

What Juvenile Defenders Should Know about the DSM-5

This resource brief is intended to support juvenile defense advocacy by providing an overview of some of the latest *Diagnostic and Statistical Manual of Mental Disorders* (DSM) revisions, as well as recommendations and implications for juvenile defense practice. The DSM is a classification manual for mental health professionals with itemized criteria for diagnosing disorders. Juvenile defenders who are knowledgeable about the DSM are better prepared to advocate for and against diagnoses of their youth clients. Defenders further enhance their advocacy when they insist that evaluators specifically identify the symptoms behind youth behaviors as well as the services and supports necessary to address those symptoms in school, at home, and in the community.

The DSM has always been relevant to juvenile defenders to the extent that DSM diagnoses drive decisions in juvenile court. Yet juvenile defenders may be unfamiliar with the latest revisions to diagnoses and diagnostic criteria and how to manage the ways they are used in the juvenile court context.

The DSM-5, a revised and updated manual, was released in 2013. The changes in the DSM-5 reflect continuing research and learning about psychiatric disorders by medical and mental health professionals. Juvenile defenders should be aware of the current disorders and diagnostic criteria, as well as how they have changed from the DSM-IV, to ensure that when

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their clients' diagnoses are discussed in court – especially by non-psychologists – it is being done accurately. Diagnoses under older criteria may no longer be valid and may lead to inappropriate intervention or services.

Diagnoses continue to be double-edged swords as they relate to juvenile defense. Some diagnoses are used to justify unnecessary confinement or invasive court-ordered services, and yet defenders might use them to mitigate client conduct. As with most aspects of juvenile defense, how one approaches a diagnosis is a client-centered decision made after weighing all of the potential implications. This is especially true when considering diagnoses becoming part of court records that will follow youth clients, for good or bad, for a long time, despite the fact that scientific research underscores the transient nature of youth physical, mental, emotional, and moral development.

For juvenile defenders, it is essential to keep in mind that immature thinking, identity issues, and moral reasoning, typical of adolescence, are often linked to illegal behavior, and must be distinguished from symptoms of psychiatric disorders. Failure to recognize and account for this developmental interplay can lead to misdiagnosis and/or punitive consequences with mismatched services for adolescents. Evaluators assessing youth in the juvenile court context must, therefore, have specific expertise in child and adolescent development, juvenile delinquency, and the elements of effective interventions for youth in the delinquency system. When seeking an evaluation, juvenile defenders should request a developmental evaluation with specific identification of the symptoms behind any diagnosis, recommendations for addressing those symptoms, and a clear articulation of the role immaturity and other developmental factors play in understanding the youth's behavior.

SUMMARY OF DSM-5 REVISIONS

I. NEURODEVELOPMENTAL DISORDERS

This category of disorders is typified by an onset of personal, social, academic, and job-related functioning impairments in the “developmental period,” a timeframe which the DSM editors kept intentionally vague to account for varying timelines of youth and adolescent development from childhood through adolescence.

Language Disorder

What's This About?

- Client has persistent difficulties in language learning, retention, and use (in all forms—written, spoken, etc.) due to deficits such as
 - Reduced vocabulary;
 - Limited ability to form correct sentence structure; and
 - Difficulty carrying on a typical conversation.
- Language abilities are significantly below those expected at that age and the limited abilities result in functional limitations in communication and achievement at work and school.



What's Changed?

Language Disorder was previously termed “Expressive Language Disorder or Mixed Receptive-Expressive Language Disorder” in the DSM-IV.

Implications for Defender Practice

- Language disorders may impair a client's ability to connect with the defender; may have affected a client's understanding of and communication during an offense and subsequent police questioning; may limit a client's ability to understand and waive rights; and may impact representation at all stages of a case, on probation, in placement, and in regards to educational and other services.

- Language impairments also severely affect a client’s ability to comprehend *Miranda* warnings adequately. Juvenile defenders should consider this in moving to suppress statements made by a client with a language disorder.
- Linguistic issues may limit a client’s ability to provide vital background information “and factual information about the allegations, recall details, or to even tell a story. This in turn may interfere with the attorney’s constitutional obligation to assess potential defenses and mitigating factors, investigate, and mount a defense.”¹
- Where defenders are not aware of and are unable to help alleviate language deficits, such deficits can negatively influence all aspects of the interview, preparation, and courtroom process, leaving the client feeling confused and misunderstood.
- Court forms, orders, or waivers of rights will likely be challenging for youth with language disorders. A client’s difficulties with language may be used to mitigate actions against them for “failure to comply.”
- Consider counseling clients with language impairments against testifying, as clients with language impairments are particularly susceptible to coercive and underhanded interrogation and cross-examination techniques.
- At disposition, defenders can raise the fact that “research and experience have demonstrated that the lack of language skills associated with undesirable behavior can be treated successfully, and that doing so can substantially alter the behavior as well.” In this way, defenders can argue for services to help rehabilitate their clients, and effectively fight against the possibility of incarceration.²
- When developing a theory of the defense, juvenile defenders should work with clients to consider whether an undiagnosed language disorder played a role in the charged offense and then consider requesting a speech-language evaluation.
- To protect clients’ due process rights, defenders should confirm the client has an Individualized Education Program (IEP) that addresses not just speech but the specific symptoms of his/her language disorder.

Attention-Deficit/Hyperactivity Disorder (ADHD)

What’s This About?

- ADHD is understood as a “persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.”
- There are 18 symptoms of ADHD (*see the appendix for full symptoms list*) which are divided between two “domains”: inattention and hyperactivity-impulsivity.
- Diagnoses may be appropriate only where the client exhibits at least six symptoms in one domain (persisting for at least six months) (five symptoms for individuals 17 and older).



What’s Changed?

- In the DSM-IV, ADHD was grouped in the now-eliminated chapter of “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.”
- In DSM-5, the age prior to which symptoms of ADHD must appear was raised to 12 (from 7 in DSM-IV).
- *This change expands the ability of professionals to diagnose ADHD in adolescents and teenagers.*

Implications for Defender Practice

- Keep in mind the dichotomy between the two domains of ADHD. Youth clients may present as inattentive, hyperactive/impulsive, or a combination of both.
- Become familiar with experts who can evaluate clients for ADHD. These evaluators may also be able to testify in court as to the linkages between the child’s undesirable behavior(s) and their ADHD.

1. Michelle LaVigne, *Breakdown in the Language Zone: the Prevalence of Language Impairments Among Juvenile and Adult Offenders and Why it Matters*, 15 U.C. DAVIS J. JUV. L. & POL’Y 37, 69 (2011).

2. *Id.* at 111.

- When considering the theory of the case, if a youth client describes battling regularly with inattention or impulsivity, the defender and client should consider requesting an evaluation to consider ADHD diagnosis and treatment. Evaluators should consider the symptoms underlying the youth’s behavior, especially the behavior leading to court involvement, and where appropriate recommend specific services to manage the symptoms.
- NJDC’s Juvenile Court Training Curriculum³ has information and advice on selecting an appropriate and effective evaluator.
- Because manifestations of the disorder must be present in multiple settings, defenders should be aware that an evaluator should not diagnose ADHD unless questionnaires regarding behavior (these are typically standardized) have been completed by parents (or other caretakers) and teachers.
- The classification of ADHD as a “neurodevelopmental disorder” may give it greater scientific and developmental credibility than it previously received, giving it more potency as a mitigating factor defenders can raise at disposition.

Intellectual Disability (Intellectual Developmental Disorder)

What’s This About?

- The diagnosis reflects deficits in intellectual functions (such as reasoning, problem solving, etc.), and deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility.



What’s Changed?

- In the DSM-IV, this was called Mental Retardation. Federal law, research journals, and medical, educational, and other professionals have replaced “mental retardation” with “intellectual disability.”
- Previously, the four levels of Mental Retardation (Mild, Moderate, Severe, and Profound) had been based on IQ testing. In the DSM-5 these severity levels are instead based on level of adaptive behavior (e.g., academic skills, social and communication ability, and self-care skills).

Implications for Defender Practice

- When developing a juvenile client’s case, defenders should take note of specific client challenges in academic, social, and communication skills as these can be indicators of a potential intellectual disability.
- Defenders should be aware that for this diagnosis to be made appropriately, there must be a systematic assessment of the client’s adaptive behaviors and not just reliance on IQ tests.
- The appropriate use of this diagnosis is especially important in competence determinations or when defenders challenge the validity of a youth’s waiver of his or her rights.
- Defenders should consider pursuing evaluations for intellectual disabilities when this diagnosis furthers the theory of defense.

Autism Spectrum Disorder (ASD)

What’s This About?

- This disorder is demonstrated by markedly impaired development in social interaction and communication across multiple contexts, and a restricted repertoire of interests, behavior, or activities.
- *See the appendix for full list of symptoms.*

3. NATIONAL JUVENILE DEFENDER CENTER & JUVENILE LAW CTR., TOWARD DEVELOPMENTALLY APPROPRIATE PRACTICE: A JUVENILE COURT TRAINING CURRICULUM, SCREENING, ASSESSING, AND EVALUATING YOUTH (2d ed. 2009).



What's Changed?

- Autism Spectrum Disorder (ASD) encompasses what were Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder not otherwise specified in the DSM-IV.
- These diagnoses are now captured in three severity levels (described in detail in the appendix), based on how much communication is impaired and the extent to which the individual exhibits restricted, repetitive patterns of behavior:
 - Level 3: "Requiring Very Substantial Support"
 - Level 2: "Requiring Substantial Support"
 - Level 1: "Requiring Support"

Implications for Defender Practice

- ASD impacts a client's responses to other people and therefore has an impact before, during, and after a charged offense. ASD can be significant in terms of a client's actions during an alleged offense, their competence to proceed, their ability to waive rights, and their disposition.
- Defenders should be aware that clients who appear to have normal intelligence, but who describe themselves as isolated, do not pick up on social cues normally, do not understand what makes them different from their peers, and have an intense interest in one or two areas (for example, they may make complicated Lego® constructions for hours even as teenagers) may have ASD.
- If ASD is suspected, and diagnosis would advance the theory of defense, an evaluation is necessary to ascertain how communication and social deficits may have affected the youth's conduct during the offense as well as their competence to proceed and ability to waive rights. In particular, crimes with specific intent, like stalking, can be challenged if an ASD diagnosis is warranted.
- In disposition planning for clients with ASD, the severity levels can be crucial because they literally dictate the "support" needed—something defenders can refer to when arguing against incarceration.

Social (Pragmatic) Communication Disorder

What's This About?

- Social Communication Disorder may be diagnosed where all of the following occur:
 - Deficits in using communication socially, such as greeting and sharing information, in a manner appropriate for the context;
 - Impairment of ability to change communication to match needs of listener;
 - Difficulties following rules for conversation and storytelling, such as taking turns and rephrasing; and
 - Difficulty understanding ambiguous meaning in language.
- The disorder exists only where the symptoms are not better explained by another disorder.



What's Changed?

This is an entirely new diagnosis in the DSM, to "more accurately recognize individuals who have significant problems using verbal and nonverbal communication for social purposes, leading to impairments in their ability to effectively communicate, participate socially, maintain social relationships, or otherwise perform academically or occupationally."⁴

Implications for Defender Practice

- Clients who have difficulty communicating effectively, and whose inability to communicate may negatively impact others' perceptions of them, may have Social Communication Disorder. Defenders should consider requesting that a psychologist or speech-language pathologist assess specific communication difficulties and make recommendations for services, provided the defense theory calls for such evaluations and/or interventions.

4. DSM5.org, Social (Pragmatic) Communication Disorder Fact Sheet, <http://www.dsm5.org/Documents/Social%20Communication%20Disorder%20Fact%20Sheet.pdf> (last visited June 4, 2014).

- Because this type of disorder may be difficult to diagnose via standard testing, judges and even defenders may attribute the inappropriate behavior of respondent-clients to deliberate non-compliance or bad attitude, even where symptoms are explained by a diagnosis of Social Communication Disorder. Defenders should think not only about how this may impact the judge's perceptions of the client, but their own.
- Defenders should be aware that this is a new diagnosis, and that as such, previous inaccurate diagnoses may have led to inconsistent treatment and services.

Other Implications for Practice Regarding Neurodevelopmental Disorders

Little attention has been paid to the specific, significant effects of neurodevelopmental disorders on the behavior of juveniles prior to, during, and after their offenses. Neurodevelopmental disorders have typically been dismissed as "special education issues," which fails to recognize that youth with these disabilities often function younger than their chronological age and have comprehension, communication, or social difficulties that may affect them at home, in the community, and in school. For example, a client who does not meet the criteria for Intellectual Development Disorder may have academic skills substantially below those expected for his/her chronological age that are the result of impaired reading, writing and/or mathematics due to a Specific Learning Disorder (SLD) (SLD has not changed in the DSM-5).

If the defense theory would be supported by an evaluation for a possible neurodevelopmental disorder, the defender must ask evaluators to assess the effects of deficits in cognitive processes such as: organization (including task initiation and follow-through); working memory (holding things in memory while using them, which is essential for carrying out multistep activities and following complex instructions); planning (including setting goals and goal-directed persistence); sustained attention; performance monitoring (including time management); emotional regulation; and impulse regulation. These deficits, properly understood and described, may play a role in understanding clients' behavior at the time of the offense and in disposition planning.

Fetal Alcohol Spectrum Disorder (FASD) (which includes other fetal substance exposure) and Traumatic Brain Injury (TBI) (seen in juveniles who lost consciousness from child abuse and/or being hit by cars, *e.g.*) are usually not considered in court evaluations but may have a significant impact on adolescent behavior. FASD is not a DSM-5 diagnosis, but the diagnosis "Other Specified Neurodevelopmental Disorders" is vaguely described as being characterized by a range of developmental disabilities, and the DSM-5 example given is "Neurodevelopmental disorder associated with prenatal alcohol exposure." TBI is included in a different section of the DSM-5: major and mild neurocognitive disorder due to traumatic brain injury. Therefore, while symptoms may present as neurodevelopmental, it is possible that an injury to the brain may actually be the cause. Provided the defense theory calls for such intervention, defenders must ask evaluators to specifically consider FASD and TBI when explaining a youth's behavior because they require substantially different interventions in school, at home, and in the community than other neurodevelopmental disorders.

In general, neurodevelopmental disorders may require services through an IEP. A client may not have an IEP and the defender may want to discuss initiating a special education eligibility determination with the client. The client may have an IEP focused on behavior problems without services for a language disorder, ADHD, ASD, or a communication disorder. Defenders can request an IEP meeting, attend it, and advocate for specialized services.

Neurodevelopmental disorders also affect youth where they live. Services to assist a youth's caretakers and to support youth in working with the defender can also be arranged. Juvenile defenders must caution probation officers and other providers that they cannot communicate with or expect the same comprehension by a youth with a neurodevelopmental disorder as they would with other young people.

II. TRAUMA- AND STRESSOR-RELATED DISORDERS

These are disorders in which exposure to a traumatic or stressful event is explicitly listed as a diagnostic criterion. The ways in which individuals react to these events can be quite disparate, ranging from extreme anger to fear to anxiety, among others. Because of the variability in psychological distress that may follow a traumatic event, these disorders have been given their own chapter in the DSM-5, though they may be or appear to be related to anxiety, dissociative, and other disorders.

Posttraumatic Stress Disorder (PTSD)

What's This About?

- The trigger for PTSD is “exposure to actual or threatened death, serious injury or sexual violation.” The exposure must result from one or more of the following scenarios:
 - directly experiencing the traumatic event;
 - witnessing the traumatic event in person;
 - learning that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
 - experiencing first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).
- Additionally, a PTSD diagnosis requires that the “disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual’s social interactions, capacity to work or other important areas of functioning.”⁵
- There are higher rates of PTSD among racial/ethnic minorities in the U.S., and it is more prevalent among females than males.



What's Changed?

This is a new chapter in the DSM. Posttraumatic Stress Disorder was previously listed as an Anxiety Disorder in the DSM-IV. The requirement for someone to respond to the traumatic event with intense fear, helplessness or horror has been deleted because that criterion proved to have no utility in predicting the onset of PTSD.

Implications for Defender Practice

- Defenders should be aware that individuals with PTSD may be quick-tempered and engage in violent behavior with little to no provocation. They may have exaggerated negative expectations regarding important aspects of life applied to themselves or others, including a lack of trust in themselves or in people in positions of authority. Therefore, it may take additional time and effort to establish a relationship of trust with a client suffering from PTSD.
- One of the symptoms of PTSD is avoidance, and it may be hard or impossible to learn from the client about past trauma he or she has experienced. Defenders may have to learn about it from a third party, such as a parent/guardian, teacher, or case file.
- Defenders should keep in mind that the DSM-5 made changes to the “marked alterations symptom cluster” by including irritable or aggressive behavior and reckless or self-destructive behavior. Defenders may want to address these issues in court, particularly for clients charged with crimes of violence against people and property, as a way of mitigating the charges.
- Avoidant behavior in adolescents associated with PTSD includes reluctance to participate in developmental opportunities, *e.g.*, dating and driving. Clients may judge themselves as cowardly, may believe that they don’t fit in and will never fit in, and may lose aspirations for the future. Aggressive behavior impacting peers and school may increase. Engaging in risky behaviors is a characteristic of immaturity typical of adolescents, but clients with trauma exposure may be involved in greater self-harm or risk-taking.
- The DSM-5 notes risk factors for developing PTSD that are commonly found in youth involved with the court system, including lower socio-economic status, education, and childhood adversity, among others.

5. DSM5.org, PTSD Fact Sheet, [http://www.dsm5.org/Documents/PTSD Fact Sheet.pdf](http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf) (last visited July 2, 2014).

Acute Stress Disorder

This disorder is similar to PTSD, but is distinguished from it in that its duration is limited to a month after the traumatic event.

Implications for Defender Practice

- When clients have experienced, witnessed, or learned about traumatic events to someone close to them, defenders should be aware of the symptoms of Acute Stress Disorder and PTSD.
- These symptoms may be especially relevant when communicating with the client, and in arguing mitigating factors at disposition, as well as generally throughout the trial process.

Other Implications for Practice Regarding Trauma- and Stressor-Related Disorders

Little attention has been paid to the specific, significant effects of trauma on the behavior of juveniles prior to, during, and after their offenses. Typically, past abuse or exposure to violence may be listed in the client's history, but is rarely connected to their sadness, anxiety, over-reacting, and substance use (and clients often do not talk about past trauma or endorse trauma symptoms when questioned). Although DSM-5 refined PTSD to make it more applicable to children and adolescents, the definition of "traumatic event" remains narrow for the juvenile population. For example, juvenile offenders experience higher than average rates of close family member deaths (which the DSM only considers to be a potential PTSD trigger if the circumstances of the death itself were traumatic) and of disrupted caregiving (due to foster care as well as parent incarceration). Children's trauma researchers consider both of these types of events as traumatic, affecting emotional regulation and reactivity to perceived threat. Evaluators may give little attention to the effects of loss and disrupted caregiving, despite the other criteria of PTSD being met, but as part of the defense theory, juvenile defenders may want them to highlight these effects, where appropriate.

Another area impacted by trauma and stressor-related disorders is substance use. The DSM-5 has dropped all references to substance "abuse," instead using only the phrase "substance use." Many juveniles use marijuana, alcohol, or other substances to numb their sadness and anger about past maltreatment, loss, and their anxiety, but the evaluator may not make this connection. A substance use disorder diagnosis may give the impression that a juvenile will be difficult to rehabilitate because use began at a young age and/or is daily, rather than contextualizing the issue as one of self-medication and the necessity for trauma treatment (which may not be part of substance use treatment). Defenders should remember—especially if their clients have high anxiety, sadness, reactivity, emotional regulation difficulties, and/or use substances—to ask evaluators to complete a thorough history that includes a broad definition of trauma and its specific effects on behavior, regardless of whether the criteria for PTSD or Acute Stress Disorder are met.

III. DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

Oppositional Defiant Disorder (ODD)

What's This About?

- An ODD diagnosis requires (1) a pattern of behavior from one of the following three categories for at least six months, that is (2) evidenced by at least four symptoms from any of the categories,
 - *Angry/Irritable Mood*: Often loses temper; often touchy/easily annoyed; often angry and resentful;
 - *Argumentative/Defiant Behavior*: Often argues with authority figures (adults where the individual is a child/adolescent); often actively defies/refuses to comply with requests from authority figures/rules; often deliberately annoys others; often blames others for his or her mistakes/misbehavior;
 - *Vindictiveness*: has been spiteful or vindictive at least twice within the past six months.
- Additionally, an ODD diagnosis requires that these behaviors occur in non-sibling interactions, where the disturbance is associated with distress in the immediate social context or negatively impacts important areas of functioning. Additionally, the behaviors cannot occur "exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder."
- For an ODD diagnosis, for children under 5 years, behavior should occur on most days for the six-month period; for older children, at least once a week for that same period.

- ODD can be distinguished from ADHD because unlike in ADHD, an ODD individual's failure to conform to requests of others is not limited solely to situations that demand sustained effort/attention/that the individual sit still.



What's Changed?

- All disorders in this new chapter of the DSM are characterized by problems in emotional and behavioral control. (These disorders had previously been spread across various DSM-IV chapters).
- The DSM-5 groups ODD into the three categories described above, in recognition that an ODD diagnosis reflects both emotional and behavioral symptoms.
- Because behaviors associated with ODD symptoms occur commonly in youth showing normal development, the criteria now provide guidance on the frequency of these symptoms needed for a behavior to be considered an ODD symptom.
- The DSM-5 adds a severity rating to the ODD criteria as a specifier, dictating the number of settings in which the ODD symptoms must be present. Mild means one setting, severe means three or more settings, and moderate two.

Implications for Defender Practice

- ODD may be diagnosed in youth clients and used against them in court. Defenders, therefore, should be prepared to challenge the accuracy of the diagnosis and/or the severity level assigned by calling a defense expert or mitigation witness, or cross-examining the court evaluator.
 - Given the changes in how ODD is diagnosed under the DSM-5, it is critical that older diagnoses be re-examined or challenged (depending on the defense strategy), as the diagnosis may no longer be valid.
- For mitigation purposes, be aware that risk factors for ODD include harsh, inconsistent, or neglectful child-rearing practices.
- ODD is frequently co-morbid with and, may be mistaken for, ADHD. Make sure evaluators are competent and can distinguish between the two.

Intermittent Explosive Disorder (IED)

What's This About?

- The core feature of an IED diagnosis is the failure to control impulsive aggressive behavior in response to provocation that would typically not result in such an aggressive outburst.
- An IED diagnosis can be made in addition to ADHD, Conduct Disorder, ODD, or Autism Spectrum Disorder diagnoses where the aggressive outbursts are in excess of those that would accompany those disorders and warrant independent clinical attention.
- The two major ways in which IED behavior manifests are:
 - Verbal aggression/physical aggression occurring twice weekly on average, for a three-month period, and which does not result in damage/destruction to people or property; or
 - Three behavioral outbursts in a 12-month period that cause harm.



What's Changed?

- Whereas physical aggression was required for a diagnosis of IED in the DSM-IV, the DSM-5 criteria for IED include verbal aggression and non-destructive/non-injurious physical aggression.
- The DSM-5 outlines the frequency with which aggressive outbursts must occur to meet the criteria for IED. DSM-5 also specifies that the aggressive outbursts are impulsive and/or anger-based in nature, and must cause marked distress, impairment in job/inter-personal functioning, or be associated with negative financial or legal consequences. The minimum age for an IED diagnosis is now 6 years (as opposed to no minimum under the DSM-IV).

Implications for Defender Practice

- Clients with a history of physical or emotional trauma are at increased risk for IED.
- If a client has had impulsive aggressive behaviors triggered by minor provocation AND if a finding of IED will enhance the defense theory, the defender may consider requesting an evaluation to see if these behaviors meet the criteria for IED.
- For purposes of disposition planning and argument, defenders should discuss available treatment options with their client, such as cognitive restructuring, coping skills training, and relaxation training.

Conduct Disorder (CD)

What's This About?

- Conduct Disorder may be diagnosed where there is a repeated and persistent pattern of behavior that violates the basic rights of others or breaks major age-appropriate social norms or rules. A diagnosis requires three or more of the following behaviors in the past 12 months, with at least one in the last six months:
 - Aggression to people or animals (bullying, threatening, or intimidating others; initiating physical fights; or engaging in physical cruelty to people or animals).
 - Destruction of property (engaging in fire-setting causing serious damage; deliberately destroying property).
 - Deceitfulness or theft (stealing items of non-trivial value; lying to obtain goods or favors or to avoid obligations).
 - Serious violations of rules (running away from home overnight; truancy).
- There are two major sub-types of CD: Childhood-onset and Adolescent-onset.
 - Those with Childhood-onset CD are more likely to have problems early and to have problems in adulthood.
 - Those with Adolescent-onset CD (usually typified by being more rebellious than is normal for one's age group) are less likely to have problems that continue into adulthood.
- There are three severity specifiers:
 1. *Mild* – consisting of few if any conduct problems in excess of those required to make the diagnosis AND where conduct problems cause only minor harm to others;
 2. *Moderate* – consisting of a number of conduct problems and effect on others is at intermediate level, and;
 3. *Severe* – consisting of many conduct problems in excess of those required to make the diagnosis OR conduct problems cause significant harm to others.



What's Changed?

There is a new specifier of “Limited Pro-Social Emotions” that has been added in the DSM-5. It is found in a minority of individuals with Conduct Disorder. This specifier exists if a child meets the full criteria for Conduct Disorder and has at least two or more of the following criteria that are displayed persistently for at least 12 months and in multiple relationships and settings:

- lack of remorse or guilt,
- callousness/lack of empathy,
- lack of concern about performance, or
- shallow or deficient affect (inability to express feelings or show emotions to others, except in ways that seem shallow, insincere, superficial, or for gain).

These characteristics reflect the individual's typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. In addition to self-reporting, reports from others who have known the youth for an extended period are required to assess these criteria.

Implications for Defender Practice

- It is important for defenders to recognize the limitations of what a Conduct Disorder diagnosis says about the client. Conduct Disorder can be attributed to a first-grader who lies and gets into fights or to a 17-year old arrested for murder. An accurate diagnosis indicates that the young person has persistent behavior problems, but not what caused the behavior problems. There are usually several different contributors to behavior problems for a youth.
- Defenders should challenge a callous and unemotional diagnosis based only on an interview in a justice setting or mental health setting. Soon after an offense, it is extremely difficult to determine a young person's remorse, especially if they believe their actions were unintentional. Anyone rendering this opinion should be asked to specify the basis of their conclusion; it is not sufficient to indicate that the young person did not respond when asked their feelings about the harm of the offense. Many teens who do not have CD are also reluctant to share their emotions with adults, including showing concern about school or others' feelings. This kind of behavior is not dispositive of a disorder.
- Most youth with CD do not show callous/unemotional traits. CD does not imply psychopathy or the lack of a conscience, and defenders should challenge indication of callous/unemotional traits whenever possible.
- CD youth without callous traits tend to be highly emotionally reactive and to have cognitive difficulties.
- A diagnosis of CD does not mean a young person cannot be rehabilitated.

Disruptive Mood Dysregulation Disorder

What's This About?

- This disorder is defined by severe recurrent temper outbursts that occur at least three times a week and where the mood between these outbursts is persistently irritable and angry most of the day.
- This is a chronic mood disorder, whereas a youth with Bipolar Disorder has periods of mania and depression that are *clearly different* from their typical mood.
- This diagnosis cannot be made before age 6 and symptoms must have started before age 10.



What's Changed?

This diagnosis is new to the DSM-5, and was included largely because of the overuse of the diagnosis of Bipolar Disorder in children and adolescents.

Implications for Defender Practice

- Defenders should be aware that chronic, severe irritability and low frustration tolerance that characterize Disruptive Mood Dysregulation Disorder interfere with family and peer relationships and school, and that this may be connected to the youth's behavior before, during, and after the offense.
- Like Intermittent Explosive Disorder, this diagnosis might be relevant for clients who have severe angry and aggressive outbursts. A description of the underlying behaviors leading to this diagnosis can help with obtaining appropriate services and can assist the judge in understanding a possible connection between the crime alleged and the youth's disorder.
- Defenders should be aware that this is a new disorder, so the field is still setting standards of practice.

IV. SUBSTANCE-RELATED AND ADDICTIVE DISORDERS



What's Changed?

- The DSM-5 does not dichotomize, as the DSM-IV did, between substance abuse and dependence.
- The DSM-5 provides criteria for substance use disorder, as well as criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, for each type of drug (alcohol, opiates, cannabis, hallucinogens, etc.), as appropriate.
- The DSM-5 added a new criterion: craving/strong desire/urge to use a substance.
- In the DSM-IV, one criterion for substance abuse had been recurrent substance-related legal problems. The DSM-5 removed this criterion. (see Implications for Defender Practice, below).
- Cannabis and caffeine withdrawal are both new to DSM-5.
- Severity of substance use disorders is based on number of criteria present—2-3 (mild disorder); 4-5 (moderate); and 6+ (severe).

Implications for Defender Practice

- Changes in the substance use disorder criteria may be particularly relevant for clients who had been previously diagnosed with a substance use disorder because they had legal problems caused by marijuana use. Because the existence of legal problems associated with substance use was deleted as a diagnostic criterion, and since two or more criteria are necessary to meet the diagnosis, clients may no longer meet the criteria for a substance use disorder.
- Substance use can often be a peer-influenced activity that is typical of immaturity in teens.
- Substance use by youth clients may be an indicator of past trauma or disabilities and may be a means of self-medication to calm and/or numb feelings and memories.
- Defenders should incorporate developmental research as mitigation where substance use was a factor in the offense charged.

APPENDIX

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) SYMPTOMS:

People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development:

1. Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:
 - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
 - Often has trouble holding attention on tasks or play activities.
 - Often does not seem to listen when spoken to directly.
 - Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (*e.g.*, loses focus, side-tracked).
 - Often has trouble organizing tasks and activities.
 - Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
 - Often loses things necessary for tasks and activities (*e.g.* school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
 - Is often easily distracted
 - Is often forgetful in daily activities.
2. Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level:
 - Often fidgets with or taps hands or feet, or squirms in seat.
 - Often leaves seat in situations when remaining seated is expected.
 - Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
 - Often unable to play or take part in leisure activities quietly.
 - Is often "on the go" acting as if "driven by a motor".
 - Often talks excessively.
 - Often blurts out an answer before a question has been completed.
 - Often has trouble waiting his/her turn.
 - Often interrupts or intrudes on others (*e.g.*, butts into conversations or games)

Source: Centers for Disease Control and Prevention, Attention-Deficit / Hyperactivity Disorder (ADHD): Symptoms and Diagnosis, <http://www.cdc.gov/ncbddd/adhd/diagnosis.html> (last visited 3/13/2014).

AUTISM SPECTRUM DISORDER DIAGNOSTIC CRITERIA

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive):
 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

[Specify current severity]

- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
 4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

[Specify current severity]

- C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

AUTISM SPECTRUM ORDER SEVERITY LEVELS

Severity Level for ASD	Social Communication	Restricted Interests & Repetitive Behaviors
Level 3 'Requiring very substantial support'	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 'Requiring substantial support'	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 'Requiring support'	Without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

Source: Autism Speaks, DSM-5 Diagnostic Criteria, <http://www.autismspeaks.org/what-autism/diagnosis/dsm-5-diagnostic-criteria> (last visited 3/13/2014).



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The National Juvenile Defender Center (NJDC) is a non-profit organization that is dedicated to promoting justice for all children by ensuring excellence in juvenile defense. NJDC provides support to public defenders, appointed counsel, law school clinical programs, and non-profit law centers to ensure quality representation in urban, suburban, rural, and tribal areas. NJDC also offers a wide range of integrated services to juvenile defenders, including training, technical assistance, advocacy, networking, collaboration, capacity building, and coordination. To learn more about NJDC, please visit www.njdc.info.