

Summary of DSM-PC ¹

I. Introduction

The *DSM-PC Child and Adolescent Version* (1996) represents the collaborative efforts of leading pediatricians, child psychologists, and child psychiatrists. The *DSM-PC* is intended to help primary care clinicians better identify psychosocial factors affecting their patients so that they can provide interventions when appropriate, be reimbursed for those interventions, and identify and refer patients who require more sophisticated care (p. 9).

Primary care clinicians provide a critical point of access for children in need of mental health services. For primary care clinicians to address behavioral and emotional problems, they need to be able to accurately describe and classify the phenomena they observe. The current mental health classification systems provide extensive detail about mental disorders, but too little detail about common problems and situations that primary care clinicians need to handle (p. 9).

The *DSM-PC Child and Adolescent Version* is based on four assumptions (p. 10):

1. The environments of children have an important impact on their mental health.
2. A functional mental health classification system must be clear, concise, based on objective information when possible, and organized so that it can be revised and refined by subsequent research.
3. In most situations, the symptoms children demonstrate vary along a continuum from normal variations to problems to disorders.
4. For a mental health classification system to be useful for clinical, training, and research purposes, it must be compatible with existing systems.

The *DSM-PC* manual is divided into two main sections: **Environmental Situations**, defining children's responses to environmental stresses and **Child Manifestations**, broken into 10 behavioral symptom clusters.

II. Environmental Situations

A list of potentially adverse situations, grouped by the nature of the situation is provided on the next pages. Table 1, p. 36 of *DSM-PC*, provides key risk and protective factors (child, environment, and child x environment interactions) to help clinicians evaluate the impact of stressors. Table 2, pp. 37-38 of *DSM-PC*, summarizes common behavioral responses to stressful events for children of various ages (e.g., infants & toddlers, early childhood).

¹ Wolraich, M. (1996). *The classification of child and adolescent mental diagnoses in primary care: Diagnostic and statistical manual for primary Care (DSM-PC) child and adolescent version*. Elk Grove Village, IL: American Academy of Pediatrics.

Environmental Situation Clusters	<u>Page in DSM-PC</u>
1. Changes in Caregiving	43
Foster Care / Adoption / Institutional Care	
Substance Abusing Parents	
Neglect, Physical, Sexual Abuse	
Quality of Nurture Problem	
Mental Disorder of Parent	
Physical Illness of Parent	
Physical Illness of Sibling	
Mental or Behavioral Disorder of Sibling	
2. Changes in Caregiving	45
Foster Care / Adoption / Institutional Care	
Substance Abusing Parents	
Neglect, Physical, Sexual Abuse	
Quality of Nurture Problem	
Mental Disorder of Parent	
Physical Illness of Parent	
Physical Illness of Sibling	
Mental or Behavioral Disorder of Sibling	
3. Other Functional Change in Family	47
Addition of a Sibling	
Change in Parental Caregiver	
4. Community / Social Challenges	48
Acculturation	
Social Discrimination	
Religious or Spiritual Problem	
5. Educational Challenges	48
Illiteracy of Parent	
Inadequate School Facilities	
Discord with Peers / Teachers	
6. Parent or Adolescent Occupational Challenges	49
Parent or Adolescent Occupational Challenge	
Unemployment	
Loss of a job	
Adverse Effect of Work Environment	
7. Housing Challenges	50
Homelessness	
Inadequate Housing	
Unsafe Neighborhood	
Dislocation	
8. Economic Challenges	51
Poverty / Inadequate Financial Status	

	<u>Page in DSM-PC</u>
9. Inadequate Access to Health or Mental Health Access	51
10. Legal System or Crime Problem Crime Problem of Parent or Adolescent	51
11. Other Environmental Situations Natural Disaster Witness of Violence	52
12. Health-Related Situations Acute or Chronic Health Conditions	52

III. Child Manifestations

This classification was developed with the recognition that behaviors throughout development are a reflection of complex interactions between environmental influences and characteristics of the child's developing neurological system. While behaviors and behavioral clusters (syndromes) are emphasized, clear distinctions between behaviors intrinsic to the child and those representing a reaction to events outside the child, are sometimes difficult to make (p. 57).

A. Behavioral Symptom Clusters

For each cluster, a spectrum of symptomatology is outlined: normal variations, problems, and disorders. Even when the child's behavior represents a normal variation for child's age, it may be a cause of concern. When behaviors occur at a level considered to be a problem, they are serious enough to disrupt the child's functioning with peers, in school, and /or in the family, but do not involve a sufficient level of severity / impairment to warrant a diagnosis of a mental disorder. In many cases, these may be treated with short term-counseling, frequently provided by the primary care clinician. Problems have been assigned an *ICD-9-CM* code. Symptoms that are at the level of a disorder are those defined in *DSM-IV* (p. 58).

Format (For an abbreviated example, see the next page of this handout)

- Presenting Complaints
- Definitions and Symptoms
- Epidemiology
- Etiology
- Spectrum: Variation / Problem / Disorder
- Differential Diagnosis
- Comorbidity

1. **Developmental Competency**

Cognitive / Adaptive Skills (see handout, p. 4)	61
Academic Skills	69
Motor Development	77
Speech and Language	83

CODE SPECTRUM	COMMON DEVELOPMENTAL PRESENTATIONS
V65.4 Developmental / Cognitive <u>Variation</u> V62.3 Developmental / Cognitive <u>Problem</u> Mental Retardation <u>Disorder</u> 317 Mild MR 318.0 Moderate MR 318.1 Severe MR 318.2 Profound MR 319. Unspecified	Infancy Early Childhood Middle Childhood and Adolescence SPECIAL INFORMATION Valid assessment considers cultural and linguistic diversity as well as differences in communication and behavioral factors. The existence of limitations in adaptive skills occurs within the context of community environments typical of same age peers.

DIFFERENTIAL DIAGNOSIS	SPECIAL INFORMATION
General Medical Conditions Examples include: Phenylketonuria Fragile X Syndrome Down Syndrome	The list of medical syndromes involving MR is too extensive to be given here in detail.
Substances--Examples include: Alcohol Lead	
Mental Disorders 299.00 Autistic Disorder	

COMMON COMORBID CONDITIONS	SPECIAL INFORMATION
Other Comorbid Mental Health Conditions Examples include: 314.01 Attention Deficit Hyperactivity Disorder 300.02 Generalized Anxiety Disorder 296.xx Major Depressive Disorder 300.3 Obsessive Compulsive Disorder 299.00 Autistic Disorder	Individuals with MR may be vulnerable to exploitation by others (being physically and sexually abused). It is estimated that individuals with MR have a prevalence of comorbid mental disorders that is estimated to be four times greater than the prevalence in the general population.
Other General Medical Conditions Examples include: Cerebral palsy Hydrocephalus / Spina bifida Epilepsy Down Syndrome	

	<u>Page in DSM-PC</u>
2. Impulsive / Hyperactive or Inattentive Behaviors	
Hyperactive / Impulsive Behaviors	93
Inattentive Behaviors	103
3. Negative / Antisocial Behaviors	
Negative Emotional Behaviors (Disorders, see Emotions / Moods)	113
Aggressive / Oppositional Behaviors	119
Secretive Antisocial Behaviors (Conduct Disorder)	127
4. Substance Use	135
5. Emotions and Moods	
Anxious Symptoms	145
Sadness & Related Symptoms (Depression, Dysthymia, Bipolar)	153
Ritualistic, Obsessive, Compulsive Symptoms	161
Suicidal Thoughts or Behaviors	165
6. Somatic and Sleep Behaviors	
Pain / Somatic Complaints [Somatoform, Pain, Conversion, Factitious (Disorders)]	173
Excessive Daytime Sleepiness (Narcolepsy)	181
Sleeplessness (Insomnia)	189
Nocturnal Arousals (Sleep Terror)	199
7. Feeding, Eating, Elimination Behaviors	
Soiling Problems (Encopresis)	209
Day / Nighttime Wetting Problems (Enuresis)	215
Purging / Binge Eating (Bulimia Nervosa)	221
Dieting / Body Image Problems (Anorexia Nervosa)	227
Irregular Feeding Behaviors (Feeding Disorder of Infancy / Childhood)	235
8. Illness-Related Behaviors	
(Psychological Factors affecting medical condition)	247
9. Sexual Behaviors	
Gender Identity Issues (Childhood Gender Identity Disorder)	255
Sexual Development Behaviors (Masturbation)	265
10. Atypical Behaviors	
Repetitive Behaviors (Stereotypic Movement Disorder, Trichotillomania, Transient Tic Disorder, Chronic Motor or Vocal Tic Disorder, Tourette's Disorder)	269
Social Interaction Behaviors [Autism, Rett's, Asperger's Childhood Disintegrative (Disorder), PDD, NOS]	277
Bizarre Behaviors (Delirium due to a general medical condition)	285

Symptoms: Should be evaluated based on frequency, intensity, seriousness, duration, site of occurrence (home, school, or both) and their relation to the differential diagnosis (p. 24).

Functioning: This is often the most critical parameter in assessing severity. The duration, extent, and pervasiveness of dysfunction determine how difficult it will be for a child to attain age-appropriate developmental progress (p. 24).

Burden of suffering: A highly subjective, but important, component of severity that assesses the depth of a child's and family's distress, anguish, and difficulty coping with their problems. This dimension encourages the clinician to understand the child's and family's reaction to, and urgency of, their clinical needs. Includes the following: intensity of child's personal suffering / distress, intrusiveness of symptoms into major areas of child's life (family, play, peers, preschool), duration of suffering, limitations on family, increase in family / peer conflict, danger to self / others, variance with normative expectations, and expected course of behavioral problem (pp. 24-25).

Risk / Protective Factors: The presence of risk factors increases the probability that a child will need further assessment and intervention. While each risk factor affects different families and children in unique ways, the presence of three or more risk factors may exceed the capacity of many families and children to adapt and function well. Similarly, the presence of several protective factors helps to offset the negative impact of risk factors. Risk factors are associated with vulnerability—a higher probability of onset, greater severity, and longer duration of major mental health problems/disorders. Protective factors refer to attributes or situations associated with an individual's resilience or resistance to the negative effects of stress and disorder. Clinicians can consider directing therapeutic interventions based on child and environmental circumstances (p. 25, 32-33).

Child characteristics include health, cognitive status, temperament, emotional health, sociability, and general reaction to stress.

The quality and continuity of the **attachment** relationship(s) and caregiving is another key feature, with high-quality, continuous caregiving and secure attachment considered protective, and low quality, discontinuous caregiving with ambivalent, insecure attachment considered a risk factor.

Environmental characteristics may include family resources, safety of physical environment, family communication, emotional and physical support / health, caregiver reaction to stress, and community resources (pp. 33-34).