimates for ODD in Columbia decreased from 22 percent using DSM-IV to 17 percent using DSM-5, but no additional analyses were reported to determine if children with ODD under the DSM-IV were reclassified as DMDD under DSM-5 (Regier et al., 2013).

Implications for Estimate of SED. The comorbidity of DMDD with other disorders is extremely high as described in the DSM-5, indicating that the prevalence increase in the SED estimates, if DMDD is included, will not increase as "it is rare to find individuals whose symptoms meet criteria for DMDD alone" (American Psychiatric Association, 2013b, p. 160). However, if children have symptoms that meet criteria for ODD or intermittent explosive disorders and DMDD, only DMDD should be assigned. Thus with this new diagnosis, children will be reclassified. When all symptom, severity, and frequency criteria are applied, DMDD is only present in roughly 1 percent of school-aged children (Copeland et al., 2013). DMDD should include many of the children who would have been diagnosed with bipolar disorder using the DSM-IV. Because these children would receive the new diagnosis of DMDD instead of ODD or bipolar disorder, the addition of DMDD to the DSM-5 should not affect prevalence estimates of SED.

3.2 Age-Related Diagnostic Criteria Changes to Mental Disorders in the DSM-5

3.2.1 Attention-Deficit/Hyperactivity Disorder (ADHD, under Neurodevelopmental Disorders)

Description. ADHD is a chronic neurodevelopmental disorder according to DSM-5 that is characterized by a persistent and pervasive pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the DSM-5 decision to eliminate the DSM-IV chapter that includes all diagnoses usually first made in infancy, childhood, or adolescence. The diagnostic criteria for ADHD in DSM-5 are similar to those in DSM-IV. The same 18 symptoms noted in the DSM-IV are used, and continue to be divided into two symptom domains (inattention and hyperactivity/impulsivity), of which at least six symptoms in one domain are required for diagnosis. The majority of ADHD criteria changes were geared toward improving detection of ADHD among adults. However, one change may have relevance to the estimation of SED: the onset criterion has been changed from "symptoms that caused impairment were present before age 7 years" to "several inattentive or hyperactive-impulsive symptoms were present prior to age 12." Table 7 shows a comparison between DSM-IV and DSM-5 diagnostic criteria for ADHD.

Estimated Prevalence. In the DSM-5 field trials in the United States and Canada based on child clinical populations (general child psychiatry outpatient services), using DSM-IV, ADHD prevalence at Baystate Medical Center was 59 percent and at Columbia it was 55 percent. Applying the DSM-5 criteria, the prevalence of ADHD was 69 percent at Baystate and 58 percent at Columbia, representing a 10 percent and 3 percent absolute difference, respectively (Regier et al., 2013). In a birth cohort study of 2,232 British children who were prospectively evaluated at ages 7 and 12 years for ADHD, the outcome of extending the age-of-onset criterion to age 12 resulted in the increase in ADHD prevalence by age 12 years by only 0.1 percent (Polanczyk et al., 2010). This negligible increase is in line with previous findings indicating that 95 percent of adults with a diagnosis of ADHD recall their symptoms starting before age 12 (R. C. Kessler et al., 2005).

Implications for Estimate of SED. Some increase can be expected in the SED estimate based on expanding ADHD criteria in the DSM-5 and more cases might be diagnosed. Based on studies from community samples comparing DSM-IV and DSM-5 criteria, ADHD is expected to have a modest increase (under 10 percent absolute difference).

Table 7. DSM-IV to DSM-5 Attention-Deficit/Hyperactivity Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Disorders Usually Diagnosed in Infancy, Childhood, and Adolescence	Disorder Class: Neurodevelopmental Disorders
A. Either (1) or (2): 1. Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:	A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2): 1. Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 or older), at least five symptoms are required.
Inattention a. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities	a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
b. often has difficulty sustaining attention in tasks or play activity	b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
c. often does not seem to listen when spoken to directly	c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
d. often does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behavior or failure to understand instructions)	d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
e. often has difficulty organizing tasks and activities	e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)	f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

(continued)

Table 7. DSM-IV to DSM-5 Attention-Deficit/Hyperactivity Disorder Comparison (continued)

DSM-IV	DSM-5
Disorder Class: Disorders Usually Diagnosed in Infancy, Childhood, and Adolescence	Disorder Class: Neurodevelopmental Disorders
g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools) h. is often easily distracted by extraneous stimuli	g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones). h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
i. is often forgetful in daily activities 2. Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:	i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments). 2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 or older), at least five symptoms are required.
Hyperactivity a. Often fidgets with hands or feet or squirms in seat b. Often leaves seat in classroom or in other situations in which remaining seated is expected c. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness) d. Often has difficulty playing or engaging in leisure activities quietly e. Is often "on the go" or often acts as if "driven by a motor" f. Often talks excessively	 a. Often fidgets with or taps hands or feet or squirms in seat. b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place). c. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless). d. Often unable to play or take part in leisure activities quietly. e. Is often "on the go" acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with). f. Often talks excessively.
Impulsivity g. Often blurts out answers before questions have been completed h. Often has difficulty awaiting turn	 g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation). h. Often has trouble waiting his/her turn (e.g., while waiting in line).

(continued)

Table 7. DSM-IV to DSM-5 Attention-Deficit/Hyperactivity Disorder Comparison (continued)

DSM-IV	DSM-5
Disorder Class: Disorders Usually Diagnosed in Infancy, Childhood, and Adolescence	Disorder Class: Neurodevelopmental Disorders
i. Often interrupts or intrudes on others (e.g., butts into conversations or games)	i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).
B. Some hyperactive-impulsive or inattentive symptoms must have been present before age 7 years.	B. Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
C. Some impairment from the symptoms is present in at least two settings (e.g., at school [or work] and at home).	C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings, (e.g., at home, school or work; with friends or relatives; in other activities).
D. There must be clear evidence of clinically significant impairment in social, academic or occupational functioning.	D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
E. The symptoms do not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorders and is not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).	E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).
Code based on type: 314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months 314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months 314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.	*Specify* whether: Combined presentation: If enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months Predominantly inattentive presentation: If enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past 6 months Predominantly hyperactive-impulsive presentation: If enough symptoms of hyperactivity-impulsivity but not inattention were present for the past 6 months. *Specify* if: In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still results in impairment in social, academic, or occupational functioning.

Table 7. DSM-IV to DSM-5 Attention-Deficit/Hyperactivity Disorder Comparison (continued)

DSM-IV	DSM-5
	Specify current severity: Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning. Moderate: Symptoms or functional impairment between "mild" and "severe" are present. Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

3.2.2 Post-traumatic Stress Disorder (PTSD, under Trauma- and Stressor-Related Disorders)

Description. DSM-5 criteria for PTSD differ significantly from those in DSM-IV for children and adolescents. The arousal cluster will now include irritability or angry outbursts and reckless behaviors. PTSD in the DSM-5 is more developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents.

Separate criteria have been added for children aged 6 years or younger. These criteria have been designed to be more developmentally appropriate for young children by including caregiver-child–related losses as a main source of trauma and focus on behaviorally expressed PTSD symptoms. According to the DSM-5, PTSD can develop at any age after 1 year of age. Clinical re-experiencing can vary according to developmental stage, with young children having frightening dreams not specific to the trauma. Young children are more likely to express symptoms through play, and they may lack fearful reactions at the time of exposure or during re-experiencing phenomena. It is also noted that parents may report a wide range of emotional or behavioral changes, including a focus on imagined interventions in their play. The preschool subtype excludes symptoms such as negative self-beliefs and blame, which are dependent on the ability to verbalize cognitive constructs and complex emotional states. The developmental preschool PTSD subtype lowers the Cluster C threshold from three to one symptom.

The new criteria were based on Scheeringa and colleagues' proposed alternative algorithm, which was derived from studies performed in young children using modified DSM-IV PTSD criteria (Scheeringa, Zeanah, & Cohen, 2011). These studies showed that children's loss of a parent/caregiver through death, abandonment, foster care placement, and other main caregiver-related events can be experienced as traumatic events. Given young children's need for a parent/child relationship to feel safe, caregiver loss may be perceived as a serious threat to a child's own safety and psychological/physical survival, which is part of the criteria defining a traumatic event. The relevance of caregiver loss as a source of trauma also applies among older children, since the loss of parents/caregivers is more associated with trauma than high-magnitude events, like a motor vehicle crash. One report of children in foster care found that the most common trauma identified by children aged 6 to12 to their therapists was "placement in foster

care" (Scheeringa et al., 2011). Table 8 shows a comparison between DSM-IV and DSM-5 diagnostic criteria for PTSD.

Estimated Prevalence. Rates of PTSD in preschool children diagnosed with DSM-IV criteria have been lower than in other age groups. This was in part related to DSM-IV language stipulating that a child must have an intense response to the event—intense fear, helplessness, or horror—that in children could be expressed by disorganized or agitated behavior. This language has been deleted from the DSM-5, because the criterion proved to have no utility in predicting the onset of PTSD and because the diagnostic criteria were not developmentally informed (American Psychiatric Association, 2013d). With DSM-IV criteria, even in severely traumatized young children, the frequencies of PTSD ranged only between 13 percent and 20 percent. With the new algorithm proposed for DSM-5, 44 percent to 69 percent of children in the same studies would be diagnosed with PTSD (Scheeringa et al., 2011).

Based on a total of 1,073 parents of children attending a large pediatric clinic that completed the Child Behavior Checklist Age 1.5-5 Years and a new interviewer-based psychiatric diagnostic measure (the Preschool Age Psychiatric Assessment), 0.1 percent of 2 to 5 year olds in one study qualified for PTSD under DSM-IV and 0.6 percent qualified with the new algorithm proposed for DSM-5 (Egger et al., 2006). In other community studies of children 1 to 6 years old recruited after mixed-traumatic events, the estimate for PTSD was 0 to 1.7 percent using DSM-IV criteria and 10 percent to 26 percent with the proposed DSM-5 algorithm (Scheeringa et al., 2011).

Table 8. DSM-IV to DSM-5 Post-traumatic Stress Disorder Comparison Children 6 Years and Younger

DSM-IV: PTSD	DSM-5: PTSD
Disorder Class: Anxiety Disorders	Disorder Class: Trauma- and Stressor-Related Disorders
A. The person has been exposed to a traumatic event in which both of the following were present: 1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. 2. The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.	A. Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: 1. Directly experiencing the traumatic event(s). 2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers. 3. Learning that the traumatic event(s) occurred to a parent or caregiving figure. Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

(continued)

Table 8. DSM-IV to DSM-5 Post-traumatic Stress Disorder Comparison Children 6 Years and Younger (continued)

DSM-IV: PTSD	DSM-5: PTSD
Disorder Class: Anxiety Disorders	Disorder Class: Trauma- and Stressor-Related Disorders
B. The traumatic event is persistently re-experienced in one or more of the following ways. 1. Recurrent and intrusive distressing recollections of the event, including images thoughts or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma expressed. 2. Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content. 3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur. 4. Intense psychological distress at exposure to the internal or external cues that symbolize or resemble an aspect of the traumatic event. 5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.	B. Presence of one or more of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: 1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment. 2. Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s). 3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma reenactment may occur in play. 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). 5. Marked psychological reactions to reminders of the traumatic event(s).
C. Persistent avoidance of stimuli associated with the trauma and the numbing of general responsiveness (not present before trauma), as indicated by three or more of the following: 1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma. 2. Efforts to avoid the activities, places, or people that arouse recollections of the trauma. 3. Inability to recall important aspect of the trauma. 4. Markedly diminished interest or participation in significant activities. 5. Feelings of detachment or estrangement from others. 6. Restricted range of affect (e.g., unable to have loving feelings). 7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).	C. One or more of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s), or negative alterations in cognitions and mood associated with the traumatic event, must be present, beginning after the traumatic event(s) or worsening after the event. Persistent avoidance of stimuli 1. Avoidance of or efforts to avoid places or physical reminders that arouse recollections of the traumatic event(s). 2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s). Negative alterations in cognitions 3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion). 4. Markedly diminished interest or participation in significant activities, including constriction play 5. Social withdrawn behavior 6. Persistent reduction in expression of positive emotions.

(continued)

Table 8. DSM-IV to DSM-5 Post-traumatic Stress Disorder Comparison Children 6 Years and Younger (continued)

DSM-IV: PTSD	DSM-5: PTSD
Disorder Class: Anxiety Disorders	Disorder Class: Trauma- and Stressor-Related Disorders
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following: 1. Difficulty falling or staying asleep 2. Irritability or outbursts of anger 3. Difficulty concentrating 4. Hyper vigilance 5. Exaggerated startle response	D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidence by two (or more) of the following: 5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep). 1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums). 4. Problems with concentration. 2. Hyper-vigilance. 3. Exaggerated startle response.
E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month.	E. Duration of the disturbance is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	F. The disturbance causes clinically significant distress or impairment in relationships with parents, sibling, peers, or other caregivers or with school behavior.
Specify if: Acute: if duration of symptoms is less than 3 months. *Specify* if: Chronic: if duration of symptoms is 3 months or more.	DROPPED
	Specify whether: With dissociative symptoms: The individual's symptoms meet the criteria for post-traumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following: 1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly). 2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts) or another medical condition (e.g., complex partial seizures).
Specify if: With delayed onset: If onset of symptoms is at least 6 months after the stressor.	*Specify* if: With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

A study based on a representative population sample of 1,420 children aged 9 to 13 at baseline and followed annually through age 16 (Great Smoky Mountains Study) found that less than 0.5 percent met the criteria for full-blown DSM-IV PTSD (lifetime prevalence was 0.1 percent, while the 3-month prevalence was 0.03 percent) (Copeland, Keeler, Angold, & Costello, 2007). Other studies with clinical populations of school-age children exposed to traumatic events have shown between 4 percent and 52 percent estimates of DSM-IV PTSD, but there is no equivalent work using these studies to estimate PTSD based on DSM-5 proposed criteria as it was done for younger children (Scheeringa et al., 2011). It is unknown how the changes proposed by Scheeringa et al. (2011) on PTSD criteria for school children will impact the estimate, since some changes will improve applicability, while others may limit it.

Implications for Estimate of SED. Some increase can be expected in the SED estimate from the inclusion of PTSD criteria in the DSM-5, particularly for younger children.

3.3 Changes to Other Mental Disorders with Minor to No Implication for SED Prevalence Estimates

Several minor changes have been made to other mental disorders sometimes assessed in psychiatric epidemiological studies of children and adolescents. These changes are summarized below, but are largely expected to have little to no impact on SED estimates either because of minimal DSM-5 changes or their very low base rate in children and adolescents.

3.3.1 Major Depressive Episode/Disorder (under Depressive Disorders)

A major depressive episode (MDE) is characterized by the combination of depressed mood or loss of interest or pleasure lasting for most of the day, nearly every day for 2 weeks or more (American Psychiatric Association, 2013b). The primary symptom (depressed mood or loss of interest/pleasure) must be accompanied by four or more additional symptoms and must cause clinically significant distress or impairment. The primary difference between MDE and MDD is that MDD includes all of the criteria for MDE as well as MDE exclusionary criteria for mania and hypomania.

Changes in the MDE/MDD criteria from DSM-IV to DSM-5 have been minimal. There have been some changes in the way that "mixed states" are described for diagnostic coding (mixed states now fall under the specifier "with mixed features"). In addition, the examples provided to describe a depressed mood have been expanded in DSM-5 from "e.g., feels sad or empty" (American Psychiatric Association, 1994, p. 327) to "e.g., feels sad, empty, hopeless" (American Psychiatric Association, 2013b, p. 160). This change in wording has not received much attention (Uher, Payne, Pavlova, & Perlis, 2013). However, the wording change has the possibility of increasing the prevalence of MDE/MDD if survey respondents and clinicians were not already equating feeling hopeless with feeling sad, empty, or depressed.

The more substantive change is that the formal bereavement exclusion for MDE/MDD in DSM-IV has been removed from DSM-5. The bereavement exclusion criterion has been a longstanding feature of MDE/MDD, designed to allow clinicians to distinguish between normal grieving and a mental illness (Fox & Jones, 2013). It has been replaced with text noting that MDE/MDD should not be confused with normal and appropriate grief but that the presence of

bereavement is not prohibitive of an MDE/MDD diagnosis. All MDE/MDD changes are expected to have minimal impact on the estimation of SED in children and adolescents. Table 9 shows a comparison between DSM-IV and DSM-5 diagnostic criteria for MDE/MDD.

Table 9. DSM-IV to DSM-5 Major Depressive Episode/Disorder Comparison

Criteria[1]	DSM-IV	DSM-5[2]
Class: Mood Disorders	✓	
Class: Depressive Disorders		✓
Five or more of the following A Criteria (at least one includes A1 or A2)	✓	✓
A1 Depressed mood—indicated by subjective report or observation by others (in children and adolescents, can be irritable mood).	✓	✓
A2 Loss of interest or pleasure in almost all activities—indicated by subjective report or observation by others.	✓	✓
A3 Significant (more than 5 percent in a month) unintentional weight loss/gain or decrease/increase in appetite (in children, failure to make expected weight gains).	✓	✓
A4 Sleep disturbance (insomnia or hypersomnia).	✓	✓
A5 Psychomotor changes (agitation or retardation) severe enough to be observable by others.	✓	✓
A6 Tiredness, fatigue, or low energy, or decreased efficiency with which routine tasks are completed.	✓	✓
A7 A sense of worthlessness or excessive, inappropriate, or delusional guilt (not merely self-reproach or guilt about being sick).	✓	✓
A8 Impaired ability to think, concentrate, or make decisions—indicated by subjective report or observation by others.	✓	✓
A9 Recurrent thoughts of death (not just fear of dying), suicidal ideation, or suicide attempts.	✓	✓
The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	✓	✓
The symptoms are not due to the direct physiological effects of a substance (e.g., drug abuse, a prescribed medication's side effects) or a medical condition (e.g., hypothyroidism).	✓	✓
The symptoms do not meet criteria for a mixed episode [3]	✓	
There has never been a manic episode or hypomanic episode.	✓	✓
MDE is not better explained by schizophrenia spectrum or other psychotic disorders.	✓	✓
The symptoms are not better accounted for by bereavement (i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation).[4]	✓	

[1] The symptom must either be new or must have clearly worsened compared with the person's pre-episode status and must persist most of the day, daily, for at least 2 weeks in a row. Exclude symptoms that are clearly due to a general medical condition, mood-incongruent delusions, or mood-incongruent hallucinations.
[2] Symptom must persist most of the day, daily, for at least 2 weeks in a row, *excluding A3 and A9*.
[3] A mixed episode is characterized by the symptoms of both a major depressive episode and a manic episode occurring almost daily for at least a 1-week period. This exclusion does not include episodes that are substance induced (e.g., caffeine) or the side effects of a medication.
[4] This differentiation requires clinical judgment based on cultural norms and the individual's history.

3.3.2 Persistent Depressive Disorder (formerly Dysthymic Disorder, under Depressive Disorders)

Dysthymic disorder is a disorder characterized by a persistently depressed mood that occurs most of the day, for more days than not, for a period of at least 2 years. In children and adolescents, mood can be irritable and duration must be at least 1 year (American Psychiatric

Association, 2013b). In the DSM-5 it has been re-named persistent depressive disorder. This name change reflects the consolidation of DSM-IV chronic MDD and dysthymic disorder. Previously, in DSM-IV, a diagnosis of dysthymic disorder was contraindicated if the patient met criteria for MDD in the first 2 years after the symptoms arose. In DSM-5 this exclusion has been removed. This change should have no impact on the estimation of SED because most if not all adolescents with chronic major depression would be classified as having MDE/MDD, and therefore would be counted as having SED already. Table 10 shows a comparison between DSM-IV and DSM-5 diagnostic criteria for dysthymic disorder/persistent depressive disorder.

Table 10. DSM-IV to DSM-5 Dysthymic Disorder/Persistent Depressive Disorder Comparison

DSM-IV	DSM-5
Name: Dysthymic Disorder	Name: Persistent Depressive Disorder
Class: Mood Disorders	Class: Depressive Disorders
Depressed mood for most of the day, for more days than not, as indicated by subjective account or observation by others, for at least 2 years.	Same Note: In children and adolescents, mood can be irritable and duration must be at least a year.
Presence while depressed of two or more of the following: • Poor appetite or overeating • Insomnia or hypersomnia • Low energy or fatigue • Low self-esteem • Poor concentration or difficulty making decisions • Feelings of hopelessness	Same
During the 2 year period of the disturbance, the person has never been without symptoms from the above two criteria for more than 2 months at a time.	Same
The disturbance is not better accounted for by MDD or MDD in partial remission.	Criteria for MDD may be continuously present for 2 years, in which case patients should be given comorbid diagnoses of persistent depressive disorder and MDD.
There has never been a manic episode, a mixed episode, or a hypomanic episode and the criteria for cyclothymia have never been met.	Same
The disturbance does not occur exclusively during the course of a chronic psychotic disorder.	The symptoms are not better explained by a psychotic disorder.
The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse or a medication) or a general medical condition.	Same
The symptoms cause clinically significant distress or impairment in important areas of functioning.	Same

3.3.3 Manic Episode and Bipolar I Disorder (under Bipolar and Related Disorders)

Bipolar I disorder, at one time referred to as manic-depressive disorder, is defined by the occurrence of at least one manic episode, which is a period of abnormally and persistently elevated, expansive, or irritable mood that is accompanied by increased energy or activity, which results in clinically significant impairment in functioning or the need for hospitalization (American Psychiatric Association, 2013b). The prevalence rate of child/adolescent mania and/or

bipolar disorder is extremely rare. In the DSM-5 field trials in the United States and Canada based on child clinical populations (general child psychiatry outpatient services), the combined bipolar I and II prevalence was 6 percent using DSM-IV and 5 percent using DSM-5. Bipolar I disorders are characterized by one or more manic episodes or mixed episodes and one or more MDEs; bipolar II disorders are characterized by one or more MDEs and at least one hypomanic episode (Regier et al., 2013).

The diagnostic criteria for manic episodes have undergone several changes between DSM-IV and DSM-5. Criterion A now requires that mood changes are accompanied by abnormally and persistently goal-directed behavior or energy. Second, wording has been added to clarify that (1) symptoms must represent a noticeable change from usual behavior, and (2) these changes have to be present most of the day, nearly every day during the minimum 1-week duration.

Exclusion criteria for manic episodes have also changed, mania that emerges after antidepressant treatment can be classified as bipolar I disorder diagnosis in the DSM-5, whereas this was a substance-induced manic disorder in DSM-IV. The criteria for bipolar I disorder have also undergone a slight change. However, in DSM-5, these subtypes were converted to specifiers instead (i.e., specify most recent episode type according to its features).

In addition to the changes in manic episode criteria, there have been changes to the overall diagnostic criteria for bipolar I disorder. In DSM-IV, bipolar I disorder was diagnosed by "type," which was characterized by the nature of the most recent episode (bipolar I disorder, single manic episode; bipolar I disorder, most recent episode hypomanic; bipolar I disorder, most recent episode manic; bipolar I disorder, most recent episode mixed; bipolar I disorder, most recent episode depressed; and bipolar I disorder, most recent episode unspecified). Each of these "types" had slightly varying criteria. In DSM-5, the diagnostic description has been simplified and these "types" have been relegated to the role of specifiers. Diagnostic procedure indicates that clinicians should first provide the bipolar I diagnosis then specify the characteristics of the most recent episode, in addition to several other specifiers. Although important to understanding the general change in diagnostic approach, these changes are geared toward communicating a more streamlined diagnostic description rather than reflecting a change in the diagnostic criteria and will not have an impact on SED prevalence estimates. Table 11 shows a comparison between DSM-IV and DSM-5 diagnostic criteria for manic episode, and Table 12 shows a comparison between DSM-IV and DSM-5 diagnostic criteria for bipolar I.

Table 11. DSM-IV to DSM-5 Manic Episode Criteria Comparison

DSM-IV Criteria	DSM-5 Criteria
Name: Bipolar I Disorder Single Manic Episode	**Name: Bipolar I Disorder Manic Episode**
Class: Bipolar Disorders	Class: Bipolar and Related Disorders
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).	A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently goal-directed behavior or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree: 1. Inflated self-esteem or grandiosity 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep) 3. More talkative than usual or pressure to keep talking 4. Flight of ideas or subjective experience that thoughts are racing	B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior: 1. Same 2. Same 3. Same 4. Same
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation 7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)	5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed. 6. Same 7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
C. The symptoms do not meet criteria for a mixed episode.	Dropped
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.	C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism). Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.	D. The episode is not attributable to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or another medical condition. Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and therefore a bipolar I diagnosis.

Table 12. DSM-IV to DSM-5 Bipolar I Disorder Comparison

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Disorder Class	Mood Disorders	Disorder Class	Bipolar and Related Disorders
Bipolar Disorder	DSM-IV specified 6 "types" of bipolar I disorder: • Bipolar I disorder, single manic episode • Bipolar I disorder, most recent episode hypomanic • Bipolar I disorder, most recent episode manic • Bipolar I disorder, most recent episode mixed • Bipolar I disorder, most recent episode depressed • Bipolar I disorder, most recent episode unspecified	Bipolar I Disorder	A. Criteria have been met for at least one manic episode (Table 11). The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes (see Table 9). B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder. Note: Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder. Note: Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder. *Specify:* With anxious distress With mixed features With rapid cycling With melancholic features With atypical features With mood-congruent psychotic features With mood-incongruent psychotic features With catatonia With peripartum onset With seasonal pattern *Specify:* Remission status if full criteria are not currently met for a manic, hypomanic, or major depressive episode.

(continued)

Table 12. DSM-IV to DSM-5 Bipolar I Disorder Comparison (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Disorder Class	Mood Disorders	Disorder Class	Bipolar and Related Disorders
Bipolar I Disorder, Single Manic Episode	A. Presence of only one manic episode (see Table 11) and no past major depressive episodes (see Table 9). Note: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms. B. The manic episode is not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. *Specify* if: Mixed: if symptoms meet criteria for a mixed episode *Specify* (for current or most recent episode): Severity/psychotic/remission specifiers With catatonic features With postpartum onset		Bipolar I episode "types" dropped from criteria tables, but diagnostic procedure still includes noting most recent episode type.
Bipolar I Disorder, Most Recent Episode Hypomanic	A. Currently (or most recently) in a hypomanic episode. B. There has previously been at least one manic episode or mixed episode. C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. *Specify:* Longitudinal course specifiers (with and without interepisode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling		Bipolar I episode "types" dropped from criteria tables, but diagnostic procedure still includes noting most recent episode type.

(continued)

Table 12. DSM-IV to DSM-5 Bipolar I Disorder Comparison (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Disorder Class	Mood Disorders	Disorder Class	Bipolar and Related Disorders
Bipolar I Disorder, Most Recent Episode Manic	A. Currently (or most recently) in a manic episode. B. There has previously been at least one major depressive episode, manic episode, or mixed episode. C. The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. *Specify* (for current or most recent episode): Severity/psychotic/remission specifiers With catatonic features With postpartum onset *Specify*: Longitudinal course specifiers (with and without interepisode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling		Bipolar I episode "types" dropped from criteria tables, but diagnostic procedure still includes noting most recent episode type.

(continued)

Table 12. DSM-IV to DSM-5 Bipolar I Disorder Comparison (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Bipolar I Disorder, Most Recent Episode Mixed	A. Currently (or most recently) in a mixed episode. B. There has previously been at least one major depressive episode, manic episode, or mixed episode. C. The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. *Specify* (for current or most recent episode): Severity/psychotic/remission specifiers With catatonic features With postpartum onset *Specify*: Longitudinal course specifiers (with and without interepisode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling		Bipolar I episode "types" dropped from criteria tables, but diagnostic procedure still includes noting most recent episode type.

(continued)

Table 12. DSM-IV to DSM-5 Bipolar I Disorder Comparison (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Disorder Class	Mood Disorders	Disorder Class	Bipolar and Related Disorders
Bipolar I Disorder, Most Recent Episode Depressed	A. Currently (or most recently) in a major depressive episode. B. There has previously been at least one manic episode or mixed episode. C. The mood episodes in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. *Specify* (for current or most recent episode): Severity/psychotic/remission specifiers Chronic With catatonic features With melancholic features With atypical features With postpartum onset *Specify*: Longitudinal course specifiers (with and without interepisode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling		Bipolar I episode "types" dropped from criteria tables, but diagnostic procedure still includes noting most recent episode type.
Bipolar I Disorder, Most Recent Episode Unspecified	A. Criteria, except for duration, are currently (or most recently) met for a manic, a hypomanic, a mixed, or a major depressive episode. B. There has previously been at least one manic episode or mixed episode. C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The mood symptoms in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.		

(continued)

Table 12. DSM-IV to DSM-5 Bipolar I Disorder Comparison (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Disorder Class	Mood Disorders	Disorder Class	Bipolar and Related Disorders
	E. The mood symptoms in Criteria A and B are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism). *Specify*: Longitudinal course specifiers (with and without interepisode recovery) With seasonal pattern (applies only to the pattern of major depressive episodes) With rapid cycling		Dropped

3.3.4 Generalized Anxiety Disorder (under Anxiety Disorders)

Generalized anxiety disorder (GAD) is an anxiety disorder characterized by excessive anxiety and worry that is not focused on a single trigger (e.g., fear of social situations, fear of having a panic attack, or fear of a specific event/situation). There have been very few changes made to GAD criteria in DSM-5. The DSM-IV criteria for GAD included that the anxiety and worry does not occur exclusively during PTSD, a mood disorder, a psychotic disorder, or PDD. In DSM-5, this has been replaced with text indicating that "the disturbance is not better explained by another mental disorder." This will have no impact on any estimate of SED prevalence. Table 13 shows a comparison between DSM-IV and DSM-5 diagnostic criteria for generalized anxiety disorder.

Table 13. DSM-IV to DSM-5 Generalized Anxiety Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Anxiety Disorders	SAME
A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).	SAME
B. The person finds it difficult to control the worry.	SAME

(continued)

Table 13. DSM-IV to DSM-5 Generalized Anxiety Disorder Comparison (continued)

DSM-IV	DSM-5
Disorder Class: Anxiety Disorders	SAME
C. The anxiety and worry are associated with three or more of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children 1. Restlessness or feeling keyed up or on edge 2. Being easily fatigued 3. Difficulty concentrating or mind going blank 4. Irritability 5. Muscle tension 6. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)	SAME Note: Only one item is required in children 1. Restlessness or feeling keyed up or on edge 2. Being easily fatigued 3. Difficulty concentrating or mind going blank 4. Irritability 5. Muscle tension 6. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
D. The focus of the anxiety and worry is not confined to features of an Axis I disorder (e.g., the anxiety or worry is not about having a panic attack [as in panic disorder], being embarrassed in public [as in social phobia], being contaminated [as in obsessive-compulsive disorder] being away from home or close relatives [as in separation anxiety disorder], gaining weight [as in anorexia nervosa], or having a serious illness [as in hypochondriasis]), and the anxiety and worry do not occur exclusively during post-traumatic stress disorder.	F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in post-traumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).
E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	SAME (part D)
F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.	E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

3.3.5 Panic Disorder and Agoraphobia (under Anxiety Disorders)

Panic disorder is an anxiety disorder characterized by panic attack(s) and the ongoing concern about experiencing additional panic attacks (American Psychiatric Association, 2013b). A panic attack is an abrupt, but quickly peaking, surge of intense fear or discomfort, accompanied by a series of physical symptoms. In DSM-IV, panic disorder and agoraphobia were conceptually linked. Agoraphobia is an anxiety disorder characterized by an intense fear or anxiety triggered by the real or anticipated exposure to a number of situations (i.e., using public transportation, being in open spaces), which causes clinically significant distress or impairment. The diagnoses in DSM-IV included panic disorder with agoraphobia, panic disorder without

agoraphobia, and agoraphobia without history of panic disorder. In DSM-5, however, panic disorder and agoraphobia have been separated and individuals meeting criteria for both disorders are considered to have comorbid mental disorders. Examining the comparison of panic disorder criteria specifically (Table 14), with the exception of the disaggregation of agoraphobia, the criteria are similar between DSM-IV and DSM-5. There are minor wording changes to the description of panic attacks that may have slight implications to the prevalence of panic disorder under DSM-5. Under DSM-IV, the specification was made that panic attacks were discrete periods of intense fear or discomfort that peaked within 10 minutes. In DSM-5, panic attacks are described as an abrupt surge of intense fear or intense discomfort that peak within a few minutes. The wording changes reflect two conceptual issues. First, the change in wording from a discrete event to an abrupt surge broadens criteria based on evidence that panic attacks do not necessarily arise "out of the blue" but can arise during periods of anxiety or other distress and that it is the sudden increase in fear/discomfort that is the hallmark of a panic attack. In addition, they have removed the 10-minute criterion, in favor of the less precise but implicitly shorter descriptive of "within minutes" (American Psychiatric Association, 2013b, p. 214). This was only a change in classification and is expected to have no impact on overarching prevalence estimates of SED. Table 14 shows a comparison between DSM-IV and DSM-5 diagnostic criteria for panic disorder and agoraphobia.

Table 14. Panic Disorder and Agoraphobia Criteria Changes from DSM-IV to DSM-5

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Diagnostic Class: Anxiety Disorders	SAME		
Panic Attack[1]	A discrete period of intense fear or discomfort, in which four or more of the following symptoms developed abruptly and reached a peak within 10 minutes • Palpitations, pounding heart, or accelerated heart rate • Sweating • Trembling or shaking • Sensations of shortness of breath or smothering • Feeling of choking • Chest pain or discomfort • Nausea or abdominal distress • Feeling dizzy, unsteady, lightheaded, or faint • Derealization (feelings of unreality) or depersonalization (being detached from oneself) • Fear of losing control or "going crazy" • Fear of dying • Paresthesias (numbness or tingling sensation) • Chills or hot flushes.	Panic Attack[1]	An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and during which time four or more of the following symptoms occur. • List is unchanged, except that "hot flushes" has been modified to "heat sensations" and there has been a reordering of symptoms.

(continued)

Table 14. Panic Disorder and Agoraphobia Criteria Changes from DSM-IV to DSM-5 (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Diagnostic Class: Anxiety Disorders	SAME		
Agoraphobia[1]	Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.	Agoraphobia	A marked fear or anxiety about two (or more) of the following five situations: • Using public transportation • Being in open spaces • Being in enclosed spaces (e.g., shops, theaters, cinemas) • Standing in line or being in a crowd • Being outside the home alone.
	The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.		SAME
	N/A		The agoraphobic situations almost always provoke fear or anxiety.
	N/A		The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.
	N/A		The fear, anxiety, or avoidance is persistent, typically lasting 6 months or more.
	N/A		The fear, anxiety, or avoidance causes clinically significant distress or impairment in important areas of functioning.
	The anxiety or phobic avoidance is not better accounted for by another mental disorder.		SAME

(continued)

Table 14. Panic Disorder and Agoraphobia Criteria Changes from DSM-IV to DSM-5 (continued)

DSM-IV Disorder	DSM-IV Criteria	DSM-5 Disorder	DSM-5 Criteria
Diagnostic Class: Anxiety Disorders	SAME		
Agoraphobia without history of Panic Disorder	The presence of agoraphobia related to fear of developing panic-like symptoms. Criteria for panic disorder have never been met. The disturbance not due to the direct physiological effects of a substance (e.g., a drug of abuse or a medication) or a general medical condition If an associated general medical condition is present, the fear described in Criterion A is clearly in excess of that usually associated with the condition.		The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms. DROPPED DROPPED SAME
Panic Disorder, with/without Agoraphobia	Both: • Recurrent and unexpected panic attacks (see below) • ≥ 1 attack has been followed by 1 month or more of 1 or more of the following Persistent concern about additional attacks Worry about the implications of the attack or its consequences A significant change in behavior related to the attacks The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse or a medication) or a general medical condition The panic attacks are not better accounted for by another mental disorder. • Without agoraphobia: Absence of agoraphobia (see below) • With agoraphobia: Presence of agoraphobia	Panic Disorder	Both: • Recurrent and unexpected panic attacks (see below) • ≥ 1 attack has been followed by 1 month or more of 1 or both of the following Persistent concern about additional attacks or their consequences A significant maladaptive change in behavior related to the attacks SAME SAME DROPPED DROPPED

[1] Not a codable disorder, considered a feature of the specific disorder in which the panic attack/agoraphobia occurs.

3.3.6 Separation Anxiety Disorder (under Anxiety Disorders)

Separation anxiety disorder (SAD) is a psychological condition in which an individual experiences excessive anxiety, fear, or distress regarding separation from home or from people to whom the individual has a strong emotional attachment (e.g., a parent, grandparents, or siblings; Table 15). SAD is the inappropriate and excessive display of fear and distress when faced with situations of separation from the home or from a specific attachment figure. The anxiety that is expressed is categorized as being atypical of the expected developmental level and age. The severity of the symptoms ranges from anticipatory uneasiness to full-blown anxiety about separation. SAD may cause significant negative effects within a child's everyday life, as well. These effects can be seen in areas of social and emotional functioning, family life, physical health, and within the academic context. The duration of this problem must persist for at least 4 weeks and must present itself before a person is 18 years of age to be diagnosed as SAD (American Psychiatric Association, 2013b).

Table 15. DSM-IV to DSM-5 Separation Anxiety Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Disorders Usually Diagnosed in Infancy, Childhood, and Adolescence	Disorder Class: Anxiety Disorders
A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three or more of the following: 1. Recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated 2. Persistent and excessive worry about losing, or about possible harm befalling, major attachment figures 3. Persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped) 4. Persistent reluctance or refusal to go to school or elsewhere because of fear of separation 5. Persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings 6. Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home 7. Repeated nightmares involving the theme of separation 8. Repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated	A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following: 1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures. 2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death. 3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure. 4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation. 5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings. 6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure. 7. SAME 8. SAME

(continued)

Table 15. DSM-IV to DSM-5 Separation Anxiety Disorder Comparison (continued)

DSM-IV	DSM-5
Disorder Class: Disorders Usually Diagnosed in Infancy, Childhood, and Adolescence	Disorder Class: Anxiety Disorders
B. The duration of the disturbance is at least 4 weeks.	B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.
C. The onset is before age 18 years.	DROPPED
D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.	SAME (now part C)
E. The disturbance does not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and, in adolescents and adults, is not better accounted for by panic disorder with agoraphobia.	D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety disorder.
Specify if: Early Onset: if onset occurs before age 6 years	DROPPED

The primary change from DSM-IV to DSM-5 has been the reclassification of SAD from the disorders usually diagnosed in infancy, childhood, and adolescence section to anxiety disorders. Criteria changes from DSM-IV to DSM-5 are largely wording changes rather than major conceptual differences. The largest differences are related to broadening the criteria to better align with the presentation of SAD among adults; consequently, this should have minimal impact on childhood estimates.

3.3.7 Social Anxiety Disorder (formerly Social Phobia [Social Anxiety Disorder], under Anxiety Disorders)

Social anxiety disorder is an anxiety disorder characterized by fear of social situations wherein the individual may be exposed to scrutiny by others (American Psychiatric Association, 2013b). In children, the anxiety must occur in peer settings and not just during interactions with adults. In addition, for children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

Diagnostic criteria for social phobia have undergone several minor wording changes from DSM-IV to DSM-5 (Table 16). One additional change is anticipated to have a broader impact on estimates of social phobia. In DSM-IV, criteria for social phobia required that an individual "recognizes that the fear is excessive or unreasonable." In DSM-5 this has been changed to note that "the fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context." This means that the patient does not need to recognize that their fear is unreasonable, so long as the clinician can determine that the fear is unreasonable.

Table 16. DSM-IV to DSM-5 Social Phobia/Social Anxiety Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Anxiety Disorders	SAME
A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.	A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech). Note: In children, the anxiety must occur in peer settings and not just during interactions with adults. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).
B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.	C. The social situations almost always provoke fear or anxiety. Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.
C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.	B. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.	D. The social situations are avoided or endured with intense fear or anxiety.
E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.	G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
F. In individuals under age 18 years, the duration is at least 6 months.	F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder, or schizoid personality disorder).	H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
	I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it (e.g., the fear is not of stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa).	J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

(continued)

Table 16. DSM-IV to DSM-5 Social Phobia/Social Anxiety Disorder Comparison (continued)

DSM-IV	DSM-5
Disorder Class: Anxiety Disorders	SAME
Specify if: Generalized: if the fears include most social situations (also consider the additional diagnosis of avoidant personality disorder)	*Specify* if: Performance only: if the fear is restricted to speaking or performing in public.

For the new social anxiety disorder, which replaces social phobia, the "generalized" (if the fears include most social situations) specifier has been deleted and replaced with a "performance only" specifier (if the fear is restricted to speaking or performing in public). The rationale is that the DSM-IV generalized specifier was difficult to operationalize. The DSM-5 describes that individuals who fear only performance situations (i.e., speaking or performing in front of an audience) appear to represent a distinct subset of social anxiety disorder in terms of etiology, age at onset, physiological response, and treatment response.

Epidemiological work in the U.S. population using data from the National Comorbidity Survey-Adolescent Supplement found that only 0.7 percent of adolescents meeting criteria for social anxiety disorder could be classified as having the performance-only social anxiety disorder (Burstein et al., 2011). Subsequent work based on a clinical sample in Boston of 204 youth seeking treatment for anxiety disorders at a university-affiliated center, found that no children endorsed discrete fear in performance situations only in the absence of fear in other social situations (Kerns, Comer, Pincus, & Hofmann, 2013). No impact in the prevalence of SED is expected from the new social anxiety disorder specifier when applied to youth.

3.3.8 Conduct Disorder (under Disruptive, Impulse-Control, and Conduct Disorders)

Conduct disorder (CD) is usually first diagnosed in childhood and was categorized in DSM-IV under the category of the same name. Conduct disorder is characterized by a repetitive and persistent pattern of behavior that violates either the rights of others or major age appropriate societal norms or rules. People with CD often show aggression to people and animals, destruction of property, deceitfulness or theft, and/or serious violations of rules. At least 3 symptoms out of 15 must be present in the past 12 months with 1 symptom having been present in the past 6 months. To be diagnosed with CD, the symptoms must cause significant impairment in social, academic, or occupational functioning. The disorder is typically diagnosed prior to adulthood (American Psychiatric Association, 2013a).

The main change to the diagnostic criteria for CD is the addition of a subtype grouping around callous and unemotional traits. The callous–lack-of-empathy trait is defined as a disregard and lack of concern about the feelings of others and more concerned about the effects of his or her actions on himself/herself than their effects on others even when they may result in substantial harm to others (American Psychiatric Association, 2013a). The purpose of this change was to better account for heterogeneity within CD. As such, this change is not expected to impact prevalence estimates of CD. In the DSM-5 field trials in the United States and Canada based on child clinical populations (general child psychiatry outpatient services), CD prevalence was the same (8 percent) using DSM-IV and DSM-5. The estimated prevalence using DSM-5 for

the new callous/unemotional specifier for CD was 5 percent (Regier et al., 2013). Table 17 shows a comparison between DSM-IV and DSM-5 diagnostic criteria for CD.

Table 17. DSM-IV to DSM-5 Conduct Disorder Comparison

DSM-IV: Conduct Disorder	DSM-5: Conduct Disorder
Disorder Class: Attention deficit and disruptive behavior disorders	Disorder Class: Disruptive, Impulse-Control, and Conduct Disorders
A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:	A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:
Aggression to people and animals	Aggression to people and animals
1. often bullies, threatens, or intimidates others	1. SAME
2. often initiates physical fights	2. SAME
3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)	3. SAME
4. has been physically cruel to people	4. SAME
5. has been physically cruel to animals	5. SAME
6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)	6. SAME
7. has forced someone into sexual activity	7. SAME
Destruction of property	Destruction of property
8 has deliberately engaged in fire setting with the intention of causing serious damage	8. SAME
9. has deliberately destroyed others' property (other than by fire setting)	9. SAME
Deceitfulness or theft	Deceitfulness or theft
10. has broken into someone else's house, building, or car	10. SAME
11. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)	11. SAME
12. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)	12. SAME
Serious violations of rules	Serious violations of rules
13. often stays out at night despite parental prohibitions, beginning before age 13 years	13. SAME
14. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)	14. SAME
15. is often truant from school, beginning before age 13 years	15. SAME

(continued)

Table 17. DSM-IV to DSM-5 Conduct Disorder Comparison (continued)

DSM-IV: Conduct Disorder	DSM-5: Conduct Disorder
Disorder Class: Attention deficit and disruptive behavior disorders	Disorder Class: Disruptive, Impulse-Control, and Conduct Disorders
B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.	B. SAME
C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.	C. SAME
Code based on age at onset: 312.81 Conduct Disorder, Childhood-Onset Type: onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years 312.82 Conduct Disorder, Adolescent-Onset Type: absence of any criteria characteristic of Conduct Disorder prior to age 10 years 312.89 Conduct Disorder, Unspecified Onset: age at onset is not known	*Specify* whether: 312.81 (F91.1) Conduct Disorder, Childhood-Onset Type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years 312.82 (F91.2) Conduct Disorder, Adolescent-Onset Type: Individuals show now symptom characteristic of conduct disorder prior to age 10 years 312.89 (F91.9) Conduct Disorder, Unspecified Onset: Criteria for a diagnosis or conduct disorder are met, but there is not enough information available to determine whether the onset of the first symptom was before or after age 10 years.
N/A	*Specify* if: With limited prosocial emotions: To qualify for this specifier, an individual must have displayed at least two of the following characteristics persistently over at least 12 months and in multiple relationships and setting. These characteristics reflect the individual's typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. Thus, to assess the criteria for the specifier, multiple information sources are necessary. In addition to the individual's self-report, it is necessary to consider reports by others who have known the individual for extended periods of time (e.g., parents, teachers, coworkers, extended family members, peers). Lack of remorse or guilt: Does not feel bad or guilty when he/she does something wrong (excluding remorse when expressed only when caught and/or facing punishment). The individual shows a general lack of concern about the negative consequences of his or her actions. For example, the individual is not remorseful after hurting someone or does not care about the consequences of breaking rules. Callous—lack of empathy: Disregards and is unconcerned about the feelings of others. The individual is described as cold and uncaring. The person appears more concerned about the effects of his or her actions on himself or herself, rather than their effects on others, even when they result in substantial harm to others.

(continued)

Table 17. DSM-IV to DSM-5 Conduct Disorder Comparison (continued)

DSM-IV: Conduct Disorder	DSM-5: Conduct Disorder
Disorder Class: Attention deficit and disruptive behavior disorders	Disorder Class: Disruptive, Impulse-Control, and Conduct Disorders
	Unconcerned about performance: Does not show concern about poor/problematic performance at school, work, or in other important activities. The individual does not put forth the effort necessary to perform well, even when expectations are clear, and typically blames others for his or her poor performance. Shallow or deficient affect: Does not express feelings or show emotions to others, except in ways that seem shallow, insincere, or superficial (e.g., actions contradict the emotion displayed; can turn emotions "on" or "off" quickly) or when emotional expressions are used for gain (e.g., emotions displayed to manipulate or intimidate others).
Specify severity: Mild: few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others Moderate: number of conduct problems and effect on others intermediate between "mild" and "severe" Severe: many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others	*Specify* current severity: Mild: Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others (e.g., lying, truancy, staying out after dark without permission, other rule breaking). Moderate: The number of conduct problems and the effect on others are intermediate between those specified in "mild" and those in "severe" (e.g., stealing without confronting a victim, vandalism). Severe: Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).

3.3.9 Oppositional Defiant Disorder (under Disruptive, Impulse-Control, and Conduct Disorders)

Oppositional defiant disorder's (ODD) is characterized by a frequent and persistent pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness that may significantly impair social functioning (American Psychiatric Association, 2013b). ODD is primarily viewed as a younger-child version of CD and it emerges mostly during the preschool years (before 5 years old), where symptoms of aggression and defiance are present but the acts committed by the child are less severe. Most research on changes to the categorization of ODD in DSM-5 have focused on understanding the underlying dimensions of ODD, towards the goal of being better able to predict different outcomes in later childhood (which children with ODD develop CD, which children develop other mental disorders, which children become nonsymptomatic) (Barry et al, 2013; Krieger et al., 2013). As such, there is no expectation that children previously diagnosed with something else will necessarily move into the ODD category in the DSM-5. However, some children previously diagnosed with ODD using DSM-IV criteria may move into the DMDD category under DSM-5 if their symptoms include chronic irritability along with anger and severe tantrums.

As described in the DSM-5 manual (American Psychiatric Association, 2013b, p, 64), cases with DMDD and ADHD should be diagnosed separately. In the DSM-5 field trials in the United States and Canada based on child clinical populations (general child psychiatry outpatient services), estimates for ODD were described for one of the sites (Columbia/Cornell Medical Centers-New York) as decreasing from 22 percent using DSM-IV to 17 percent using DSM-5 (Regier et al., 2013).Thus, the prevalence of ODD may decrease very slightly when DSM-5 criteria are applied, but given that DMDD only occurs in 1 percent of the school-age population, this effect is expected to be minimal. In terms of SED, DSM-5 recategorization of irritability from ODD to DMDD is expected to result in no difference in the SED prevalence estimate. Table 18 shows a comparison between DSM-IV and DSM-5 oppositional defiant disorder.

Table 18. DSM-IV to DSM-5 Oppositional Defiant Disorder Comparison

DSM-IV: Oppositional Defiant Disorder	DSM-5: Oppositional Defiant Disorder
Disorder Class: Attention Deficit and Disruptive Behavior Disorders	Disorder Class: Disruptive, Impulse-Control, and Conduct Disorders
A. A pattern of negativistic; hostile, and defiant behavior lasting at least 6 months, during which four (or more of the following are present: 1. Often loses temper 2. Often argues with adults 3. Often actively defies or refuses to comply with adults requests or rules 4. Often deliberately annoys people 5. Often blames others for his or her mistakes or misbehavior 6. Is often touchy or easily annoyed by others 7. Is often angry and resentful 8. Is often vindictive Note: Consider a criterion met only if the behavior occurs more frequently that is typically observed in individuals of comparable age and developmental level.	A. A pattern of angry/irritable mood, argumentative/ defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms of the following categories, and exhibited during interaction with at least one individual who is not a sibling: Angry/Irritable Mood 1. Often loses temper 2. Is often touchy or easily annoyed 3. Is often angry and resentful Argumentative/Defiant Behavior 4. Often argues with authority figures or, for children and adolescents, with adults 5. Often actively defies or refuses to comply with requests from authority figures or with rules 6. Often deliberately annoys others 7. Often blames others for his or her mistakes or misbehavior Vindictiveness 8. Has been spiteful or vindictive at least twice within the past 6 months. Note: The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children younger than 5 years, the behavior should occur on most days for a period of at least 6 months unless otherwise noted (Criterion AB). For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months. Unless otherwise noted (Criterion AB). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture.

(continued)

Table 18. DSM-IV to DSM-5 Oppositional Defiant Disorder Comparison (continued)

DSM-IV: Oppositional Defiant Disorder	DSM-5: Oppositional Defiant Disorder
Disorder Class: Attention Deficit and Disruptive Behavior Disorders	Disorder Class: Disruptive, Impulse-Control, and Conduct Disorders
B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning,	B. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues) or it impacts negatively on social, educational, occupational, or other important areas of functioning,
C. The behavior does not occur exclusively during the course of a Psychiatric or Mood Disorder.	C. The behavior does not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also the criteria are not met for disruptive mood dysregulation disorder.
D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 or older, criteria are not met for Antisocial Personality Disorder	Dropped
	Specify current severity: Mild: Symptoms are confined to only one setting (e.g., at home, at school, at work, with peers). Moderate: Some symptoms are present in at least two settings Severe: Some symptoms are present in three or more settings.

3.3.10 Eating Disorders (under Feeding and Eating Disorders)

Anorexia Nervosa. Anorexia nervosa is an eating disorder characterized by an intense fear of gaining weight and the refusal to maintain a minimally normal body weight. Individuals with anorexia also exhibit a misperception of body shape and/or size. There have been several DSM-5 criteria changes. In DSM-IV, a diagnosis of anorexia nervosa was excluded if the patient maintained bodyweight at or above the 85th percentile for his or her height/age. In DSM-5 this criterion is similar, but adds sex, developmental norms, and physical health and uses body mass index data. The DSM-5 adds "persistent behavior that interferes with weight gain" as an added way to meet a criterion. The DSM-5 does not include criteria on menstruating females' absence of three consecutive menses, as the DSM-IV does. The restrictive type and binge-eating/purging types differ in that DSM-IV specifies "during the current episode" and DSM-5 specifies "during the past 3 months." The DSM-5 adds criteria for partial and full remission, while the DSM-IV does not include this information. Data from a U.S. sample of 215 youth 8 to 21 years enrolled as new patients with eating disorders in six clinics showed an increase from 30 percent to 40 percent in anorexia nervosa when comparing DSM-IV and DSM-5 criteria (Ornstein et al., 2013). Table 19 shows a comparison between DSM-IV and DSM-5 for anorexia nervosa.

Bulimia Nervosa. Bulimia nervosa is an eating disorder characterized by binge eating followed by inappropriate compensatory behaviors designed to prevent weight gain. In addition, the self-evaluation of individuals with bulimia nervosa is excessively influenced by weight and body shape. The major change in criteria for diagnosis of bulimia nervosa is reducing the binge frequency threshold from twice per week in DSM-IV to once per week in DSM-5. The other

differences include the DSM-IV differentiating between purging and nonpurging type (the DSM-5 does not) and the DSM-5 specifying criteria for partial remission, full remission, and severity, while the DSM-IV does not. DSM-IV to DSM-5 criteria changes may increase the prevalence rate. Data from an Australian cohort study of 2,822 adolescents and young adults (57.0 percent female) whose parents were recruited from antenatal clinics at a single hospital and followed through age 20, indicate that rates of bulimia nervosa are higher when applying the DSM-5 criteria versus the DSM–IV (Allen, Byrne, Oddy, & Crosby, 2013). Similarly, data from a U.S. sample of 215 youth 8 to 21 years enrolled as new patients with eating disorders in six clinics showed an increase in bulimia nervosa from 7.3 percent to 11.8 percent when comparing DSM-IV and DSM-5 criteria (Ornstein et al., 2013). Table 20 shows a comparison between DSM-IV and DSM-5 for bulimia nervosa.

Table 19. DSM-IV to DSM-5 Anorexia Nervosa Comparison

DSM-IV	DSM-5
Disorder Class: Eating Disorders	Disorder Class: Feeding and Eating Disorders
A. Refusal to maintain bodyweight at or above minimally normal weight for height/age (less than 85th percentile).	A. Restriction of energy intake relative to requirements, leading to a significant low body weight in the context of the age, sex, developmental trajectory, and physical health (less than minimally normal/expected[1]).
B. Intense fear of gaining weight or becoming obese, even though underweight.	B. Intense fear of gaining weight or becoming fat or persistent behavior that interferes with weight gain.
C. Disturbed by one's body weight or shape, self-worth influenced by body weight or shape, or persistent lack of recognition of seriousness of low bodyweight.	SAME
D. In menstruating females, absence of at least 3 consecutive non-synthetically induced menstrual cycles. *Specify* type: Restricting type: During the current episode, has not regularly engaged in binge-eating or purging.[2] Binge-eating/purging type: During the current episode, has regularly engaged in binge-eating or purging.[2]	DROPPED *Specified* whether: Restricting type: During the last 3 months…SAME. Binge-eating/purging type: During the last 3 months…SAME. Partial remission: After full criteria met, low bodyweight has not been met for sustained period, BUT at least one of the following two criteria still met: Intense fear of gaining weight/becoming obese or behavior that interferes with weight gain OR Disturbed by weight and shape. Full remission: After full criteria met, none of the criteria met for sustained period of time.

[1] Severity is based on body mass index (BMI) derived from World Health Organization categories for thinness in adults; corresponding percentiles should be used for children and adolescents: Mild: BMI greater than or equal to 17 kg/m^2, Moderate: BMI 16-16.99 kg/m^2, Severe: BMI 15-15.99 kg/m^2, Extreme: BMI less than 15 kg/m^2.

[2] Purging is self-induced vomiting or misuse of laxatives, diuretics, or enemas.

Table 20. DSM-IV to DSM-5 Bulimia Nervosa Comparison

DSM-IV	DSM-5
Disorder Class: Eating Disorders	Disorder Class: Feeding and Eating Disorders
A. Recurrent episodes of binge eating, as characterized by both: 1. Eating, within any 2-hour period, an amount of food that is definitively larger than what most individuals would eat in a similar period of time under similar circumstances. 2. A feeling that one cannot stop eating or control what or how much one is eating.	SAME
B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting or excessive exercise.	SAME
C. The binge eating and inappropriate compensatory behaviors occur, on average, at least twice a week for 3 months.	C. The binge eating and inappropriate compensatory behaviors occur, on average, at least once a week for 3 months.
D. Self-evaluation is unjustifiability influenced by body shape and weight.	SAME
E. The disturbance does not occur exclusively during episodes of anorexia nervosa.	SAME
Specify type: Purging type: During the current episode, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas. Nonpurging Type: During the current episode, the person has used inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.	Not a criterion.
Not a criterion.	*Specify* if: Partial remission: After full criteria were previously met, *some but not all* of the criteria have been met for a sustained period of time. Full remission: After full criteria were previously met, *none* of the criteria have been met for a sustained period of time.
Not a criterion.	Current severity[1]: Mild: An average of 1-3 episodes of inappropriate compensatory behaviors per week. Moderate: An average of 4-7 episodes of inappropriate compensatory behaviors per week. Severe: An average of 8-13 episodes of inappropriate compensatory behaviors per week. Extreme: An average of 14 or more episodes of inappropriate compensatory behaviors per week.

[1] The level of severity may be increased to reflect other symptoms and the degree of functional disability.

Binge Eating Disorder. Binge eating disorder had been included in DSM-IV as a "criteria set provided for further study," and has been included in DSM-5 as a disorder. This disorder is characterized by binge or out of control eating accompanied by significant distress about eating. Binge eating disorder is differentiated from bulimia nervosa in that there are no inappropriate compensatory behaviors (e.g., purging or excessive exercise) seen in binge eating disorder. As noted previously, this disorder was added into DSM-5 because a significant subset of people presenting with an eating disorder had exhibited binge eating behaviors that were not accompanied by any behaviors intended to compensate for the binge eating (Call, Walsh, & Attia, 2013; Crow et al., 2012; Striegel-Moore & Franko, 2008). Changes between the criteria enumerated in DSM-IV and those in DSM-5 are minimal. The only change, which represents a less stringent requirement in DSM-5, reduces the minimum frequency/duration of the binge eating behavior to at least once a week for 3 months (it had been at least 2 days a week for 6 months). Table 21 shows a comparison between DSM-IV and DSM-5 for binge eating disorder.

Table 21. DSM-IV to DSM-5 Binge Eating Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Criteria Sets and Axes Provided for Further Study	Disorder Class: Feeding and Eating Disorders
A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)	SAME
B. The binge-eating episodes are associated with three (or more) of the following: 1. Eating much more rapidly than normal 2. Eating until feeling uncomfortably full 3. Eating large amounts of food when not feeling physically hungry 4. Eating alone because of feeling embarrassed by how much one is eating 5. Feeling disgusted with oneself, depressed, or very guilty after overeating	SAME
C. Marked distress regarding binge eating is present.	SAME
D. The binge eating occurs, on average, at least 2 days a week for 6 months. Note: The method of determining frequency differs from that used for bulimia nervosa; future research should address whether the preferred method of setting a frequency threshold is counting the number of days on which binges occur or counting the number of episodes of binge eating.	D. The binge eating occurs, on average, at least once a week for 3 months.
E. The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of anorexia nervosa or bulimia nervosa.	SAME

(continued)

Table 21. DSM-IV to DSM-5 Binge-Eating Disorder Comparison (continued)

DSM-IV	DSM-5
Disorder Class: Criteria Sets and Axes Provided for Further Study	Disorder Class: Feeding and Eating Disorders
	Specify if: In partial remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time. In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time. *Specify* current severity: Severity is also noted in the diagnosis, from mild to extreme: Mild: 1-3 binge-eating episodes per week Moderate: 4-7 binge-eating episodes per week Severe: 8-13 binge-eating episodes per week Extreme: 14 or more binge-eating episodes per week

Avoidant/Restrictive Food Intake Disorder. DSM-IV feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder, and the criteria have been significantly expanded. The DSM-IV disorder was rarely used, and limited information is available on its course and outcome or the characteristics of children with this disorder. A large number of children and adolescents substantially restrict their food intake and experience significant associated physiological or psychosocial problems but do not meet criteria for any DSM-IV eating disorder. Avoidant/restrictive food intake disorder is a broad category intended to capture this range of presentations. In the DSM-5 field trials in the United States and Canada based on child clinical populations (general child psychiatry outpatient services), avoidant/restrictive food intake disorder prevalence was described for one site (Columbia/Cornell Medical Centers-New York) and it was 11 percent using DSM-5 (not applicable for DSM-IV) (Regier et al., 2013). Table 22 shows a comparison between DSM-IV and DSM-5 for avoidant/restrictive food intake disorder.

Table 22. DSM-IV to DSM-5 Avoidant/Restrictive Food Intake Disorder Comparison

DSM-IV	DSM-5
Name: Feeding Disorder of Infancy or Early Childhood	Name: Avoidant/Restrictive Food Intake Disorder
Disorder Class: Feeding and Eating Disorders of Infancy or Early Childhood	Disorder Class: Feeding and Eating Disorders
A. Feeding disturbance as manifested by persistent failure to eat adequately with significant failure to gain weight or significant loss of weight over at least 1 month.	A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following: 1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children) 2. Significant nutritional deficiency. 3. Dependence on enteral feeding or oral nutritional supplements. 4. Marked interference with psychosocial functioning.
B. The disturbance is not due to an associated gastrointestinal or other general medical condition (e.g., esophageal reflux).	D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another mental disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.
C. The disturbance is not better accounted for by another mental disorder (e.g., Rumination Disorder) or by lack of available food.	B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
--	C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
D. The onset is before age 6 years.	DROPPED D. The eating disturbance is not attributable to a concurrent medical condition on not better explained by another mental disorder. When the eating disturbance the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention. *Specify* if: In remission: After full criteria for avoidance/restrictive food intake disorder were previously met, the criteria have not been met for a sustained period of time.

3.3.11 Body Dysmorphic Disorder (under Obsessive-compulsive and Related Disorders)

Body dysmorphic disorder (BDD) is a mental illness characterized by an excessive preoccupation with a perceived physical defect or flaw that causes significant distress or functional impairment. There have been several important changes in BDD criteria from DSM-IV to DSM-5. First, BDD has been reclassified from somatoform disorders in DSM-IV to

obsessive-compulsive and related disorders under DSM-5. Second, DSM-5 BDD has an added diagnostic criterion indicating that the patient must have had repetitive behaviors or mental acts that were in response to preoccupations with perceived defects or flaws in physical appearance. Third, a "with muscle dysmorphia" specifier has been added to reflect a growing literature on the diagnostic validity and clinical utility of making this distinction in individuals with BDD. Finally, the delusional variant of BDD (which identifies individuals who are completely convinced that their perceived defects or flaws are truly abnormal in appearance) is no longer coded as both a delusional disorder (somatic type) and BDD. Under DSM-5, this presentation is designated only as BDD with the "absent insight/delusional beliefs" specifier and not as a delusional disorder.

Under DSM-IV criteria, BDD was a fairly common disorder affecting approximately 2.4 percent of the general population at any time (point prevalence) as estimated by a random sample telephone survey conducted in 2004 among 2,513 adults residing in the United States (Keel, Brown, Holm-Denoma, & Bodell, 2011). As a comparison, this is similar to point prevalence estimates of DSM-IV defined GAD. Estimates under DSM-5 criteria are not currently available for children or adults. However, criteria-induced changes in the estimates are likely to be minor. Over 90 percent of people with BDD report repetitive behaviors or mental acts in response to their preoccupation with a perceived physical deficit (Able, Johnston, Adler, & Swindle, 2007), and this was the only restrictive change to diagnostic criteria. BDD affects both males and females and has been identified in children as young as age 5 and as old as age 80 (Able et al., 2007). Moreover, patients with BDD report that unwanted, anxiety provoking obsessions related to BDD cause significant distress (e.g., avoidance of social situations due to anxiety of being ridiculed) and the repetitive behaviors are time consuming, functionally impairing (e.g., being late for work due to compulsive compensatory behavior), and can be dangerous (e.g., skin picking leading to infection). Suicidal thoughts is a significant concern among people with BDD; suicidal ideation is as high as 80 percent in this population and one in four make a suicide attempt (Able et al., 2007). There are very few prospective studies of BDD, but retrospective studies suggest a mean onset of BDD around age 16 and indicate a chronic course with a low probability of remission without treatment (Able et al., 2007). Since approximately 75 percent of those with BDD meeting criteria for MDD as well, even if BDD was not assessed in a clinical instrument, the majority of the cases with BDD would be classified as having SED due to co-morbidity. Table 23 shows a comparison between DSM-IV and DSM-5 for body dysmorphic disorder.

Table 23. DSM-IV to DSM-5 Body Dysmorphic Disorder Comparison

DSM-IV	DSM-5
Disorder Class: Somatoform Disorders	Disorder Class: Obsessive-Compulsive and Related Disorders
A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.	A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
	B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.
B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	C. The preoccupation causes clinically significant distress or impairment in social, occupational or other areas of functioning.
C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa). --	D. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder. *Specify* if: With muscle dysmorphia: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case. *Specify* if: Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., "I look ugly" or "I look deformed"). With good or fair insight: The individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true. With poor insight: The individual thinks that the body dysmorphic beliefs are probably true. With absent insight/delusional beliefs: The individual is completely convinced that the body dysmorphic beliefs are true.

4. Instrumentation

The purpose of this section is to describe current plans to integrate the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM-5) changes into the leading diagnostic instruments for assessing childhood mental disorders. Instrument developers provided information about plans to update diagnostic interviews. Table 24 describes the major diagnostic instruments, including both structured and semistructured interviews. Table 24 also describes the diagnostic coverage for each instrument. The final column provides an update on the status of each instrument's DSM-5 compatibility.

Table 24. Summary of Diagnostic Instruments Used to Assess Child Mental Disorders

Instrument	Age Range	Rater	Mode	Diagnostic Criteria	Diagnostic Coverage	Administered By	DSM-5 Update
K-SADS	6-18 years	Child Parent	In person Phone	DSM-IV	Affective, anxiety, behavioral, eating, psychotic, substance abuse	Clinician	Interview is DSM-5 compatible. Computer version under construction.
DISC-IV	6-17 years	Child Parent	In person	DSM-IV ICD-10	Anxiety, mood, schizophrenia, behavior, substance use, miscellaneous disorders (30 disorders total)	Trained lay interviewer	Not DSM-5 compatible. Will possibly update in the future.
CAPA	9-18 years	Child Parent	In person Phone	DSM-IV	Anxiety, mood, behavioral, substance, and antisocial personality	Trained lay interviewer (at least bachelor degree)	Scoring algorithms will be updated.
NCS-A CIDI	13-17 years	Child Parent	In person Phone	DSM-IV	Mood, anxiety, disruptive behavior, substance use, eating, neurasthenia, and suicidality (19 total)	Trained lay interviewer	No plans to update.
PAPA	2-5 Years	Parent	In person Phone	DSM-IV	Mood, anxiety, disruptive behaviors, psychosis, attachment, enuresis, encopresis	Trained lay interviewer	Scoring algorithms will be updated.
YAPA	19-21 years	Self	In person	DSM-IV	Mood, anxiety, behavior disorders, personality disorders, substance abuse, risk factors, living situations, relationships	Trained lay interviewer	Unknown

CAPA = Child and Adolescent Psychiatric Assessment; DISC-IV = Diagnostic Interview Schedule for Children, Version 4; DSM-IV = *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed.; ICD-10 = International Classification of Disease, revision 10; K-SADS = Kiddie-Schedule for Affective Disorders and Schizophrenia; NCS-A-CIDI = National Comorbidity Survey Replication Adolescent Supplement-Composite International Diagnostic Interview; PAPA = Preschool Age Psychiatric Assessment; YAPA = Young Adult Psychiatric Assessment

In addition to their measurement of disorders and symptoms, these diagnostic interviews also measure functional impairment. Each instrument measures functional impairment slightly differently.

- The version of the Composite International Diagnostic Interview (CIDI) used in the National Comorbidity Survey (NCS) for adults and adolescents includes an expanded version of the Sheehan Disability Scale after each diagnostic module to assess overall level of impairment associated with a disorder.
- The Child and Adolescent Psychiatric Assessment (CAPA), Preschool Age Psychiatric Assessment (PAPA) and Young Adult Psychiatric Assessment (YAPA) interviews incorporate some assessment of impairment within the diagnostic algorithms to establish the presence of an Axis I disorder. For example, problems in school, arguments with peers and family members, and legal actions are all assessed at the beginning of the CAPA/PAPA/YAPA instruments prior to the diagnosis-specific modules on attention-deficit/hyperactivity disorder (ADHD), depression, anxiety, oppositional defiant disorder (ODD), and conduct disorder (CD). The CAPA/PAPA/YAPA instruments close with a separate "incapacities" module that assesses impairment for all endorsed symptoms. Interviewers are asked to review all problems or symptoms that emerged during the interview. Then, taking these one at a time, they must determine whether symptoms in that area caused incapacity. The interviewer is asked to distinguish two levels of disturbance or impaired functioning—partial and severe. "Partial incapacity" refers to a notable reduction of function in a particular area. If a person is still able to do things, but does them less well or more slowly, then it is coded as a partial incapacity. "Severe incapacity" refers to a complete, or almost complete, inability to function in a particular area. If neither of these applies, the interviewer codes "absent."
- The Diagnostic Interview Schedule for Children (DISC) incorporates a series of impairment questions at the end of each diagnostic section, which are only asked if a "clinically significant" number of symptoms have already been endorsed, usually half or more of those required for the diagnosis. These questions are uniform across all diagnoses. They inquire as to whether the symptoms present during the last year have resulted in any degree of impairment in six different social domains. Each set of questions has a two-part structure, the first determining whether impairment is present and the second measuring severity or frequency. The DISC assesses three levels of impairment severity. The Clinical Report produced by the C-DISC generates a tally of the degree of impairment. The separate SAS algorithms can also be used to generate diagnoses with varying degrees of diagnosis-specific impairment.
- The Kiddie-Schedule for Affective Disorders and Schizophrenia (K-SADS) determines severity of a disorder using the Child Global Assessment of Functioning (C-GAF) (Shaffer et al. 1983), which is administered as the sixth and final module of the instrument. Severe impairment is indicated by a C-GAF score of 50 or less when a diagnosis of an Axis I mental disorder is present. Moderate severity is indicated by a C-GAF score in the range of 51-70 along with presence of an Axis 1 disorder. Mild severity is indicated by a C-GAF score greater than 70 in the presence of an Axis 1 disorder.

One goal of the project is to develop a model that can predict SED using a mental health screener and other predictor variables. One possible screener is the Strengths and Difficulties

Questionnaire (SDQ), which has been the subject of one validation study comparing parent SDQ ratings with clinician ratings using the K-SADS (Kessler, Gruber, & Sampson, 2006), as well as the Centers for Disease Control and Prevention's (CDC's) SDQ validation study, which compared the SDQ with the CAPA/PAPA. These studies found that the SDQ had some limited ability to predict presence of a disorder, depending on reporter (parent versus child) and severity of disorder. For the purpose of this report, it should be noted that screeners are not directly tied to DSM symptom classifications. Accordingly, the developers of the SDQ have confirmed that they do not consider the SDQ to be a diagnostic instrument and therefore do not anticipate any adaptations based on DSM-5 changes.

Finally, with increasing evidence about the comparable validity and reliability between telephone and face-to-face administration of mental health interviews, psychiatric researchers have been conducting clinical interviews over the telephone for the past 20 years (Aneshensel, Frerichs, Clark, & Yokopenic, 1982; Reich & Earls, 1990; Rohde, Lewinsohn, & Seeley, 1997; Sobin et al., 1993). In fact, telephone administration has become widely accepted as a way to conduct clinical appraisals of both adults and adolescents (Kessler et al., 2009). However, most of the research conducted with telephone administrations of diagnostic mental health interviews has been done with adults. The only adolescent instrument to be directly compared by telephone and face-to-face administration was the CIDI in an appraisal study performed by Kessler et al. (2009). The CAPA and PAPA instruments have only been used in a limited fashion by telephone, and no formal studies have compared CAPA or PAPA diagnostic outcomes (or for many of the other diagnostic tools) when gathered in person versus by telephone. Duke University investigators estimated that approximately 112 CAPA interviews were completed over the telephone with 15- and 16-year-old adolescents in the Great Smoky Mountain Study (GSMS). Among these 112 telephone CAPA interviews, the Duke investigators reported no adverse events (e.g., reports to the Institutional Review Board for suspected child abuse or child suicidal or homicidal ideation). The published literature does indicate that reliability, validity, and epidemiological studies have been conducted by telephone with adolescents and children as young as 12 years of age (Merikangas, Avenevoli, Costello, Koretz, & Kessler, 2009; Reich & Earls, 1990; Rohde et al., 1997; Sobin, Weissman, Goldstein, & Adams, 1993). However, no methodological work has been done to evaluate the specific impact of a change in the mode of administration (from face to face to telephone) on the CAPA or PAPA outcomes.

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5. Summary and Conclusions

Changes included in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) raise issues relevant to the definition of childhood serious emotional disturbance (SED). Within the original *Federal Register* definition, SED was defined as including "any diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R)." Diagnostic "V" codes and Axis II disorders (personality disorders and mental retardation) as well as substance use disorders (SUDs), pervasive developmental disorder (PDD), and autism were all specifically excluded. The *Federal Register* made no specific mention of learning disorders; however, these are not usually considered in operational definitions of SED. With the release of the DSM-5, three specific issues could be considered:

1. Due to the DSM-5 removal of the Axis system, the operational definition of SED may now need to explicitly state which DSM-5 mental disorders are excluded from the SED definition of "any DSM-5 mental disorder."
2. A decision will need to be made about which disorders within the new DSM-5 neurodevelopmental disorders class should be included versus excluded within the definition of SED. Many, but not all, disorders within the neurodevelopmental disorders were previously excluded from the 1993 definition.
3. A decision will need to be made as to whether one of the new DSM-5 childhood disorders, social communication disorder (SCD), should be included as meeting criteria for SED. If SCD is considered a "developmental disorder," it might be excluded based upon the 1993 SED definition.

DSM-5 changes also will impact the diagnostic instruments used to assess the presence of a mental disorder in childhood. Only one diagnostic interview for children and adolescents, the Kiddie-Schedule for Affective Disorders and Schizophrenia (K-SADS), has already been updated to explicitly use DSM-5 diagnostic criteria. The scoring algorithms associated with the Child and Adolescent Psychiatric Assessment (CAPA) and Preschool Age Psychiatric Assessment (PAPA) will be updated to accommodate new DSM-5 diagnostic changes. This is possible within the CAPA and PAPA interviews as they are symptom and functioning based and not structured in diagnostic-specific modules like the other diagnostic interviews. CAPA and PAPA scoring algorithms use questions embedded in the entire instrument to indicate the presence of particular mental disorders. The Diagnostic Interview Schedule for Children (DISC) will possibly be updated in the future, but the developers did not articulate a specific plan to do so. Particularly in the near future, the release of the DSM-5 will narrow the number of diagnostic measures to be considered for use in children's mental health surveillance efforts.

Research examining the impact of DSM-5 changes suggests that there may be a slight increase in the overarching prevalence of diagnosed mental disorders among children and adolescents. The potential for this slight increase stems mainly from the changed criteria for attention-deficit/hyperactivity disorder (ADHD)—the new impulsivity criteria and lower percentage of criteria needed for the diagnosis. A much smaller increase may be due to the

lowered age of onset for post-traumatic stress disorder (PTSD). Epidemiological studies, including an assessment of eating disorders among adolescents, may also see an increase in eating disorder-specific prevalence estimates. Most DSM-5 changes for children reclassified disorders from one category to another. These changes would have no overarching impact on an estimate of "any mental disorder." For instance, the prevalence of ODD is expected to decrease using DSM-5 as some cases will now be diagnosed under the new disruptive mood dysregulation disorder (DMDD).

The definition of SED includes the presence of *both* a childhood mental disorder and functional impairment. If the additional cases identified with updated DSM-5 criteria are not accompanied by functional impairments that substantially interfere with a child's ability to function at home, school, or in the community, an SED prevalence estimate would not be significantly impacted. DSM-5 field trials examined impact on prevalence estimates without consideration of functioning. Additional research will be necessary to determine the full impact of DSM-5 changes specifically on estimates of the prevalence of SED among children and adolescents.

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