

DSM-5 and Neurodevelopmental and Other Disorders of Childhood and Adolescence

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In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the classification of mental disorders for children and adolescents has been revised. Although some changes are welcome and needed, others have been controversial. In this article, I examine the diagnostic changes along with some of the associated controversies and resolutions. The implications for the practice of child forensic psychiatry, including problems that may be encountered by forensic psychiatrists who evaluate adults with childhood-onset mental disorders, are examined. The pitfalls associated with improper use of The Manual by legal professionals are also reviewed.

J Am Acad Psychiatry Law 42:165–72, 2014

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)¹ represents the culmination of a multinational interdisciplinary effort to incorporate a body of empirical studies into a resource for classifying mental illness (Ref. 1, p.7). The DSM-5 Child and Adolescent Disorders Work Group was cognizant of the controversy surrounding their recommendation to reclassify several DSM-IV² disorders, including some that affect children and adolescents. The contents of DSM-5, at times, reflect their responsiveness to those concerns.³

In this article, I examine changes in DSM-5 regarding disorders that have their onset primarily in childhood and adolescence and I focus on disorders that are more likely to be encountered by child forensic psychiatrists in the course of practice. The discussion may also be of interest to forensic mental health professionals who work with adults who have childhood-onset mental disorders.

The implications of a mental disorder in a child or adolescent are substantial. The disorder may interfere with normal development and the youth's efforts to relate to family and peers and to reach normal developmental milestones, such as becoming inde-

pendent, caring for himself, interacting with peers, and obtaining an education. Therefore, identifying and addressing psychiatric disorders in children is imperative.

Although the end of childhood has been legislatively defined for educational, legal, and other purposes, there is no evidence-based endpoint for the neurodevelopmental period. For this reason, DSM-5 contains no references to the age at which the neurodevelopmental period ends and adulthood begins. Yet, the point at which individuals are reasonably expected to transition from childhood to adulthood is the crux of many of the controversies involving psychiatric disorders, including those affecting children and adolescents. Many youths encounter challenges and setbacks as they navigate the social and educational systems on their way to independence. This can be a normal part of the developmental process and may be conducive to the refinement of coping skills, as well as the development of empathy and resilience. However, a setback may also be the manifestation of a mental disorder, when a change in biological, psychological, or developmental functioning results in a youth's enduring behavioral, cognitive, or emotional impairment (Ref. 1, p 20).

Many of the disorders in DSM-5 that have their onset during childhood and adolescence, such as autism spectrum disorder, can be found in a chapter titled "Neurodevelopmental Disorders." Others, including conduct disorder and reactive attachment

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Disclosures of financial or other potential conflicts of interest: None.

disorder, are located elsewhere in The Manual. Neurocognitive disorders, which are acquired disorders that may affect children and adolescents but primarily are diagnosed in adults, will not be addressed in this article.

Autism Spectrum Disorder

The level of impairment experienced by individuals with pervasive developmental disorders, which are characterized by deficits in social interaction, varies from mild to severe. In DSM-IV, individuals with Asperger's disorder and those with autistic disorder show deficits in social interaction and restricted, repetitive behavior. Individuals with autistic disorder also have early signs of cognitive developmental delay and language deficits.

The DSM-5 Neurodevelopmental Disorders Work Group determined that autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett's disorder, and pervasive developmental disorder, not otherwise specified, were not being applied consistently and correctly by clinicians. This inconsistency was obfuscating efforts to understand these disorders and to identify effective treatment interventions. The Work Group addressed this concern by using a dimensional approach to reclassifying these five maladies as a single diagnosis: autism spectrum disorder.

A table provided in DSM-5 in the neurodevelopmental disorders chapter (Ref. 1, pp 34–6) provides examples of the different levels of severity. Specifiers for autism spectrum disorder include whether there is accompanying intellectual or language impairment or an association with a medical or genetic condition or environmental factor; with another neurodevelopmental, mental, or behavioral disorder; or with catatonia. Thus, for example, in the absence of intellectual impairment, the DSM-5 diagnosis for a person with a DSM-IV diagnosis of Asperger's disorder is autism spectrum disorder without intellectual impairment and without structural language impairment.

The decision to subsume Asperger's disorder as part of autism spectrum disorder has been controversial. Many clinicians, teachers, parents, and advocates fear that the change will stigmatize individuals with Asperger's disorder because autism historically has been thought of as a more severe disease.^{3–5} This concern has been particularly troubling in regard to high-functioning individuals with Asperger's disorder

who have learned to adapt in the classroom, workplace, and elsewhere; some affected individuals have even managed to function without accommodations and without disclosing the diagnosis. Although Asperger's disorder is no longer a separate diagnosis, individuals and clinicians may continue to use the term in the interest of reducing the stigma and preserving the therapeutic alliance.

Also, some have voiced concerns that removing the Asperger's disorder diagnosis from DSM-5 will cause affected individuals to lose eligibility for educational and other supportive services.^{6,7} However, the DSM-5 diagnostic criteria for autism spectrum disorder are broader than the DSM-IV classifications for both autistic disorder and Asperger's disorder. The DSM-IV criteria required developmental delay or abnormal function to begin before the person's third birthday. However, in DSM-5, the symptom presentation for autism spectrum disorder must be evident during early development "but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life" (Ref. 1, p 50).

The DSM-5 criteria capture the myriad clinical presentations of individuals within the autism spectrum. This consolidation may hinder the efforts of policy makers who use specific DSM-IV diagnoses (i.e., autistic disorder versus Asperger's disorder versus pervasive developmental disorder, NOS, to determine which individuals receive public support for rehabilitation and therapeutic services, e.g., education, therapy, health care, and housing). However, elimination of the artificial distinction may reduce the pressure that was encountered occasionally by clinicians to overdiagnose autistic disorder so that affected individuals could qualify for support services.

A welcome addition to the DSM-5 autism spectrum disorder classification is the requirement for mental health professionals to individualize assessments by determining how therapeutic "intervention, compensation, and current supports may mask difficulties in at least some contexts" (Ref. 1, p 53). Although the clinical presentation may change, especially after effective therapeutic interventions, a child who has autism spectrum disorder continues to have that diagnosis as an adult "even if the symptoms are no longer present" (Ref. 1, p 54). These changes may enhance the thoroughness of forensic testimony or make it more challenging, since adults do not have to

meet all diagnostic criteria for autism spectrum disorder if, in the judgment of the evaluator, the disorder is present. Forensic experts may be expected to focus on capacity and impairment, rather than on exact diagnosis.

The DSM-5 has lowered the threshold for diagnosing autism spectrum disorder by emphasizing the importance of adaptive functioning and clinical assessment. The revised diagnostic criteria may place a financial burden on agencies and organizations that are charged with the duty of distributing funds equitably to qualifying individuals. Only time will tell what the long-term outcome will be, but forensic psychiatrists may be consulted to review cases on behalf of agencies and individuals regarding eligibility for services and diagnostic updates.

Forensic psychiatrists are asked to provide evaluations and testimony about capacity or competence, sentence mitigation, and rehabilitation needs of individuals with autism spectrum disorder. Expert witnesses are now in a position to reinforce the fact that there are no clear lines of diagnostic distinction between DSM-IV autistic disorder and related disorders. An evaluation of an individual with autism spectrum disorder should include a determination of whether or which support services are needed to reduce the individual's impairment by improving his adaptive functioning.

Attention-Deficit/Hyperactivity Disorder

The increasing prevalence of the diagnosis of attention-deficit/hyperactivity disorder (AD/HD) has received significant media attention because of concerns about overdiagnosis and overprescribing of stimulants.^{8–13} The competitive advantage in academics and athletics that stimulant use may afford individuals who do not have AD/HD is also troubling.^{14–16} Recreational use of stimulants (Ref. 17 and APA, unpublished manuscript, 2011) may contribute to addictive disorders, life-threatening health problems, and legal problems.^{15,16}

Despite these concerns, the changes in the DSM-5 criteria for AD/HD have lowered the threshold for making the diagnosis in individuals who are older than 17 years, in whom the prevalence is 2.5 percent (Ref. 1, p 61). For diagnosis of AD/HD in adults, DSM-5 has reduced the minimum number of inattention symptoms from six to five and the age of symptom onset from before 7 years to before 12 years. These changes were made because recollection

of childhood symptoms by adults “tends to be unreliable” (Ref. 1, p 61). Examples are provided to aid with diagnosing AD/HD in older individuals.

Forensic psychiatrists are likely to consult on cases involving AD/HD when individuals have been denied supportive services in primary or secondary school or reasonable accommodations in college or the workplace. Criminal court cases involving possession of stimulants, the ability of an individual with AD/HD to follow and comprehend legal proceedings without stimulant therapy (which is not generally prescribed in adult penal institutions due to, among other things, security concerns associated with narcotics), and psychosis related to stimulant use may involve psychiatric expert evaluation and testimony. Lowering the diagnostic threshold is likely to increase the number of requests for forensic psychiatric consultation in civil litigation, workplace and education accommodation reviews, and disability benefit petitions.

Specific Learning Disorder

Learning disorders is another area in which there are fewer diagnoses in DSM-5 than in DSM-IV. In DSM-5 several DSM-IV learning disorders have been consolidated into a single diagnosis, specific learning disorder. Specifiers will be used to identify domains of restricted educational progress. For example, the diagnosis formerly called reading disorder is now specific learning disorder with impairment in reading.

Specific learning disorder, which tends to be apparent in most affected individuals during the early school years, persists even when the affected individual is able to maintain average achievement “by extraordinarily high levels of effort or support” (Ref. 1, p 69). The diagnosis also may be made when a person who is intellectually gifted demonstrates “unexpected academic underachievement” (Ref. 1, p 69) or uses “compensatory strategies, extraordinarily high effort, or support” (Ref. 1, p 69) to sustain satisfactory achievement but shows impairment when barriers, such as timed examinations, impede his capacity to achieve (Ref. 1, p 69).

Individuals with specific learning disorder may become involved in legal proceedings when the need for supportive services or reasonable accommodations in education, employment, or community settings is disputed. Litigation involving the validity of contracts, crisis management, harassment, discrimina-

tion, and adjudicative competence may also illuminate how specific learning disorder impedes an affected individual's ability to function in society. The prevalence of comorbidity in individuals with specific learning disorder may also result in forensic psychiatrists' assessing affected individuals and testifying during adjudicative capacity and criminal responsibility hearings. The diagnostic changes in DSM-5 will present new challenges for forensic psychiatrists in courtrooms and elsewhere, since a subgroup of evaluatees who are from different cultures and who may have experienced social or educational deprivation will no longer be eligible for educational and workplace supportive services based on DSM-5 criteria for specific learning disorder. Forensic psychiatrists also will be put in the position of explaining to judges, employers, and education administrators why gifted individuals who meet DSM-5 criteria for specific learning disorder may now be eligible for those same interventions. The changes are likely to result in lively debate for forensic mental health professionals in court testimony and policy debates.

Intellectual Disability and Mental Retardation

Although DSM-5 avoids using terminology that blurs the lines between clinical practice and the law, there are exceptions to this principle. In 2010, Rosa's Law¹⁸ replaced the term mental retardation with intellectual disability as a matter of U.S. federal law. In keeping with this change, DSM-5 has also replaced the diagnosis mental retardation with intellectual disability, and the nomenclature in the International Classification of Diseases, 10th revision (ICD-10)¹⁹ is intellectual developmental disorder. In the text, the latter diagnosis is placed in parentheses and listed after the DSM-5 diagnosis, to facilitate the transition from DSM coding to the ICD-10 coding structure (Ref. 1, p 12).

The term mental retardation has been widely considered stigmatizing, and the change in nomenclature marks a step forward in our awareness of and approach to understanding intellectual disability as a limitation that may be responsive, at times, to therapeutic interventions and rehabilitation. The elimination of the multiaxial diagnostic system in DSM-5 will also serve to lessen stigmatization, as it results in the removal of intellectual disorders diagnoses from Axis II, where they shared a somewhat stigmatizing position with the personality disorder diagnoses.

DSM-5 specifiers for intellectual disability (mild, moderate, severe, and profound) have not changed from DSM-IV. DSM-5 provides a table and examples of deficits listed in three domains of adaptive functioning: conceptual (academic), social, and practical. These domains all have implications for forensic evaluators. For example, adults with mild intellectual disability may have conceptual deficits in abstract reasoning, managing money, executive functioning, and short-term memory. They may have a limited capacity to appreciate risk in social situations and may be more gullible than their same-age peers. They may also need help with practical skills, such as making health care and legal decisions and performing a skilled job competently.

DSM-5 stresses the importance of norming tests to account for cultural variances and an examinee's native language. This may be an important consideration for forensic psychiatrists who consult in cases involving immigrants where a diagnosis of intellectual disability is being considered or applied, such as a disability claim or a petition for a workplace accommodation. Some individuals may malingering intellectual disability disorder to avoid legal consequences. It may be more challenging to detect malingering in an individual who is from a culture or who speaks a language with which the forensic mental health professional is not familiar.

DSM-5 also describes the circumstances under which a child who has been diagnosed with intellectual disability benefits from interventions that significantly improve adaptive functioning, "such that the diagnosis of Intellectual Disability is no longer appropriate" (Ref. 1, p 39). At times, this change will result in lively debate among forensic mental health professionals in courtrooms and elsewhere, especially when intellectual disability disorder is tendered as a basis for adjudicative incompetence or a bar to capital sentencing.

In 2002, the U.S. Supreme Court determined in *Atkins v. Virginia*²⁰ that individuals with mental retardation cannot be executed. In that case, the condition was vaguely described as intellectual functioning in the subaverage range: roughly below IQ 70 and deficits in social and practical functioning with an onset before age 18.²¹ New definitions of intellectual disability in DSM-5 may provide guidance as mental health experts and the Supreme Court grapple with this difficult forensic matter.

The clinical validity of intellectual disability disorder may also be debated by forensic mental health experts when an individual seems to meet diagnostic criteria in the absence of supporting documentation from the neurodevelopmental period. The absence of such information is particularly important when forensic psychiatrists evaluate institutionalized adults who demonstrate obvious intellectual impairment and deficits in adaptive functioning and who lack supporting educational and medical documentation to affirm the diagnosis. DSM-5's emphasis on clinical impression and adaptive functioning in the diagnosis of intellectual disability disorder is likely to increase forensic psychiatry's role in courtroom testimony regarding affected and allegedly affected individuals.

Disruptive Mood Dysregulation Disorder: A New Childhood Disorder

One of the most significant additions to DSM-5 diagnoses is disruptive mood dysregulation disorder, a new mood disorder classified in the depressive disorders section but exclusive to children and adolescents. This disorder may be identified in individuals who have persistent irritability or anger and recurrent episodes (on average three times per week) of developmentally inappropriate verbal or behavioral dyscontrol. The symptoms start before age 10 years, the diagnosis is made between ages 6 and 18, and the disorder causes significant impairment.

Disruptive mood dysregulation disorder was introduced due to "considerable concern" (Ref. 1, p 157) that some children with this symptom profile are overdiagnosed with and treated for bipolar disorder. However, researchers who study bipolar disorder in children and adolescents found that disruptive mood dysregulation disorder could not be distinguished from oppositional defiant disorder and conduct disorder and lacked substantial diagnostic stability.^{17,22} In addition, some in the research community questioned the diagnostic utility of disruptive mood dysregulation disorder in clinical populations.^{22,23}

The initial diagnostic criteria proposed for disruptive mood dysregulation disorder were revised, perhaps in response to these concerns, to improve the utility and validity of the diagnosis. The resultant criteria more clearly distinguished disruptive mood dysregulation disorder from bipolar disorder, oppositional defiant disorder, and intermittent explosive

disorder. Individuals with disruptive mood dysregulation disorder have persistent symptoms, whereas youths with bipolar disorder have discrete episodes of mania or hypomania. In other words, the duration of mood symptoms is the benchmark that distinguishes the two disorders.

Children with disruptive mood dysregulation disorder are more likely to develop unipolar depressive disorders and anxiety disorders and thus should be treated if they are depressed, not manic or psychotic.²⁴⁻²⁶ The change in treatment protocol may reduce the frequency of prescribing atypical antipsychotics, anticonvulsants, lithium, and other medications for bipolar disorder in children, thereby improving treatment response rates and reducing the risk of more serious medication side effects. Treating youths with disruptive mood dysregulation disorder will also reduce the likelihood that, in the event of a first psychotic and/or manic episode, medications that are used to treat these disorders will obfuscate their clinical presentation.

Disruptive mood dysregulation disorder will play a significant role in child forensic psychiatry, especially where at-risk and justice-involved youths are concerned. A subgroup of individuals with disruptive mood dysregulation disorder are caught up in the juvenile justice system because of allegations of domestic violence, assault, and resisting arrest, among other offenses. Early identification and treatment of these youths with antidepressants and other interventions may contain their behavior and delay the onset or reduce the frequency of involvement with the judicial system, by raising the threshold beyond which they become aggressive.

Trauma- and Stressor-Related Disorders

Research into the genetics, neuroscience, and neuroimaging of anxiety disorders supports differences in heritability of disorders that are based on fear (phobias), obsessions and compulsions, dissociation, and trauma. The DSM-5, therefore, has assigned a separate chapter to each of these groups of anxiety disorders.

The trauma- and stressor-related disorders group includes several diagnoses, defined somewhat differently than in DSM-IV, including reactive attachment disorder and disinhibited social engagement disorder, that have significant implications for children and adolescents and for forensic practice. Forensic mental health experts may be asked to com-

ment on the quality or consequences of attachment in cases involving child welfare services, child custody and adoption, juvenile delinquency, criminal responsibility, and capital sentencing, where attachment between the defendant and his caretaker may be presented as an aggravating or a mitigating factor.

Disorders associated with social neglect (e.g., deficient caretaking during childhood, especially during the first months of life) may result in deficits in parent-child attachment. However, the trauma- and stressor-related disorders section of DSM-5 contains an advisory about assessing attachment in individuals who are from cultures in which attachment has not been studied; the diagnosis should be assigned with caution.

The Trauma- and Stressor-Related Disorders group also includes posttraumatic stress disorder (PTSD). DSM-5 provides a list of diagnostic criteria that are specific to children six years of age or younger that describes reenactment of trauma in play and dissociative responses to trauma. The difficulty of determining whether recurring distressing dreams in young children are related to traumatic incidents is also discussed.

In children and adolescents, the symptoms in Criterion E for PTSD, including marked alterations in arousal and reactivity, such as irritable behavior, angry outbursts without much provocation, and self-destructive behavior (thrill-seeking, high-risk behavior, and reckless behavior leading to accidental harm to self or others) (Ref. 1, p 272), may result in referrals to mental health professionals, especially in justice-involved youths. The diagnostic criteria will facilitate identification of aggressive youths who may benefit from evidence-based clinical interventions for PTSD.

This is particularly important in Latino, Native American, and African American youths, who have higher rates of PTSD, even after adjusting for demographic factors and exposure to trauma (Ref. 1, p 276). These youths also are disproportionately represented in the juvenile justice system. However, cultural sensitivity is a requirement when diagnosing PTSD, especially when a forensic psychiatrist is evaluating a child from another country where he may have been exposed to various traumas and is struggling to acculturate.

The changes in the PTSD diagnostic criteria may increase the likelihood that child forensic psychiatrists will be asked to testify about PTSD and aggres-

sion in school, special education, individualized education programs (IEPs), and expulsion hearings and in juvenile court waiver or bindover and disposition or sentencing hearings. When youths who have been exposed to severe trauma engage in aggressive, risky, or thrill-seeking behavior and appear to be callous and unemotional, judicial administrators may want to know whether the history of traumatization is contributing to the behavior and warrants mental health intervention. Child forensic psychiatrists may be increasingly retained to examine this question and to recommend therapeutic interventions for affected individuals.

Disruptive, Impulse-Control, and Conduct Disorders

Conduct disorder is one of the only diagnoses in the DSM-5 that contains no exclusionary criteria for other clinically treatable diagnoses, and consequently, it may lend itself to diagnosis by lay persons who lack facility with clinical diagnoses. The diagnosis, which can also be made in adults, requires the affected individual to meet 3 of 15 criteria in one of four categories: aggression toward people and animals, destruction of property, deceitfulness or theft, or serious violation of rules. One specifier, with limited prosocial emotions, merits further discussion.

Individuals with limited prosocial emotions meet two of the following four criteria: lack of remorse or guilt about their behavior until they are caught; lack of empathy; seeming unconcerned about consequences of unsatisfactory academic, professional, or other achievement; and "shallow or deficient affect" (Ref. 1, p 471). These youths often misuse substances and have a higher rate of suicidal ideation and attempted and completed suicides (Ref. 1, p 473). The behavioral description of conduct disorder overlaps considerably with the behavior exhibited by individuals with psychosis, mood disorders, and PTSD. Also, many youths with conduct disorder become involved in the juvenile justice system, where the prevalence of mental disorders is higher than in the general population, even when conduct disorder is excluded.²⁶

Perception of the limited prosocial emotions specifier has not been studied in juvenile court judges. However, when conduct disorder with callous and unemotional features was studied in mental health professionals who evaluate justice-involved youths, the response was both negative and punitive. This

outcome has led to concerns about the influence of this specifier on mental health professionals and on the jurists and attorneys to whom they provide expert consultation.²⁷

The facility with which the conduct disorder with limited prosocial emotions diagnosis can be made increases the likelihood that other treatable diagnoses may be overlooked, as often happens when mental health services in juvenile corrections facilities are reviewed.^{28,29} The concern extends to youths charged with more serious offenses, whose cases are bound over or waived from juvenile to criminal court. These individuals tend to have more serious mental disorders than youths whose cases remain in the juvenile court system.³⁰

Although defense attorneys have concerns about the adjudicative competence of youths who seem to lack the maturity to understand the legal process and to assist in their defense,³¹ immaturity is not considered a mental disease or defect for purposes of adjudicative incompetence.³² Juveniles also are more likely than adults to make false confessions.³³ Consequently, in the United States, a youth with conduct disorder with limited prosocial emotions may be adjudicated delinquent or bound over, even if he does not understand the legal process and has treatable mental disorders that have been overlooked.

Although youths should not be absolved of responsibility for their actions, those with treatable mental disorders should not be overlooked, but rather should be placed in juvenile and other settings that foster mental health rehabilitation. For example, DSM-5 indicates that “individuals with conduct disorder are at risk for later mood disorders, anxiety disorders, posttraumatic stress disorder, impulse-control disorders, psychotic disorders, somatic symptom disorders and substance-related disorders as adults” (Ref. 1, p 473). Nevertheless, in the discussion accompanying the diagnosis, the prevalence of these evolving mental disorders in children and adolescents is not discussed, and an opportunity to alert diagnosticians to the need for early identification of and interventions for affected individuals is missed.

Conduct disorder with limited prosocial emotions represents a defined condition that may alter the trajectory of the lives of youths who have undiagnosed but more treatable comorbid disorders. The absence of exclusionary criteria illuminates the dangers associated with using DSM-5 inappropriately in forensic settings. It also suggests that, in rare cases, it may

unintentionally contribute to adverse outcomes, even when it is used for its intended purpose.

DSM-5 and Legal Practice

Although there are many changes in DSM-5 that may enhance how mental disorders are classified and studied, one thing has not changed: the danger of legal professionals, policy makers, and others using The Manual to advance legal, political, and nonmedical agendas. It is important, therefore, for child forensic psychiatrists to be familiar with the “Cautionary Statement for Forensic Use of DSM-5” (Ref. 1, p 25).

DSM-5 is not intended for legal use. Legal professionals who use the text to address matters pertaining to children and adolescents risk misinterpreting or misusing the information. The child and adolescent forensic mental health professional who is cognizant of the “imperfect fit between legal questions to be addressed and questions of ultimate concern to the law” (Ref. 1, p 25) is in an excellent position to remind legal professionals of the drawbacks associated with using the DSM-5 in resolving legal questions.

Conclusion

Classification of mental disorders is based on a growing body of research in the clinical and biological sciences that makes periodic re-evaluation of diagnoses necessary. In the case of some diagnoses, such as disruptive mood dysregulation disorder, diagnostic changes may result in identification of youths who can be stabilized with safer more effective treatments. In other cases, such as autism spectrum disorder, the change may be more controversial because of concerns about stigma, even though the diagnostic revision may cause more individuals with Asperger’s disorder to become eligible for supportive services.

Regardless of the changes in DSM-5, forensic psychiatrists who treat youths and adults who have neurodevelopmental and other childhood disorders are in a position to educate legal professionals, to inform policy decisions, and to influence mental health and legal outcomes for a group of affected individuals for years to come. We welcome the challenge.

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